UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549



FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2020
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from _____ to _____
Commission file number 001-38769

Cigna Corporation

(Exact name of registrant as specified in its charter)

Delaware	**82-4991898**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
900 Cottage Grove Road, Bloomfield, Connecticut	**06002**
(Address of principal executive offices)	(Zip Code)
(860) 226-6000	
Registrant's telephone number, including area code	

Securities registered pursuant to Section 12(b) of the Act:		
Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, Par Value $0.01	**CI**	**New York Stock Exchange, Inc.**

Securities registered pursuant to Section 12(g) of the Act:
NONE

Indicate by check mark					**Yes**	**No**
• if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.					☒	☐
• if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act					☐	☒
• whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days					☒	☐
• whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files)					☒	☐
• whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.						
Large accelerated filer	☒	Accelerated filer	☐	Non-accelerated filer		☐
		Smaller reporting company	☐	Emerging growth company		☐
• If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.					☐	
• whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report					☒	
• whether the registrant is a shell company (as defined in Rule 12b-2 of the Act)					☐	☒

The aggregate market value of the voting stock held by non-affiliates of the registrant as of June 30, 2020 was approximately $68.9 billion.
As of January 31, 2021, 351,845,606 shares of the registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Form 10-K incorporates by reference information from the registrant's definitive proxy statement related to the 2021 annual meeting of shareholders.

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CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements are based on Cigna's current expectations and projections about future trends, events and uncertainties. These statements are not historical facts. Forward-looking statements may include, among others, statements concerning future financial or operating performance, including our ability to deliver affordable, personalized and innovative solutions for our customers and clients, including in light of the challenges presented by the COVID-19 pandemic; future growth, business strategy, strategic or operational initiatives; economic, regulatory or competitive environments, particularly with respect to the pace and extent of change in these areas; financing or capital deployment plans and amounts available for future deployment; our prospects for growth in the coming years; strategic transactions; and other statements regarding Cigna's future beliefs, expectations, plans, intentions, liquidity, cash flows, financial condition or performance. You may identify forward-looking statements by the use of words such as "believe," "expect," "plan," "intend," "anticipate," "estimate," "predict," "potential," "may," "should," "will" or other words or expressions of similar meaning, although not all forward-looking statements contain such terms.

Forward-looking statements are subject to risks and uncertainties, both known and unknown, that could cause actual results to differ materially from those expressed or implied in forward-looking statements. Such risks and uncertainties include, but are not limited to: our ability to achieve our strategic and operational initiatives; our ability to adapt to changes in an evolving and rapidly changing industry; the scale, scope and duration of the COVID-19 pandemic and its potential impact on our business, operating results, cash flows or financial condition, our ability to compete effectively, differentiate our products and services from those of our competitors and maintain or increase market share; price competition and other pressures that could compress our margins or result in premiums that are insufficient to cover the cost of services delivered to our customers; the potential for actual claims to exceed our estimates related to expected medical claims; our ability to develop and maintain satisfactory relationships with physicians, hospitals, other health service providers and with producers and consultants; our ability to maintain relationships with one or more key pharmaceutical manufacturers or if payments made or discounts provided decline; changes in the pharmacy provider marketplace or pharmacy networks; changes in drug pricing or industry pricing benchmarks; political, legal, operational, regulatory, economic and other risks that could affect our multinational operations; risks related to strategic transactions and realization of the expected benefits of such transactions, as well as integration difficulties or underperformance relative to expectations; dependence on success of relationships with third parties; risk of significant disruption within our operations or among key suppliers or third parties; our ability to invest in and properly maintain our information technology and other business systems; our ability to prevent or contain effects of a potential cyberattack or other privacy or data security incident; potential liability in connection with managing medical practices and operating pharmacies, onsite clinics and other types of medical facilities; the substantial level of government regulation over our business and the potential effects of new laws or regulations or changes in existing laws or regulations; uncertainties surrounding participation in government-sponsored programs such as Medicare; the outcome of litigation, regulatory audits, investigations; compliance with applicable privacy, security and data laws, regulations and standards; potential failure of our prevention, detection and control systems; unfavorable economic and market conditions, stock market or interest rate declines, risks related to a downgrade in financial strength ratings of our insurance subsidiaries; the impact of our significant indebtedness and the potential for further indebtedness in the future; unfavorable industry, economic or political conditions; credit risk related to our reinsurers; as well as more specific risks and uncertainties discussed in Part I, Item 1A – Risk Factors and Part II, Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations of this Form 10-K and as described from time to time in our future reports filed with the Securities and Exchange Commission (the "SEC").

You should not place undue reliance on forward-looking statements, which speak only as of the date they are made, are not guarantees of future performance or results, and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Cigna undertakes no obligation to update or revise any forward-looking statement, whether as a result of new information, future events or otherwise, except as may be required by law.

PART I

Item 1. BUSINESS

OVERVIEW

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us") is a global health service organization.

Our Purpose and Mission

To improve the health, well-being and peace of mind of those we serve

Our Strategy

Champions for affordable, predictable, and simple health care

Making it affordable: We build on our leading, differentiated position to lower the total cost of care.

Making it predictable: We take the surprise out of the system and help people make informed health care choices.

Making it simple: We make it easier for the people we serve to get the care they need.

Cigna is a global health services company uniquely capable of driving affordable, predictable, and simple health care, with expansive and deep capabilities that accelerate our strategy to achieve our mission of improving health, well-being and peace of mind. Cigna's employees are champions for the people we serve and over the past decade, our focus has shifted to helping individuals and families thrive by offering solutions to prevent and better manage health challenges. When sickness or disability do occur, we support our customers by offering broad choices to help them best access high quality, affordable, whole person care. We see three primary ways to help individuals maintain, improve or recover their physical or mental health: 1) behavioral and lifestyle changes – with more than 1,000 health coaches helping individuals set and meet health goals; 2) affordable, effective medication options – with access to our leading pharmacy services improving health and driving affordability; and 3) targeted medical and surgical interventions – with a clear and proven strategy around partnerships and value-based care quality programs, powered by data and analytics and aligned incentives. We maximize use of evidence-based care, while delivering best-in-class service for our customers with acute and chronic conditions through enhanced real-time insights across an expanded platform with industry-leading solutions to support care decisions.

Our portfolio of offerings solves diverse challenges across the health care system. We offer a differentiated set of pharmacy, medical, behavioral, dental and supplemental products and services, primarily through two brands: Cigna and Evernorth. Our capabilities include: 1) a broad portfolio of solutions and services, some of which can be offered on a stand-alone basis; 2) integrated behavioral, medical and pharmacy management solutions; 3) leading specialty pharmacy, clinical and care management expertise; and 4) advanced analytics that help us engage more meaningfully with individuals, plan sponsors we serve and our provider partners.

We put medicine within reach for patients, and help providers improve access to prescription drugs, by making them more affordable.

We work with key stakeholders across the health care system to improve health outcomes and patient satisfaction, increase efficiency in drug distribution and manage costs of the pharmacy benefit.

In 2020 Cigna launched Evernorth, a new health services platform, and renamed the Health Services segment as Evernorth, accordingly. Evernorth brings together our array of health services capabilities, as well as those from partners across the health care system in pharmacy solutions, benefits management solutions, care solutions and intelligence solutions. Innovative products include: Healthy Ways to Work[SM], a broad suite of solutions to help health plans and employers move forward by addressing unique challenges resulting from the COVID-19 pandemic; FamilyPath[SM], a comprehensive fertility solution to reduce avoidable costs, provide holistic care coordination and deliver more flexible options for individuals; and inMynd[SM], a solution that helps clients and customers better recognize, treat and support mental health conditions.

We present the financial results of our businesses in the following segments (see "Executive Overview" section of the MD&A located in Part II, Item 7 of this Form 10-K for a Financial Summary):

Evernorth includes a broad range of coordinated and point solution health services, including pharmacy solutions, benefits management solutions, care solutions and intelligence solutions, which are provided to health plans, employers, government organizations and health care providers.

U.S. Medical includes Cigna's U.S. Commercial and U.S. Government businesses that provide comprehensive medical and coordinated solutions to clients and customers. U.S. Commercial products and services include medical, pharmacy, behavioral health, dental, vision, health advocacy programs and other products and services for insured and self-insured customers. U.S. Government solutions include Medicare Advantage, Medicare Supplement, and Medicare Part D plans for seniors, Medicaid plans, and individual health insurance plans both on and off the public exchanges.

International Markets includes supplemental health, life and accident insurance products and health care coverage in our international markets as well as health care benefits to globally mobile employees of multinational organizations.

Group Disability and Other contains the remainder of our business operations, consisting of the following:

- ***Group Disability and Life*** provides group long-term and short-term disability, group life, accident, voluntary and specialty insurance products and related services. The sale of this business to New York Life was completed on December 31, 2020. The transaction with New York Life included the sale of our businesses offering group long-term and short-term disability, group life, accident, and specialty insurance products and related services. Our business that offers group voluntary products and services was not sold to New York Life and results of this business will be reported in the U.S. Medical segment beginning in the first quarter of 2021. See Note 5 to the Consolidated Financial Statements and Liquidity section of the MD&A for additional information on the impacts of this sale on our results of operations, liquidity and financial position.
- ***Corporate-Owned Life Insurance ("COLI")*** offers permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for financing employer-paid future benefit obligations.
- ***Run-off businesses:***
    - ***Reinsurance:*** predominantly comprised of guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("GMIB") business effectively exited through reinsurance with Berkshire Hathaway Life Insurance Company of Nebraska ("Berkshire") in 2013.
    - ***Settlement Annuity*** business in run-off.
    - ***Individual Life Insurance and Annuity and Retirement Benefits Businesses:*** comprised of deferred gains from the sales of these businesses.

In 2020, our business was impacted by the emergence and unprecedented global spread of the novel strain of coronavirus ("COVID-19"). COVID-19 was declared a pandemic by the World Health Organization in March 2020 because the virus had surfaced in nearly all regions around the world. The COVID-19 pandemic has pervasively impacted the economy, financial markets and the global health care delivery systems. Cigna's COVID-19 response actions focused on customer care, employee care and safety, as well as support for the medical community and execution of business continuity plans over our operations. COVID-19 continues to spread and we are actively managing our response and assessing impacts to our financial position and operating results, as well as adverse developments in our business. While it is difficult to predict the impact of the COVID-19 pandemic on our results beyond 2020, we believe that such results may be impacted by, among other things, higher medical costs to treat those affected by the virus, lower customer volumes due to rising unemployment, lower future risk adjustment revenue due to disrupted care impeding appropriate documentation of customer risk profiles in our Medicare Advantage business, the return of costs for those who had previously deferred care, vaccine costs, continued cost share waivers, the potential for continued deferral of care, or lower investment returns. Additionally, in response to the pandemic, U.S. federal and state governments have enacted new regulatory requirements as discussed in the "Business - Regulation" section of this Form 10-K.

Other Information

The financial information included in this Form 10-K for the fiscal year ended December 31, 2020 is in conformity with accounting principles generally accepted in the United States of America ("GAAP") unless otherwise indicated. In the segment discussions that follow, we use the terms "adjusted revenues" and "pre-tax adjusted income from operations" to describe segment results. See the introduction to the Management Discussion and Analysis section of this Form 10-K for definitions of those terms. Industry rankings and percentages set forth herein are for the year ended December 31, 2020 unless otherwise indicated. In addition, statements set forth in this document concerning our rank or position in an industry or particular line of business have been developed internally based on publicly available information unless otherwise noted.

Cigna Holding Company (formerly Cigna Corporation) was incorporated in Delaware in 1981. Halfmoon Parent, Inc. was incorporated in Delaware in March 2018. Halfmoon Parent, Inc. was renamed Cigna Corporation and Cigna Holding Company became its subsidiary concurrent with the consummation of the combination with Express Scripts on December 20, 2018.

You can access our website at http://www.cigna.com to learn more about our company. We make annual, quarterly and current reports and proxy statements and amendments to those reports available, free of charge through our website (http://www.cigna.com, under the "Investors—Quarterly Reports and SEC Filings" captions) as soon as reasonably practicable after we electronically file these materials with, or furnish them to, the Securities and Exchange Commission ("SEC"). We also use our website as a means of disclosing material information and for complying with our disclosure obligations under the SEC's Regulation FD (Fair Disclosure). Important information, including news releases, analyst presentations and financial information regarding Cigna is routinely posted on and accessible at http://www.cigna.com. Accordingly, investors should monitor the Investor Relations portion of our website, in addition to following our press releases, SEC filings and public conference calls and webcasts. The information contained on, or that may be accessed through, our website is neither incorporated by reference into nor a part of this report. See also "Code of Ethics and Other Corporate Governance Disclosures" in Part III, Item 10 of this Form 10-K for additional information regarding the availability of our Codes of Ethics on our website.

EVERNORTH

Evernorth brings together coordinated and point solution health services including pharmacy solutions, benefits management solutions, care solutions and intelligence solutions, and specialized expertise – from inside and outside the company – to deliver custom and flexible solutions that meet the needs of our clients and customers. In 2020, Evernorth reported adjusted revenues of $116.1 billion and pre-tax adjusted income from operations of $5.4 billion.

HOW WE WIN

Evernorth accelerates delivery of innovative and flexible solutions to create value and meet the diverse needs of health plans, employers, health care providers and government organizations by:

- **Partnering** in unconventional ways to solve complex problems across a fragmented health care ecosystem, fueled by connected data and expertise that drives purposeful innovation
- **Creating** flexible and focused solutions tailored to client needs, using Evernorth's combined strengths and capabilities, as well as strategic partnerships, to deliver: better, more efficient care for patients; better experiences for clients, providers and customers; and enhanced choices for clients and customers through our open architecture model
- **Evaluating** medicines, digital therapeutics and other health solutions for efficacy, adherence, value and price to assist clients in selecting a cost-effective formulary
- **Offering** home delivery and specialty customer-centric solutions that meet the needs of our clients and customers in ways that unlock greater value and better health services while providing better and specialized clinical care
- **Aggregating** purchasing volume to deliver discounts and drive risk-sharing and value-based care across the pharmaceutical supply chain
- **Promoting** the use of generics and lowest-cost, clinically effective brands of medications

The following chart depicts a high-level summary of our principal products and services in this segment with definitions on subsequent pages.

Principal Products & Services		*Brands/ Subsidiaries*	*Key Relationships*	*Primary Competitors*
Pharmacy Solutions		Express Scripts Pharmacy, Accredo®, Freedom Fertility Pharmacy®, Therapeutic Resource Center®	Clients, Customers, Health Care Providers	Independent Pharmacy Benefit Managers ("PBMs"), Managed Care PBMs, Retail Pharmacies, Specialty Pharmacies
Benefits Management Solutions	Pharmacy and Medical Benefits Management	eviCore Healthcare®, Express Scripts PBM, myMatrixx®, Care Continuum®, Evernorth Embarc Benefit Protection℠, Evernorth FamilyPath℠	Clients, Customers, Health Care Providers, Consultants, Health Plans, Commercial and Government Payors	Health Plans, Independent PBMs, Managed Care PBMs, Third-Party Benefit Administrators, Group Purchasing Organizations, Clinical Solutions and Health Care Data Analytics Companies
	Supply Chain Administration and Network Management	Value Based Programs (Express Scripts SafeGuardRx®, Patient Assurance℠), National Preferred Formulary, SaveOnSP, Express Scripts MedRx Management℠, Express Scripts Parachute Rx℠, Ascent Health Services, Econdisc, Inside Rx®	Clients, Self-paying customers (InsideRx only), Pharmacy Providers	Health Plans, Independent PBMs, Managed Care PBMs, Third Party Benefit Administrators, Group Purchasing Organizations
Care Solutions		Evernorth Healthy Ways to Work℠, inMynd℠, Health Connect 360℠, Evernorth Digital Health Formulary℠, Advanced Utilization Management, Enhanced Fraud, Waste & Abuse, Advanced Opioid Management®, ScreenRx®, Behavioral Health	Clients, Customers	Independent PBMs, Managed Care PBMs, Third-Party Benefit Administrators
Evernorth Intelligence Solutions		Express Scripts Lab, RationalMed®, MediCUBE®, Express Scripts ScriptVision℠	Health Care Providers, Clients	Health Care Data Analytics Companies
Provider Services		CuraScript SD®	Health Care Providers, Clinics, Hospitals	Specialty Drug Distributors

Principal Products & Services

- *Pharmacy Solutions:* The pharmacy operations consist of ten order processing pharmacies, five patient contact centers, 26 specialty branch pharmacies and 11 high-volume automated home delivery and specialty dispensing pharmacies located throughout the United States. Dispensing pharmacies are located in Arizona, Delaware, Florida, Indiana, Massachusetts, Missouri, New Jersey, Pennsylvania and Tennessee.
  - *Express Scripts Pharmacy:* Express Scripts Pharmacy dispenses approximately 1.5 billion adjusted prescriptions[(1)] annually to members of pharmacy plans managed by our Express Scripts PBM. The service offers free standard shipping of maintenance medications nationwide, usually in a 90-day supply, directly to the customer's home. The service allows for automatic refills on eligible medications and unrestricted telephone access to specially trained pharmacists who can help answer customer questions. The front-end of our pharmacy is organized in Therapeutic Resource Centers, where specialized pharmacists focus their practice of pharmacy by condition, which offers customers a more personalized experience, while providing enhanced clinical care. Our differentiated practice of pharmacy, coupled with our advanced automated dispensing technology, results in safer and more accurate pharmacy operations when compared to retail pharmacies, convenient access to maintenance medications and better management of our clients' drug costs through operating efficiencies and generic substitutions. Our research shows that Express Scripts Pharmacy achieves a higher level of therapeutic interventions, better adherence and cost savings than is achieved through retail pharmacy networks.
  - *Specialty Pharmacy Services:* Specialty medications are primarily characterized as high-cost medications for the treatment of complex and rare diseases. These medications broadly include those with frequent dosing adjustments, intensive clinical monitoring, the need for customer training, specialized product administration requirements or medications limited to certain

(1) Non-specialty network scripts filled through 90-day programs and home delivery scripts are multiplied by three. All other network and specialty scripts are counted as one script.

specialty pharmacy networks by manufacturers. Through a combination of assets and capabilities, we provide an enhanced level of predictable care and therapy management for customers taking specialty medications, increased visibility and improved outcomes for payors, and custom programs for biopharmaceutical manufacturers. Accredo is focused on dispensing injectable, infused, oral and inhaled drugs that require a higher level of clinical service and support than traditional pharmacies typically offer. Accredo supports successful outcomes for customers and reduces waste for clients through specialty trained clinicians, a nationwide footprint and a network of in-home nursing services, reimbursement and customer assistance programs and biopharmaceutical services. Drug manufacturers occasionally select Accredo for exclusive dispensing of a highly specialized therapy. Freedom Fertility Pharmacy is dedicated exclusively to supporting patients undergoing fertility treatment. Accredo and Freedom Fertility Pharmacy serve customers within a pharmacy benefit plan administered by Express Scripts PBM, as well as customers in a plan administered by other PBMs and health plans.

- *Benefits Management Solutions:* We drive high-quality, cost-effective care through prescription drug utilization and cost management services. We support our clients' plan design selections to deliver balanced affordability, choice, simplicity and convenience. We focus our solutions to align with our clients' service, care and cost management needs. As a result, we believe we deliver better outcomes, higher customer satisfaction and a more affordable prescription drug benefit. We process drug claims via Express Scripts Pharmacy, Accredo and our retail networks by integrating retail network pharmacy administration, benefit design consultation, drug utilization review, drug formulary management and pharmacy fulfillment services. We administer payments to retail networks and bill benefits costs to our clients through our end-to-end adjudication services.
  - *Drug Utilization Review program:* When pharmacies submit claims for prescription drugs to us, we review them electronically in real time for health and safety. We then alert the dispensing pharmacy of any detected issues. Clients may also choose to enroll in programs that result in communications about potential therapy concerns being sent to prescribers after the initial claim submission.
  - *Benefits Design Consultation:* We consult with our clients on how best to structure and leverage the pharmacy benefit to meet plan objectives for affordable access to the prescription medications customers need to stay healthy, and ensure the safe and effective use of those medications.
  - *myMatrixx:* myMatrixx is a unique PBM with an exclusive focus on workers' compensation. We combine high touch customer service with clinical expertise and state-of-the-art business intelligence systems to deliver simplified solutions and positive outcomes. myMatrixx leverages Express Scripts' robust pharmacy network and provides a smooth and personalized experience for clients and injured workers.
  - *eviCore Medical Benefits Management:* eviCore healthcare is a leading provider of integrated health benefit management solutions that focus on driving adherence to evidence-based clinical guidelines, improving the quality of patient outcomes and reducing the cost of care. eviCore provides technology-enabled managed solutions in clinical diagnostic areas such as advanced imaging, cardiology and gastroenterology, as well as in whole person (longitudinal) areas such as musculoskeletal, oncology, fertility and post-acute care. eviCore contracts with health plans and other commercial and government payors to promote the appropriate use of health care services by the customers they serve. In certain instances, this occurs through capitated risk arrangements, when we assume the financial obligation for the cost of health care services provided to eligible customers covered by eviCore health care management programs.
  - *Medical Drug Management:* We offer a comprehensive range of services and guaranteed savings for managing medically billed specialty drugs. Our solutions apply utilization management, site of care management and claims prepayment review to effectively reduce wasteful spend, while providing services tailored to customers ensuring safety and healthier outcomes. We also offer MedRx(SM), a suite of solutions and consultative services for medical rebates contracting, and medically-billed drug preferencing and value-based contracting.

- *Supply Chain Administration and Network Management:*
  - *Retail Network Pharmacy Administration:* We contract with retail pharmacies to provide prescription drugs to customers of the pharmacy benefit plans we manage. We negotiate with pharmacies throughout the United States to discount drug prices provided to customers and manage national and regional networks responsive to client preferences related to cost containment, convenience of access for customers and network performance. We also manage networks of pharmacies customized for or under direct contract with specific clients and have contracted with pharmacy provider networks to comply with the Center for Medicare and Medicaid Services ("CMS") access requirements for the federal Medicare Part D prescription drug program ("Medicare Part D"). All retail pharmacies in our network communicate with us online and in real-time to process prescription drug claims. When a plan customer presents their identification card at a network pharmacy, the pharmacy sends specific customer, prescriber and prescription information in an industry-standard format through our systems, which process the claim and respond to the pharmacy with relevant information to process the prescription.
  - *Drug Formulary Management:* Formularies are lists of drugs with designations that may be used to determine drug coverage, customer out-of-pocket costs and communicate plan preferences in competitive drug categories. Our formulary management services support clients in establishing formularies that assist customers and physicians in choosing clinically-

appropriate, cost-effective drugs and prioritize access, safety and affordability. We administer specific formularies on behalf of our clients, including standard formularies developed and offered by Express Scripts and custom formularies in which we play a more limited role. Most of our clients select standard formularies, governed by our National Pharmacy & Therapeutics Committee, which is comprised of a panel of independent physicians and pharmacists in active clinical practice representing a variety of specialties and practice settings, typically with major academic affiliations. In making formulary recommendations, this committee considers only the drug's safety and efficacy and not the cost of the drug, including any negotiated manufacturer discount or rebate arrangement. This process is designed to ensure the clinical recommendation is not affected by our financial arrangements. We fully comply with this committee's clinical recommendations regarding drugs that must be included or excluded from the formulary based on their assessment of safety and efficacy.

- *Administration of Group Purchasing Organizations:* Express Scripts operates various group purchasing organizations that negotiate pricing for the purchase of pharmaceuticals, fees and formulary rebates with pharmaceutical manufacturers on behalf of their participants. They also provide various administrative services to their participants including management and reporting.
- *Copay Solutions:* Our first-to-market innovative copay solutions helps patients afford their medications, protect plan design preferences and achieve lower trend. In partnership with SaveOnSP on the first non-essential health benefits copay assistance solution, we've driven significant savings by targeting high-cost, high-volume drugs. SaveOnSP recommends plan-design and coverage changes for certain drugs, enabling maximum savings and reducing plan and client costs. As manufacturer programs and regulations change, this aggressive solution adapts, delivering lower specialty plan cost and enhanced customer support.
- *Inside Rx:* Inside Rx is a prescription medication savings program that offers eligible customers with discounts on many brand and generic medications for self-paying customers. This program is not insurance but offers savings at more than 60,000 participating retail pharmacies (including all major chains) in the United States and Puerto Rico. The program also offers discounts on prescription medications for pets. Inside Rx earns a small fee from our supply chain partners every time a customer fills a prescription via the program. This lets us provide access to our savings card at no cost to the customer.
- *Express Scripts Parachute Rx:* Express Scripts Parachute Rx is a prescription discount program administered by Inside Rx to assist Americans who are newly uninsured as a result of the COVID-19 pandemic by providing access to affordable and predictable prices on select generic and brand-name medications. The program is not insurance but offers discounts on certain prescription medications for uninsured customers. Express Scripts created this limited-time program through its close partnerships with manufacturers and retail pharmacies across the country.
- *Value-Based Programs:*
  - *Express Scripts SafeGuardRx:* We offer a solution platform aimed at therapy classes that pose budgetary threats and clinical challenges to customers. Our solutions are designed to keep our clients ahead of the drug cost curve while providing customers the personalized care and access they need. These solutions are offered throughout our pharmacy benefit management services and include, but are not limited to care for: cardiovascular, diabetes, hepatitis, inflammatory conditions, neurological, multiple sclerosis, oncology, pulmonary and rare conditions. Innovative programs, such as SafeGuardRx, combine utilization management, formulary management, specialized care from our Therapeutic Resource Centers and financial savings, to help us to change the market in key categories. These services optimize the safe and appropriate dispensing of therapeutic agents, minimize waste and improve clinical and financial outcomes. Through these services, specialist pharmacists provide the expert, personalized care that customers increasingly demand.
  - *Patient Assurance Program:* This program addresses the need for greater affordability and access to medications by providing a fixed out-of-pocket cost to customers in non-government funded benefit plans.

- *Care Solutions:* We offer clinical programs to help our clients drive better whole-person health outcomes at a lower cost by identifying and addressing potentially unsafe or wasteful prescribing, dispensing and use of prescription drugs and communicating with, or supporting communications with, physicians, pharmacies and customers.
  - Through our Healthy Ways to Work initiative, we're helping our partners and their employees navigate COVID-19 with a suite of agile solutions focused on helping people return to a healthy, safe and productive workplace, including digital and onsite support, population health and clinical care and resiliency development to help people cope with change.
  - Our inMynd mental health solution provides access to expert guidance and support for anxiety, depression and insomnia, including access to individualized support and resources, condition-specific care through our Neuroscience Therapeutic Resource Centers and a new digital Cognitive Behavioral Therapy program.
  - Health Connect 360 is a transformational, outcomes based, clinical management model that bridges pharmacy, medical, lab and customer engagement data to develop insights and deliver personalized health care clinical support. Clinical outcomes and quality metrics are tailored to meet client needs.

- Through the Evernorth Digital Health Formulary, we evaluate, procure, implement and manage digital health solutions on behalf of clients, alleviating administrative burden and ensuring clinical effectiveness, data security, user-friendly experiences and financial value.
- Advanced Utilization Management programs are the number-one tool for decreasing client spend on pharmacy. These include prior authorization, drug quantity management and step therapy.
- Enhanced Fraud, Waste & Abuse helps plan sponsors identify potential problem customers and prescribers with unusual or excessive utilization patterns. The program is designed to help identify outliers and situations of abnormal use or prescribing patterns by analyzing types of prescriptions, refill patterns and pharmacy utilization.
- Embarc Benefit Protection shields members from the high costs of life-saving gene therapies, so that customers who need treatment can get it, through financial protection for high-cost therapies, access to quality, cost-effective in-network providers and support from a dedicated gene therapy case management team.
- FamilyPath is raising the bar for fertility health by providing more comprehensive, more flexible coverage and proactive care for growing families, including expanded medical and pharmacy benefit management; access to vetted provider and lab networks; and dedicated Fertility Advisors to proactively support and guide patients.

- *Evernorth Intelligence Solutions:* By bringing together world-class talent, multi-disciplinary expertise and advanced data and analytics, we unlock actionable insights to help drive greater predictability, affordability and simplicity. We work together with our clients and partners to create dynamic solutions, services and platforms that guide better decisions and improved performance (see "*Business - Data, Analytics, and Technology*" section of this Form 10-K for further information).
  - *Evernorth Labs:* We accelerate innovation through increased collaboration with clients, customers and partners to develop solutions for launch in their businesses. With our Labs, which are state-of-the-art research facilities and shared spaces for collaboration, ideation and innovation, we gather with our clients and industry leaders to solve the toughest challenges in the health care system, including: better managing the most complex and expensive disease states, such as oncology; improving care access and delivery, such as worksite, home and virtual care; and planning for emerging trends, such as artificial intelligence, and industry disruptors, such as COVID-19.
  - *Data, advanced analytics and platforms:* We use advanced predictive modeling to shape solutions that help decrease healthcare fragmentation, drive optimized care coordination, reduce key cost drivers and improve health outcomes. In-depth trend analysis helps us to identify and effectively address challenges like opioid abuse, COVID-19 and other emerging health crises. We use market surveillance and forecasting to pinpoint and proactively address cost drivers. Our platform strategy as a service gives clients the tools to build successful businesses in a flexible, customizable way: Trend Central® provides access to key performance indicators to help plan sponsors reduce costs and work towards healthier outcomes; HealthPredict℠ produces high patient-level risk scores, to show the highest value opportunities for proactive intervention; MediCUBE gives our academic detailing pharmacists the analytical power to identify ways to save plans from significant unnecessary spend and improve quality metrics; RationalMed improves patient health and safety by integrating medical, pharmacy and laboratory claims data to initiate changes and correct errors in care, lowering both medical and prescription drug costs; and ScriptVision provides a suite of real-time, data-driven capabilities that empower physicians to make the best prescribing choices, including ePrescribing (including controlled substances), real-time prescription benefit information, electronic prior authorizations, clinical care messages such as drug interactions and high-risk medication alerts and data on and patient adherence rates.

- *Provider Services:* CuraScript SD is a specialty distributor of pharmaceuticals and medical supplies (including injectable and infusible pharmaceuticals and medications to treat specialty and rare or orphan diseases) directly to health care providers, clinics and hospitals in the United States for office or clinic administration. Through this business, we provide distribution services primarily to office and clinic-based physicians who treat customers with chronic diseases and regularly order costly specialty pharmaceuticals. This business provides competitive pricing on pharmaceuticals and medical supplies, operates three distribution centers and ships most products overnight within the United States; it also provides distribution capabilities to Puerto Rico and Guam. It is a contracted supplier with most major group purchasing organizations and leverages our distribution platform to operate as a third-party logistics provider for several pharmaceutical companies.

Customers

Our customers in the Evernorth segment include clients and patients, as described below, along with a description of our current and former significant clients:

- *Clients:* We provide services to managed care organizations, health insurers, third-party administrators, employers, union-sponsored benefit plans, workers' compensation plans, government health programs, providers, clinics, hospitals and others. We provide services to a majority of customers in our U.S. Medical segment.

- *Patients:* Prescription drugs are dispensed to patients connected to the service offerings we provide to clients. Prescription drugs are dispensed primarily through networks of retail pharmacies under non-exclusive contracts with us and via home delivery from Express Scripts Pharmacy and specialty drug fulfillment pharmacies.

The Department of Defense TRICARE® Pharmacy Program is the military health care program serving active-duty service customers, National Guard and Reserve customers and retirees, as well as their dependents. Under this contract, we provide online claims adjudication, home delivery services, specialty pharmacy clinical services, claims processing and contact center support and other services critical to managing pharmacy trend. In 2020 and 2019, revenues from this contract were significant to the segment.

In 2019, Express Scripts and Prime Therapeutics LLC ("Prime") entered into an agreement effective on April 1, 2020 which is delivering improved choice and affordability for Prime's clients and their patients by enhancing retail pharmacy networks and pharmaceutical manufacturer value. In 2021, the relationship with Prime was expanded to include the option for Prime's plans to access the Accredo specialty pharmacy and Express Scripts home delivery in-network pharmacies.

On January 30, 2019, Anthem, Inc. ("Anthem"), a former customer, exercised its right to early termination of its pharmacy benefit management services agreement, effective March 1, 2019. As of December 31, 2019, the transition of customers was substantially complete. For further discussion of our Anthem relationship, see the "Executive Summary – Key Transactions and Business Developments" section of our MD&A located in Part II, Item 7 of this Form 10-K.

Competition

The health care industry has undergone periods of substantial consolidation and may continue to consolidate in the future. We believe the primary competitive factors in the industry include the ability to: negotiate with retail pharmacies to ensure our retail pharmacy networks meet the needs of our clients and customers; provide home delivery and specialty pharmacy services; negotiate discounts and rebates on prescription drugs with drug manufacturers; navigate the complexities of government-reimbursed business including Medicare, Medicaid and the public exchanges; manage cost and quality of specialty drugs; use the information we obtain about drug utilization patterns and consumer behavior to reduce costs for our clients and customers and the level of service we provide.

- *Managed Care PBMs:* CVS Caremark (owned by CVS Health Corporation), Humana, IngenioRx (owned by Anthem), OptumRx (owned by UnitedHealth Group Inc.) and Prime Therapeutics (owned by a collection of Blue Cross / Blue Shield Plans) compete with us on a variety of products and in various regions throughout the United States.
- *Independent PBMs:* MedImpact, Navitus Health Solutions, Elixir (owned by Rite Aid Corporation) and many other regional PBMs compete with us on a variety of products across the United States.
- *Pharmacies:* CVS, Walgreens Boots Alliance, Inc., WalMart, Inc., Rite Aid, Kroger and other independent pharmacies compete with us for the delivery of prescription drug needs to our customers. In addition, many PBMs own and operate home delivery and specialty pharmacies including CVS, OptumRx, Walgreens, Humana and Elixir. New entrants continue to emerge including Amazon Pharmacy, Capsule and Hims.
- *Third-Party Benefits Administrators:* Third parties that specialize in claim adjudication and benefit administration, such as SS&C Health, are direct competitors. With the emergence of alternative benefit models through Private Exchanges, the competitive landscape also includes brokers, health plans and consultants. Some of these competitors may deploy greater financial, marketing and technological resources than we do and new market entrants, including strategic alliances aimed at modifying the current health care delivery models or entering the prescription drug sector from another sector of the health care industry, may increase competition as barriers to entry are relatively low. For example, GoodRx is a new entrant focused on serving the uninsured and underinsured in the cash pay pharmacy administration space.
- *Clinical Solutions and Health Care Data Analytics Companies:* Optum (owned by UnitedHealth Group Inc.), Anthem, Magellan Health, HealthHelp, Cotiviti and Inovalon are among the companies that compete with us in this market.

Operations

- *Sales and Account Management:* Our sales and account management teams market and sell pharmacy benefit management solutions and are supported by client service representatives, clinical pharmacy managers and benefit analysis consultants. These teams work with clients to develop innovative strategies that put medicine within reach of customers while helping health benefit providers improve access to and affordability of prescription drugs.
- *Supply Chain:* Our supply chain contracting and strategy teams negotiate and manage pharmacy retail network contracts, pharmaceutical and wholesaler purchasing contracts and manufacturer rebate contracts. As our clients continue to experience increased cost trends, our supply chain teams develop innovative solutions such as our SafeGuardRx platform and preferred pharmacy networks to combat these cost increases. In addition, our Formulary Consulting team, consisting of pharmacists and

financial analysts, provides services to our clients to support formulary decisions, benefit design consultation and utilization management programs.

- *Clinical Support:* Our staff of highly trained health care professionals provides clinical support for our medical, behavioral and pharmacy customers. Our services include:
    - Case management support for our customers through the continuum of health care – from inpatient hospitalization to at home care – as well as health coaching and on-site coaching
    - Condition-specific specialized customer care through our Therapeutic Resource Center facilities staffed with specialist pharmacists, nurses and other clinicians
    - Clinical development and operational support for our pharmacy benefit management services by our clinical solutions staff of pharmacists and physicians who conduct a wide range of activities including: identifying emerging medication-related safety issues and alerting physicians, clients and customers (as appropriate); providing drug information services; managing formulary; and developing utilization management, safety (drug utilization review) and other clinical interventions

Suppliers

We maintain an inventory of brand-name and generic pharmaceuticals in our home delivery and specialty pharmacies. Our specialty pharmacies also carry biopharmaceutical products to meet the needs of our customers, including pharmaceuticals for the treatment of rare or chronic diseases; if a drug is not in our inventory, we can generally obtain it from a supplier within a reasonable amount of time.

We purchase pharmaceuticals either directly from manufacturers or through authorized wholesalers. Evernorth uses one wholesaler more than others in the industry, but holds contracts with other wholesalers if needs for an alternate source arise. Generic pharmaceuticals are generally purchased directly from manufacturers.

Industry Developments

See the "Industry Developments" section of the MD&A located in Part II, Item 7 of this Form 10-K for discussion of key industry developments impacting this segment.

Intellectual Property Rights

The trademarks and service marks covering products, services and businesses provided under the Evernorth segment include, but are not limited to, the following: EXPRESS SCRIPTS®, EVERNORTH℠, EVERNORTH HEALTH℠, MEDCO®, ACCREDO®, CURASCRIPTSD®, MYMATRIXX®, EVICORE HEALTHCARE®, FREEDOM FERTILITY PHARMACY®, CARE CONTINUUM®, RATIONALMED®, SCREENRX®, EXPRESSALLIANCE®, EVERNORTH DIGITAL HEALTH FORMULARY℠, THERAPEUTIC RESOURCE CENTER®, ADVANCED OPIOID MANAGEMENT®, SAFEGUARDRX®, HIV CARE VALUE℠, RARE CONDITIONS CARE VALUE®, NEUROLOGICAL CARE VALUE℠, CARDIOVASCULAR CARE VALUE℠, HEPATITIS CURE VALUE®, MARKET EVENTS PROTECTION℠, ONCOLOGY CARE VALUE℠, DIABETES CARE VALUE℠, INFLAMMATORY CONDITIONS CARE VALUE℠, INFLATION PROTECTION℠, PULMONARY CARE VALUE®, MULTIPLE SCLEROSIS CARE VALUE℠, MIGRAINE CARE VALUE℠, CHOLESTEROL CARE VALUE℠, HEALTH CONNECT 360℠, EMBARC BENEFIT PROTECTION℠, INMYND℠, EXPRESS SCRIPTS PATIENT ASSURANCE℠, MEDICUBE®, EXPRESS SCRIPTS PHARMACY®, FAMILYPATH℠, SCRIPTVISION℠, HEALTHY WAYS TO WORK℠ and INSIDE RX®. We, or our affiliated companies, own trademarks and trademark registrations for these and other company marks.

We also hold a portfolio of patents and pending patent applications. We are not substantially dependent on any single patent or group of related patents.

U.S. MEDICAL

U.S. Medical includes Cigna's U.S. Commercial and U.S. Government businesses that provide comprehensive medical and coordinated solutions to clients and customers. U.S. Commercial products and services include medical, pharmacy, behavioral health, dental, vision, health advocacy programs and other products and services for insured and self-insured customers. U.S. Government solutions include Medicare Advantage, Medicare Supplement, and Medicare Part D plans for seniors, Medicaid plans, and individual health insurance plans both on and off the public exchanges. In 2020, U.S. Medical reported adjusted revenues of $38.5 billion and pre-tax adjusted income from operations of $3.8 billion.

HOW WE WIN

- **Broad and deep portfolio of solutions** across U.S. Commercial and U.S. Government segments
- **Commitment** to highest-quality health outcomes and customer experiences
- **Collaborative** physician engagement models emphasizing value over volume of services
- **Integrated and coordinated benefit solutions** that deliver value for our customers, clients and partners
- **Technology and data analytics** powering actionable insights and affordable, predictable solutions
- **Talented and caring people** embracing change and putting customers at the center of all we do

We differentiate ourselves by providing innovative, personalized and affordable health care benefit solutions based on the unique needs of the individuals and clients we serve. We increase value through our integrated approach and use of technology and data analytics to enhance patient engagement and health care outcomes, underscoring our strategic focus on delivering an industry-leading customer experience. We continue to strengthen our collaborative relationships with providers as we accelerate our transition to a value-based reimbursement system.

We offer a mix of core health insurance products and services to employers, other groups and individuals along with specialty products and services designed to improve the quality of care, lower cost and help customers achieve better health outcomes. Many of these products are available on a standalone basis, but we believe they create additional value when integrated with a Cigna-administered health plan. Our products are available through several distribution channels including brokers, direct sales and public and private exchanges. Our three funding solutions (i.e., administrative services only ("ASO"), insured – guaranteed cost ("GC") and insured – experience-rated ("ER") arrangements) enable us to customize the amount of risk taken by, and lower costs for, our clients.

The following chart depicts a high-level summary of our principal products and services in this segment, with definitions on subsequent pages.

Principal Products & Services	*Major Brand(s)*	*Geography*	*Funding Solution(s)*	*Market Segment(s)*	*Primary Distribution Channel(s)*	*Primary Competitors*
U.S. Commercial Medical						
Managed Care	Cigna HealthCare	Nationwide	GC, ER, ASO	U.S. Commercial	Brokers, Private Exchanges, Direct	National Insurers, Local Healthplans, Third-Party Administrators ("TPAs")
Preferred Provider Organization ("PPO")	Cigna	Nationwide				National Insurers, TPAs
Consumer-Driven	Cigna	Nationwide				National Insurers, Local Health Maintenance Organizations ("HMOs")
U.S. Government Medical						
Individual and Family Plans	Cigna	11 states(1)	GC	Individual	Public Exchanges, Brokers, Direct	Local Healthplans, Start-ups, National Insurers
Medicare Advantage	Cigna	18 states(2) & District of Columbia	GC	U.S. Government	Direct, Brokers	National Insurers, Local Healthplans
Medicare Stand –Alone Prescription Drug Plans	Cigna, Express Scripts	Nationwide	GC, ASO	U.S. Government	Direct, Brokers	National Insurers
Medicare Supplement	Cigna	48 states(3) & District of Columbia	GC	U.S. Government	Brokers, Direct, Private Exchanges	National Insurers
Medicaid	Cigna	Texas	GC	U.S. Government	Direct, Brokers	National Insurers
Specialty Products and Services						
Stop-Loss	Cigna	Nationwide	GC	U.S. Commercial	Brokers, Direct	National Insurers, Specialty Companies
Cost Containment	Cigna	Nationwide	GC, ER, ASO	U.S. Commercial	Direct	National Insurers, Specialty Companies
Consumer Health Engagement	Cigna	Nationwide	GC, ER, ASO	U.S. Commercial, U.S. Government	Brokers, Direct	National Insurers, Specialty Companies
Pharmacy Management	Cigna	Nationwide	GC, ER, ASO	U.S. Commercial, U.S. Government	Brokers, Direct	National PBMs
Behavioral Health	Cigna Behavioral Health	Nationwide	GC, ER, ASO	U.S. Commercial	Brokers, Direct	National Insurers, Specialty Companies
Dental & Vision	Cigna Dental HealthCare	Nationwide	GC, ER, ASO	U.S. Commercial, U.S. Government	Brokers, Direct	Dental Insurers, National Insurers

(1) AZ, CO, FL, IL, KS, MO, NC, TN, TX, UT, VA
(2) AL, AZ, AR, CO, DE, FL, GA, IL, KS, MD, MS, MO, NC, NJ, PA, SC, TN, TX
(3) All states except MA and NY

Principal Products & Services

U.S. Commercial Medical

- *Managed Care Plans* are offered through our insurance companies, HMOs and TPA companies. HMO, Surefit, LocalPlus®, Network and Open Access Plus plans use meaningful cost-sharing incentives to encourage the use of "in-network" versus "out-of-network" health care providers. The national provider network for Managed Care Plans is somewhat smaller than the national network used with the PPO plan product line.
- *PPO Plans* feature a network with broader provider access than the Managed Care Plans.
- *Consumer-Driven Products* are typically paired with a high-deductible medical plan and offer customers a tax-advantaged way to pay for eligible health care expenses. These products, consisting of health savings accounts, health reimbursement accounts and flexible spending accounts, encourage customers to play an active role in managing their health and health care costs.

U.S. Government Medical

- *Individual and Family Plans* are primarily Patient Protection and Affordable Care Act ("ACA") compliant exclusive provider organization ("EPO") or HMO plans marketed to individuals under age 65 who do not have access to health care coverage through an employer or government program such as Medicare or Medicaid. Customers receive comprehensive health care benefits and have access to a local network of health care providers who have been selected with cost and quality in mind.
- *Medicare Advantage Plans* allow Medicare-eligible beneficiaries to receive health care benefits, including prescription drugs, through a managed care health plan such as our coordinated care plans. Our Medicare Advantage Plans include HMO and PPO plans marketed to individuals. A significant portion of our Medicare Advantage customers receive medical care from our value-based models that focus on developing highly engaged physician networks, aligning payment incentives to improved health outcomes and using timely and transparent data sharing.
- *Medicare Stand-Alone Prescription Drug Products* provide a number of prescription drug plan options, as well as service and information support, to Medicare eligible and dually eligible Medicaid customers, either directly to individuals or through a qualified employer group. Our stand-alone plans offer the coverage of Medicare combined with the flexibility to select a product that provides enhanced benefits and a formulary that meets an individual's specific needs. Eligible beneficiaries benefit from broad network access and enhanced service intended to promote adherence, wellness and affordability for our eligible beneficiaries.
- *Medicare Supplement Plans* provide Medicare-eligible beneficiaries with federally standardized Medigap-style plans. Beneficiaries may select among the various plans with specific plan options to meet their unique needs and may visit, without the need for a referral, any health care provider or facility that accepts Medicare throughout the United States.
- *Medicaid Managed Care* provides both acute care and Long-Term Services and Supports ("LTSS") by integrating primary care, behavioral health care, pharmacy services and LTSS for individuals who are age 65 or older or adults who have a disability. LTSS includes services such as attendant care and day activity and health services. Members have access to a service coordinator who is responsible for coordinating acute care and LTSS for members.

Specialty Products and Services

- *Pharmacy Management* services and benefits can be combined with our medical offerings. The comprehensive suite of pharmacy management services available to clients and customers, utilizing Evernorth's capabilities, includes benefits management, specialty pharmacy services, clinical solutions, home delivery and certain health management services.
- *Behavioral Health* services consist of a broad national network of behavioral health providers which includes one of the largest virtual networks in the United States, behavioral health specialty case and utilization management, a crisis intervention line accessible anytime, employee assistance programs and work/life programs. We focus on integrating our programs and services with medical, pharmacy and disability programs to facilitate customized, holistic care as well as to provide resources that increase resiliency and address non-medical factors that affect overall well-being.
- *Cost Containment Programs* are designed to contain the cost of covered health care services and supplies. These programs reduce out-of-network utilization and costs, protect customers from balance billing and educate customers regarding the availability of lower cost in-network services. In addition, under these programs we negotiate discounts with out-of-network providers, review provider bills and recover overpayments. We charge fees for providing or arranging for these services. These programs may be administered by third-party vendors that have contracted with Cigna.
- *Stop-Loss* insurance coverage is offered to self-insured clients whose group health plans are administered by Cigna. Stop-loss insurance provides reimbursement for claims in excess of a predetermined amount for individuals, the entire group, or both.

- *Consumer Health Engagement* services are offered to customers covered under plans administered by Cigna or by third-party administrators. These services consist of an array of health management, disease management and wellness services. Our Medical Management programs include case, specialty and utilization management and a 24/7 Health Information line which ensures around the clock access to a medical professional. Our Health Advocacy program services include early intervention in the treatment of chronic conditions and an array of health and wellness coaching. We administer incentives programs designed to encourage customers to engage in health improvement activities.
- *Dental & Vision* solutions include dental HMO plans, dental PPO plans, exclusive dental provider organization plans, traditional dental indemnity plans and a dental discount program. Employers and other groups can purchase our products on either an insured or self-insured basis as standalone products or in conjunction with medical products. Additionally, individual customers can purchase insured dental PPO plans as standalone products or in conjunction with individual medical policies.

Revenues: Fees and Premiums

- *ASO.* Plan sponsors (i.e., employers, unions and other groups) self-fund all claims, but may purchase stop-loss insurance to limit exposure. We collect fees from plan sponsors for providing access to our participating provider network and for other services and programs including: claims administration; behavioral health services; disease management; utilization management; cost containment; dental and pharmacy benefit management. Approximately 84% of our U.S. Commercial medical customers are in ASO arrangements.
- *Insured*. In most states, individual and group insurance premium rates must be approved by the applicable state regulatory agency (typically department of insurance) and state or federal laws may restrict or limit the use of rating methods. Premium rates for groups and individuals are subject to state review to determine whether they are adequate, not excessive and not unfairly discriminatory. In addition, the ACA subjects individual and small group policy rate increases above an identified threshold to review by the United States Department of Health and Human Services (“HHS”) and requires payment of premium refunds on individual and group medical insurance products if minimum medical loss ratio (“MLR”) requirements are not met. The MLR represents the percentage of premiums used to pay claims and expenses for activities that improve the quality of care. In our individual business, premiums may also be adjusted as a result of the government risk adjustment program that accounts for the relative health status of our customers.
    - *Guaranteed Cost Insurance.* Premium rates are established at the beginning of a policy period and, depending on group size, may be based in whole or in part on prior experience of the policyholder or on a pool of similar policyholders. We generally cannot subsequently adjust premiums to reflect actual claim experience until the next annual renewal. The policyholder does not participate, or share in, actual claim experience. We keep any experience surplus or margin if costs are less than the premium charged (subject to minimum medical loss ratio rebate requirements discussed above) and bear the risk for actual costs in excess of the premium charged. Approximately 10% of U.S. Commercial medical customers are in guaranteed cost arrangements.
    - *Experience-rated Insurance.* Premium rates are established at the beginning of a policy period and are typically based on prior claim experience of the policyholder. When claims and expenses are less than the premium charged (an “experience surplus” or “margin”), the policyholder may be credited for a portion of this experience surplus or margin. If claims and expenses exceed the premium charged (an “experience deficit”), we bear these costs. In certain cases, experience deficits incurred while the policy is in effect are accumulated and may be recovered through future policy year experience surpluses or margins. Approximately 5% of U.S. Commercial medical customers are in experience-rated arrangements.
    - *Medicare Advantage.* Premium rates are established at the beginning of a policy period based upon prior claim experience. We cannot subsequently adjust premiums to reflect actual claim experience until the next policy period. We receive fixed monthly payments from CMS for each plan customer based on customer demographic data and actual customer health risk factors compared to the broader Medicare population. We also may earn additional revenue from CMS related to quality performance measures (known as ‘‘Star Ratings’’). See the ‘‘Executive Overview’’ section of our MD&A of this Form 10-K for additional discussion of our Star Ratings. Premiums may be received from customers when our plan premium exceeds the revenue received from CMS. The ACA requires Medicare Advantage plans to meet a minimum MLR of 85%. If the MLR for a CMS contract is less than 85%, we are required to pay a rebate to CMS and could be required to make additional payments if the MLR continues to be less than 85% for successive years.

See the “Business - Regulation” section of this Form 10-K for additional information about premiums, commercial MLR requirements and risk mitigation programs of the ACA.

Market Segments

- *U.S. Commercial* comprises employers from the following market segments:
  - *National.* Multistate employers with 5,000 or more U.S.-based, full-time employees. We offer primarily ASO funding solutions in this market segment.
  - *Middle Market.* Employers generally with 500 to 4,999 U.S.-based, full-time employees. This segment also includes single-site employers with more than 5,000 employees and Taft-Hartley plans and other groups. We offer ASO, experience-rated and guaranteed cost insured funding solutions in this market segment.
  - *Select.* Employers generally with 51-499 eligible employees. We usually offer ASO with stop-loss insurance coverage and guaranteed cost insured funding solutions in this market segment.
  - *Small Group.* Employers generally with 2-50 eligible employees. We offer guaranteed cost insured funding solutions in select geographies with a strategic partner, Oscar Health, in this market segment.
- *U.S. Government* comprises the following market segments:
  - *Individual.* Includes individuals under age 65 who do not have access to health care coverage through an employer or government program such as Medicare or Medicaid. We offer guaranteed cost, medical ACA-compliant and dental plans in this segment.
  - *Medicare.* Includes individuals who are Medicare-eligible beneficiaries, as well as employer group sponsored pre- and post-65 retirees. We also have dual-eligible customers who receive both Medicare and Medicaid benefits. We receive revenue from CMS based on customer demographic data and health risk factors. In 2020, revenues from CMS were significant to the segment.

Primary Distribution Channels

- *Brokers.* Sales representatives distribute our products and services to a broad group of insurance brokers and consultants across the United States.
- *Direct.* Cigna sales representatives distribute our products and services directly to employers, unions and other groups or individuals across the United States. Various products may also be sold directly to insurance companies, HMOs and third-party administrators. This may take the form of in-person contact, telephone or group selling venues. Cigna also offers an online direct to consumer enrollment platform for our individual market segment.
- *Private Exchanges.* We partner with select companies that have created private exchanges where individuals and organizations can acquire health insurance. We actively evaluate private exchange participation opportunities as they emerge in the market and target our participation to those models that best align with our mission and value proposition.
- *Public Exchanges.* Cigna offers individual ACA-compliant policies through public health insurance exchanges in select geographies.

Competition

The primary competitive factors affecting our business are quality and cost effectiveness of service and provider networks; effectiveness of medical care management; products that meet the needs of employers and their employees; total cost management; technology; and effectiveness of marketing and sales. Financial strength, as indicated by ratings issued by nationally recognized rating agencies, is also a competitive factor. Our health advocacy capabilities, holistic approach to consumer engagement, breadth of product offerings, clinical care and health management capabilities and array of product funding options are competitive advantages. We believe our focus on improving the health, well-being and peace of mind of those we serve, and how we deliver better affordability, predictability, and simplicity in health care will allow us to further differentiate ourselves.

- *National Insurers.* United HealthGroup Inc., Aetna Inc. (owned by CVS Health Corporation), Anthem, Humana and Blue Cross Blue Shield plans compete with us in a variety of products and regions throughout the United States.
- *Local Healthplans.* Blue Cross Blue Shield plans, local affiliates of major insurance companies and hospitals and regional stand-alone managed care and specialty companies compete with us in the states in which we offer managed care products. Additionally, plan sponsors may contract directly with providers.
- *TPAs.* Third-party administrators compete with us for ASO business.
- *Start-ups.* Emerging participants including alternative health service models, consortiums and other health plans seeking to disrupt, often through competitive technology.
- *Dental Insurers.* Various companies offering primarily dental insurance compete with us on these products.
- *Specialty Companies.* Specialty insurance or service companies that offer niche products and services compete with us.

Partnering to Deliver on the Promise of More Affordable, Predictable, Simple Health Care

Cigna's strategy engages customers in their health, collaborates with providers to help them improve their performance and connects customers and providers through aligned health goals, incentives and actionable information to enable better decisions and outcomes. Our delivery strategy is designed to ensure our customers have access to the right care, in the preferred and appropriate setting at the right time. Fueled by advanced insights and predictive analytics, Cigna is committed to developing innovative solutions that span the health care delivery system and can be applied to different types of providers. Currently we have numerous collaborative arrangements with our participating health care providers that reach over 2.9 million customers and are actively developing new arrangements to support our strategy.

- *Accountable Care Program.* We have approximately 240 collaborative care arrangements with primary care groups built on the patient-centered medical home and accountable care organization ("ACO") models. Our arrangements span 34 states and reach over 2.9 million customers. We have made adjustments to the program to deepen our partnerships in responding to the challenges and needs arising from the COVID-19 pandemic.
- *Hospital Quality Program.* We have contracts with 175 hospital systems, involving over 540 hospitals, with reimbursements tied to quality metrics.
- *Specialist Programs.* We have over 300 arrangements with specialist groups in value-based reimbursement arrangements. These arrangements include specialties in orthopedics, obstetrics and gynecology, cardiology, gastroenterology, oncology, nephrology and neurology. Arrangements include incentives for enhanced care coordination and episodes of care reimbursements for meeting cost and quality goals. We are expanding these programs to include bundled payment arrangements beginning with orthopedics.
- *Independent Practice Associations.* We have value-based physician engagement models in our Medicare Advantage business that allow physician groups to share financial outcomes with us. This clinical model also includes outreach to new and at-risk patients to ensure they are accessing their primary care physician.
- *Participating Provider Network.* We provide our customers with an extensive network of participating health care providers, hospitals and other facilities, pharmacies and providers of health care services and supplies. In most instances, we contract with them directly; however, in some instances, we contract with third parties for access to their provider networks and care management services. In addition, we have entered into strategic alliances with several regional managed care organizations to gain access to their provider networks and discounts.
- *Virtual Care.* We encourage access for customers through telehealth services as a way to support the patient/doctor relationship. Our telehealth coverage provides the flexibility for the customer to access their own medical and behavioral providers, as well as a network of telehealth providers for urgent care needs.

Industry Developments

See the "Industry Developments" section of the MD&A in this Form 10-K for discussion of key industry developments impacting this segment.

INTERNATIONAL MARKETS

Cigna's International Markets segment has operations in over 30 countries or jurisdictions providing a full range of comprehensive medical and supplemental health, life and accident benefits to individuals and employers. Products and services include comprehensive health coverage, hospitalization, dental, critical illness, personal accident, term life, medical cost containment and variable universal life. In 2020, International Markets reported adjusted revenues of $5.9 billion and pre-tax adjusted income from operations of $900 million.

South Korea represents our single largest geographic market for International Markets. For information on this concentration of risk for the International Markets segment's business in South Korea, see "Other Items Affecting Results of International Markets" in the International Markets section of the MD&A located in Part II, Item 7 of this Form 10-K.

HOW WE WIN

·Offering a broad range of health and protection-related solutions to meet the needs of the growing middle class and globally mobile
·Leveraging **deep consumer insights** to drive product and **service innovation**
·Maintaining leading innovative, direct-to-consumer **distribution capabilities**
·Providing access to quality, affordable care through one of the **largest global provider networks**
·Implementing locally-licensed and compliant solutions managed by **strong, locally-developed talent**

Demand for our products and services is driven by the growing global middle class, aging populations, increasing prevalence of chronic conditions and rising global health care costs. Our focus on product and service innovation means we continue to deliver solutions that meet the evolving needs of individual and group customers. Our products, distribution channels and funding sources range by customer and geography.

International Markets is well positioned to address the growing demand for access to quality, affordable care and supplemental health and life protection that fill gaps in public and private care. We distinguish ourselves through differentiated direct-to-consumer distribution, customer insights, product innovation, a leading provider network and compliant solutions. We identify and pursue attractive market opportunities to bring health and protection solutions and tailor those solutions to the market and customer needs. Over the past several years, we have extended our product offerings and geographic reach. The chart below provides a high-level summary of our principal products and services in this segment with definitions on subsequent pages.

Principal Products & Services	*Major Brand(s)*	*Geography*	*Funding Solution(s)*	*Key Relationships*	*Primary Distribution Channel(s)*	*Primary Competitors*
Global Health Care	Cigna Global Health Benefits, Cigna Global Individual Health	Worldwide (except as limited by applicable law)	ER, GC, ASO	Multinational Companies, Inter-governmental and Non-governmental Organizations Globally mobile individuals	Brokers, Agents, Direct-to-Consumer	Global insurers
Local Health Care	Cigna, ManipalCigna, CignaCMB	United Kingdom, Spain, Hong Kong, India, China, Singapore, Middle East, Thailand	ER, GC, ASO	Employer Groups Individuals	Brokers, Agents, Direct-to-Consumer	Global insurers and local non-U.S. insurers
Supplemental Health, Life, & Accident	Cigna LINA Korea, CignaCMB, ManipalCigna, CignaFinans	Asia Pacific, India, Turkey	GC	Individuals	Affinity, Bancassurance, Brokers, Agents, Direct-to-Consumer	Global insurers and local non-U.S. insurers

Principal Products & Services

Global Health Care products and services include insurance and administrative services for medical, dental, pharmacy, vision and life, accidental death and dismemberment and disability risks. We are leading providers of products and services that meet the needs of multinational employers, intergovernmental and nongovernmental organizations and globally mobile individuals with a focus on keeping employees healthy and productive. The employer benefits products and services are offered through guaranteed cost, experience-rated and administrative services only funding solutions, while individuals purchase guaranteed cost coverage. For definitions of funding solutions, see “Revenues: Fees and Premiums” section in the “Business - U.S. Medical” section of this Form 10-K.

Local Health Care products and services include medical, dental, pharmacy and vision as well as life coverage. The customers of local health care businesses are employers and individuals located in specific countries where the products and services are purchased. These employer services can similarly be funded through a range of options; individuals purchase on a guaranteed cost basis.

Supplemental Health, Life and Accident Insurance products and services generally provide simple, affordable coverage of risks for the health and financial security of individuals. Supplemental health products provide stated benefit payments for certain specified health risks and include personal accident, accidental death, critical illness, hospitalization, travel, dental, dementia, cancer and other specified condition coverages. We also offer customers term and variable universal life insurance and certain savings products in select markets.

Competition

We anticipate that the competitive environment will continue to intensify as insurance and financial services providers more aggressively pursue expansion opportunities across geographies, particularly Asia. We believe competitive factors will include speed-to-market, customer insights, branding, product, distribution and service innovation, underwriting and pricing, efficient management of marketing and operating processes, commission levels paid to distribution partners, the quality of compliance functions, claims, network coverage and medical cost management and talent acquisition and retention. Additionally, in most overseas markets, perception of commitment to the market and financial strength will likely be an important competitive factor.

Pricing and Reinsurance

Premium rates and fees for our global and local health care products reflect assumptions about future claims, expenses, customer demographics, investment returns and profit margins. For products using networks of contracted health care providers and facilities, premiums reflect assumptions about the impact of these contracts and utilization management on future claims. Most contracts permit rate changes at least annually.

The profitability of health care products is dependent upon the accuracy of projections for health care inflation (unit cost, location of delivery of care, currency of incurral and utilization), customer demographics, the adequacy of fees charged for administration and effective medical cost management.

Premium rates for our supplemental benefits products are based on assumptions about mortality, morbidity, customer acquisition and retention, customer demographics, expenses and capital requirements, as well as interest rates. Variable universal life insurance products fees consist of mortality, administrative, asset management and surrender charges assessed against the contractholder's fund balance. Mortality charges on variable universal life may be adjusted prospectively to reflect expected mortality experience. Most contracts permit premium rate changes at least annually.

A global approach to underwriting risk management allows each local business to underwrite and accept risk within specified limits. Retentions are centrally managed through cost-effective use of external reinsurance to limit our liability on a per event (catastrophe) basis.

Industry Developments and Other Items Affecting International Markets

Pressure on social health care systems, a rapidly aging population and increased wealth and education in developing insurance markets are leading to higher demand for health insurance and financial security products. In the supplemental health, life and accident business, direct marketing channels continue to grow and attract new competitors with industry consolidation among financial institutions and other affinity partners.

Data privacy regulation has tightened in all markets in the wake of high-profile data privacy incidents, impacting affinity partner and customer attitudes toward direct marketing of insurance and other financial services. It has also placed an added emphasis on the importance of operational compliance. In addition to data privacy, consumer protection, specifically market conduct and culture, continues to be a focus for regulators in many markets.

Capital requirement standards continue to evolve with several markets implementing new capital regimes over the next few years.

GROUP DISABILITY AND OTHER

Group Disability and Other includes Cigna's Group Disability and Life business which offers group long-term and short-term disability, and group life, accident, voluntary and specialty insurance products and services. Additionally, this segment includes COLI and the Company's run-off operations. In 2020, Group Disability and Other reported adjusted revenues of $5.3 billion and pre-tax adjusted income from operations of $290 million.

On December 31, 2020, Cigna completed the sale of the Group Disability and Life business to New York Life Insurance Company for $6.2 billion. In connection with the sale, the substantial majority of our Group Disability and Life operating segment was sold to New York Life Insurance Company, and our continuing operations in voluntary products and services will be reported in the U.S. Medical segment following the sale.

Group Disability and Life

In 2020, our Group Disability and Life operating segment included our commercial long- and short-term disability products and our term life group insurance products. We also offered personal accident insurance and will continue to offer voluntary products and services.

Principal Products & Services

- *Group Long-term and Short-term Disability* insurance products generally provide a fixed level of income to replace a portion of wages lost due to disability. As part of our group disability insurance products, we also assisted employees in returning to work and employers with resources to manage the cost of employee disability.
- *Leave Administration* solutions help customers effectively manage workforce absence and provide coverage for paid leave.
- *Group Term Life* insurance may be employer-paid basic life insurance, employee-paid supplemental life insurance or a combination thereof.
- *Personal Accident Insurance* coverage consists primarily of accidental death and dismemberment and travel accident insurance to employers.
- *Voluntary Products and Services* include plans that provide employers with administrative solutions designed to provide a complete and simple way to manage their benefits program. These voluntary offerings include accidental injury insurance, critical illness coverage and hospital care coverage, and provide additional dollar payouts to employees for unexpected accidents, hospitalization or more serious illnesses. Group voluntary products and services are not included in the sale of the Group Disability and Life business to New York Life and results of these products and services will be reported in the U.S. Medical segment starting with the first quarter of 2021.

Premiums charged for disability and term life insurance products are usually established in advance of the policy period and are generally guaranteed for one to three years, but selectively guaranteed for up to five years. Policies are generally subject to termination by the policyholder or by the insurance company annually. Premium rates reflect assumptions about future claims, expenses, credit risk, investment returns and profit margins. These assumptions may be based in whole or in part on prior experience of the account or on a pool of accounts, depending on the group size and the statistical credibility of the experience that varies by product.

These products and services are distributed through brokers and direct sales and are available in guaranteed cost, experience-rated and ASO arrangements.

Other Operations

Other Operations includes the following:

Corporate-Owned Life Insurance

The principal products of the COLI business are permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for financing employer-paid future benefit obligations. Permanent life insurance provides coverage that, when adequately funded, does not expire after a term of years. The contracts are primarily non-participating universal life policies. Fees for universal life insurance products consist primarily of mortality and administrative charges assessed against the policyholder’s fund balance. Interest credited and mortality charges for universal life and mortality charges on variable universal life may be adjusted prospectively to reflect expected interest and mortality experience. To reduce our exposure to large individual losses, we purchase reinsurance from unaffiliated reinsurers.

Run-off Settlement Annuity Business

Our settlement annuity business is a closed, run-off block of single premium annuity contracts. These contracts are primarily liability settlements with approximately 20% of the liabilities associated with guaranteed payments not contingent on survivorship. Non-guaranteed payments are contingent on the survival of one or more parties involved in the settlement.

Run-off Reinsurance

Our reinsurance operations are an inactive business in run-off.

In February 2013, we effectively exited the GMDB and GMIB business by reinsuring 100% of our future exposures, net of retrocessional arrangements in place at that time, up to a specified limit. For additional information regarding this reinsurance transaction and the arrangements that secure our reinsurance recoverables, see Note 10 to the Consolidated Financial Statements.

Individual Life Insurance and Annuity and Retirement Benefits Businesses

This business includes deferred gains recognized from the 1998 sale of the individual life insurance and annuity business and the 2004 sale of the retirement benefits business. For more information regarding the arrangements that secure our reinsurance recoverables for the retirement benefits business, see Note 10 to the Consolidated Financial Statements.

DATA, ANALYTICS AND TECHNOLOGY

Cigna's investments in data, analytics and technology remain outcome-driven with a focus on driving affordability, simplicity, predictability and growth across all of our business platforms. We deliver value for our clients, customers and stakeholders by creating better health outcomes, improving customer experience and lowering total cost of care.

Data and Analytics. We conduct timely, rigorous and objective research and analysis that informs evidence-based medical and pharmacy benefit management and evaluates the clinical, economic and individual impact of enhanced benefit designs and programs. The combination of our predictive analytics, machine and deep learning capabilities create augmented intelligence that inform decision-making of our health care professionals. We anticipate needs and meet customers where they are, from predicting chronic diseases, to using data to reduce payment and claims fraud, optimizing whole person health and optimizing networks to improve provider access and assist members with care navigation.

We are uniquely positioned to create actionable intelligence by leveraging our rich, integrated data sets and providing differentiating outcomes. During 2020, we were able to leverage both internal and external data related to COVID-19 in order to enhance our ability to predict infections and hospitalizations, inform our operational preparedness and optimize care management to improve health outcomes for our customers, across each of our businesses.

Innovation remains at the forefront of our data, analytic and technology solutions. The advancement of our internal capabilities and strategic partnerships continues to produce new and more effective ways to close gaps in care, optimize treatment and improve outcomes. During 2020, significant continued technology integration delivered cost synergies and drove differentiated innovation in areas such as pharmacy supply chain, specialty pharmacy and retail networks. In the future, we expect continued value realization with focus on customer-facing systems and opportunities for enhanced value in specialty, claims and retail. (See Evernorth Intelligence Solutions section of the "*Business - Evernorth*" discussion of this Form 10-K for additional information on our intelligent solutions and capabilities).

Our data and analytics talent powers these differentiated capabilities through deep expertise in data management, business analytics, intelligence and data science, with ongoing investments in talent development, analytic and big data technologies enabled by Cigna Technology Services (see below), as well as innovative third party partnerships while ensuring controls are designed to protect sensitive client and customer information.

Technology. Cigna Technology Services enables the strategy by focusing on strong foundational technology services, delivery of a business-aligned technology project portfolio and creating technology solutions to differentiate us in the market. Our innovation continues to support three strategic areas: customer benefit administration and health journey; digital health; and care delivery and management. Our technology drives improved customer experience, increases engagement and advances population health through provider collaboration tools and enables delivery of advanced analytics and predictive intelligence to provide key areas of competitive advantage.

We continue to bring new technology-enabled products and services to the market, including biometric stress prediction and focused insights in spaces such as women's health and opioid addiction. Our digital health focus has shown value across the enterprise by creating engaging experiences that give customers the right information at the right time. This includes an enhanced MyCigna.com experience with new features, including refill and payment options, without leaving the mobile application. Cybersecurity protections, such as multi-factor authentication, have been launched across Cigna's digital offerings providing better peace of mind and a stronger sense of security.

Our technology team, powered by approximately 7,000 employees and several thousand external resources working with our partners, supports the various information systems essential to our operations including the health benefit claims processing systems and specialty and home delivery pharmacy systems. Uninterrupted point-of-sale electronic retail pharmacy claims processing is a significant operational requirement for our business. We believe we have substantial capacity for growth in our United States pharmacy claims processing facilities. Our pharmacy technology platform allows us to safely, rapidly and accurately adjudicate over one billion adjusted prescriptions annually. Our technology helps retail pharmacies focus on patient care and our real-time safety checks help avoid hundreds of thousands of medication errors annually. The Cigna companies hold over 230 United States patents. We use these patents to protect our proprietary technological advances and to differentiate ourselves in the market.

INVESTMENT MANAGEMENT

Our investment operations provide investment management and related services for our various businesses, including the insurance-related invested assets in our General Account ("General Account Invested Assets"). We acquire or originate, directly or through intermediaries, a broad range of investments including private placement and public securities, commercial mortgage loans, real estate, mezzanine, private equity partnerships and short-term investments. Invested assets also include policy loans that are fully collateralized by insurance policy cash values. We also enter into derivative financial instruments, primarily to minimize the risk of changes in foreign currency exchange rates on our investments. Invested assets are managed primarily by our subsidiaries and, to a lesser extent, external managers with whom our subsidiaries contract. Net investment income is included as a component of adjusted income from operations for each of our segments and Corporate. Realized investment gains (losses) are reported by segment but excluded from adjusted income from operations. For additional information about invested assets, see the "Investment Assets" section of the MD&A and Notes 11 and 12 to the Consolidated Financial Statements.

We manage our investment portfolios to reflect the underlying characteristics of related insurance and contractholder liabilities and capital requirements, as well as regulatory and tax considerations pertaining to those liabilities and state investment laws. Insurance and contractholder liabilities range from short duration health care products to longer-term obligations associated with life insurance products and the run-off settlement annuity business. Assets supporting these liabilities are managed in segregated investment portfolios to facilitate matching of asset durations and cash flows to those of corresponding liabilities. Investment results are affected by the amount and timing of cash available for investment, economic and market conditions and asset allocation decisions. We routinely monitor and evaluate the status of our investments, obtaining and analyzing relevant investment-specific information and assessing current economic conditions, trends in capital markets and other factors such as industry sector, geographic and property-specific information.

Separate Accounts

Our subsidiaries or external advisors manage invested assets of Separate Accounts on behalf of contractholders, including the Cigna Pension Plan, variable universal life products sold through our corporate-owned life insurance business and other life insurance products. These assets are legally segregated from our other businesses and are not included in General Account Invested Assets. Income, gains and losses generally accrue directly to the contractholders.

Investing in Innovation

In addition to the portfolio investments in our general and separate accounts discussed above that support our insurance operations, we do targeted investing within the health care industry specifically. In 2018, Cigna committed $250 million to Cigna Ventures, our strategic corporate venture fund to invest in promising startups and growth-stage companies who, like us, are unlocking new growth possibilities in health care. Specifically, we invest in companies making groundbreaking progress in three strategic areas: insights / analytics, digital health / experience, care delivery / enablement. To date, Cigna Ventures has six venture capital partners and 14 direct investments. Through these deep partnerships we collaborate, innovate and develop new solutions that address critical market challenges of affordability, predictability and simplicity impacting the people we serve.

HUMAN CAPITAL MANAGEMENT

Cigna's mission is to improve the health, well-being and peace of mind of those we serve by enabling affordable, predictable and simple health care. A global healthy and diverse workforce is essential to achieving our mission and our business growth strategies. We are continually investing in our global workforce to support our employees' health and well-being, further drive diversity and inclusion, provide fair and market-competitive pay and foster their growth and development. As of the end of the 2020 fiscal year, we had approximately 73,700 employees, with 89% of our employees based in the United States. Almost all of our employees are full-time, with less than 2% of employees regularly working fewer than 30 hours per week.

Health, Well-Being and Other Benefits

Tending to our employees' health, well-being and peace of mind is more than just our mission – it is a critical business imperative for our company. At Cigna, we believe that the provision of health and well-being benefits for our employees is our responsibility as an employer, and should not be outsourced to the government or other third parties. Ensuring that our employees have comprehensive health and well-being benefits is not only the right thing to do from a societal perspective – it is also one of the most important investments in our enterprise that we make each year. That is because we strongly believe that a healthy workforce is more productive, has fewer absences and is a critical enabler for us to drive our business and our strategy forward, thereby creating significant shareholder value. In 2020, Cigna invested approximately 17% of total payroll in health, well-being and other benefits, including life and disability programs, 401(k) contributions and retirement-related benefits for its employees in the United States.

In addition to traditional medical and pharmacy benefits, we provide mental health support to employees, including: employee assistance program (EAP) benefits that are free to all employees and to any member of their household, digital tools that provide access to education and therapy to help individuals build greater resilience and cope with stress, anxiety and depression.

Diversity, Equity & Inclusion

At Cigna, we take an expansive view of diversity including race, ethnicity, nationality, gender, veteran status, ability, sexual orientation and gender identity. As of the end of the 2020 fiscal year, 70% of our employees were women, and 37% of our employees in the United States were from underrepresented groups (which includes Black/African American, Hispanic or Latinx, Asian, Pacific Islander, American Indian/Alaskan and employees who identified as two races or more).

We are committed to fairness in pay and opportunity for all of our employees. Our compensation practices, which include benchmarking compensation by role, eliminating inquiries regarding applicants' compensation history from the hiring process and monitoring for potential disparities, promote equity in pay. Our most recent pay equity analysis, conducted in 2020, showed that in the United States female employees at Cigna earn 99.9 cents for every dollar earned by similarly-situated male employees, and employees from underrepresented groups earn 99.7 cents for every dollar earned by similarly-situated white employees.

We are committed to attracting and recruiting key diverse talent across various leadership development programs and other entry level positions with the business. This success is rooted in strategic relationships with diverse student groups at our partner colleges and universities as well as our commitment to multiple national, regional and local organizations, which provide us focused recruiting opportunities with women, the LGBTQA+ community, military veterans and underrepresented minority groups.

Talent Acquisition, Development and Retention

Our talent acquisition and rewards strategies are designed to ensure we attract and retain skilled employees who are engaged in our mission. Our compensation program is rooted in market competitive base salaries and incentives that reward contributions that advance the Company's strategy and mission. Our online learning platform and career development tools and events offer a broad range of training, education and development resources to all employees. In 2020, U.S. employees on average engaged in 53 hours of learning through these resources. Enterprise leadership development programs include New Leader Experience, Leading with Excellence, Transformative Leadership, Inclusive Leadership and Leaders in Transition. Cigna also offers an education reimbursement program for both full and part-time employees who meet the continuing education criteria. We believe these strategies and programs contribute to employee engagement and retention. In 2020, the voluntary turnover rate was 3.9% for exempt employees in the United States.

MISCELLANEOUS

- Revenues from U.S. Federal Government agencies, under a number of contracts, represent 15% of our consolidated revenues in 2020.
- The Company is not dependent on business from one or a few brokers or agents. In addition, our insurance businesses are generally not committed to accept a fixed portion of the business submitted by independent brokers and agents and generally all such business is subject to approval and acceptance.

REGULATION

The laws and regulations governing our business continue to increase each year and are subject to frequent change. We are regulated by federal, state and international legislative bodies and agencies, which generally have discretion to issue regulations and interpret and enforce laws and rules. These regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals, which could materially impact the health care system. We expect continued legislative and regulatory debate of issues related to our businesses. As has become increasingly common with public policy reforms in the health services industry, executive, judicial or legislative intervention could alter, slow or eliminate the impact of any proposal following the related regulation's promulgation, including, for example, the executive order issued in January 2021 regarding a regulatory freeze pending review which may delay or ultimately result in revision or repeal of various regulatory actions taken in 2020.

Many aspects of our business are directly regulated by federal and state laws and administrative agencies, such as the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), the Internal Revenue Service ("IRS"), the U.S. Departments of Labor ("DOL"), Treasury and Justice ("DOJ"), the Office of Personnel Management ("OPM"), the Federal Trade Commission ("FTC"), the U.S. Securities and Exchange Commission ("SEC"), the Office of the National Coordinator for Health Information Technology ("ONC"), state departments of insurance and state boards of pharmacy. Our business practices may also be shaped by judicial decisions.

In addition, aspects of our business are subject to indirect regulation. The self-funded benefit plans sponsored by our U.S. employer clients are regulated under federal law. These self-funded clients expect us to ensure that our administration of their plans complies with the regulatory requirements applicable to them.

Our business operations and the books and records of our regulated businesses are routinely subject to examination and audit at regular intervals by state insurance and HMO regulatory agencies, state boards of pharmacy, CMS, DOL, IRS, OPM and comparable international regulators to assess compliance with applicable laws and regulations. Our operations are also subject to nonroutine examinations, audits and investigations by various state and federal regulatory agencies, generally as the result of a complaint. In addition, we may be implicated in investigations of our clients whose group benefit plans we administer on their behalf. As a result, we routinely receive subpoenas and other demands or requests for information from various state insurance and HMO regulatory agencies, state attorneys general, the HHS Office of Inspector General ("HHS-OIG"), the DOJ, the DOL and other state, federal and international authorities. We may also be called upon by members of the U.S. Congress to provide information, including testifying before Congressional committees and subcommittees, regarding certain of our business practices. If Cigna is determined to have failed to comply with applicable laws or regulations, these examinations, audits, investigations, reviews, subpoenas and demands may:

- result in fines, penalties, injunctions, consent orders or loss of licensure;
- suspend or exclude from participation in government programs or limit our ability to sell or market our products;
- require changes in business practices;
- damage relationships with the agencies that regulate us and affect our ability to secure regulatory approvals necessary for the operation of our business; or
- damage our brand and reputation.

Our international subsidiaries are subject to regulations in international jurisdictions, including in certain cases many regulations similar to the federal and state regulations described below, which are complex and where foreign insurers may face more rigorous regulations than their domestic competitors and may also be affected by geopolitical developments or tensions.

The laws and regulations governing our business, as well as the related interpretations, are subject to frequent change and can be inconsistent or in conflict with each other. Changes in our business environment are likely to continue as elected and appointed officials at the national and state levels continue to propose and enact significant modifications to existing laws and regulations. Even

where we believe that we are in compliance with the various laws and regulations, any enforcement actions by federal, state or international government officials alleging non-compliance with these rules and regulations could subject us to penalties or restructuring or reorganization of our business. For a discussion of the risks related to our compliance with these laws and regulations see the Risk Factors section located in Part I, Item 1A of this Form 10-K. Management continues to be actively engaged with regulators and policymakers with respect to legislation and rulemaking.

COVID-19-related Regulatory Actions

In response to COVID-19 which was declared a pandemic by the World Health Organization in early 2020, U.S. federal and state governments have increasingly enacted new legislative and regulatory requirements, as well as provided flexibility to industry participants within existing legal requirements. These regulatory actions primarily provide for:

- client and customer premium relief to avoid the cancellation or non-renewal of policies;
- mandating or requesting waiver of customer cost-sharing and other related costs such as COVID-19 testing or treatment, as well as establishing provider reimbursement and vaccine immunizations coverage requirements;
- extending claims filing deadlines for providers, customers and facilities;
- mandating or encouraging waiver of customer cost-share related to telemedicine services, as well as requiring certain reimbursement levels for telemedicine providers to encourage its utilization;
- increasing the Medicare fee-for-service reimbursement for certain items and services;
- enacting coverage and reimbursement requirements at in-network levels for certain services received from out-of-network providers;
- clarification regarding permissible sharing of information and coordination among health care providers;
- revising or suspending the use of certain medical management procedures; and
- mandating prescription drug benefit administration requirements primarily related to formulary exceptions and restrictions, and prior authorization and prescription drug refill limits.

These actions are in effect for various durations, but generally track the different states of emergency that have been declared at the state and federal level. Of particular significance is the Public Health Emergency declared by the Secretary of HHS on January 31, 2020, which sets the effective period for certain of the requirements established through federal COVID-19 legislation, such as covering testing without cost sharing.

Patient Protection and the Affordable Care Act

The Patient Protection and Affordable Care Act ("ACA") mandated broad changes to the U.S. health care system, including insured and self-insured health benefit plans and pharmacy benefit managers. Our business model is impacted by the ACA, including our relationships with current and future producers and health care providers, products, service providers and technologies. The provisions of the ACA imposed, among other things, certain assessments on health insurers, created health insurance exchanges for individuals and small group employers to purchase insurance coverage and implemented minimum medical loss ratios ("MLRs") for our Medicare and commercial businesses. Certain states have adopted MLR requirements applicable to our commercial businesses that are more stringent than those established by the ACA. Other provisions of the ACA in effect include reduced Medicare Advantage payment rates, the requirement to cover preventive services with no enrollee cost-sharing, banning the use of lifetime and annual limits on the dollar amount of essential health benefits, increasing restrictions on rescinding coverage, extending coverage of dependents up to age 26, restrictions on differential pricing, enforcement mechanisms and rules related to health care fraud and abuse enforcement activities and certain pharmacy benefit transparency requirements. The employer mandate requires employers with 50 or more full-time employees to offer affordable health insurance that provides minimum value (each as defined under the ACA) to full-time employees and their dependents, including children up to age 26, or be subject to penalties based on employer size. The ACA also changed certain tax laws to effectively limit tax deductions for certain employee compensation paid by health insurers. In December 2019, the federal government repealed the non-deductible health insurance industry fee effective for 2021, as well as repealing the enacted but never implemented 40% excise tax on certain employer-sponsored coverage (known as the "Cadillac Tax") and the medical device tax.

In 2018, the DOL issued final rules that revised the definition of "employer" under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") to make it easier for employers, including self-employed individuals, to form bona fide employer groups, all of whose employees would be counted in determining whether they were small or large groups for purposes of the ACA. While the regulation of these groupings by state insurance departments is not affected by the DOL's final association health plan rules, the final rules have resulted in an increase in interest among employers, associations, producers and benefit consultants in forming new groupings for purposes of offering insured or self-funded group health plans.

Since its adoption, there have been several attempts to repeal or limit the utility of the ACA. Certain insurers, including Cigna, have sued the federal government for failure to pay cost-sharing subsidies ("CSR") under the ACA. In the first set of consolidated appeals, the Court of Appeals for the Federal Circuit issued a decision on August 14, 2020, finding that (i) the CSR reimbursement provision of the ACA imposes an obligation on the government to pay, but (ii) the insurers' damages must be reduced by the amount of additional premium tax credit payments that each insurer received as a result of the government's termination of CSR payments. Our premium rates for the 2018, 2019 and 2020 plan years reflected a lack of government funding for cost-sharing reduction subsidies. The insurers filed petitions for rehearing en banc in the Federal Circuit and the court denied those petitions. On February 19, 2021, two insurers filed a petition seeking U.S. Supreme Court review. The matter remains unresolved and our case is stayed pending final resolution of the consolidated appeals, including the petition for writ of certiorari in the U. S. Supreme Court. In December 2017, U.S. tax reform legislation was signed into law that, among other things, reduced the "individual mandate" penalty for individuals without health insurance to zero dollars, effective January 1, 2019. As a result of this change, a federal district court has ruled that the "individual mandate" is unconstitutional and that the entire law must be struck down. On appeal, the Court of Appeals for the Fifth Circuit agreed that the "individual mandate" is unconstitutional but ordered the district court to reexamine whether the other provisions of the ACA can remain in effect. The California-led states and the U.S. House of Representatives filed petitions seeking to appeal the Fifth Circuit's ruling to the U.S. Supreme Court. The U.S. Supreme Court heard oral arguments on the appeals on November 10, 2020 and a decision is expected by the end of June 2021.

See Note 3 to the Consolidated Financial Statements for more information regarding accounting policies around the risk mitigation programs under the ACA.

Medicare and Medicaid Regulations

Through our subsidiaries, we offer individual and group Medicare Advantage, Medicare Prescription Drug ("Part D") and Medicare Supplement products. We also provide Medicare Part D-related products and services to other Medicare Part D sponsors, Medicare Advantage Prescription Drug Plans and employers and clients offering Medicare Part D benefits to Medicare Part D eligible beneficiaries. As part of our Medicare Advantage and Medicare Part D business, we contract with CMS to provide services to Medicare beneficiaries. As a result, our ability to obtain payment (and the determination of the amount of such payments), market to, enroll and retain customers and expand into new service areas is subject to compliance with CMS' numerous and complex regulations and requirements that are frequently modified and subject to administrative discretion, review and enforcement. We offer Medicaid and dual-eligible products and participate in state Medicaid programs directly or indirectly through our clients who are Medicaid managed care contractors. We also perform certain Medicaid subrogation services and certain delegated services, including utilization management, for clients, which are regulated by federal and state laws. Our Medicaid and dual-eligible products are regulated by CMS and state Medicaid agencies audit our performance to determine compliance with contracts and regulations.

CMS evaluates Medicare Advantage plans and Part D plans under its "Star Rating" system. The Star Rating system considers various measures adopted by CMS, including, for example, quality of care, preventive services, chronic illness management, coverage determinations and appeals and customer satisfaction. A plan's Star Rating affects its image in the market and plans that perform very well are able to offer enhanced benefits and market more effectively and for longer periods of time than other plans. Medicare Advantage plans' quality-bonus payments are determined by the Star Rating, with plans receiving a rating of four or more stars eligible for such payments. The Star Rating system is subject to change annually by CMS, which may make it more difficult to achieve and maintain four stars or greater. For example, beginning with Star Ratings for payment year 2024, CMS will place more emphasis on patient experience survey-based measures which could reduce Star Ratings predictability year over year. Additionally, as a result of the COVID-19 pandemic's impact on 2020 care patterns and utilization, CMS finalized rules applying relief to Medicare Advantage and Part D Plan Star Ratings for payment year 2023 by utilizing the higher of the payment year 2023 or 2022 measure level Star Ratings.

CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage plans according to customers' health status. The risk-adjustment model generally pays more where a plan's membership is expected to have increased costs because of the health status of its members. Under this model, rates paid to Medicare Advantage plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient and physician providers to CMS within prescribed deadlines. We generally rely on providers, including certain providers who are employees, to appropriately document their claims and other submissions with appropriate diagnoses from which we extract hierarchical condition codes to submit to CMS as the basis for our payments received under the actuarial risk-adjustment model. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to the plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. In 2012, CMS released a payment methodology that provided for sample audit error rates to be

extrapolated to the entire Medicare Advantage contract after comparing audit results with a similar audit of Medicare Fee for Service (the "FFS Adjuster") and applying an FFS Adjuster to establish actuarial equivalency in payment rates as required by the Medicare statute. However, a methodology to calculate the FFS Adjuster was not finalized and CMS has, to date, not completed any Risk Adjustment Data Validation ("RADV") audits using extrapolation.

On November 1, 2018, CMS released a proposed rule titled "Proposed Rule on Changes to MA and Part D Programs for CY 2020 and 2021" that would revise its RADV methodology for RADV audits of contract year 2011 and all subsequent years by, among other things, extrapolating the error rate related to RADV audit findings without applying the FFS Adjuster. If the proposed rule is adopted in its current form, it could result in some combination of degraded plan benefits, higher monthly premiums and reduced choice for the population served by all MA insurers. The Company, along with other Medicare Advantage organizations and additional interested parties, submitted comments to CMS on the proposed rule as part of the notice-and-comment rulemaking process. The comment period concluded on August 28, 2019 and CMS is expected to act by November 2021. RADV audits for our contract years 2011 through 2015 are currently in process. It is uncertain whether CMS will finalize the rule as proposed. See below under "Federal and State Oversight of Government-Sponsored Health Care Programs" for a discussion of RADV audits.

Coverage of prescription drugs under Medicare Part D is also regulated by CMS and our contracts with CMS contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions affect our ultimate payments from CMS. For example, premiums from CMS are subject to risk corridor payments which compare costs targeted in our annual bids with actual prescription costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the payments we received (known as a risk corridor).

We expect CMS, HHS-OIG, DOJ and other federal agencies to continue to closely scrutinize each component of the Medicare Advantage program and modify the terms and requirements of the program. Noncompliance with these laws and regulations may result in significant consequences, including fines and penalties, enrollment sanctions, exclusion from the Medicare and Medicaid programs, limitations on expansion and criminal penalties.

False Claims Act and Anti-Kickback Laws

Our products and services are also subject to the federal False Claims Act (the "False Claims Act") and federal and state anti-kickback laws. Additionally, the federal government has made investigating and prosecuting health care fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks in return for customer referrals, billing for unnecessary medical services, upcoding and improper marketing. The regulations and contractual requirements in this area are complex, frequently modified and subject to administrative discretion and judicial interpretation.

False Claims Act and Related Criminal Provisions. The False Claims Act imposes civil penalties on any person who makes or causes to be made claims or records or statements that he or she knows or should know are false with respect to governmental programs, such as Medicare and Medicaid, to obtain reimbursement or for failure to return overpayments. Private individuals may bring *qui tam* or "whistleblower" suits against providers under the False Claims Act, which authorizes the payment of a portion of any recovery to the individual bringing suit. The ACA amended the federal anti-kickback laws to state any claim submitted to a federal or state health care program that violates the anti-kickback laws is also a false claim under the False Claims Act. The False Claims Act generally provides for the imposition of civil penalties and for treble damages, creating the possibility of substantial financial liabilities. Criminal statutes similar to the False Claims Act provide that if a corporation is convicted of presenting a claim or making a statement it knows to be false, fictitious or fraudulent to any federal agency, the corporation may be fined. Conviction under these statutes may also result in exclusion from participation in federal and state health care programs. Many states have also enacted laws similar to the False Claims Act, some of which may include criminal penalties, substantial fines and treble damages.

Anti-Kickback and Referral Laws. Subject to certain exceptions and "safe harbors," the federal anti-kickback statute generally prohibits, among other things, knowingly and willfully paying, receiving or offering any payment or other remuneration to induce a person to purchase, lease, order or arrange for items (including prescription drugs) or services reimbursable in whole or in part under Medicare, Medicaid or another federal health care program. Many states have similar laws, some of which are not limited to items or services paid for with government funds. Sanctions for violating these federal and state anti-kickback laws may include criminal and civil fines and exclusion from participation in federal and state health care programs.

Anti-kickback laws have been cited as a partial basis, along with state consumer protection laws described below, for investigations and multistate settlements relating to financial incentives provided by drug manufacturers to pharmacies or payors in connection with "product conversion" or promotion programs. Other anti-kickback and referral laws may also be applicable including criminal and

civil laws restricting illegal kickbacks and conflicts of interest in connection with an ERISA plan, the federal "Stark Law," and various state anti-kickback restrictions.

In November 2020, HHS and HHS-OIG released a final rule which eliminates an anti-kickback regulatory safe harbor protection for price concessions, including rebates, that are offered by pharmaceutical manufacturers to plan sponsors or pharmacy benefit managers under the Medicare Part D program. The final rule creates two new safe harbors: (i) for price reductions by manufacturers to plan sponsors under Medicare Part D and Medicaid managed care organizations that are reflected at the time of dispense and (ii) for fixed-fee service arrangements between manufacturers and pharmacy benefit managers. HHS-OIG has temporarily postponed the effective date of the new safe harbors to March 22, 2021. Additionally, HHS recently agreed to postpone the elimination of the aforementioned regulatory safe harbor to January 1, 2023.

Federal Civil Monetary Penalties Law. The federal civil monetary penalty statute provides for civil monetary penalties against any person who gives something of value to a Medicare or Medicaid program beneficiary that the person knows or should know is likely to influence the beneficiary's selection of a particular provider for Medicare or Medicaid items or services. Under this law, our wholly-owned home delivery pharmacies, specialty pharmacies and home health providers are restricted from offering certain items of value to influence a Medicare or Medicaid patient's use of services. The ACA also includes several civil monetary provisions, such as penalties for the failure to report and return a known overpayment and failure to grant timely access to the HHS-OIG under certain circumstances.

Federal and State Oversight of Government-Sponsored Health Care Programs

Participation in government-sponsored health care programs subjects us to a variety of federal and state laws and regulations and risks associated with audits conducted under these programs. These audits may occur years after the provision of services. Risks include potential fines and penalties, restrictions on our ability to participate or expand our presence in certain programs and restrictions on marketing our plans. For example, with respect to our Medicare Advantage business, CMS and the HHS-OIG perform audits to determine a health plan's compliance with federal regulations and contractual obligations, including program audits and Risk Adjustment Data Validation Audits, which focus on compliance with proper coding practices. Certain of our contracts are currently subject to RADV audits by CMS and the HHS-OIG. CMS has announced that its goal is to subject all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. The DOJ is also currently conducting an industry-wide investigation of the risk adjustment data submission practices and business processes, including medical chart reviews and health exams, of Cigna and a number of other Medicare Advantage organizations under Medicare Parts C and D. See Note 21 to the Consolidated Financial Statements for more information.

For our Medicare Part D business, compliance with certain contractual provisions and regulatory requirements is subject to review by Recovery Audit Contractor audits in which third-party contractors conduct post-payment reviews on a contingency fee basis to detect and correct improper payments.

Government Procurement Regulations

We have a contract with the U.S. Department of Defense ("DoD"), which subjects us to applicable Federal Acquisition Regulations ("FAR") and the DoD FAR Supplement, which govern federal government contracts. Further, there are other federal and state laws applicable to our DoD arrangement and our arrangements with other clients that may be subject to government procurement regulations. In addition, certain of our clients participate as contracting carriers in the Federal Employees Health Benefits Program administered by the OPM, which includes various pharmacy benefit management standards.

Employee Retirement Income Security Act

Our domestic subsidiaries sell most of their products and services to sponsors of employee benefit plans that are governed by ERISA. ERISA is a complex set of federal laws and regulations enforced by the IRS and the DOL, as well as the courts. ERISA regulates certain aspects of the relationship between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Certain of our domestic subsidiaries are also subject to requirements imposed by ERISA affecting claim payment and appeals procedures for individual health insurance and insured and self-insured group health plans and for the insured dental, disability, life and accident plans we administer. Certain of our domestic subsidiaries also may contractually agree to comply with these requirements on behalf of the self-insured dental, disability, life and accident plans they administer. We believe the conduct of our pharmacy benefit management business is not generally subject to the fiduciary obligations of ERISA. However, there can be no assurances that the DOL may not assert that pharmacy benefit managers are fiduciaries. From time to time, states have considered legislation to declare a pharmacy benefit manager or health benefit manager a fiduciary with respect to its clients.

Plans subject to ERISA can also be subject to state laws and the legal question of whether and to what extent ERISA preempts a state law will continue to be subject to court interpretation, including by the U.S. Supreme Court.

Privacy, Security and Data Standards Regulations

Many of our activities involve the receipt or use of confidential health and other personal information. In addition, we use aggregated and de-identified data for our own research and analysis purposes and, in some cases, provide access to such de-identified data, or analytics created from such data, to pharmaceutical manufacturers and third-party data aggregators. We may also use such information to create analytic models designed to predict, and potentially improve, outcomes and patient care. There are also industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements for using and disclosing personal information.

The federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") impose minimum standards on health insurers, pharmacy benefit managers, HMOs, health plans, health care providers and clearinghouses for the privacy and security of protected health information. HIPAA regulations may also hold us liable for violations by our business associates (e.g., entities that provide services to health plans and providers). HIPAA also established rules that standardize the format and content of certain electronic transactions, including, but not limited to, eligibility and claims. To the extent insurers offer plans through a public exchange, participants and their downstream entities such as pharmacy benefit managers must adhere to privacy and security standards for personally identifiable information and to impose standards that are at least as protective as those the exchange has implemented for itself. These standards may differ from, and be more stringent than, HIPAA.

The Health Information Technology for Economic and Clinical Health Act ("HITECH") imposes additional contracting requirements for covered entities, the extension of privacy and security provisions to business associates, the requirement to provide notification to various parties in the event of a data breach of protected health information and enhanced financial penalties for HIPAA violations, including potential criminal penalties for individuals. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The federal Gramm-Leach-Bliley Act and its implementing regulations generally place restrictions on the disclosure of nonpublic information to nonaffiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their nonpublic personal information is used, including an opportunity to "opt out" of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law.

State and local authorities are increasingly focused on protecting individuals from identity theft and a number of states have adopted comprehensive data security laws and regulations requiring, among other things, certain minimum data security standards and security breach notifications that may apply to us in certain circumstances, as well as certain limitations on access to and use of personal information. Neither HIPAA nor the Gramm-Leach-Bliley privacy regulations preempt more stringent state laws and regulations which may differ in approach and enforcement. The California Consumer Privacy Act, which went into effect in January 2020, provides additional privacy rights for California residents although it generally does not apply to certain regulated data such as information covered by HIPAA. In November 2020, California further expanded privacy rights for California residents by enacting the California Privacy Rights Act which includes additional protections on sensitive personal information, creates new individual rights for residents and imposes additional requirements for those entities collecting personal information of California residents and their service providers beginning in 2023. We anticipate federal and state regulators to continue to enact legislation related to privacy and cybersecurity.

The Cybersecurity Information Sharing Act of 2015 ("CISA") encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. States have also begun to issue regulations specifically related to cybersecurity, which may differ or conflict from state to state. In October 2017, the National Association of Insurance Commissioners ("NAIC"), an organization of state insurance regulators, adopted the Insurance Data Security Model Law that creates rules for insurers and other covered entities addressing data security, investigation and notification of breaches. This includes maintaining an information security program based on ongoing risk assessment, overseeing third-party service providers, investigating data breaches and notifying regulators of a cybersecurity event. As the model law is intended to serve as model legislation only, states will need to enact legislation for the model law to become mandatory and enforceable. We will continue to monitor states' activity regarding cybersecurity regulation.

HHS, including the ONC, the Office for Civil Rights and CMS, has enacted regulations, and proposed additional regulations, to support the seamless and secure access, exchange and use of electronic health information by or between patients, enrollees and entities such as payers and health care providers. These regulations include, among others, proposed changes to HIPAA designed to

promote greater patient access and control over health information maintained by health plans and health care providers and improve information sharing for case management and care coordination. Other interoperability regulations prohibit information blocking by certain entities and require certain regulated plans to make specified patient, clinical and plan-related data available to enrollees via interoperable technology and applications. These regulations apply to a variety of entities, including health plans like Medicare plans and qualified health plans, as well as health care providers, certified health information technology developers and health information networks and exchanges and generally require significant enhancements to information technology and data governance practices. The regulations and proposals demonstrate an increased interest in information sharing and will impact how industry participants, including us, comply with disclosure requirements and share information with individuals and other healthcare organizations. We continue to monitor developments and to submit comments on proposed regulations where appropriate.

In addition, international laws, rules and regulations governing the use and disclosure of personal information can be more stringent than in the United States, and they vary from jurisdiction to jurisdiction. The European Union's General Data Protection Regulation ("GDPR"), which became effective May 2018, enhanced or created obligations regarding the handling of personal data relating to European residents, such as regarding notices, data protection impact assessments and individual rights, and provides for greater penalties for noncompliance than the previous European Directive or laws. In addition, many countries outside of Europe where we conduct business have implemented or may implement data protection laws and regulations, some of which include requirements modeled after those in the GDPR. Some non-U.S. jurisdictions are also instituting data residency regulations requiring that data be maintained within the respective jurisdiction or otherwise restricting transfer of personal data across borders unless specified regulatory requirements are met.

See Part I. Item 1A, "Risk Factors" for a discussion of the risks related to compliance with privacy and security regulations.

Consumer Protection Laws

We engage in direct-to-consumer activities and are increasingly offering mobile and web-based solutions to our customers. We are therefore subject to federal and state regulations applicable to electronic communications and other consumer protection laws and regulations, such as the Telephone Consumer Protection Act and the CAN-SPAM Act. The FTC is also increasingly exercising its enforcement authority in the areas of consumer privacy and data security, with a focus on web-based, mobile data and "big data." Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

State and federal policymakers have taken actions intended to increase transparency and predictability of health care costs for consumers. For example, in October 2020, the HHS, the DOL and the Department of the Treasury issued a final rule that requires most group health plans and health insurance issuers in the individual and group markets to disclose price and cost-sharing information for all items and services to participants and enrollees. The cost-sharing information requirements under the rule take effect in a phased approach beginning January 1, 2023. In addition to providing personalized cost-sharing information, beginning January 1, 2022, health plans and health insurers must also publicly disclose (i) in-network provider negotiated rates, (ii) historical out-of-network allowed amounts and billed charges and (iii) in-network negotiated rates and historical net prices for all covered prescription drugs. Beginning in 2021, insurers will be able to receive credit in their MLR calculations for certain savings they share with enrollees. Separately, in December 2020, Congress passed the No Surprises Act which prohibits health care providers, in certain situations, from balance billing the patient and requires that they work directly with insurers to agree on out-of-network reimbursement, including utilizing an independent dispute resolution process outlined in the Act. The Act is effective January 1, 2022 and we expect regulations implementing the Act to be issued starting in 2021. Many states already have addressed balance billing, or surprise medical bills. These laws and regulations vary in their approach, resulting in different impacts on the health care system as a whole.

Additionally, most states have consumer protection laws that have been the basis for investigations and multistate settlements relating to financial incentives provided by drug manufacturers to retail pharmacies in connection with product conversion programs. Such statutes have also been cited as the basis for claims or investigations by state attorneys general relative to privacy and data security.

Office of Foreign Assets Control Sanctions and Anti-Money Laundering

We are also subject to regulation by the Office of Foreign Assets Control of the U.S. Department of the Treasury that administers and enforces economic and trade sanctions against targeted foreign countries and regimes based on U.S. foreign policy and national security goals. Certain of our products are subject to the Department of the Treasury anti-money laundering regulations under the Bank Secrecy Act. In addition, we are subject to similar regulations in non-U.S. jurisdictions in which we operate.

Corporate Practice of Medicine and Other Laws

Many states in which our subsidiaries operate limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of

physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed health care providers, developing operating policies and procedures, implementing professional standards and controls and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-splitting and similar issues. However, any enforcement actions by governmental officials alleging noncompliance with these statutes could subject us to penalties or restructuring or reorganization of our business.

Laws and Legislation Affecting Plan Design and Pharmacy Network Access

Some states have enacted laws that prohibit managed care plan sponsors from implementing certain restrictive benefit plan design features, and many states have laws or have introduced legislation to regulate various aspects of managed care plans, including provisions relating to the pharmacy benefit. For example, some states, under so-called “freedom of choice” legislation, provide customers of the plan may not be required to use network providers, but must instead be provided with benefits even if they choose to use non-network providers. Some states have also enacted legislation that can negatively impact the use of cost-saving network configurations for plan sponsors. Other states have enacted legislation purporting to prohibit health plans from offering customers financial incentives for use of home delivery pharmacies. Medicare and some states have issued guidance and regulations that limit our ability to fill or refill prescriptions electronically submitted by a physician to our home delivery pharmacy without first obtaining consent from the patient. Such restrictions generate additional costs and limit our ability to maximize efficiencies, which could otherwise be gained through the electronic prescription and automatic refill processes. Legislation has been introduced in some states to prohibit or restrict therapeutic intervention, or to require coverage of all Food and Drug Administration approved drugs. Other states mandate coverage of certain benefits or conditions, and require health plan coverage of specific drugs if deemed medically necessary by the prescribing physician. States are also standardizing the process for, and restricting the use of, utilization management rules and shortening the time frames within which prescription drug prior authorization determinations must be made. Even where states do not regulate pharmacy benefit or utilization management companies directly, these laws will apply to many of our clients, including managed care organizations and health insurers.

Additionally, Medicare Part D and a majority of states now have laws, regulations or some form of legislation affecting our ability, or our clients’ ability, to limit access to a pharmacy provider network or remove a provider from a network. Such laws, regulations or legislation may require us or our clients to admit any retail pharmacy or provider willing to meet the plan’s terms and conditions for network participation (“any willing provider”) or may direct that a provider may not be removed from a network except in compliance with certain procedures (“due process”).

Certain states have laws prohibiting certain pharmacy benefit management clients from imposing additional co-payments, deductibles, limitations on benefits, or other conditions on covered individuals utilizing a retail pharmacy when the same conditions are not otherwise imposed on covered individuals utilizing home delivery pharmacies. However, the laws require the retail pharmacy to agree to the same reimbursement amounts and terms and conditions as are imposed on the home delivery pharmacies. An increase in the number of prescriptions filled at retail pharmacies may have a negative impact on the number of prescriptions filled through home delivery.

Pharmacy Benefit Management and Drug Pricing Regulation

Our pharmacy benefit management services are subject to numerous laws and regulations. These laws and regulations govern, and proposed legislation and regulations may govern, critical practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; certain pharmacy contracting practices including disclosure of cost information to customers; the receipt and retention of transmission fees from contracted pharmacies; use of, administration of, or changes to drug formularies, the use and disclosure of maximum allowable cost ("MAC") pricing, or clinical programs; “most favored nation” pricing, which provides that a pharmacy participating in a specific government program must give the program the best price the pharmacy makes available to any third-party plan; disclosure of data to third parties; drug utilization management practices; the level of duty a pharmacy benefit manager owes its clients or customers; configuration of pharmacy networks; the operations of our subsidiary pharmacies; disclosure of negotiated provider reimbursement rates; disclosure of negotiated drug rebates, calculation of certain customer cost-share for prescription drug claims; pricing that includes differential or spread (i.e., a difference between the drug price charged to the plan sponsor by a pharmacy benefit manager and the price paid by the manager to the dispensing provider); disclosure of fees associated with administrative service agreements and patient care programs that are attributable to customers’ drug utilization; and registration or licensing of pharmacy benefit managers.

We expect federal and state governments to continue to prioritize means of addressing out-of-pocket costs for consumers, particularly related to prescription drug costs. Policy proposals, issued via regulation or legislation, vary broadly in their approaches to achieve that

goal. At the federal level, several executive orders were issued in 2020. Although the orders did not contain any policy changes that take effect immediately, they directed agencies to pursue regulations intended to expand access to affordable prescription drug medication through various methods. Resulting regulations from HHS and its agencies: outlined paths for certain prescription drugs to be imported from Canada under the Federal Food, Drug and Cosmetic Act, effective November 30, 2020; amended the anti-kickback safe harbors to eliminate the regulatory safe harbor protection for price concessions, including rebates, that are offered by pharmaceutical manufacturers to plan sponsors or pharmacy benefit managers under the Medicare Part D program effective January 2023 and created new safe harbors related to point-of-sale price reductions and fixed-fee service arrangements, as described above under the heading "Anti-Kickback and Referral Laws;" issued rules intended to implement a program to make insulin and epinephrine available at participating federally qualified health centers at pricing under the Public Health Service Act Section 340B program effective March 22, 2021; and established a demonstration of the most favored nation international pricing model, an approach to international reference pricing, for Medicare Part B drugs which was subsequently halted by court intervention. As noted earlier, the executive order issued in January 2021 regarding a regulatory freeze pending review may delay or ultimately result in revision or repeal of various actions taken in response to the 2020 executive orders.

Additionally, proposals at the federal and state levels consider increased regulation of pharmacy benefit managers and health plans as a means to limit consumer out of pocket costs, including proposing to limit the use of various pharmacy benefit management tools; mandating the treatment of fees, discounts or financing mechanisms that otherwise are set in private contractual terms; increasing supply chain transparency; expanding regulatory requirements or definitions of fiduciaries; or mandating plan benefit designs that cap consumer out-of-pocket expense.

Some states have enacted statutes regulating the use of MAC pricing. These statutes, referred to as "MAC Transparency Laws," generally require pharmacy benefit managers to disclose specific information related to MAC pricing to pharmacies and provide certain appeal rights for pharmacies. MAC Transparency Laws also restrict the application of MAC and may require operational changes to maintain compliance with the law. Some states have also enacted laws regulating pharmacy pricing and protecting the profitability of pharmacies for dispensing certain MAC-priced drugs. Some states have enacted laws requiring that the customer cost-share for a prescription drug claim not exceed certain price points, such as the pharmacy's usual and customary charge or its contracted reimbursement for the drug. In a recent Supreme Court decision, the Court found that certain MAC Transparency Laws may be applied by states to ERISA plans in addition to health plans regulated by the applicable state. We continue to assess the impact of the decision on other state laws seeking to regulate pharmacy benefit management services.

In March 2018, the NAIC adopted changes to the Health Carrier Prescription Drug Benefit Management Model Act. The changes address issues relating to (i) transparency, accuracy and disclosure regarding prescription drug formularies and formulary changes during a policy year; (ii) accessibility of prescription drug benefits using a variety of pharmacy options; and (iii) tiered prescription drug formularies and discriminatory benefit design. While the actions of the NAIC do not have the force of law, they are used as a template to influence states to adopt laws based on the model legislation. An enhanced NAIC model act on pharmacy benefit manager licensure and regulation was adopted by a subgroup of the NAIC subject to a thirty day comment period with further consideration expected to occur in 2021.

The federal Medicaid Drug Rebate Program requires participating drug manufacturers to provide rebates on all drugs reimbursed through state Medicaid programs, including through Medicaid managed care organizations. Manufacturers of brand-name products must provide a rebate equivalent to the greater of (a) 23.1% of the average manufacturer price ("AMP") paid by retail community pharmacies or by wholesalers for certain drugs distributed to retail community pharmacies, or (b) the difference between AMP and the "best price" available to essentially any customer other than the Medicaid program and certain other government programs, with certain exceptions. We negotiate rebates with drug manufacturers and, in certain circumstances, sell services to drug manufacturers. Investigations are being and have been conducted by certain government entities which call into question whether a drug's "best price" was properly calculated and reported with respect to rebates paid by the manufacturers to the Medicaid programs. We are not responsible for such calculations, reports or payments.

Pharmacy Regulation

Our home delivery and specialty pharmacies also subject us to extensive federal, state and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. We are licensed to do business as a pharmacy in the states in which our pharmacies are located. Most of the states into which we deliver pharmaceuticals have laws that require out-of-state home delivery pharmacies to register with, or be licensed by, the board of pharmacy or a similar regulatory body in the state. These states generally permit the pharmacy to follow the laws of the state where the pharmacy is located, although some states require compliance with certain laws in that state as it impacts or relates to drugs distributed or dispensed into that state.

Our various pharmacy facilities also provide services under certain Medicare and state Medicaid programs. Participation in these programs requires our pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations, and exposes the pharmacies to various changes the federal and state governments may impose regarding reimbursement methodologies and amounts to be paid to participating providers under these programs. In addition, several of our pharmacy facilities are participating providers under Medicare Part D and are required to adhere to certain requirements applicable to Medicare Part D. Additionally, we are subject to CMS rules regarding the administration of our Medicare plans and pricing between our plans and related parties, including our pharmacy business.

Other statutes and regulations affect our home delivery and specialty pharmacy operations, including the federal and state anti-kickback laws and the federal civil monetary penalty law described above. Federal and state statutes and regulations govern the labeling, packaging, advertising, adulteration and security of prescription drugs and the dispensing of controlled substances and certain of our pharmacies must register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities. The FTC requires mail order sellers of goods generally to engage in truthful advertising, to stock a reasonable supply of the product to be sold, to fill mail orders within thirty days and to provide clients with refunds when appropriate. The United States Postal Service also has significant statutory authority to restrict the delivery of drugs and medicines through the mail.

Financial Reporting, Internal Control and Corporate Governance

Regulators closely monitor the financial condition of licensed insurance companies and HMOs. States regulate the form and content of statutory financial statements, the type and concentration of permitted investments and corporate governance over financial reporting. Our insurance and HMO subsidiaries are required to file periodic financial reports and schedules with regulators in most of the jurisdictions in which they do business as well as annual financial statements audited by independent registered public accounting firms. Certain insurance and HMO subsidiaries are required to file an annual report of internal control over financial reporting with most jurisdictions in which they do business. Insurance and HMO subsidiaries' operations and financial statements are subject to examination by such agencies. Many states have expanded regulations relating to corporate governance and internal control activities of insurance and HMO subsidiaries as a result of model regulations adopted by the NAIC with elements similar to corporate governance and risk oversight disclosure requirements under federal securities laws.

Guaranty Associations, Indemnity Funds, Risk Pools and Administrative Funds

Most states and certain non-U.S. jurisdictions require insurance companies to support guaranty associations or indemnity funds that are established to pay claims on behalf of insolvent insurance companies. Some states have similar laws relating to HMOs and other payors, such as consumer operated and oriented plans (co-ops) established under the ACA. In the United States, these associations levy assessments on member insurers licensed in a particular state to pay such claims. Certain states require HMOs to participate in guaranty funds, special risk pools and administrative funds. For additional information about guaranty funds and other assessments, see Note 21 to the Consolidated Financial Statements.

Certain states continue to require health insurers and HMOs to participate in assigned risk plans, joint underwriting authorities, pools or other residual market mechanisms to cover risks not acceptable under normal underwriting standards, although some states have eliminated these requirements as a result of the ACA.

Solvency and Capital Requirements

Many states have adopted some form of the NAIC model solvency-related laws and risk-based capital ("RBC") rules for life and health insurance companies and HMOs. The RBC rules recommend a minimum level of capital depending on the types and quality of investments held, the types of business written and the types of liabilities incurred. If the ratio of the insurer's adjusted surplus to its RBC falls below statutorily required minimums, the insurer could be subject to regulatory actions ranging from increased scrutiny to conservatorship.

In addition, various non-U.S. jurisdictions prescribe minimum surplus requirements that are based upon solvency, liquidity and reserve coverage measures. Our HMOs and life and health insurance subsidiaries, as well as non-U.S. insurance subsidiaries, are compliant with applicable RBC and non-U.S. surplus rules.

The Risk Management and Own Risk and Solvency Assessment Model Act ("ORSA"), adopted by the NAIC, provides requirements and principles for maintaining a group solvency assessment and a risk management framework and reflects a broader approach to U.S. insurance regulation. ORSA includes a requirement to file an annual ORSA Summary Report in the lead state of domicile. To date, an overwhelming majority of the states have adopted the same or similar versions of ORSA. We file our ORSA report annually as required.

Holding Company Laws

Our domestic insurance companies and certain of our HMOs are subject to state laws regulating subsidiaries of insurance holding companies. Under such laws, certain dividends, distributions and other transactions between an insurance company or an HMO subsidiary and its affiliates may require notification to, or approval by, one or more state insurance commissioners. In addition, the holding company acts of states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO subsidiary without prior regulatory approval. State holding company laws and regulations also subject our insurance companies and certain HMO subsidiaries to additional regulatory scrutiny related to their oversight of affiliates performing regulated services on behalf of the insurance company or HMO and require the Company to file an annual Enterprise Risk Report, which summarizes material risks that could pose enterprise risk to the insurance company subsidiaries.

Marketing, Advertising and Products

In most states, our insurance companies and HMO subsidiaries are required to certify compliance with applicable advertising regulations on an annual basis. Our insurance companies and HMO subsidiaries are also required by most states to file and secure regulatory approval of products prior to the marketing, advertising and sale of such products.

Licensing and Registration Requirements

Our insurance companies and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. Additionally, certain subsidiaries contract to provide claim administration, utilization management and other related services for the administration of self-insured benefit plans. These subsidiaries may be subject to state third-party administration and other licensing requirements and regulation, as well as third-party accreditation requirements.

We have received full accreditation for Utilization Review Accreditation Commission Pharmacy Benefit Management version 2.2 Standards, which includes quality standards for drug utilization management, and select subsidiaries have received full accreditation for Utilization Review Accreditation Commission for Health Utilization Management version 7.2, which includes quality standards for medical utilization management.

Certain states have adopted pharmacy benefit management registration, licensure or disclosure laws. In addition to registration laws, some states have adopted legislation mandating disclosure of various aspects of our financial practices, including those concerning pharmaceutical company revenue, as well as prescribing processes for prescription switching programs and client and provider audit terms.

Our international subsidiaries are often required to be licensed when entering new markets or starting new operations in certain jurisdictions. The licensure requirements for these subsidiaries vary by country and are subject to change.

International Regulations

Our operations outside the United States expose us to laws of multiple jurisdictions and the rules and regulations of various governing bodies and regulators, including those related to the provision of insurance, financial and other disclosures, the provision of health care-related services, corporate governance, privacy, data protection, data mining, data transfer, intellectual property, labor and employment, consumer protection, direct-to-consumer communications activities, tax, anti-corruption and anti-money laundering. Foreign laws and rules may include requirements that are different from, or more stringent than, similar requirements in the United States.

Our operations in countries outside the United States:

- are subject to local regulations of the jurisdictions where we operate;
- in some cases, are subject to regulations in the jurisdictions where customers reside; and
- in all cases, are subject to the Foreign Corrupt Practices Act (“FCPA”).

In particular, in South Korea, regulators are focused on protecting the rights of individual customers by enforcing “Treating Customers Fairly” concepts. This regulatory focus has resulted in rigorous data localization requirements, network separation obligations and system monitoring restrictions, as well as obligations to closely monitor marketing communications and sales scripts. Anti-money laundering requirements in South Korea and other countries where we do business also may impose obligations to collect certain information about each customer at time of sale or to risk rank each customer to determine possible future money laundering risk.

The FCPA prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official or employee to obtain or retain business or otherwise secure a business advantage. Outside of the United States, we may interact with

government officials in several different capacities: as regulators of our insurance business; as clients or partners who are state-owned or partially state-owned; as health care providers who are employed by the government; as hospitals that are state-owned; and as officials issuing permits in connection with real estate transactions. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the SEC and DOJ have increased their enforcement activities with respect to FCPA. The UK Bribery Act of 2010 applies to all companies with a nexus to the United Kingdom. Under this act, any voluntary disclosures of FCPA violations may be shared with United Kingdom authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. Other countries in which we do business also have anti-corruption laws to which we are subject.

Item 1A. ***RISK FACTORS***

As a large global health service company operating in a complex industry, we encounter a variety of risks and uncertainties, which could have a material adverse effect on our business, liquidity, results of operations, financial condition or the trading price of our securities. You should carefully consider each of the risks and uncertainties discussed below, together with other information contained in this Annual Report on Form 10-K, including Management's Discussion and Analysis of Results of Operations and Financial Condition. These risks and uncertainties are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect us. The following risk factors have been organized by category for ease of use; however many of the risks may have impacts in more than one category. These categories, therefore, should be viewed as a starting point for understanding the significant risks facing us and not as a limitation on the potential impact of the matters discussed. Risk factors are not necessarily listed in order of importance.

Strategic and Operational Risks

Future performance of our business will depend on our ability to execute our strategic and operational initiatives effectively.

The future performance of our business will depend in large part on our ability to effectively implement and execute our strategic and operational initiatives. Successfully executing on these initiatives depends on a number of factors, including our ability to:

- differentiate our products, services and solutions from those of our competitors;
- develop, introduce and partner to bring forward new and innovative products, solutions or programs that focus on improving patient outcomes and assist in controlling costs or are in response to government regulation and the increased focus on consumer-directed products;
- develop and create data and analytic solutions to support and improve outcomes for our products, services and solutions, including creating and developing solutions and services through partnerships with other industry participants;
- grow our product portfolio, expand our addressable markets and identify and introduce the proper mix, coordination or integration of products that will be accepted by the marketplace;
- evaluate drugs for efficacy, value and price to assist clients in selecting a cost-effective formulary;
- offer cost-effective home delivery pharmacy and specialty services;
- access or continue accessing key drugs and successfully penetrate key treatment categories in our specialty pharmacy business;
- leverage purchase volume to deliver discounts to health benefit providers;
- attract and retain sufficient numbers of qualified employees;
- attract, develop and maintain collaborative relationships with a sufficient number of qualified partners;
- attract new and maintain existing customer and client relationships;
- transition health care providers from volume-based fee-for-service arrangements to a value-based system;
- improve medical cost competitiveness in our targeted markets;
- manage our medical, pharmacy, administrative and other operating costs effectively; and
- contract with health care providers, pharmacy providers and pharmaceutical manufacturers on favorable terms.

For our strategic initiatives to succeed, we must effectively collaborate across our operations, integrate our acquired businesses, actively work to ensure consistency throughout the organization and promote a global mind-set along with a focus on individual customers and clients. If we fail to do so, our business may be unable to grow as planned, or the result of expansion may be unsatisfactory. We will be unable to rapidly respond to competitive, economic and regulatory changes if we do not make important strategic and operational decisions quickly, define our appetite for risk, implement new governance, managerial and organizational processes smoothly and communicate roles and responsibilities clearly. If these initiatives fail or are not executed effectively, our consolidated financial position and results of operations could be negatively affected.

We operate in a highly competitive, evolving and rapidly changing industry and our failure to adapt could negatively impact our business.

The health service industry continues to be dynamic and rapidly evolving. Any significant shifts in the structure of the industry could alter industry dynamics and adversely affect our ability to attract or retain clients and customers. Industry shifts could result (and have resulted) from, among other things:

- a large intra- or inter-industry merger or industry consolidation;
- strategic alliances;
- new or alternative business models or new government options or offerings;
- continuing consolidation among physicians, hospitals and other health care providers, as well as changes in the organizational structures chosen by physicians, hospitals and health care providers;

- new market entrants, including those not traditionally in the health service industry;
- the ability of larger employers and clients to contract directly with providers;
- technological changes and rapid shifts in the use of technology, such as telehealth;
- the impact or consequences of legislation or regulatory changes;
- changes in the United States Postal Service or the consolidation of shipping carriers;
- increased drug acquisition cost or unexpected changes to drug pricing trend;
- changes in the generic drug market or the failure of new generic drugs to come to market; or
- changes in utilization of health care, prescription drugs or other covered services and items, including under risk-based contracts in the health benefit management market and for those businesses that utilize risk adjustment methodology.

Our failure to anticipate or appropriately adapt to changes in the industry could negatively impact our competitive position and adversely affect our business and results of operations.

The scale, scope and duration of the COVID-19 pandemic continues to be unknown and the overall impact on our business, operating results, cash flows or financial condition has been and may continue to be material.

The COVID-19 pandemic has adversely affected global economies, financial markets and the overall environment for our business, and the extent to which it may impact our future results of operations and overall financial performance remains uncertain.

The COVID-19 pandemic has in some instances, and may continue to, heighten the potential adverse effects on our business, operating results, cash flows or financial condition as described below or in other risk factors within this section of the Form 10-K including, but not limited to, the likelihood of and impact from:

- unfavorable economic conditions on our clients and customers (both employers and individuals), health care providers, pharmaceutical manufacturers, pharmacy providers and third-party vendors, as well as federal and state entities and programs;
- changes in medical claims submission and processing patterns or procedures; changes in customer base and product mix; changes in utilization of prescription drugs, medical or other covered items or services, including increased behavioral health services utilization; changes in medical cost trends; changes in our health management practices; and the introduction of new benefits and products causing actual claims to exceed our estimates;
- changes in health care utilization patterns, provider billing practices and other external events that we cannot forecast or project and over which we have little or no control impacting our ability to accurately predict, price for and manage health care costs and ultimately our profitability, including impacts from care deferral on, among other things, risk adjustment revenue and acuity of future care;
- increased costs or reductions in revenue, including costs for COVID-19-related care, testing and treatment and related cost-share waivers for our customers; vaccine and other coverage mandates; and support for employees, clients, customers and providers;
- significant disruptions in service within our operations or among our key suppliers or other third parties, including decreased worker productivity and operational and sales disruptions, including as a result of remote working arrangements, increased medical, emergency or other leave, quarantines, government actions or restrictions;
- compliance with substantial government regulation, including privacy and security requirements associated with providing telehealth and remote care options for individuals and new laws or regulations or changes in existing laws or regulations, such as vaccine and coverage mandates and premium deferrals, which laws or regulations may vary significantly by jurisdiction;
- prioritization of matters relating to COVID-19 resulting in delays in responsiveness by regulatory agencies and other third parties in matters arising in the ordinary course of business;
- cyberattacks or other privacy or data security incidents, including as a result of the transition to a remote work environment by substantially all of our workforce and the workforces of third parties with whom we contract;
- significant shifts in the structure of the industry which could alter dynamics and, if we fail to adapt, negatively impact our business;
- risks inherent in foreign operations, including political, legal, operational, regulatory, economic and other risks;
- economic and market conditions affecting the value of our financial instruments and the value of particular assets and liabilities; and
- fluctuations in equity market prices, interest rates and credit spreads limiting our ability to raise or deploy capital and affecting our overall liquidity.

Additionally, if we do not respond appropriately to the pandemic, or if our clients or customers do not perceive our response to be adequate, we could suffer damage to our reputation, which could adversely affect our business.

We believe COVID-19's adverse impact on our business, operating results, cash flows or financial condition will be driven primarily by the severity and duration of the pandemic, including the impact of the breadth and timing of implementation and the efficacy and costs of vaccination programs, the pandemic's impact on our employees, clients, customers, suppliers and partners, as well as the U.S.

and global economies and the continued actions taken by governmental authorities and other third parties in response to the pandemic. Those primary drivers are largely beyond our knowledge and control, and may be more adverse than our current expectations. Given these uncertainties, we cannot estimate the full impact COVID-19 will have on our business, operating results, cash flows or financial condition, but the adverse impact could be material.

Our failure to compete effectively, to differentiate our products and services from those of our competitors and maintain or increase market share could materially adversely affect our results of operations, financial position and cash flows.

We operate in a highly competitive environment and an industry subject to significant market pressures brought about by customer and client needs, legislative and regulatory developments and other market factors. In particular markets, our competitors may have greater, better or more established capabilities, resources, market share, reputation or business relationships, or lower profit margin or financial return expectations. Our clients are well informed and organized and can easily move between our competitors and us. Our Express Scripts client contracts generally have three-year terms and may be subject to periodic renegotiation of pricing terms based on market factors. As described in greater detail in the description of our business in Item 1 of this Form 10-K, one of our key clients in the Evernorth segment is the United States Department of Defense. If one or more of our large clients terminates or does not renew a contract for any reason, including as a result of being acquired, or if the provisions of a contract with a large client are modified, renewed or otherwise changed with terms less favorable to us, our results of operations could be adversely affected and we could experience a negative reaction in the investment community resulting in decreases in the trading price of our securities or other adverse effects.

Our success depends, in part, on our ability to compete effectively in our markets, set prices appropriately in highly competitive markets to keep or increase our market share, increase customers as planned, differentiate our business offerings by innovating and delivering products and services that provide enhanced value to our customers, provide quality and satisfactory levels of service and retain accounts with favorable medical cost experience or more profitable products versus retaining or increasing our customer base in accounts with unfavorable medical cost experience or less profitable products.

We must remain competitive to attract new customers, retain existing customers and further integrate additional product and service offerings. To succeed in this highly competitive marketplace, it is imperative that we maintain a strong reputation. The negative reputational impact of a significant event, including a failure to execute on customer or client contracts or strategic or operational initiatives, failure to comply with applicable laws or regulations, or failure to innovate and deliver products and services that demonstrate greater value to our customers, could affect our ability to grow and retain profitable arrangements, which could have a material adverse effect on our business, results of operations, financial position and cash flows.

We face price competition and other pressures that could compress our margins or result in premiums that are insufficient to cover the cost of services delivered to our customers.

While we compete on the basis of many service and quality-related factors, we expect that price will continue to be a significant basis of competition. Our client contracts are subject to negotiation as clients seek to contain their costs, including by reducing benefits offered. Increasingly, our clients seek to negotiate performance guarantees that require us to pay penalties if the guaranteed performance standard is not met. Clients can easily move between our competitors and us. Our clients are well informed and typically have knowledgeable consultants that seek competing bids from our competitors before contract renewal. In addition, as brokers and benefit consultants seek to enhance their revenue streams, they look to take on services that we typically provide. Each of these events could negatively impact our financial results.

Federal and state regulatory agencies may restrict or prevent entirely our ability to implement changes in premium rates. Fiscal or other concerns related to the government-sponsored programs in which we participate, such as Medicare Advantage plans and Medicare Part D plans, may cause decreasing reimbursement rates, delays in premium payments, restrictions on implementing changes in premium rates or insufficient increases in reimbursement rates. Any limitation on our ability to maintain or increase our premium or reimbursement levels, or a significant loss of customers or clients resulting from our need to increase or maintain premium or reimbursement levels, could adversely affect our business, cash flows, financial condition and results of operations.

Premiums in the U.S. Medical segment are generally set for one-year periods and are priced well in advance of the date on which the contract commences or renews. Our revenue on Medicare Advantage plans, Individual and Family Plans (“IFP”) and Medicare Part D plans is based on rates and bids submitted midyear in the year before the contract year. Although we base the premiums we charge and our Medicare Advantage, IFP and Medicare Part D rates and bids on our estimate of future health care costs over the contract period, actual costs may exceed what we estimate in setting premiums. Our health care costs also are affected by external events that we cannot forecast or project and over which we have little or no control, including changes in regulations, as well as provider billing practices and changes in customers’ health care utilization patterns, which may, among other things, impact our ability to appropriately document their health conditions. Our participation in health insurance exchanges through our IFP offerings involves

uncertainties associated with mix and volume of business and could adversely affect our results of operations, financial position and cash flows. Our profitability depends, in part, on our ability to accurately predict, price for and effectively manage future health care costs. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenue can result in significant changes in our financial results.

Strong competition within the pharmacy benefit business has also generated greater demand for lower product and service pricing, increased revenue sharing and enhanced product and service offerings. These competitive factors have historically applied pressure on our operating margins and caused many companies, including us, to reduce the prices charged for products and services while sharing with clients a greater portion of the formulary fees and related rebates received from pharmaceutical manufacturers. Our inability to maintain positive trends, or failure to identify and implement new ways to mitigate pricing pressures, could negatively impact our ability to attract or retain clients or sell additional services, which could negatively impact our margins and have a material adverse effect on our business and results of operations.

The reserves we hold for expected medical claims are based on estimates that involve an extensive degree of judgment and are inherently variable. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to contain future costs may be limited.

We maintain and record medical claims reserves on our balance sheet for estimated future payments. Our estimates of health care costs payable are based on a number of factors, including historical claim experience, but this estimation process requires extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns or procedures, changes in customer base and product mix, changes in the utilization of prescription drugs, medical or other covered items or services, changes in medical cost trends, changes in our health management practices, changes in regulations and the introduction of new benefits and products. If we are not able to accurately and promptly anticipate and detect medical cost trends, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited. Additionally, we must estimate the amount of rebates payable by us under the ACA's and CMS' minimum loss ratio rules and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program. Because establishing reserves is an inherently uncertain process involving estimates of future losses, there can be no certainty that ultimate losses will not exceed existing reserves which may adversely affect our results of operations, financial position and cash flows.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other health service providers and with producers and consultants, our business and results of operations may be adversely affected.

We contract with or employ physicians, hospitals and other health service providers and facilities to provide health services to our customers. Our results of operations are substantially dependent on our ability to contract for these services at competitive prices. In any particular market, physicians, hospitals and health service providers may enter into exclusive arrangements with competitors or simply refuse to contract with us, demand higher payments or take other actions that could result in higher medical costs or less desirable products or services for our customers. In some markets, certain providers, particularly hospitals, physician/hospital organizations and multispecialty physician groups, may have significant or controlling market positions that could result in a diminished bargaining position for us. If providers refuse to contract with us, use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially adversely affected. Additionally, certain regulations may impact our ability to obtain competitive prices. Establishing collaborative arrangements with physician groups, specialist groups, independent practice associations, hospitals and health care delivery systems is key to our strategic focus to transition from volume-based fee-for-service arrangements to a value-based health care system. If such collaborative arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our attractiveness to customers may be reduced and our ability to profitably grow our business may be adversely affected.

Our ability to develop and maintain satisfactory relationships with providers may also be negatively impacted by other factors not associated with us, such as changes in Medicare or Medicaid reimbursement levels, increasing pressure on revenue and other pressures on health care providers and increasing consolidation activity among hospitals, physician groups and providers. Continuing consolidation among physicians, hospitals and other providers, the emergence of accountable care organizations, vertical integration of providers and other entities, changes in the organizational structures chosen by physicians, hospitals and providers and new market entrants, including those not traditionally in the health care industry, may affect the way providers interact with us and may change the competitive landscape in which we operate. In some instances, these organizations may compete directly with us, potentially affecting the way we price our products and services or causing us to incur increased costs if we change our operations to be more competitive.

Out-of-network providers are not limited by any agreement with us in the amounts they bill. While benefit plans place limits on the amount of charges that will be considered for reimbursement and regulations seek to prescribe payment levels, establish methodologies and dispute resolution processes, out-of-network providers are increasingly sophisticated and aggressive. As a result, the outcome of disputes where we do not have a provider contract may cause us to pay higher medical or other benefit costs than we projected.

Additionally, certain of our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we compete. Our sales could be materially adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels.

If we lose our relationship with one or more key pharmaceutical manufacturers, or if the payments made or discounts provided by pharmaceutical manufacturers decline, our business and results of operations could be adversely affected.

We maintain contractual relationships with numerous pharmaceutical manufacturers, which provide us with, among other things:

- discounts for drugs we purchase to be dispensed from our home delivery and specialty pharmacies;
- discounts, in the form of rebates, for drug utilization;
- fees for administering rebate programs, including invoicing, allocating and collecting rebates;
- fees for services provided to pharmaceutical manufacturers by our specialty pharmacies; and
- access to limited distribution specialty pharmaceuticals by our specialty pharmacies.

Our contracts with pharmaceutical manufacturers are typically nonexclusive and terminable on relatively short notice by either party. The consolidation of pharmaceutical manufacturers, the termination or material alteration of our contractual relationships, or our failure to renew such contracts on favorable terms could have a material adverse effect on our business and results of operations. In addition, arrangements between payors and pharmaceutical manufacturers have been the subject of debate in federal and state legislatures and various other public and governmental forums. Adoption of new laws, rules or regulations or changes in, or new interpretations of, existing laws, rules or regulations, relating to any of these programs could materially adversely affect our business and results of operations.

If significant changes occur within the pharmacy provider marketplace, or if other issues arise with respect to our pharmacy networks, including the loss of or adverse change in our relationship with one or more key pharmacy providers, our business and financial results could be adversely affected.

More than 67,700 pharmacies participated in one or more of our networks as of December 31, 2020. The ten largest retail pharmacy chains represent approximately 64% of the total number of stores in our largest network. In certain geographic areas of the United States, our networks may be comprised of higher concentrations of one or more large pharmacy chains. Contracts with retail pharmacies are generally nonexclusive and are terminable on relatively short notice by either party. If one or more of the larger pharmacy chains terminates its relationship with us, or is able to renegotiate terms substantially less favorable to us, our customers' access to retail pharmacies or our business could be materially adversely affected. The entry of one or more additional large pharmacy chains into the pharmacy benefit management business, the consolidation of existing pharmacy chains or increased leverage or market share by the largest pharmacy providers could increase the likelihood of negative changes in our relationship with such pharmacies. Changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could have a negative impact on our claims volume or our competitiveness in the marketplace, which could cause us to fall short of certain guarantees in our contracts with clients or otherwise impair our business or results of operations.

Changes in drug pricing or industry pricing benchmarks could materially impact our financial performance.

Contracts in the prescription drug industry, including our contracts with retail pharmacy networks and our pharmacy and specialty pharmacy clients, generally use pricing metrics published by third parties as benchmarks to establish pricing for prescription drugs. If these benchmarks are no longer published by third parties, we, or our contractual partners, adopt other pricing benchmarks for establishing prices within the industry, legislation or regulation requires the use of other pricing benchmarks, or future changes in drug prices substantially deviate from our expectations, the short- or long-term impacts may have a material adverse effect on our business and results of operations.

As a global company, we face political, legal, operational, regulatory, economic and other risks that present challenges and could negatively affect our multinational operations or our long-term growth.

As a global company, our business is increasingly exposed to risks inherent in foreign operations. These risks can vary substantially by market, and include political, legal, operational, regulatory, economic and other risks, including government intervention that we

do not face in our U.S. operations. The global nature of our business and operations may present challenges including, but not limited to, those arising from:

- geopolitical business conditions and demands, including the United Kingdom's withdrawal from the European Union;
- regulation that may discriminate against U.S. companies, favor nationalization or expropriate assets;
- price controls or other pricing issues and exchange controls; restrictions that prevent us from transferring funds out of the countries in which we operate; foreign currency exchange rates and fluctuations and restrictions on converting currencies from foreign operations into other currencies; uncertainty with respect to the interpretation of tax positions;
- reliance on local employees and interpretations of labor laws in foreign jurisdictions;
- managing our partner relationships in countries outside of the United States;
- providing data protection on a global basis and sufficient levels of technical support in different locations;
- the global trend for companies to enact local data residency requirements;
- acts of civil unrest, war and terrorism, as well as other political and economic conflicts such as through imposition of economic or political sanctions;
- man-made disasters, natural disasters and pandemics, such as the COVID-19 pandemic, in locations where we operate; and
- general economic and political conditions.

These factors may increase in significance as we continue to expand globally and operating in new foreign markets may require considerable management time before operations generate any significant revenues and earnings. Any one of these challenges could negatively affect our operations or long term growth. For example, due to the concentration of our international business in South Korea, the International Markets segment is exposed to potential losses resulting from economic and regulatory changes in that country and the geopolitical climate in the Korean Peninsula, as well as foreign currency movements affecting the South Korean currency, that could have a significant impact on the segment's results and our consolidated financial results.

International operations also require us to devote significant resources to implement controls and systems in new markets to comply with, and to ensure that our vendors and partners comply with, U.S. and foreign laws prohibiting bribery, corruption and money laundering, in addition to other regulations regarding, among other things, our products, direct-to-consumer communications, customer privacy, data protection and data residency. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business and significant reputational harm. Our success depends, in part, on our ability to anticipate these risks and manage these challenges. Our failure to comply with laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could have a material adverse effect on our business, results of operations, financial condition, liquidity and long-term growth.

Strategic transactions involve risks and we may not realize the expected benefits because of integration difficulties, underperformance relative to our expectations and other challenges.

As part of our strategy, we regularly consider and enter into strategic transactions, including mergers, acquisitions, joint ventures, licensing arrangements, divestitures and other relationships (collectively referred to as "strategic transactions"). There is significant competition for attractive targets and opportunities and we may be unable to identify and successfully complete strategic transactions in the future. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives, and we may divest or wind down such businesses. We may be unable to complete any such divestiture on terms favorable to us, within the expected timeframes, or at all. We may have continued financial exposure to divested businesses following the completion of any such transaction, including increased costs due to potential litigation, contingent liabilities and indemnification of the buyer related to, among other things, lawsuits, regulatory matters or tax liabilities.

Our ability to achieve the anticipated benefits of strategic transactions, including synergies, cost savings, innovation and operational efficiencies, is subject to numerous uncertainties and risks, including our ability to successfully combine or separate business operations, resources and systems, including data security systems and internal financial control standards, in an efficient and effective manner. Integration and separation activities may result in additional and unforeseen expenses, and the anticipated benefits may not be fully realized or may take longer to realize than expected. These activities are complex, costly and time-consuming and may divert management's attention from ongoing business concerns. Delays or issues encountered in these activities could have a material adverse effect on the revenues, expenses, operating results and financial condition of the company.

Strategic transactions could result in increased costs, including facilities and systems consolidation or separation costs and costs to retain key employees, decreases in expected revenues, earnings or cash flows and goodwill or other intangible asset impairment charges. As of December 31, 2020, our goodwill and other intangible assets had a carrying value of approximately $80 billion, representing 51% of our total consolidated assets. The value of our goodwill may be materially and adversely impacted if the businesses we acquire do not perform in a manner consistent with our assumptions. Future evaluations requiring an impairment to

goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could negatively impact our debt ratings or potentially impact our compliance with existing debt covenants. In addition, the trading price of our securities may decline if, among other things, we are unable to achieve our estimates of earnings growth and operational cost savings, or the transaction costs related to acquisitions, integrations or divestitures are greater than expected. The trading price also may decline if we do not achieve the perceived benefits of a transaction as rapidly or to the extent anticipated by financial or industry analysts.

Additionally, joint ventures and equity investments present risks that are different from acquisitions, including risks related to: specific operations and finances of the businesses we invest in, selection of appropriate parties, differing objectives of the various parties, competition between and among parties, compliance activities (including compliance with applicable CMS requirements), growing the business in a manner acceptable to all the parties, maintaining positive relationships among the parties, clients and customers, initial and ongoing governance of joint ventures and customer and business disruption that may occur upon a joint venture termination.

Further, we may finance strategic transactions by issuing common stock for some or all of the purchase price that could dilute the ownership interests of our shareholders, or by incurring additional debt that could increase costs and impact our ability to access capital in the future.

In addition, effective internal controls are necessary to provide reliable and accurate financial reports and to mitigate the risk of fraud. The integration of businesses is likely to cause increasing complexity in our systems and internal controls and make them more difficult to manage. Any difficulties in assimilating businesses into our control system could cause us to fail to meet our financial reporting obligations. We also rely on the internal controls and financial reporting controls of joint venture entities and other entities in which we invest and their failure to maintain effectiveness or comply with applicable standards may materially and adversely affect us. Ineffective internal controls could also cause investors to lose confidence in our reported financial information that could negatively impact the trading price of our securities and our access to capital.

We are dependent on the success of our relationships with third parties for various services and functions.

To improve operating costs, productivity and efficiencies, we contract with third parties for the provision of specific services. Our operations may be adversely affected if a third party fails to satisfy its obligations to us, if the arrangement is terminated in whole or in part or if there is a contractual dispute between us and the third party. Even though contracts are intended to provide certain protections, we have limited control over the actions of third parties. For example, noncompliance with any privacy or security laws and regulations, any security breach involving one of our third-party vendors or a dispute between us and a third-party vendor related to our arrangement could have a material adverse effect on our business, results of operations, financial condition, liquidity and reputation.

Outsourcing also may require us to change our existing operations, adopt new processes for managing these service providers or redistribute responsibilities to realize the potential productivity and operational efficiencies. If there are delays or difficulties in changing business processes or our third-party vendors do not perform as expected, we may not realize, or not realize on a timely basis, the anticipated economic and other benefits of these relationships. This could result in additional costs or regulatory compliance issues or create other operational or financial problems for us. Terminating or transitioning, in whole or in part, arrangements with key vendors could result in additional costs or penalties, risks of operational delays or potential errors and control issues during the termination or transition phase. We may not be able to find an alternative vendor in a timely manner or on acceptable terms. If there is an interruption in business or loss of access to data resulting from a security breach, termination or transition in services, we may not be able to meet the demands of our customers and, in turn, our business and results of operations could be adversely impacted.

A significant disruption in service within our operations or among our key suppliers or other third parties could materially adversely affect our business and results of operations.

Our business is highly dependent upon our ability to perform, in an efficient and uninterrupted fashion, necessary business functions, such as claims processing and payment, internet support and customer call centers, data centers and corporate facilities, processing new and renewal business, maintaining appropriate shipment and storage conditions for prescriptions (such as temperature and protection from contamination) and home delivery processing. In some instances, our ability to provide services or products (including processing and dispensing prescriptions) depends on the availability of services and products provided by suppliers, providers, pharmaceutical manufacturers, vendors or shipping carriers. A disruption, or threat of disruption, in our supply chain, including as a result of the COVID-19 pandemic, or inability to access or deliver products that meet requisite quality safety standards in a timely and efficient manner could adversely impact our business. Additionally, any failure or disruption of our performance of, or our ability to perform, key business functions, including through unavailability or cyberattack of our information technology systems or those of third parties, could cause slower response times, decreased levels of service satisfaction and harm to our reputation. Our information

technology and other systems interface with and depend on third-party systems and we could experience service denials if demand for such service exceeds capacity or a third-party system fails or experiences an interruption. Our failure to implement adequate business continuity and disaster recovery strategies could significantly reduce our ability to provide products and services to our customers and clients, which could have material adverse effects on our business and results of operations.

Our business depends on our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems.

Our business is highly dependent on maintaining effective information systems as well as the integrity and timeliness of the data we use to serve our customers and health care providers and to operate our business. If our data were found to be inaccurate or unreliable due to fraud or other error, or if we, or any of the third-party service providers we engage, were to fail to maintain information systems and data integrity effectively, we could experience operational disruptions that may impact our clients, customers and health care providers and hinder our ability to provide services and products, establish appropriate pricing for products and services, retain and attract clients and customers, establish reserves and report financial results timely and accurately and maintain regulatory compliance, among other things.

Our information technology strategy and execution are critical to our continued success. We must continue to invest in long-term solutions that will enable us to anticipate customer needs and expectations, enhance the customer experience, act as a differentiator in the market and protect against cybersecurity risks and threats. Our success is dependent, in large part, on maintaining the effectiveness of existing technology systems and continuing to deliver and enhance technology systems that support our business processes in a cost-efficient and resource-efficient manner. Increasing regulatory and legislative changes will place additional demands on our information technology infrastructure that could have a direct impact on resources available for other projects tied to our strategic initiatives. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Connectivity among technologies is becoming increasingly important. We must also develop new systems to meet current market standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and customer needs. Failure to do so may present compliance challenges and impede our ability to deliver services in a competitive manner. Further, because system development projects are long-term in nature, they may be more costly than expected to complete and may not deliver the expected benefits upon completion. Our failure to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems could adversely affect our results of operations, financial position and cash flow.

As a large health service company, we are subject to cyberattacks or other privacy or data security incidents. If we are unable to prevent or contain the effects of any such attacks, we may suffer exposure to substantial liability, reputational harm, loss of revenue or other damages.

Our business depends on our clients' and customers' willingness to entrust us with their health-related and other sensitive personal information. Computer systems may be vulnerable to physical break-ins, computer viruses or malware, programming errors, attacks by third parties or similar disruptive problems. We have been, and will likely continue to be, the target of computer viruses or other malicious codes, unauthorized access, cyberattacks or other computer-related penetrations. There have been, and will likely continue to be, large scale cyberattacks within the health service industry. Additionally, hardware, software or applications we develop or procure from third parties may contain defects in design, manufacturer defects or other problems that could unexpectedly compromise information technology. Human or technological error has and could in the future result in, for example, unauthorized access to, disclosure, modification, misuse, loss, or destruction of company, customer, or other third-party data or systems; theft of sensitive, regulated, or confidential data including personal information and intellectual property; the loss of access to critical data or systems through ransomware, destructive attacks or other means; and business delays, service or system disruptions or denials of service.

As we increase the amount of personal information that we store and share digitally, our exposure to unintended disclosures, data security and related cybersecurity risks increases, including the risk of undetected attacks, damage, loss or unauthorized access or misappropriation of proprietary or personal information, and the cost of attempting to protect against these risks also increases. If disruptions, disclosures or breaches are not detected quickly, their effect could be compounded. We have implemented security technologies, processes and procedures to protect consumer identity and provide employee awareness training around phishing, malware and other cyber risks; however, there are no assurances that such measures will be effective against all types of breaches.

Cybersecurity threats are rapidly evolving and those threats and the means for obtaining access to our proprietary systems are becoming increasingly sophisticated. Cyberattacks can originate from a wide variety of sources including third parties, such as external service providers, and the techniques used change frequently or are often not recognized until after they have been launched. Those parties may also attempt to fraudulently induce employees, customers or other users of our systems to disclose sensitive information in order to gain access to our data or that of our customers. In addition, while we have certain standards for all vendors

that provide us services, our vendors, and in turn, their own service providers, may become subject to the same types of security breaches. Finally, our offices may be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human error or similar events that could negatively affect our systems and our customers' and clients' data.

The costs to eliminate or address security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers.

In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us, our customers or other third parties could expose our customers' private information and our customers to the risk of financial or medical identity theft. Unauthorized dissemination of confidential and proprietary information about our business and strategy could also negatively affect the achievement of our strategic initiatives. Such events could cause us to breach our contractual obligations and violate applicable laws. These events would negatively affect our ability to compete, others' trust in us, our reputation, customer base and revenues and expose us to mandatory disclosure requirements, litigation and other enforcement proceedings, material fines, penalties or remediation costs and compensatory, special, punitive and statutory damages, consent orders and other adverse actions, any of which could adversely affect our business, results of operations, financial condition or liquidity.

In managing medical practices and operating pharmacies, onsite clinics and other types of medical facilities, we may be subject to additional liability that could result in significant time and expense.

In addition to contracting with physicians and other health care providers for services, we employ physicians, pharmacists, nurses and other health care providers at our home delivery and specialty pharmacies, onsite low acuity and primary care practices and infusion clinics that we manage and operate for our customers, as well as certain clinics for our employees. We also provide in-home care through health care providers that we employ, as well as, through third-party contractors. As such, we may be subject to liability for certain acts, omissions, or injuries caused by our employees or agents, or occurring at one of these practices, pharmacies or clinics. The defense of any actions may require the diversion of personnel and other resources and the incurrence of significant costs that could have a material adverse effect on our business, results of operations, financial condition, liquidity and reputation.

Legal and Compliance Risks

Our business is subject to substantial government regulation, as well as new laws or regulations or changes in existing laws or regulations that could have a material adverse effect on our business, results of operations, financial condition and liquidity.

Our business is regulated at the federal, state, local and international levels. The laws and rules governing our business and related interpretations are increasing in number and complexity, are subject to frequent change and can be inconsistent or in conflict with each other. Noncompliance with applicable regulations by us or our third-party vendors could have material adverse effects on our business, results of operations, financial condition, liquidity and reputation.

We must identify, assess and respond to new trends in the legislative and regulatory environment, as well as comply with the various existing regulations applicable to our business. There are currently pending, and in the future there will likely be, legislative or regulatory proposals which seek to manage the health services industry, including managing prescription drug costs and health records, as well as regulating drug distribution. We expect federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system. In addition, changes to government policies not specifically targeted to the health services industry, such as a change in tax laws and the corporate tax rate or government spending cuts, could have significant impacts on our business, results of operations, financial condition and liquidity. The trading price of our securities may react to the announcement of such proposals. We are unable to predict whether any such proposals will be enacted, or the specific terms thereof, including their effect on our operations; however, certain of these proposals could, if enacted, adversely impact our business and results of operations.

Existing or future laws, rules, regulatory interpretations or judgments could force us to change how we conduct our business, affect the products and services we offer and where we offer them, restrict revenue and enrollment growth, increase our costs, including medical, operating, health care technology and administrative costs, and require enhancements to our compliance infrastructure and internal controls environment. For example, a decision invalidating the ACA or portions thereof could result in material changes to the way we conduct our business, as well as the loss of subsidies related to our IFP offerings. We are required to obtain and maintain insurance and other regulatory approvals to, among other things, market many of our products, expand into additional geographic or product markets, increase prices for certain regulated products and consummate some of our acquisitions and dispositions. Delays in obtaining or failure to obtain or maintain these approvals could reduce our revenue or increase our costs. Existing or future laws and rules could also require or lead us to take other actions such as changing our business practices, and could increase our liability.

Further, failure to effectively implement or adjust our strategic and operational initiatives, such as by reducing operating costs, adjusting premium pricing or benefit design or transforming our business model in response to regulatory changes may have a material adverse effect on our results of operations, financial condition and cash flows.

For more information on regulations affecting our business, see "Business – Regulation" in Part I, Item 1 of this Form 10-K.

There are various risks associated with participating in government-sponsored programs, such as Medicare, including dependence upon government funding, compliance with government contracts and increased regulatory oversight and enforcement.

Through our U.S. Government business, we contract with CMS and various state governmental agencies to provide managed health care services including Medicare Advantage plans and Medicare Part D plans. Additionally, our Evernorth business provides services to government entities and payers participating in government health care programs.

Our revenues from government funded programs, including our Medicare programs and our government clients, are dependent, in whole or in part, upon annual funding from the federal government or applicable state or local governments. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities. These entities generally have the right to not renew or cancel their contracts with us on short notice without cause or if funds are not available. Unanticipated changes in funding, such as the application of sequestration by the federal or state governments or the failure to provide for continued appropriations or regular ongoing scheduled payments to us, could substantially reduce our revenues and profitability.

The Medicare program has been the subject of regulatory reform initiatives. The premium rates paid to Medicare Advantage plans and Medicare Part D plans are established by contract, although the rates differ depending on a combination of factors, some of which are outside our control. For example, the base premium rate paid differs depending upon a combination of various factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Additionally, a portion of each Medicare Advantage plan's reimbursement is tied to the plan's Star Rating, with those plans receiving a rating of four or more stars eligible for quality-based bonus payments. A plan's Star Rating affects its image in the market and plans that perform well are able to offer enhanced benefits, market more effectively and for longer periods of time than other plans. The Star Rating system is subject to change annually by CMS, which may make it more difficult to achieve four stars or greater. Our Medicare Advantage plans' and Medicare Part D plans' operating results, premium revenue and benefit offerings are likely to continue to be significantly determined by their Star Ratings. There can be no assurances that we will be successful in maintaining or improving our Star Ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our Star Ratings. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership or impact our financial performance. See Part II, Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Information – Industry Developments and Other Matters Affecting our Evernorth and U.S. Medical Segments for additional information on our Star Ratings.

Additionally, if we fail to comply with CMS' contractual requirements, including data submission, enrollment and marketing, provider network adequacy, provider directory accuracy, quality measures, claims payment, continuity of care, timely and accurate processing of appeals and grievances, oversight of first tier downstream and related entities and call center performance, we may be subject to administrative actions, including enrollment sanctions or contract termination, fines or other penalties that could impact our profitability. As described under "Business – Regulation" in Part I, Item 1 of this Form 10-K, on November 1, 2018, CMS released a proposed rule that would revise its RADV methodology and, if adopted in its current form, could result in some combination of degraded plan benefits, higher monthly premiums or reduced choice for the population served by all Medicare Advantage insurers. While it is uncertain whether CMS will finalize the rule as proposed, if adopted, it could have a material impact on the Company's future results of operations.

Any failure to comply with various state and federal health care laws and regulations, including those directed at preventing fraud and abuse in government funded programs, could result in investigations or litigation, such as actions under the federal False Claims Act and similar whistleblower statutes under state laws. This could subject us to damage awards, including treble damages, fines, penalties or other enforcement actions, restrictions on our ability to market or enroll new customers, limits on expansion, restrictions or exclusions from programs or other agreements with federal or state governmental agencies, which could adversely impact our business, cash flows, financial condition, results of operations and reputation.

We face risks related to litigation, regulatory audits and investigations.

We are routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal matters arising, for the most part, in the ordinary course of business. These legal matters could include benefit claims, breach of contract actions, tort claims, claims arising from consumer protection laws, false claims act laws, claims disputes under federal or state laws and disputes regarding reinsurance arrangements, employment and employment discrimination-related suits, antitrust claims, employee benefit claims, wage and hour claims, tax, privacy, intellectual property and whistleblower claims, shareholder suits and other securities law claims, real estate disputes, claims related to disclosure of certain business practices and claims arising from customer audits and contract performance, including government contracts. In addition, we have incurred and likely will continue to incur liability for practices and claims related to our health care business, such as marketing misconduct, failure to timely or appropriately pay for or provide health care, provider network structure, poor outcomes for care delivered or arranged, provider disputes including disputes over compensation or contractual provisions, ERISA claims, allegations related to calculations of cost sharing and claims related to our administration of self-funded business. We are also routinely involved in legal matters arising from our health services business, including without limitation claims related to the dispensing of pharmaceutical products by our home delivery and specialty pharmacies, pharmacy benefit management services, such as formulary management services, health benefit management services and provider services. There are currently, and may be in the future, attempts to bring class action lawsuits against the Company and other companies in our industry; individual plaintiffs also may bring multiple claims regarding the same subject matter against us and other companies in our industry.

Court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial noneconomic or punitive damages may be sought. We procure insurance coverage to cover some of these potential liabilities, however we also self-insure a significant portion of our litigation risks. While we maintain some third-party insurance coverage, including excess liability insurance with third-party insurance carriers, certain liabilities or types of damages, such as punitive damages, may not be covered by insurance, insurers may dispute coverage or the amount of insurance may be insufficient to cover the entire damages awarded. Resolving disputes is often expensive and disruptive, regardless of the outcome. Additionally, it is possible that the resolution of current or future legal matters and claims could result in changes to our industry and business practices, losses material to our results of operations, financial condition and liquidity or damage to our reputation.

We are frequently the subject of regulatory market conduct and other reviews, audits and investigations by state insurance and health and welfare and pharmacy departments, attorneys general, DOJ, CMS, DOL and the OIG and comparable authorities in foreign jurisdictions. Additionally, we are, and may in the future be, subject to *qui tam* actions in which the government may or may not intervene. With respect to our Medicare Advantage and Medicare Part D businesses, CMS and OIG perform audits to determine a health plan's compliance with federal regulations and contractual obligations, including compliance with proper coding practices and fraud and abuse enforcement practices through audits designed to detect and correct improper payments. Certain of our contracts are currently subject to RADV audits by CMS and the OIG. The DOJ is conducting an industry-wide investigation of the risk adjustment data submission practices and business processes, including review of medical charts and health exams, of Cigna and a number of other Medicare Advantage organizations under Medicare Parts C and D. There also continues to be heightened review by federal and state regulators of business and reporting practices within the health services industry, including with respect to claims payment and related escheat practices, and increased scrutiny by other federal and state governmental agencies (such as state attorneys general) empowered to bring criminal actions in circumstances that could have previously given rise only to civil or administrative proceedings.

In addition, various government agencies have conducted investigations and audits into certain pharmacy benefit management practices. Many of these investigations and audits have resulted in other companies being subject to civil penalties, including the payment of money and entry into corporate integrity agreements. We cannot predict what effect, if any, such government investigations and audits may ultimately have on us or on the industry in general. However, we will likely continue to experience government scrutiny and audit activity, which has and may in the future result in civil penalties.

Regulatory audits, investigations or reviews or actions by other government agencies could result in changes to our business practices, retroactive adjustments to certain premiums, significant fines, penalties, civil liabilities, criminal liabilities or other sanctions, including corporate integrity agreements, restrictions on our ability to participate in government programs, market certain products or engage in business-related activities, that could have a material adverse effect on our business, results of operation, financial condition and liquidity. In addition, disclosure of an adverse investigation or audit or the imposition of fines or other sanctions could negatively affect our reputation in certain markets and make it more difficult for us to sell our products and services.

A description of material pending legal actions and other legal and regulatory matters is included in Note 21 to the Consolidated Financial Statements included in this Form 10-K. The outcome of litigation and other legal or regulatory matters is always uncertain.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, our business and reputation could be materially adversely affected.

Most of our activities involve the receipt, use, storage or transmission of a substantial amount of individuals' protected health information and personally identifiable information. We also use aggregated and anonymized data for research and analysis purposes, and in some cases, provide access to such de-identified data, or analytics created from such data, to pharmaceutical manufacturers and third-party data aggregators and analysts. We may also use such information to create analytic models designed to predict, and potentially improve, outcomes and patient care. The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with clients. In some cases, such laws, rules, regulations and contractual requirements also apply to our vendors and require us to obtain written assurances of their compliance with such requirements. We are also subject to various other consumer protection laws that regulate our communications with customers. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is designed to protect credit card account data as mandated by payment card industry entities. International laws, rules and regulations governing the use and disclosure of such information, such as the GDPR, can be more stringent than in the United States, and they vary across jurisdictions. In addition, more jurisdictions are regulating the transfer of data across borders and domestic privacy and data protection laws are generally becoming more onerous.

These laws, rules and contractual requirements are subject to change and the regulatory environment surrounding data security and privacy is increasingly demanding. Compliance with existing or new privacy, security and data laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For more information on privacy regulations to which we are subject, see "Business – Regulation" in Part I, Item 1 of this Form 10-K.

HIPAA requires covered entities to comply with the HIPAA privacy, security and breach rules. In addition, business associates must comply with the HIPAA security and breach requirements. While we endeavor to provide appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain sensitive personal information in order to provide services to these customers. HHS administers an audit program to assess HIPAA compliance efforts by covered entities and business associates. In addition, HHS continues to exercise its enforcement authority, such as enforcement actions resulting from investigations brought on by notification to HHS of a breach. An audit resulting in findings or allegations of noncompliance or the implementation of an enforcement action could have an adverse effect on our results of operations, financial position, cash flows and reputation.

Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could materially adversely affect our business and reputation, including our results of operations, financial position and cash flows.

Effective prevention, detection and control systems are critical to maintain regulatory compliance and prevent fraud and failure of these systems could adversely affect us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities including kickbacks for referral of customers, billing for unnecessary medical services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us are complex and subject to change. In addition, ongoing vigorous law enforcement, a highly technical regulatory scheme and the Dodd-Frank Act and related regulations enhance regulators' enforcement powers and whistleblower incentives and protections. Our compliance efforts in this area will continue to require significant resources. Failure of our prevention, detection or control systems related to regulatory compliance or the failure of employees to comply with our internal policies including data systems security or unethical conduct by managers and employees, could adversely affect our reputation and also expose us to litigation and other proceedings, fines and penalties.

In addition, provider or customer fraud that is not prevented or detected could impact our medical costs or those of our self-insured clients. Further, during an economic downturn, we may experience increased fraudulent claims volume that may lead to additional costs due to an increase in disputed claims and litigation.

Economic Risks

Economic and market conditions affect the value of our financial instruments and the value of particular assets and liabilities, investment income and interest expense.

As an insurer, we have substantial investment assets that support insurance and contractholder deposit liabilities and surplus requirements in our regulated companies. The market values of our investments vary depending on economic and market conditions with no offsetting change in the value of a majority of our liabilities. A substantial portion of our investment assets are in fixed interest-yielding debt securities of varying maturities and commercial mortgage loans. The value of these investment assets can fluctuate significantly with changes in market conditions. A rise in interest rates would likely reduce the value of our investment portfolio, increase interest expense on our indebtedness and increase investment income as investment assets mature and are replaced. In addition, an economic contraction could result in delay in payment of principal or interest by issuers, or defaults by issuers, reducing our investment income and requiring us to write down the value of our investments.

Significant stock market or interest rate declines could result in additional unfunded pension obligations resulting in the need for additional plan funding by us and increased pension expenses.

We currently have unfunded obligations in our frozen pension plans. A significant decline in the value of the plans' equity and fixed income investments or unfavorable changes in applicable laws or regulations could materially increase our expenses and change the timing and amount of required plan funding. This could reduce the cash available to us, including our subsidiaries. We are also exposed to interest rate and equity risk associated with our pension obligations. Sustained declines in interest rates could have an adverse impact on the funded status of our pension plans and our reinvestment yield on new investments. See Note 15 to the Consolidated Financial Statements for more information on our obligations under the pension plans.

A downgrade in the financial strength ratings of our insurance subsidiaries could adversely affect new sales and retention of current business, and a downgrade in our debt ratings would increase the cost of borrowed funds and could negatively affect our ability to access capital.

Financial strength, claims paying ability and debt ratings by recognized rating organizations are each important factors in establishing the competitive position of insurance and health benefits companies. Ratings information by nationally recognized ratings agencies is broadly disseminated and generally used throughout the industry. We believe that the claims paying ability and financial strength ratings of our principal insurance subsidiaries are important factors in marketing our products to certain customers. Our debt ratings impact both the cost and availability of future borrowings and, accordingly, our cost of capital. Each of the rating agencies reviews ratings periodically and there can be no assurance that current ratings will be maintained in the future. A downgrade of any of these ratings in the future could make it more difficult to either market our products successfully or raise capital to support business growth.

We maintain significant indebtedness in the ordinary course of business and may incur further indebtedness in the future. Our indebtedness could adversely affect our financial condition, our ability to react to changes in the economy or our industry and could divert our cash flow from operations for debt service costs, leaving us with less cash flow from operations available to fund growth, stock repurchases, dividends and other corporate purposes.

The total indebtedness of Cigna was approximately $32.9 billion as of December 31, 2020. Carrying indebtedness:

- requires us to dedicate a portion of our cash flow from operations to debt payments, thereby reducing the availability of cash flow to fund our operations and growth strategy, including investments, acquisitions and capital expenditures, make stock repurchases, pay dividends and for general corporate purposes;
- increases our vulnerability to general adverse economic and industry conditions, which may require us to dedicate an even greater percentage of our cash flow from operations to the payment of principal and interest on our debt and limit our access to capital markets such that additional capital may not be available or may be available only on unfavorable terms;
- exposes us to increases in interest rates to the extent increased interest expense is not offset by increased income from our investment assets; and
- limits our flexibility in planning for, or reacting to, changes in or challenges relating to our business and industry.

The covenants in our debt instruments may have the effect, among other things, of restricting our financial and operating flexibility to respond to significant changes in business and economic conditions. We may incur or assume significantly more debt in the future which may subject us to additional restrictive covenants and increase the risks described above. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek additional dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt.

Unfavorable developments in economic conditions may adversely affect our business, results of operations and financial condition.

Many factors, including geopolitical issues, future economic downturns, natural disasters and pandemics, availability and cost of credit and other capital and consumer spending can negatively impact the U.S. and global economies. Our results of operations could be materially adversely affected by the impact of unfavorable economic conditions on our clients and customers (both employers and individuals), health care providers, pharmacy manufacturers, pharmacy providers and third-party vendors. For example:

- Employers may take action to reduce their operating costs by modifying, delaying or canceling plans to purchase our products or making changes in the mix of products purchased that are unfavorable to us.
- Higher unemployment rates and workforce reductions could result in lower enrollment in our employer-based plans (including an increase in the number of employees who opt out of employer-based plans) or our individual plans.
- Because of unfavorable economic conditions or the ACA, employers may stop offering health care coverage to employees or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs.
- If clients are not successful in generating sufficient funds or are precluded from securing financing, they may not be able to pay, or may delay payment of, accounts receivable that are owed to us.
- Our clients or potential clients may force us to compete more vigorously on factors such as price and service to retain or obtain their business.
- Our clients may be acquired, consolidated, or otherwise fail to successfully maintain or grow their business or workforce, which could reduce the number of customers we serve or otherwise result in lower than anticipated utilization of our services.
- A prolonged unfavorable economic environment could adversely impact the financial position of hospitals and other health care providers, potentially increasing our medical costs.
- Our third-party vendors could significantly and quickly increase their prices or reduce their output to reduce their operating costs. Our business depends on our ability to perform necessary business functions in an efficient and uninterrupted fashion.
- Other insurers' financial condition may be weakened, increasing the risk that we will receive significant assessments for obligations of insolvent insurers pursuant to guaranty associations, indemnity funds or other similar laws and regulations.

These factors could lead to a decrease in our customer base, revenues or margins or an increase in our operating costs.

In addition, during and following a prolonged unfavorable economic environment, federal and state budgets could be materially adversely affected, resulting in reduced or delayed reimbursements or payments in federal and state government programs such as Medicare and Social Security or under contracts with government entities. These federal and state budgetary pressures also could cause the government to impose new or a higher level of taxes or assessments on us, such as premium taxes on insurance companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Although we could attempt to mitigate or cover our exposure from such increased costs through, among other things, increases in premiums, there can be no assurance that we will be able to mitigate or cover all of such costs, which may have a material adverse effect on our business, results of operations, financial condition and liquidity.

We are subject to the credit risk of our reinsurers.

We enter into reinsurance arrangements with other insurance companies, primarily in connection with acquisition or divestiture transactions when the underwriting company is not being acquired or sold.

Under all reinsurance arrangements, reinsurers assume insured losses, subject to certain limitations or exceptions that may include a loss limit. These arrangements also subject us to various obligations, representations and warranties with the reinsurers. Reinsurance does not relieve us of liability as the originating insurer. We remain liable to the underlying policyholders if a reinsurer defaults on obligations under the reinsurance arrangement. Although we regularly evaluate the financial condition of reinsurers to minimize exposure to significant losses from reinsurer insolvencies, reinsurers may become financially unsound. If a reinsurer fails to meet its obligations under the reinsurance contract or if the liabilities exceed any applicable loss limit, we will be forced to cover the claims on the reinsured policies.

The collectability of amounts due from reinsurers is subject to uncertainty arising from a number of factors, including whether the insured losses meet the qualifying conditions of the reinsurance contract, whether reinsurers or their affiliates have the financial capacity and willingness to make payments under the terms of the reinsurance contract and the magnitude and type of collateral supporting our reinsurance recoverable, such as holding sufficient qualifying assets in trusts or letters of credit issued. Although a portion of our reinsurance exposures are secured, the inability to collect a material recovery from a reinsurer could have a material adverse effect on our results of operations, financial condition and liquidity.

Item 1B. ***UNRESOLVED STAFF COMMENTS***

None.

Item 2. ***PROPERTIES***

As of the end of fiscal year 2020, our global real estate portfolio consisted of approximately 12.4 million square feet of owned and leased properties. Our domestic portfolio had approximately 10.5 million square feet in 42 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Our international properties contain approximately 2.1 million square feet located throughout the following countries: Australia, Bahrain, Belgium, Canada, China, France, Germany, Hong Kong, India, Indonesia, Kenya, Kuwait, Lebanon, Malaysia, Netherlands, New Zealand, Oman, Singapore, South Korea, Spain, Switzerland, Taiwan, Thailand, Turkey, United Arab Emirates and the United Kingdom.

Our principal domestic office locations include the Wilde Building located at 900 Cottage Grove Road in Bloomfield, Connecticut (our corporate headquarters), Two Liberty Place located at 1601 Chestnut Street in Philadelphia, Pennsylvania, and Evernorth's corporate offices located at and around One Express Way in St. Louis, Missouri. The Wilde Building measures approximately 893,000 square feet and is owned. Express Scripts' campus measures approximately 1.2 million square feet of leased space and Two Liberty Place measures approximately 322,000 square feet and is leased space.

The pharmacy operations consist of ten order processing pharmacies, five patient contact centers, 26 specialty branch pharmacies and 11 high-volume automated home delivery and specialty dispensing pharmacies located throughout the United States. Dispensing pharmacies are located in Arizona, Delaware, Florida, Indiana, Massachusetts, Missouri, New Jersey, Pennsylvania and Tennessee.

We believe our properties are adequate and suitable for our business as presently conducted. The foregoing does not include information on investment properties.

Item 3. ***LEGAL PROCEEDINGS***

The information contained under Litigation Matters and Regulatory Matters in Note 21 to the Consolidated Financial Statements of this Form 10-K is incorporated herein by reference.

Item 4. ***MINE SAFETY DISCLOSURES***

Not Applicable.

Information about our Executive Officers

The principal occupations and employment histories of our executive officers are listed below.

DAVID M. CORDANI, 55, Chief Executive Officer of Cigna beginning December 2009; Director since October 2009; President beginning June 2008; and Chief Operating Officer from June 2008 until December 2009.

NOELLE K. EDER, 51, Executive Vice President, Chief Information Officer beginning September 2020; Executive Vice President, Chief Information and Digital Officer at Hilton Worldwide Holdings from March 2018 until August 2020; Executive Vice President, Chief Card Customer Experience Officer at Capital One Financial Corporation from November 2016 until 2018; and Executive Vice President, Customer Experience and Operations at Capital One Financial Corporation from September 2014 until November 2016.

BRIAN C. EVANKO, 44, Executive Vice President and Chief Financial Officer beginning January 2021; President, Government Business from November 2017 to January 2021; President, U.S. Individual Business from August 2013 to November 2017; Business Financial Officer, Cigna Global Individual, Health, Life and Accident from August 2011 to August 2013.

NICOLE S. JONES, 50, Executive Vice President and General Counsel of Cigna beginning June 2011; Senior Vice President and General Counsel of Lincoln Financial Group from May 2010 until June 2011; Vice President and Deputy General Counsel of Cigna from April 2008 until May 2010; and Corporate Secretary of Cigna from September 2006 until April 2010.

KRISTEN LAURIA, 52, Executive Vice President, Chief Marketing Officer beginning March 2020; General Manager, Watson Media and Weather at IBM from February 2017 until March 2020; Vice President, Strategy and Business Development, IBM Analytics Group at IBM from April 2016 until February 2017; and Chief Marketing Officer, IBM Global Business Services at IBM from August 2014 to August 2016.

MATTHEW G. MANDERS, 59, President, Government and Solutions beginning January 2021; President, Strategy and Solutions from November 2018 until January 2021; President, Government & Individual Programs and Group Insurance from February 2017 through November 2017; President, U.S. Markets from June 2014 until February 2017; President, Regional and Operations from November 2011 until June 2014; President, U.S. Service, Clinical and Specialty from January 2010 until November 2011; and President, Cigna HealthCare, Total Health, Productivity, Network & Middle Market from June 2009 until January 2010.

STEVEN B. MILLER, MD, 63, Executive Vice President and Chief Clinical Officer beginning December 2018; Senior Vice President and Chief Medical Officer, of Express Scripts from October 2007 through December 2018.

JOHN M. MURABITO, 62, Executive Vice President, Human Resources and Services of Cigna beginning August 2003.

EVERETT NEVILLE, 56, Executive Vice President, Strategy and Business Development beginning January 2021; Senior Vice President, Value Creation and Solutions from January 2020 until January 2021; Chief Value Officer from December 2018 until January 2020; Executive Vice President, Strategy, Supply Chain & Specialty, Express Scripts from January 2018 until December 2018; Senior Vice President, Strategy, Supply Chain & Specialty from November 2016 until January 2018; Senior Vice President, Supply Chain from March 2015 until November 2016; Vice President, Pharma Strategy and Contracting from March 2009 until March 2015.

ERIC P. PALMER, 44, President and Chief Operating Officer, Evernorth beginning January 2021; Executive Vice President and Chief Financial Officer from June 2017 to January 2021; Deputy Chief Financial Officer from February 2017 until June 2017; Senior Vice President, Chief Business Financial Officer from November 2015 to February 2017; Vice President, Business Financial Officer, Health Care from April 2012 to November 2015; and Vice President, Business Financial Officer, U.S. Commercial Markets from June 2010 to April 2012.

JASON D. SADLER, 52, President, International Markets beginning June 2014; President, Global Individual Health, Life and Accident from July 2010 until June 2014; and Managing Director Insurance Business Hong Kong, HSBC Insurance Asia Limited from January 2007 until July 2010.

MICHAEL W. TRIPLETT, 59, President, U.S. Commercial beginning February 2017; Regional Segment Lead from June 2009 to February 2017.

TIMOTHY C. WENTWORTH, 60, Chief Executive Officer, Evernorth beginning September 2020; President, Health Services from February 2020 until September 2020; President, Express Scripts and Cigna Services from December 2018 until February 2020; Chief Executive Officer of Express Scripts from May 2016 until December 2018; President from February 2014 through December 2018; and Senior Vice President and President, Sales and Account Management from April 2012 until February 2014.

PART II

Item 5. ***MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES***

As of December 31, 2020, the number of shareholders of record was 33,418. Cigna's common stock is listed with, and trades on, the New York Stock Exchange under the symbol "CI".

On January 6, 2021 Cigna initiated a quarterly cash dividend and declared the first quarterly cash dividend of $1.00 per share of Cigna common stock to be paid on March 25, 2021 to shareholders of record as of March 10, 2021. Cigna currently intends to pay regular quarterly dividends, with future declarations subject to approval by its Board of Directors and the Board's determination that the declaration of dividends remains in the best interests of Cigna and its shareholders. The decision of whether to pay future dividends and the amount of any such dividends will be based on the Company's financial position, results of operations, cash flows, capital requirements, the requirements of applicable law and any other factors the Board of Directors may deem relevant.

For the years ended December 31, 2020 and 2019 Cigna paid a yearly cash dividend of $0.04 per share of Cigna common stock.

Issuer Purchases of Equity Securities

The following table provides information about Cigna's share repurchase activity for the quarter ended December 31, 2020:

Period	Total # of shares purchased [1]	Average price paid per share	Total # of shares purchased as part of publicly announced program [2]	Approximate dollar value of shares that may yet be purchased as part of publicly announced program [3]
October 1-31, 2020	**2,513,269**	**$ 174.20**	**2,511,898**	**$ 3,154,849,988**
November 1-30, 2020	**2,264,316**	**$ 208.21**	**2,263,127**	**$ 2,683,607,700**
December 1-31, 2020	**3,933,971**	**$ 206.97**	**3,915,223**	**$ 3,873,160,092**
Total	**8,711,556**	**$ 197.84**	**8,690,248**	**N/A**

(1) Includes shares tendered by employees under the Company's equity compensation plans as follows: 1) payment of taxes on vesting of restricted stock (grants and units) and strategic performance shares and 2) payment of the exercise price and taxes for certain stock options exercised. Employees tendered 1,371 shares in October, 1,189 shares in November and 18,748 shares in December 2020.

(2) Additionally, the Company maintains a share repurchase program authorized by the Board of Directors. Under this program, the Company may repurchase shares from time to time, depending on market conditions and alternate uses of capital. The timing and actual number of shares repurchased will depend on a variety of factors, including price, general business and market conditions and alternate uses of capital. The share repurchase program may be effected through Rule 10b5-1 plans, open market purchases, each in compliance with Rule 10b-18 under the Exchange Act, or privately negotiated transactions. The program may be suspended or discontinued at any time and does not have an expiration date. In December 2020, the Board increased repurchase authority by an additional $2 billion. From January 1, 2021 through February 24, 2021, the Company repurchased 8.1 million shares for approximately $1.7 billion, leaving repurchase authority at $2.1 billion as of February 24, 2021.

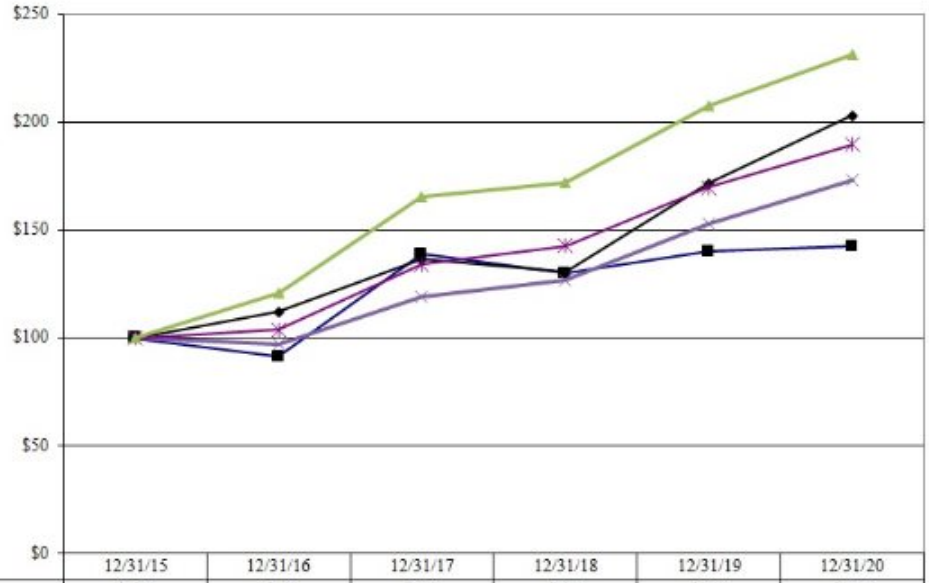
(3) Approximate dollar value of shares is as of the last date of the applicable month.

Stock Price Performance Graph

The graph below compares the cumulative total shareholder return on our common stock for the five years ended December 31, 2020 with the cumulative total return of the Standard & Poor's 500 Index, the Standard & Poor's 500 Health Care Providers & Services Index and the Standard & Poor's Managed Health Care, Life & Health Insurance Indexes. The stock performance shown in the graph is not intended to forecast or be indicative of future performance.

With consideration to Cigna's evolved strategy and recent divestiture of the Group Disability and Life business, for future filings we will select to present the S&P 500 Health Care Index as our peer group for this disclosure. Peer indices disclosed in previous filings are included herein for comparison.

Five Year Cumulative Total Shareholder Return*
December 31, 2015 - December 31, 2020



	12/31/15	12/31/16	12/31/17	12/31/18	12/31/19	12/31/20
Cigna	$100	$91	$139	$130	$140	$142
S&P 500	$100	$112	$136	$130	$171	$203
S&P 500 Health Care Index	$100	$97	$119	$126	$153	$173
S&P 500 Health Care Providers & Services Index	$100	$104	$134	$143	$170	$190
S&P Managed Health Care, Life & Health Ins. Indexes **	$100	$121	$165	$172	$207	$231

* Assumes that the value of the investment in Cigna common stock and each index was $100 on December 31, 2015 and that all dividends were reinvested.
** Weighted average of S&P Managed Health Care (75%) and Life and Health Insurance (25%) Indexes.

Item 6. ***SELECTED FINANCIAL DATA***

The selected financial data previously required by Item 301 of Regulation S-K has been omitted in reliance on SEC Release No. 33-10890, Management's Discussion and Analysis, Selected Financial Data and Supplementary Financial Information.

Item 7. ***MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS***

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Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") is intended to provide information to assist you in better understanding and evaluating our financial condition as of December 31, 2020 compared with December 31, 2019 and our results of operations for 2020 compared with 2019 and 2018 and is intended to help you understand the ongoing trends in our business. We encourage you to read this MD&A in conjunction with our Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K ("Form 10-K") and the "Risk Factors" contained in Part I, Item 1A of this Form 10-K. For comparisons of our results of operations for 2019 compared with 2018, please refer to the previously filed MD&A included in Part II, Item 7 of our Form 10-K for the year ended December 31, 2019.

Unless otherwise indicated, financial information in this MD&A is presented in accordance with accounting principles generally accepted in the United States of America ("GAAP"). See Note 3 to the Consolidated Financial Statements in this Form 10-K for additional information regarding the Company's significant accounting policies. In some of our financial tables in this MD&A, we present either percentage changes or "N/M" when those changes are so large as to become not meaningful. Changes in percentages are expressed in basis points ("bps").

In this MD&A, our consolidated measures "adjusted income from operations," earnings per share on that same basis and "adjusted revenues" are not determined in accordance with GAAP and should not be viewed as substitutes for the most directly comparable GAAP measures of "shareholders' net income," "earnings per share" and "total revenues." We also use pre-tax adjusted income from operations and adjusted revenues to measure the results of our segments.

We use adjusted income from operations as our principal financial measure of operating performance because management believes it best reflects the underlying results of our business operations and permits analysis of trends in underlying revenue, expenses and profitability. We define adjusted income from operations as shareholders' net income (or income before taxes for the segment metric) excluding realized investment gains and losses, amortization of acquired intangible assets, special items and prior to 2020, results of Anthem, Inc. and Coventry Health Care Inc. ("Coventry") (collectively, the "transitioning clients") (see the "Key Transactions and Business Developments" section of this MD&A for further discussion of transitioning clients). Cigna's share of certain realized investment results of its joint ventures reported in the International Markets segment using the equity method of accounting are also excluded. Income or expense amounts excluded from adjusted income from operations because they are not indicative of underlying performance or the responsibility of operating segment management include:

- *Realized investment gains (losses) including changes in market values of certain financial instruments between balance sheet dates, as well as gains and losses associated with invested asset sales.*
- *Amortization of acquired intangible assets because these relate to costs incurred for acquisitions.*
- *Results of transitioning clients prior to 2020, because those results are not indicative of ongoing results.*
- *Special items, if any, that management believes are not representative of the underlying results of operations due to the nature or size of these matters.*

The term adjusted revenues is defined as total revenues excluding the following adjustments: revenue contribution from transitioning clients prior to 2020, special items and Cigna's share of certain realized investment results of its joint ventures reported in the International Markets segment using the equity method of accounting. We exclude these items from this measure because management believes they are not indicative of past or future underlying performance of the business.

EXECUTIVE OVERVIEW

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as “Cigna,” the “Company,” “we,” “our” or “us”) is a global health services organization with a mission of helping those we serve improve their health, well-being and peace of mind. We offer a differentiated set of pharmacy, medical, dental and related products and services offered by our subsidiaries. For further information on our business and strategy, see Item 1, "Business" in this Form 10-K.

COVID-19 Update

The novel strain of coronavirus (“COVID-19”) was declared a pandemic by the World Health Organization in March 2020. From the onset of the COVID-19 pandemic we have taken actions to drive affordability, reduce uncertainty and make health care easier. For customers, these actions include COVID-19 related cost share waivers, expanded access to virtual care, support for access to medication and advocating for whole person health through various behavioral health initiatives. We have supported the medical community by simplifying processes and donating medications for a COVID-19 clinical trial. Cigna and the Cigna Foundation have assisted our communities through several initiatives including the launch of the Brave of Heart Fund that provides financial assistance to survivors of front-line U.S. health care workers who gave their lives in the fight against COVID-19. Cigna also provides emotional support services to their families. The Evernorth team launched ParachuteRx, a drug cost assistance program to certain customers without health coverage due to furlough or job loss. Cigna Medical Group was among the first in the United States to administer antibody therapies to high-risk COVID-19 patients in a non-hospital setting. Cigna also partnered with other organizations on digital access to vaccination records for those who have received the COVID-19 vaccine to facilitate return to work and daily activities.

We have continued to support our workforce by enabling remote work where appropriate, and implemented enhanced safety protocols and programs that support the health and mental well-being of our employees. We have continued to execute our business continuity plans over our operations such as leveraging purchasing volume across the pharmaceutical supply chain in order to mitigate risk associated with prescription drug supply. We did not incur significant disruptions to our operations during 2020 from COVID-19.

We will continue to work with our clients, customers, providers and employees to provide support during the pandemic.

The COVID-19 pandemic has pervasively impacted the economy, financial markets and the global health care delivery systems. The effects of the COVID-19 pandemic on the Company began to emerge in the United States at the end of the first quarter and were not material to the Company's results of operations or financial condition for that period.

Beginning in April, we experienced a significant deferral of care by our customers. The deferral of care moderated over the course of the second quarter with utilization levels eventually returning to nearly normal levels by the end of June. In the third quarter, we experienced increased medical utilization as we observed a reduction to the level of deferred care and our customers sought care for COVID-19 testing and treatment.

In the fourth quarter, as COVID-19 cases increased, the costs for testing and treatment exceeded the savings related to the deferral of care. These impacts were most prevalent in the U.S. Medical segment where fourth quarter earnings were adversely impacted by increased costs of COVID-19 care and decreased contributions from our specialty products. Full year U.S. Medical results reflect COVID-19 impacts of deferral of care by our customers partially offset by the cost of COVID-19 care, the cost of COVID-19 related actions including premium relief programs for employer clients, cost share waivers for customers, customer disenrollment and actions to support providers and employees.

Our Group Disability and Other results reflect significantly elevated life insurance claims related to the COVID-19 pandemic and its effects in the third and fourth quarters. Quarterly and year-to-date earnings in our Evernorth segment also reflected effects of the pandemic, specifically, a favorable mix of claims as a result of both the type of drugs dispensed as well as the distribution method used for dispensing and fulfilling, partially offset by lower 30-day retail script volume. Segment results are discussed further in the "Segment Reporting" section of this MD&A and discussion of the impact of COVID-19 on our investment portfolio and related considerations regarding our investment outlook can be found in Note 11 to the Consolidated Financial Statements and in the "Investment Assets" discussion of this MD&A.

While it is difficult to predict the impact of the COVID-19 pandemic on our results beyond 2020, we believe that such results may be impacted by, among other things, higher medical costs to treat those affected by the virus, lower customer volumes due to rising unemployment, lower future risk adjustment revenue due to disrupted care impeding appropriate documentation of customer risk profiles in our Medicare Advantage business, the return of costs for those who had previously deferred care, vaccine costs, continued cost share waivers, the potential for continued deferral of care, or lower investment returns.

Cigna has taken actions to enhance our liquidity that, combined with our other sources of liquidity described in the "Liquidity and Capital Resources Outlook" section below, and our current projections for operating cash flows, we believe are sufficient to support our operations and meet our obligations.

The situation surrounding COVID-19 remains fluid, and we are actively managing our response and assessing impacts to our financial position and operating results, as well as adverse developments in our business.

For further information regarding the potential impact of COVID-19 on the Company, see “Risk Factors” contained in Part I, Item 1A of this Form 10-K.

Financial Highlights

See Note 1 to the Consolidated Financial Statements for a description of our segments. Unless otherwise specified, the commentary provided below describes our results for the year ended December 31, 2020 compared with the year ended December 31, 2019. Results for 2018 only include Express Scripts for the period following the acquisition on December 20, 2018.

Summarized below are certain key measures of our performance by segment for the years ended December 31:

Financial highlights by segment

	For the Years Ended December 31,			Increase (Decrease)	Increase (Decrease)
(Dollars in millions, except per share amounts)	**2020**	**2019**	**2018**	**2020 vs. 2019**	**2019 vs. 2018**
Revenues					
Adjusted revenues by segment					
Evernorth	**$ 116,130**	$ 96,447	$ 6,606	20 %	N/M
U.S. Medical	**38,451**	36,519	32,791	5	11 %
International Markets	**5,877**	5,615	5,366	5	5
Group Disability and Other	**5,264**	5,182	5,061	2	2
Corporate, net of eliminations	**(5,655)**	(3,588)	(1,713)	(58)	(109)
Adjusted revenues	**160,067**	140,175	48,111	14	191
Revenue contribution from transitioning clients	**—**	13,347	459	N/M	N/M
Net realized investment results from certain equity method investments	**130**	44	(43)	195	N/M
Special items	**204**	—	123	N/M	N/M
Total revenues	**$ 160,401**	$ 153,566	$ 48,650	4 %	216 %
Shareholders’ net income	**$ 8,458**	$ 5,104	$ 2,637	66 %	94 %
Adjusted income from operations	**$ 6,795**	$ 6,476	$ 3,557	5 %	82 %
Earnings per share (diluted)					
Shareholders’ net income	**$ 22.96**	$ 13.44	$ 10.54	71 %	28 %
Adjusted income from operations	**$ 18.45**	$ 17.05	$ 14.22	8 %	20 %
Pre-tax adjusted income from operations by segment					
Evernorth	**$ 5,363**	$ 5,092	$ 380	5 %	N/M
U.S. Medical	**3,807**	3,831	3,502	(1)	9 %
International Markets	**900**	762	735	18	4
Group Disability and Other	**290**	501	529	(42)	(5)
Corporate, net of eliminations	**(1,552)**	(1,824)	(403)	15	N/M
Consolidated pre-tax adjusted income from operations	**8,808**	8,362	4,743	5	76
Adjustment for transitioning clients	**—**	1,726	62	N/M	N/M
Income attributable to noncontrolling interests	**37**	20	14	85	43
Net realized investment gains (losses)	**279**	221	(124)	26	N/M
Amortization of acquired intangible assets	**(1,982)**	(2,949)	(235)	33	N/M
Special items	**3,726**	(810)	(879)	N/M	8
Income before income taxes	**$ 10,868**	$ 6,570	$ 3,581	65 %	83 %

For further analysis and explanation of each segment’s results, see the “Segment Reporting” section of this MD&A.

Consolidated Results of Operations (GAAP basis)

(Dollars in millions)	For the Years Ended December 31, 2020	2019	2018	Increase (Decrease) 2020 vs. 2019		Increase (Decrease) 2019 vs. 2018	
Pharmacy revenues	**$ 107,769**	$ 103,099	$ 5,479	$ 4,670	5 %	$ 97,620	N/M
Premiums	**42,627**	39,714	36,113	2,913	7	3,601	10 %
Fees and other revenues	**8,761**	9,363	5,578	(602)	(6)	3,785	68
Net investment income	**1,244**	1,390	1,480	(146)	(11)	(90)	(6)
Total revenues	**160,401**	153,566	48,650	6,835	4	104,916	216
Pharmacy and other service costs	**103,484**	97,668	4,793	5,816	6	92,875	N/M
Medical costs and other benefit expenses	**32,710**	30,819	27,528	1,891	6	3,291	12
Selling, general and administrative expenses	**14,072**	14,053	11,934	19	—	2,119	18
Amortization of acquired intangible assets	**1,982**	2,949	235	(967)	(33)	2,714	N/M
Total benefits and expenses	**152,248**	145,489	44,490	6,759	5	100,999	227
Income from operations	**8,153**	8,077	4,160	76	1	3,917	94
Interest expense and other	**(1,438)**	(1,682)	(498)	244	15	(1,184)	(238)
Debt extinguishment costs	**(199)**	(2)	—	(197)	N/M	(2)	N/M
Gain (loss) on sale of business	**4,203**	—	—	4,203	N/M	—	N/M
Net realized investment gains (losses)	**149**	177	(81)	(28)	(16)	258	N/M
Income before income taxes	**10,868**	6,570	3,581	4,298	65	2,989	83
Total income taxes	**2,379**	1,450	935	929	64	515	55
Net income	**8,489**	5,120	2,646	3,369	66	2,474	93
Less: Net income attributable to noncontrolling interests	**31**	16	9	15	94	7	78
Shareholders' net income	**$ 8,458**	$ 5,104	$ 2,637	$ 3,354	66 %	$ 2,467	94 %
Consolidated effective tax rate	**21.9 %**	22.1 %	26.1 %	(20) bps		(400) bps	
Medical customers (in thousands)							
U.S. Medical	**15,013**	15,548	15,389	(535)	(3) %	159	1 %
International Markets	**1,660**	1,597	1,572	63	4	25	2
Total	**16,673**	17,145	16,961	(472)	(3) %	184	1 %

Reconciliation of Shareholders' Net Income (GAAP) to Adjusted Income from Operations

	Dollars in Millions For the Years Ended December 31, 2020	2019	2018	Diluted Earnings Per Share For the Years Ended December 31, 2020	2019	2018
Shareholders' net income	**$ 8,458**	$ 5,104	$ 2,637	**$ 22.96**	$ 13.44	$ 10.54
After-tax adjustments required to reconcile to adjusted income from operations						
Net realized investment (gains) losses	**(244)**	(190)	104	**(0.66)**	(0.50)	0.42
Amortization of acquired intangible assets	**1,431**	2,248	177	**3.88**	5.92	0.71
Adjustment for transitioning clients	**—**	(1,316)	(47)	**—**	(3.46)	(0.19)
Special items						
Integration and transaction-related costs	**404**	427	669	**1.10**	1.11	2.67
Debt extinguishment costs	**151**	—	—	**0.41**	—	—
Charge for organizational efficiency plan	**24**	162	—	**0.07**	0.43	—
Charges associated with litigation matters	**19**	41	19	**0.05**	0.11	0.08
Risk corridors recovery	**(76)**	—	—	**(0.21)**	—	—
Contractual adjustment for a former client	**(155)**	—	—	**(0.42)**	—	—
(Gain) on sale of business	**(3,217)**	—	—	**(8.73)**	—	—
Charges (benefits) associated with tax reform	**—**	—	(2)	**—**	—	(0.01)
Total special items	**(2,850)**	630	686	**(7.73)**	1.65	2.74
Adjusted income from operations	**$ 6,795**	$ 6,476	$ 3,557	**$ 18.45**	$ 17.05	$ 14.22

Commentary: 2020 versus 2019

Unless indicated otherwise, the commentary presented below, and in the segment discussions that follow, compare results for the year ended December 31, 2020 with results for the year ended December 31, 2019.

Shareholders' net income increase was driven by the gain on sale of the Group Disability and Life business, lower amortization charges and higher adjusted income from operations, partially offset by the absence of earnings from transitioning clients.

Adjusted income from operations increased, driven in part by higher earnings in the Evernorth segment reflecting customer growth and increased script volumes, an increase in the International Markets segment results and lower interest costs in Corporate due to a lower level of outstanding debt. These favorable effects were partially offset by lower earnings in the Group Disability and Other segment reflecting significantly elevated life claims related to the effects of COVID-19.

Medical customers decreased due to declines in the Middle Market and National Accounts market segments and increased disenrollment driven by the impacts of COVID-19. Those decreases were partially offset by growth in the Select, International and Medicare Advantage segments.

Pharmacy revenues increased, reflecting the transition of U.S. Medical's customers to Evernorth, higher claims volumes, driven by the Evernorth collaboration with Prime Therapeutics and an increase in pricing, primarily due to inflation on branded drugs. These factors were substantially offset by the absence of revenues from the transitioning clients and, to a lesser extent, an increase in the generic fill rate. See the "Evernorth segment" section of this MD&A for further discussion of pharmacy revenues.

Premiums increased, reflecting customer growth in insured products and rate increases reflecting expected medical cost inflation and the return of the health insurance industry tax. These factors were partially offset by the impact of premium relief programs implemented in response to significantly lower than historical utilization as customers deferred care in 2020 due to the COVID-19 pandemic.

Fees and other revenues decreased, primarily reflecting the transition of U.S. Medical's commercial customers to Evernorth's retail pharmacy network beginning in the third quarter of 2019 (see Note 3(K) to the Consolidated Financial Statements for further information).

Net investment income decrease was driven by lower yields, including lower income from partnership investments due to current economic conditions. These effects were partially offset by higher average assets. See the "Investment Assets" section of this MD&A for further discussion.

Pharmacy and other service costs increased, reflecting the transition of U.S. Medical's customers to Evernorth, higher claims volumes, driven by the Evernorth collaboration with Prime Therapeutics and an increase in pricing, primarily due to inflation on branded drugs. These factors were substantially offset by the impact of the absence of the transitioning clients and, to a lesser extent, effective management of supply chain and the favorable impact of the mix of claims.

Medical costs and other benefit expenses increased, reflecting both customer growth and direct costs associated with COVID-19, partially offset by care deferrals in insured products in U.S. Medical and higher life claims in Group Disability and Other due to the effects of the COVID-19 pandemic.

Selling, general and administrative expenses were essentially flat, primarily reflecting lower charges in 2020 for the organizational efficiency plan and the risk corridors claim recovery recognized in the third quarter of 2020 (see the "Risk Mitigation Programs - Individual ACA Business" section of this MD&A and Note 21 to the Consolidated Financial Statements for further discussion), offset by the return of the health insurance industry tax.

Amortization of acquired intangible assets decreased, primarily reflecting lower amortization of customer-related intangibles associated with the transitioning clients.

Income tax expense increased for 2020, largely attributable to the sale of Cigna's Group Disability and Life business. The consolidated effective tax rate decreased slightly, driven by recognition of certain incremental federal and state tax benefits, largely offset by the return of the nondeductible health insurance industry tax.

Key Transactions and Business Developments

Sale of Group Disability and Life Business

As discussed in Note 5 to the Consolidated Financial Statements, Cigna sold the U.S. Group Disability and Life business to New York Life Insurance Company for $6.2 billion on December 31, 2020. The "Liquidity and Capital Resources" section of this MD&A provides discussion of the use of proceeds from this divestiture.

Organizational Efficiency Plan

Consistent with our commitment to affordability for our customers and clients, during the fourth quarter of 2019 the Company committed to a plan to increase our organizational alignment and operational efficiency and reduce costs. As a result, we recognized a charge in Selling, general and administrative expenses of $207 million, pre-tax ($162 million, after-tax) in the fourth quarter of 2019 and an additional charge of $31 million pre-tax ($24 million, after-tax) in the first quarter of 2020. We expect to realize annualized after-tax savings of approximately $200 million. A substantial portion of the savings was realized in 2020.

Merger with Express Scripts

As discussed in more detail in our 2019 Form 10-K, Cigna acquired Express Scripts on December 20, 2018 in a cash and stock transaction valued at $52.8 billion. Costs related to this transaction are reported in "integration and transaction-related costs" as a special item and excluded from adjusted income from operations because they are not indicative of future underlying performance of the business. The integration of this acquisition has been completed.

On January 30, 2019, Anthem, a former client, exercised its early termination right and terminated its pharmacy benefit management services agreement with us, effective March 1, 2019. There was a twelve-month transition period that ended March 1, 2020. We excluded the results of Express Scripts' contract with Anthem (and also Coventry) from our non-GAAP reporting metrics adjusted revenues and adjusted income from operations for 2019 and refer to these clients as transitioning clients. As of December 31, 2019, the transition was substantially complete; therefore, beginning in 2020, we no longer exclude results of transitioning clients from our reported adjusted revenues and adjusted income from operations.

Industry Developments and Other Matters

The "Business - Regulation" section of this Form 10-K provides a detailed description of The Patient Protection and Affordable Care Act (“ACA”) provisions and other legislative initiatives that impact our businesses, including regulations issued by the Centers for Medicare & Medicaid Services (“CMS”) and the Departments of the Treasury and Health and Human Services. Our businesses continue to operate in a dynamic environment, and the laws and regulations applicable to us, including the ACA, continue to be subject to legislative, regulatory and judicial challenges. The following table provides information on the expected impact of these items and other matters:

Item	Description
Medicare Advantage ("MA")	**Medicare Star Quality Ratings ("Star Ratings"):** CMS uses a Star Rating system to measure how well MA plans perform and scores performance in several categories, including quality of care and customer service. Star Ratings range from one to five stars. CMS recognizes plans with Star Ratings of four stars or greater with quality bonus payments and the ability to offer enhanced benefits. Approximately 77% of our MA customers were in four star or greater plans for bonus payments received in 2020 and 87% for bonus payments to be received in 2021. In October 2020, CMS announced the Star Ratings for bonus payments to be received in 2022. We expect the percentage of our MA customers in four star or greater plans will increase to 88% for bonus payments to be received in 2022.
	MA Rates: Final MA reimbursement rates for 2021 were published by CMS in April 2020, and final rates for 2022 were published by CMS in January 2021. We do not expect the new rates to have a material impact on our consolidated results of operations in 2021 or 2022.
	Risk Adjustment: As discussed in the “Regulation” and “Risk Factors” sections of this Form 10-K, our MA business is subject to reviews, including risk adjustment data validation (“RADV”) audits by CMS and the Office of the Inspector General (“OIG”). We expect that CMS, OIG and other federal agencies will continue to closely scrutinize components of the Medicare program. The “Regulation” section of this Form 10-K also discusses a proposed rule issued by CMS in 2018 for RADV audits of contract year 2011 and all subsequent years that included, among other things, extrapolation of the error rate related to RADV audit findings without applying the adjustment for underlying fee-for-service data errors as currently contemplated by CMS’ RADV audit methodology. RADV audits for our contract years 2011 through 2015 are currently in process. CMS has announced its intent to use third-party auditors to audit all Medicare Advantage contracts by either a comprehensive or a targeted RADV review for each contract year. If the proposed rule is adopted in its current form, it could result in some combination of degraded plan benefits, higher monthly premiums and reduced choice for the population served by all MA insurers. The Company, along with other MA organizations and additional interested parties, submitted comments to CMS on the proposed rule as part of the notice-and-comment rulemaking process. The comment period concluded on August 28, 2019 and CMS is expected to act by November 2021. If CMS adopts the rule as proposed, there could be a material impact on the Company’s future results of operations, though we expect the rule would be subject to legal challenges. In addition, the Company is subject to OIG RADV audits that are in process. Also, as described in Note 21 to the Consolidated Financial Statements, the U.S. Department of Justice is currently conducting an industry-wide investigation of risk adjustment data submission practices and business processes, which in the case of certain other MA organizations has resulted in litigation.

Item	Description
Affordable Care Act	**Cost-Sharing Reduction Subsidies:** The ACA provides for cost-sharing reductions that offset the amount that qualifying customers pay for deductibles, copays and coinsurance. The federal government stopped funding insurers for the cost-sharing reduction ("CSR") subsidies in 2017. Certain insurers have sued the federal government for failure to pay cost-sharing reduction subsidies and the matter remains unresolved. In the first set of consolidated appeals, the Court of Appeals for the Federal Circuit issued a decision on August 14, 2020, finding that (i) the CSR reimbursement provision of the ACA imposes an obligation on the government to pay, but (ii) the insurers' damages must be reduced by the amount of additional premium tax credit payments that each insurer received as a result of the government's termination of CSR payments. On September 28 and October 2, 2020, the insurers filed petitions for rehearing en banc in the Federal Circuit. The court denied those petitions on November 10 and December 16, 2020, respectively. On February 19, 2021 two insurers filed a petition seeking Supreme Court review. As described in Note 21 to the Consolidated Financial Statements, we filed a lawsuit in May 2020 against the federal government seeking payment of these subsidies. Our case is stayed until either the Federal Circuit's judgments in the CSR appeals become final and non-appealable or the Supreme Court resolves any petition for writ of certiorari. Our premium rates for the 2018, 2019 and 2020 plan years reflected a lack of government funding for cost-sharing reduction subsidies.
	ACA Litigation: As described in the "Business - Regulation" section of this Form 10-K, a federal district court ruled that the "individual mandate" in the ACA is unconstitutional and that the entire law must be struck down. On appeal, the Court of Appeals for the Fifth Circuit agreed that the "individual mandate" is unconstitutional but ordered the district court to reexamine whether the other provisions of the ACA can remain in effect, thereby leaving in doubt whether the entire ACA is unconstitutional until there is a final judicial determination on appeal. The California-led states and the U.S. House of Representatives filed petitions seeking to appeal the Fifth Circuit's ruling to the U.S. Supreme Court. On March 2, 2020, the Supreme Court agreed to hear the appeals. The case was argued before the Supreme Court on November 10, 2020, and a decision is expected by the end of June 2021.

Risk Mitigation Programs – Individual ACA Business

Risk Corridors. In 2016, we recorded an allowance for the balance of our ACA risk corridors receivable based on court decisions and the large program deficit. On April 27, 2020, the U.S. Supreme Court ruled that insurers are entitled to the full amount due under the risk corridors program. The Supreme Court remanded the cases before it to the lower courts for further proceedings consistent with its opinion. We filed a lawsuit in May 2020 seeking payment of these funds. We received $120 million in payments in September 2020, which resolved our risk corridors claim.

Risk Adjustment. At the end of each program year the risk adjustment balances are subject to audit by CMS through the RADV program. RADV audits for the 2017 and 2018 benefit years have been completed, subject to the error rates appeal period. Final settlement for the 2017 and 2018 benefit years is expected in 2021 and 2022, respectively. Based on the information currently available, we have adjusted our risk adjustment balances to reflect our estimate of expected outcome as of December 31, 2020 and December 31, 2019.

(In millions)	December 31, 2020	December 31, 2019
Risk Adjustment		
Receivables [1]	**$ 80**	$ 47
Payables [2]	**(153)**	(213)
Total risk adjustment balance	**$ (73)**	$ (166)

(1) Receivables, net of allowances, are reported in Accounts receivable, net in the Consolidated Balance Sheets.
(2) Payables are reported in Accrued expenses and other liabilities (current) in the Consolidated Balance Sheets.

Risk adjustment program charges of $(26) million pre-tax were fully offset by RADV adjustment favorability of $26 million pre-tax for 2020, compared with net charges of $162 million pre-tax ($126 million after-tax) in 2019 and $147 million pre-tax ($116 million after-tax) in 2018.

LIQUIDITY AND CAPITAL RESOURCES

(In millions)			
Financial Summary	**2020**	**2019**	**2018**
Short-term investments	**$ 359**	$ 423	$ 316
Cash and cash equivalents	**$ 10,182**	$ 4,619	$ 3,855
Short-term debt	**$ 3,374**	$ 5,514	$ 2,955
Long-term debt	**$ 29,545**	$ 31,893	$ 39,523
Shareholders' equity	**$ 50,321**	$ 45,338	$ 41,028

Liquidity

We maintain liquidity at two levels: the subsidiary level and the parent company level.

Liquidity requirements at the subsidiary level generally consist of:

- pharmacy, medical costs and other benefit payments;
- expense requirements, primarily for employee compensation and benefits, information technology and facilities costs;
- income taxes; and
- debt service.

Our subsidiaries normally meet their liquidity requirements by:

- maintaining appropriate levels of cash, cash equivalents and short-term investments;
- using cash flows from operating activities;
- matching investment durations to those estimated for the related insurance and contractholder liabilities;
- selling investments; and
- borrowing from affiliates, subject to applicable regulatory limits.

Liquidity requirements at the parent company level generally consist of:

- debt service;
- payment of declared dividends to shareholders;
- lending to subsidiaries as needed; and
- pension plan funding.

The parent company normally meets its liquidity requirements by:

- maintaining appropriate levels of cash and various types of marketable investments;
- collecting dividends from its subsidiaries;
- using proceeds from issuing debt and common stock; and
- borrowing from its subsidiaries, subject to applicable regulatory limits.

Dividends from our insurance, Health Maintenance Organization ("HMO") and foreign subsidiaries are subject to regulatory restrictions. See Note 19 to the Consolidated Financial Statements for additional information regarding these restrictions. Most of Evernorth's subsidiaries are not subject to regulatory restrictions regarding dividends and therefore provide significant financial flexibility to Cigna.

Cash flows for the years ended December 31 were as follows:

(In millions)	2020	2019	2018
Net cash provided by operating activities	**$ 10,350**	$ 9,485	$ 3,770
Net cash provided by (used in) investing activities:			
Cash proceeds from sale of U.S. Group Disability and Life business, net of cash sold	**5,592**	—	—
Cash used to acquire Express Scripts, net of cash acquired	**—**	—	(24,062)
Other acquisitions	**(139)**	(153)	(393)
Net investment sales (purchases)	**(1,406)**	480	(1,383)
Purchases of property and equipment and other	**(1,071)**	(1,061)	(540)
Net investing activities	**2,976**	(734)	(26,378)
Net cash (used in) provided by financing activities:			
Debt (repayments) issuances	**(4,736)**	(5,175)	24,212
Stock repurchase	**(4,042)**	(1,987)	(342)
Other, net	**245**	(25)	(355)
Net financing activities	**(8,533)**	(7,187)	23,515
Foreign currency effect on cash	**41**	(8)	(24)
Change in cash, cash equivalents and restricted cash	**$ 4,834**	$ 1,556	$ 883

The following discussion explains variances in the various categories of cash flows for the year ended December 31, 2020 compared with the same period in 2019.

Operating activities

Cash flows from operating activities consist principally of cash receipts and disbursements for pharmacy revenues and costs, premiums, fees, investment income, taxes, benefit costs and other expenses.

Cash flows from operating activities increased, primarily driven by higher pharmacy and services costs payables due to business growth, offset by increases in accounts receivable due to business growth, higher inventory purchases and the resumption of the health insurance industry tax.

Investing and Financing activities

Cash flows from investing activities increased, primarily due to the net proceeds from the sale of the Group Disability and Life business, partially offset by higher net investment purchases.

Cash used in finance activities increased, primarily due to stock repurchases and debt repayments, partially offset by higher debt issuance.

We maintain a share repurchase program authorized by our Board of Directors. Under this program, we may repurchase shares from time to time, depending on market conditions and alternate uses of capital. The timing and actual number of shares repurchased will depend on a variety of factors including price, general business and market conditions and alternate uses of capital. The share repurchase program may be effected through open market purchases in compliance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended, including through Rule 10b5-1 trading plans or privately negotiated transactions. The program may be suspended or discontinued at any time.

For the year ended December 31, 2020, we repurchased 21.9 million shares for approximately $4.1 billion. From January 1, 2021 through February 24, 2021, we repurchased 8.1 million shares for approximately $1.7 billion. Share repurchase authority was $2.1 billion as of February 24, 2021.

Capital Resources

Our capital resources consist primarily of cash, cash equivalents and investments maintained at regulated subsidiaries required to underwrite insurance risks, cash flows from operating activities, our commercial paper program, credit agreements and the issuance of long-term debt and equity securities. Our businesses generate significant cash flow from operations, some of which is subject to regulatory restrictions relative to the amount and timing of dividend payments to parent. Dividends from U.S. regulated subsidiaries were $2.3 billion in 2020 and 2019. Nonregulated subsidiaries also generate significant cash flow from operating activities, which is typically available immediately to parent for general corporate purposes.

We prioritize our use of capital resources to:

- Invest in capital expenditures, primarily related to technology to support innovative solutions for our customers, provide the capital necessary to maintain or improve the financial strength ratings of subsidiaries and to repay debt and fund pension obligations if necessary;
- pay dividends to shareholders;
- consider acquisitions that are strategically and economically advantageous; and
- return capital to shareholders through share repurchases.

At December 31, 2020, our debt-to-capitalization ratio was 39.5%, a decline from 45.2% at December 31, 2019.

In connection with the sale of the Group Disability and Life business that closed on December 31, 2020, we deployed approximately $3.0 billion to debt repayment by: (i) repaying in full our $1.4 billion 364-Day Term Loan Credit Agreement entered into on April 1, 2020, on December 31, 2020; (ii) redeeming in full the $1.0 billion aggregate principal amount of Cigna's Senior Floating Rate Notes due 2021 on January 15, 2021 at a redemption price calculated in accordance with the terms and conditions of the indenture governing the Notes; and (iii) repaying certain of our outstanding commercial paper balances in January 2021.

In 2018, Cigna entered into a $3.25 billion five-year revolving credit agreement and a $3.0 billion term loan credit agreement in financing the Express Scripts acquisition. The term loan credit agreement was repaid in full and terminated in the fourth quarter of 2019.

In 2019, Cigna entered into an additional $1.0 billion 364-day revolving credit agreement that expired in October 2020, at which point we replaced the revolving credit agreement with a new $1.0 billion 364-day revolving credit agreement which will expire in October 2021.

Our revolving credit agreements provide us the ability to borrow amounts for general corporate purposes, including for purpose of providing liquidity support if necessary under our commercial paper program discussed below. As of December 31, 2020, there were no outstanding balances under either of the revolving credit agreements.

Cigna also maintains a commercial paper program and may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time not to exceed $4.25 billion. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The commercial paper program had approximately $1.0 billion outstanding at December 31, 2020 at an average interest rate of 0.2%.

See Note 7 to the Consolidated Financial Statements for further information on our credit agreements and commercial paper program.

Our capital management strategy to support the liquidity and regulatory capital requirements of our foreign operations and certain international growth initiatives is to retain overseas a significant portion of the earnings generated by our foreign operations. This strategy does not materially limit our ability to meet our liquidity and capital needs in the United States.

Liquidity and Capital Resources Outlook

We maintain sufficient liquidity to meet our cash needs through our cash and cash equivalents balances, cash flows from operations, commercial paper program, credit agreements and the issuance of long-term debt and equity securities. As of December 31, 2020, we had $4.25 billion of undrawn committed capacity under our revolving credit agreements (which amounts are available for general corporate purposes, including providing liquidity support for our commercial paper program), $3.2 billion of remaining capacity under our commercial paper program and $10.5 billion in cash and short-term investments, approximately $5.2 billion of which was held by the parent company or certain nonregulated subsidiaries. We actively monitor our debt obligations and engage in issuance or redemption activities as needed in accordance with our capital management strategy. A description of our outstanding debt can be found in Note 7 to the Consolidated Financial Statements.

On January 6, 2021, Cigna initiated a quarterly cash dividend and declared the first quarterly cash dividend of $1.00 per share of Cigna common stock to be paid on March 25, 2021 to shareholders of record as of March 10, 2021. Cigna currently intends to pay regular quarterly dividends, with future declarations subject to approval by its Board of Directors and the Board's determination that the declaration of dividends remains in the best interests of Cigna and its shareholders. The decision of whether to pay future dividends and the amount of any such dividends will be based on the Company's financial position, results of operations, cash flows, capital requirements, the requirements of applicable law and any other factors the Board of Directors may deem relevant.

As of December 31, 2020, our unfunded pension liability was $977 million, an increase of $104 million from December 31, 2019, primarily attributable to a decrease in discount rates of approximately 80 basis points, partially offset by investment asset returns. In 2020, we made an immaterial pension contribution as required under the Pension Protection Act of 2006. We expect the required contributions for 2021 to be immaterial. See Note 15 to the Consolidated Financial Statements for additional information.

Risks to our liquidity and capital resources outlook include cash projections that may not be realized and the demand for funds could exceed available cash if our ongoing businesses experience unexpected shortfalls in earnings or we experience material adverse effects from one or more risks or uncertainties described more fully in the "Risk Factors" section of this Form 10-K. Though we believe we have adequate sources of liquidity, significant disruption or volatility in the capital and credit markets could affect our ability to access those markets for additional borrowings or increase costs. In addition to the sources of liquidity discussed above, the parent company can borrow an additional $1.7 billion from its subsidiaries without further approvals as of December 31, 2020.

Guarantees and Contractual Obligations

We are contingently liable for various contractual obligations entered into in the ordinary course of business. See the: "Liquidity and Capital Resources" section of this MD&A for additional information on how we manage our liquidity requirements related to these obligations. See Note 21 to the Consolidated Financial Statements for discussion of various guarantees.

(In millions, on an undiscounted basis)	Total	2021	2022 to 2023	2024 to 2025	Thereafter
On-Balance Sheet					
Insurance liabilities					
Contractholder deposit funds	$ 5,430	$ 282	$ 502	$ 462	$ 4,184
Future policy benefits	12,339	338	776	900	10,325
Health Care Medical claims payable	3,041	3,041			
Unpaid claims and claim expenses	1,195	1,141	11	9	34
Long-term debt [1]	48,029	3,595	8,048	6,062	30,324
Other noncurrent liabilities	623	156	104	99	264
Operating leases	705	150	288	146	121
Off-Balance Sheet					
Purchase Obligations	3,197	1,399	1,283	493	22
Total	$ 74,559	$ 10,102	$ 11,012	$ 8,171	$ 45,274

(1) Amounts include scheduled interest payments and current maturities of long-term debt. Finance leases are included in long-term debt and primarily represent obligations for information technology network storage, servers and equipment. See Note 18 to the Consolidated Financial Statements for information regarding finance leases. See Note 7 to the Consolidated Financial Statements for information regarding our long-term debt.

On balance sheet:

- ***Insurance liabilities.*** Excluded from the table above are $4 billion of insurance liabilities ($3 billion in contractholder deposit funds; $1 billion in future policy benefits) associated with the sold retirement benefits, individual life insurance and annuity businesses, reinsured workers' compensation, as well as the group life and personal accident businesses as their related net cash flows are not expected to impact our cash flows. Excluding these amounts, the sum of the obligations presented above exceeds the corresponding insurance and contractholder liabilities of $17 billion recorded on the balance sheet. This is because some of the recorded insurance liabilities reflect discounting for interest and the recorded contractholder liabilities exclude future interest crediting, charges and fees. The timing and amount of actual future cash flows may differ from those presented above.
  - ***Contractholder deposit funds:*** see Note 9 to the Consolidated Financial Statements for our accounting policy for this liability. Expected future cash flows presented above also include estimated future interest crediting on current fund balances based on current investment yields less the estimated cost of insurance charges and mortality and administrative fees for universal life policies.
  - ***Future policy benefits and unpaid claims and claim expenses:*** see Note 9 to the Consolidated Financial Statements for our accounting policies for these liabilities. Expected future cash flows for these liabilities presented in the table above are undiscounted. The expected future cash flows for guaranteed minimum death benefit ("GMDB") reported in future policy benefits do not consider any of the related reinsurance arrangements.
- ***Long-term debt*** includes scheduled interest payments and current maturities of long-term debt. See Note 7 to the Consolidated Financial Statements for information regarding long-term debt. Finance leases are included in long-term debt and primarily represent obligations for information technology network storage, servers and equipment. See Note 18 to the Consolidated Financial Statements for information regarding finance leases.
- ***Other noncurrent liabilities*** include estimated payments for guaranteed minimum income benefit ("GMIB") contracts (without considering any related reinsurance arrangements), pension, other postretirement and postemployment benefit obligations, supplemental and deferred compensation plans, interest rate and foreign currency swap contracts and reinsurance liabilities. Estimated payments of $61 million for deferred compensation, non-qualified and international pension plans and other postretirement and postemployment benefit plans are expected to be paid in less than one year and are included in the table above. We expect to make immaterial contributions to the qualified domestic pension plans during 2021 and they are reflected in the above table. We expect to make payments subsequent to 2021 for these obligations; however, subsequent payments have been excluded from the table as their timing is based on plan assumptions that may materially differ from actual activities. See Note 15 to the Consolidated Financial Statements for further information on pension obligations.
- ***Operating leases*** see Note 18 to the Consolidated Financial Statements for additional information.

The table above excludes the liabilities for uncertain tax positions because we cannot reasonably estimate the timing of such future payments. In the event we are unable to sustain all of our $1.2 billion of uncertain tax positions it could result in future tax payments of approximately $900 million. See Note 20 to the Consolidated Financial Statements for additional information on uncertain tax positions.

Off-Balance Sheet:

- Purchase obligations. As of December 31, 2020, purchase obligations consisted of estimated payments required under contractual arrangements for future services and investment commitments and they are included in the table below.

(In millions)		
Debt securities	**$**	**149**
Commercial mortgage loans		**10**
Limited liability entities (other long-term investments) [(1)]		**2,325**
Total investment commitments		**2,484**
Future service commitments		**713**
Total purchase obligations	**$**	**3,197**

(1) See Note 11 to the Consolidated Financial Statements for additional information.

Our estimated future service commitments primarily represent contracts for certain outsourced business processes and information technology maintenance and support. We generally have the ability to terminate these agreements, but do not anticipate doing so at this time. Purchase obligations exclude contracts that are cancellable without penalty and those that do not contractually require minimum levels of goods or services to be purchased.

Guarantees

We are contingently liable for various financial and other guarantees provided in the ordinary course of business. See Note 21 to the Consolidated Financial Statements for additional information on guarantees.

CRITICAL ACCOUNTING ESTIMATES

The preparation of Consolidated Financial Statements in accordance with GAAP requires management to make estimates and assumptions that affect reported amounts and related disclosures in the Consolidated Financial Statements. Management considers an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been selected could have a material effect on our consolidated results of operations or financial condition.

Management has discussed how critical accounting estimates are developed and selected with the Audit Committee of our Board of Directors and the Audit Committee has reviewed the disclosures presented below. We regularly evaluate items that may impact critical accounting estimates.

As discussed in the executive overview of this MD&A, the COVID-19 pandemic has pervasively impacted the economy, financial markets and the global health care delivery systems. If the impact of the COVID-19 pandemic beyond 2020 is worse than management's current projections, these adverse effects to our business could impact the estimated fair value of our reporting units.

In addition to the estimates presented in the following tables, there are other accounting estimates used in preparing our Consolidated Financial Statements, including estimates of liabilities for future policy benefits, as well as estimates with respect to pension and postretirement benefits other than pensions and certain compensation accruals.

Management believes the current assumptions used to estimate amounts reflected in our Consolidated Financial Statements are appropriate. However, if actual experience significantly differs from the assumptions used in estimating amounts reflected in our Consolidated Financial Statements, the resulting changes could have a material adverse effect on our consolidated results of operations and in certain situations, could have a material adverse effect on liquidity and our financial condition. The tables below present the adverse impacts of certain possible changes in assumptions. The effect of assumption changes in the opposite direction would be a positive impact to our consolidated results of operations, liquidity or financial condition, except for assessing impairment of goodwill.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Goodwill and other intangible assets Goodwill represents the excess of the cost of businesses acquired over the fair value of their net assets at the acquisition date. Intangible assets primarily reflect the value of customer relationships and other intangibles acquired in business combinations. Fair values of reporting units are estimated using models and assumptions that we believe a hypothetical market participant would use to determine a current transaction price. The significant assumptions and estimates used in determining fair value include the discount rate and future cash flows. A discount rate is selected to correspond with each reporting unit's weighted average cost of capital, consistent with that used for investment decisions considering the specific and detailed operating plans and strategies within each reporting unit. Projections of future cash flows for each reporting unit are consistent with our annual planning process for revenues, pharmacy costs, benefits expenses, operating expenses, taxes, capital levels and long-term growth rates. In addition to these assumptions, we consider market data to evaluate the fair value of each reporting unit. The fair value of intangibles and the amortization method were determined using an income approach that relies on projected future cash flows including key assumptions for customer attrition and discount rates. Management revises amortization periods if it believes there has been a change in the length of time that an intangible asset will continue to have value. The Company conducts its quantitative evaluation for goodwill impairment at least annually during the third quarter at the reporting unit level and performs qualitative impairment assessments on a quarterly basis to determine if events or changes in circumstances indicate that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. Goodwill and other intangibles as of December 31 were as follows (in millions): · **2020 – Goodwill $44,648; Other intangible assets $35,179** · 2019 – Goodwill $44,602; Other intangible assets $36,562 See Note 17 to the Consolidated Financial Statements for additional discussion of our goodwill and other intangible assets.	We completed our normal annual evaluations for impairment of goodwill and intangible assets during the third quarter of 2020. The evaluations indicated that the fair value estimates of our reporting units exceed their carrying values by significant margins. Changes in assumptions concerning future financial results or other underlying assumptions, including macroeconomic factors, government legislation, changes in the competitive landscape or other market conditions could impact our ability to achieve profitability projections. If we consistently do not achieve our earnings and cash flow projections or our cost of capital rises significantly, the assumptions and estimates underlying the goodwill and intangible asset impairment evaluations could be adversely affected and result in future impairment charges that would negatively impact our operating results and financial position.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Income taxes – uncertain tax positions We evaluate tax positions to determine whether the benefits are more likely than not to be sustained on audit based on their technical merits. The Company establishes a liability if the probability that the position will be sustained is 50% or less. For uncertain positions that management believes are more likely than not to be sustained, the Company recognizes a liability based upon management's estimate of the most likely settlement outcome with the taxing authority. These amounts primarily relate to federal and state uncertain positions of the value and timing of deductions and uncertain positions of attributing taxable income to states Balances that are included in the Consolidated Balance Sheets are as follows (in millions): · **2020 – $1,210** · 2019 – $1,018 See Note 20 to the Consolidated Financial Statements for additional discussion around uncertain tax positions and the Liquidity and Capital Resource section of this MD&A for a discussion of their potential impact on liquidity.	The factors that could impact our estimates of uncertain tax positions include the likelihood of being sustained upon audit based on the technical merits of the tax position and related assumed interest and penalties. If our positions are upheld upon audit, our net income would increase.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Unpaid claims and claim expenses – U.S. Medical Unpaid claims and claim expenses include both reported claims and estimates for losses incurred but not yet reported. Unpaid claims and claim expenses in U.S. Medical are primarily impacted by assumptions related to completion factors and medical cost trend. Variation of actual results from either assumption could impact the unpaid claims balance as noted below. A large number of factors may cause the medical cost trend to vary from the Company's estimates, including: changes in health management practices, changes in the level and mix of benefits offered and services utilized, and changes in medical practices. Completion factors may be affected if actual claims submission rates from providers differ from estimates (that can be influenced by a number of factors, including provider mix and electronic versus manual submissions), or if changes to the Company's internal claims processing patterns occur. Unpaid claims and claim expenses for the U.S. Medical segment as of December 31 were as follows (in millions): · **2020 – gross $3,184; net $2,960** · 2019 – gross $2,892; net $2,589 These liabilities are presented above both gross and net of reinsurance and other recoverables. See Note 9 to the Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.	Based on studies of our claim experience, it is reasonably possible that a 100 basis point change in the medical cost trend and a 50 basis point change in completion factors could occur in the near term. A 100 basis point increase in the medical cost trend rate would increase this liability by approximately $45 million, resulting in a decrease in net income of approximately $35 million after-tax, and a 50 basis point decrease in completion factors would increase this liability by approximately $90 million, resulting in a decrease in net income of approximately $70 million after-tax.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Valuation of debt security investments Most debt securities are classified as available for sale and are carried at fair value with changes in fair value recorded in accumulated other comprehensive income (loss) within shareholders' equity. Fair value is defined as the price at which an asset could be exchanged in an orderly transaction between market participants at the balance sheet date. Determining fair value for a financial instrument requires management judgment. The degree of judgment involved generally correlates to the level of pricing readily observable in the markets. Financial instruments with quoted prices in active markets or with market observable inputs to determine fair value, such as public securities, generally require less judgment. Conversely, private placements including more complex securities that are traded infrequently are typically measured using pricing models that require more judgment as to the inputs and assumptions used to estimate fair value. There may be a number of alternative inputs to select based on an understanding of the issuer, the structure of the security and overall market conditions. In addition, these factors are inherently variable in nature as they change frequently in response to market conditions. Approximately two-thirds of our debt securities are public securities, and one-third are private placement securities. Typically, the most significant input in the measurement of fair value is the market interest rate used to discount the estimated future cash flows of the instrument. Such market rates are derived by calculating the appropriate spreads over comparable U.S. Treasury securities, based on the credit quality, industry and structure of the asset. See Notes 11A. and 12 to the Consolidated Financial Statements for a discussion of our fair value measurements, the procedures performed by management to determine that the amounts represent appropriate estimates and our accounting policy regarding unrealized appreciation on debt securities.	If the derived interest rates used to calculate fair value increased by 100 basis points, the fair value of the total debt security portfolio of $18 billion would decrease by approximately $1.3 billion, resulting in an after-tax decrease to shareholders' equity of approximately $0.8 billion as of December 31, 2020.

SEGMENT REPORTING

The following section of this MD&A discusses the results of each of our segments. See Note 1 to the Consolidated Financial Statements for a description of our segments.

In segment discussions, we present adjusted revenues and "pre-tax adjusted income from operations," defined as income before taxes excluding realized investment gains (losses), amortization of acquired intangible assets, special items and, for periods prior to 2020, results of transitioning clients. Ratios presented in this segment discussion exclude the same items as pre-tax adjusted income from operations. See Note 22 to the Consolidated Financial Statements for additional discussion of these metrics and a reconciliation of income before income taxes to pre-tax adjusted income from operations, as well as a reconciliation of total revenues to adjusted revenues. Note 22 to the Consolidated Financial Statements also explains that segment revenues include both external revenues and sales between segments that are eliminated in Corporate.

In these segment discussions, we also present "pre-tax adjusted margin," defined as pre-tax adjusted income from operations divided by adjusted revenues.

As of the third quarter 2020, the segment previously reported as Health Services is reported as Evernorth, and the segment previously reported as Integrated Medical is reported as U.S. Medical. There are no changes to the underlying business reported in either segment.

See the "Executive Overview" section of this MD&A for summarized financial results of each of our segments.

Evernorth Segment

Evernorth includes a broad range of coordinated and point solution health services, including pharmacy solutions, benefits management solutions, care solutions and intelligence solutions. As described in the introduction to Segment Reporting, Evernorth performance is measured using the below metrics:

- Adjusted gross profit and pre-tax adjusted income from operations, which exclude the impact of special items.
- Adjusted pharmacy script volume is calculated by multiplying the total non-specialty network scripts filled through 90-day programs and home delivery scripts by three and counting all other network and specialty scripts as one script.
- Generic fill rate is defined as the total number of generic scripts divided by the total overall scripts filled. Generally, higher generic fill rates reduce revenues, as generic drugs are typically priced lower than the branded drugs they replace. However, as ingredient cost paid to pharmacies on generic drugs is incrementally lower than the price charged to our clients, higher generic fill rates generally have a favorable impact on our gross profit. The home delivery generic fill rate is currently lower than the network generic fill rate as fewer generic substitutions are available among maintenance medications (such as therapies for chronic conditions) commonly dispensed from home delivery pharmacies as compared to acute medications that are primarily dispensed by pharmacies in our retail networks.

The key factors that impact Evernorth revenues and costs of revenues are volume, mix of claims and price. These key factors are discussed further below. See Note 3 to the Consolidated Financial Statements included in this Form 10-K for additional information on revenue and cost recognition policies for this segment.

- As our clients' claim volumes increase or decrease, our resulting revenues and cost of revenues correspondingly increase or decrease. Our gross profit could also increase or decrease as a result of changes in purchasing discounts.
- The mix of claims generally considers the type of drug and distribution method used for dispensing and fulfilling. Types of drugs can have an impact on our pharmacy revenues, pharmacy and other service costs and gross profit, including amounts payable under certain financial and performance guarantees with our clients. In addition to the types of drugs, the mix of generic claims (i.e., generic fill rate) also impacts our gross profit. Furthermore, our gross profit differs among network, home delivery and specialty distribution methods and can impact our profitability.
- Our client contract pricing is impacted by our ongoing ability to negotiate supply chain contracts for pharmacy network, pharmaceutical and wholesaler purchasing and manufacturer rebates. As we seek to improve the effectiveness of our integrated solutions for the benefit of our clients, we are continuously innovating and optimizing the supply chain. Our gross profit could also increase or decrease as a result of supply chain initiatives implemented. Inflation also impacts our pricing because most of our contracts provide that we bill clients and pay pharmacies based on a generally recognized price index for pharmaceuticals. Therefore, the rate of inflation for prescription drugs and our efforts to manage this inflation for our clients can affect our revenues and cost of revenues.

In this MD&A, we present revenues and gross profit, as well as adjusted revenues and adjusted gross profit, consistent with our segment reporting metrics, which exclude special items and, for periods prior to 2020, contributions from transitioning clients. As of December 31, 2019, the transition of these clients was substantially complete; therefore, beginning in 2020, we no longer exclude results of transitioning clients from our adjusted metrics. See the "Key Transactions and Business Developments" section of this Form 10-K MD&A for further discussion of transitioning clients and why we present this information.

Results of Operations

Financial Summary	**For the Years Ended December 31,**			**Change Favorable (Unfavorable)**		**Change Favorable (Unfavorable)**	
(In millions)	**2020**	**2019**	**2018**	**2020 vs. 2019**		**2019 vs. 2018**	
Total revenues	**$ 116,334**	$ 109,794	$ 7,065	$ 6,540	6 %	$ 102,729	N/M
Less: Transitioning clients	**—**	(13,347)	(459)	13,347	N/M	(12,888)	N/M
Less: Contractual adjustment for a former client	**(204)**	—	—	(204)	N/M	—	N/M
Adjusted revenues[1]	**$ 116,130**	$ 96,447	$ 6,606	$ 19,683	20	$ 89,841	N/M
Gross profit	**$ 7,797**	$ 8,908	$ 604	$ (1,111)	(12)	$ 8,304	N/M
Adjusted gross profit[1]	**$ 7,593**	$ 6,984	$ 531	$ 609	9	$ 6,453	N/M
Pre-tax adjusted income from operations	**$ 5,363**	$ 5,092	$ 380	$ 271	5 %	$ 4,712	N/M
Pre-tax adjusted margin	**4.6 %**	5.3 %	5.8 %	(70) bps		(50) bps	

(Dollars and adjusted scripts in millions)	**For the Years Ended December 31, 2020**	**2019**	**Change Favorable (Unfavorable)**
Selected Financial Information[1]			
Pharmacy revenue by distribution channel			
Adjusted network revenues	**$ 56,181**	$ 41,483	35 %
Adjusted home delivery and specialty revenues	**49,886**	45,836	9 %
Other revenues	**5,403**	4,900	10 %
Total adjusted pharmacy revenues	**$ 111,470**	$ 92,219	21 %
Pharmacy script volume			
Adjusted network scripts[2]	**1,206**	941	28 %
Adjusted home delivery and specialty scripts[2]	**287**	283	1 %
Total adjusted scripts[2]	**1,493**	1,224	22 %
Generic fill rate			
Network	**87.4 %**	87.1 %	30 bps
Home delivery	**85.2 %**	84.3 %	90 bps
Overall generic fill rate	**87.2 %**	86.8 %	40 bps

(1) Amounts exclude special items and, for periods prior to 2020, contributions from transitioning clients.
(2) Non-specialty network scripts filled through 90-day programs and home delivery scripts are multiplied by three. All other network and specialty scripts are counted as one script.

2020 versus 2019

In the first quarter of 2020, U.S. Government operating segment customers transitioned to Express Scripts' retail pharmacy network. In the third quarter of 2019, U.S. Commercial operating segment customers transitioned to Express Scripts' retail pharmacy network. Results of operations for 2018 reflected the results for the period following the acquisition of Express Scripts on December 20, 2018 along with the legacy Cigna home delivery business.

Adjusted network revenues. The increase reflected the transition of U.S. Medical's customers, higher claims volume, due to our collaboration with Prime Therapeutics, and increased prices due to inflation on branded drugs. These favorable effects were partially offset by claims mix due to the increase in the generic fill rate.

Adjusted home delivery and specialty revenues. The increase reflected higher prices, due to inflation on branded drugs and higher home delivery and specialty claims volume. These increases were partially offset by claims mix due to an increase in the generic fill rate.

Adjusted gross profit. The increase reflected customer growth, higher adjusted pharmacy script volumes, benefits from the effective management of supply chain and the favorable impact of claims mix as a result of the types of drugs dispensed, the distribution method used for dispensing and fulfilling and an increase in the generic fill rate.

Pre-tax adjusted income from operations. The increase reflected customer growth, higher adjusted pharmacy scripts volumes, benefits from the effective management of supply chain, and the favorable impact of claims mix as a result of the types of drugs dispensed, the distribution method used for dispensing and fulfilling and an increase in the generic fill rate, partially offset by an increase in operating expenses due to client transitions.

U.S. Medical Segment

U.S. Medical includes Cigna's U.S. Commercial and U.S. Government businesses that provide comprehensive medical and coordinated solutions to clients and customers. U.S. Commercial products and services include medical, pharmacy, behavioral health, dental, vision, health advocacy programs and other products and services for insured and self-insured customers. U.S. Government solutions include Medicare Advantage, Medicare Supplement, and Medicare Part D plans for seniors, Medicaid plans, and individual health insurance plans both on and off the public exchanges. As described in the introduction to Segment Reporting, performance of the U.S. Medical segment is measured using pre-tax adjusted income from operations. Key factors affecting profitability for this segment include:

- customer growth;
- revenues from integrated specialty products, including pharmacy services sold to clients and customers across all funding solutions;
- percentage of Medicare Advantage customers in plans eligible for quality bonus payments;
- benefit expenses as a percentage of premiums (medical care ratio or "MCR") for our insured commercial and government businesses; and
- selling, general and administrative expense as a percentage of adjusted revenues (expense ratio).

Results of Operations

Financial Summary	**For the Years Ended December 31,**			**Change Favorable (Unfavorable)**		**Change Favorable (Unfavorable)**	
(In millions)	**2020**	**2019**	**2018**	**2020 vs. 2019**		**2019 vs. 2018**	
Adjusted revenues	**$ 38,451**	$ 36,519	$ 32,791	$ 1,932	5 %	$ 3,728	11 %
Pre-tax adjusted income from operations	**$ 3,807**	$ 3,831	$ 3,502	$ (24)	(1) %	$ 329	9 %
Pre-tax adjusted margin	**9.9 %**	10.5 %	10.7 %		(60) bps		(20) bps
Medical care ratio	**79.4 %**	80.8 %	78.9 %		140 bps		(190) bps
Expense ratio	**22.8 %**	22.9 %	24.7 %		10 bps		180 bps

	For the Years Ended December 31,			**Change Favorable (Unfavorable)**		**Change Favorable (Unfavorable)**	
(In thousands)	**2020**	**2019**	**2018**	**2020 vs. 2019**		**2019 vs. 2018**	
U.S. Medical Customers							
U.S. Commercial	**2,141**	2,114	1,911	27	1 %	203	11 %
U.S. Government	**1,387**	1,361	1,407	26	2 %	(46)	(3) %
Insured	**3,528**	3,475	3,318	53	2 %	157	5 %
Service	**11,485**	12,073	12,071	(588)	(5) %	2	— %
Total	**15,013**	15,548	15,389	(535)	(3) %	159	1 %

	As of December 31,			**Change Favorable (Unfavorable)**		**Change Favorable (Unfavorable)**	
(In millions)	**2020**	**2019**	**2018**	**2020 vs. 2019**		**2019 vs. 2018**	
Unpaid claims and claim expenses – U.S. Medical	**$ 3,184**	$ 2,892	$ 2,697	$ 292	10 %	$ 195	7 %

2020 versus 2019

Adjusted revenues. The increase for the year ended December 31, 2020 compared with 2019 reflects customer growth in our Medicare Advantage and U.S. Commercial insured businesses, as well as higher premium rates due to anticipated underlying medical cost trend and the resumption of the health insurance industry tax. These favorable effects were partially offset by the impact of premium relief programs for clients beginning in the second quarter of 2020 in response to significantly lower than historical utilization as individuals deferred care due to the COVID-19 pandemic.

Pre-tax adjusted income from operations was essentially flat reflecting customer growth in our U.S. Commercial insured and Medicare Advantage businesses and net favorable COVID-19 related impacts; offset by the return of the health insurance industry tax and less favorable prior period development. COVID-19 related impacts include deferral of care by our customers; partially offset by direct COVID-19 costs, costs of actions we have taken to support customers, providers and employees, and increased disenrollment resulting from the economic impacts of the pandemic.

Medical care ratio. The decrease reflects COVID-19 related impacts and the pricing effect of the health insurance industry tax. COVID-19 related impacts include deferral of care by our customers; partially offset by direct COVID-19 costs and premium relief programs extended to employer clients.

Expense ratio. The expense ratio was flat reflecting higher insured revenues as well as efficiencies from continued disciplined expense management and the resumption of the health insurance industry tax.

Other Items Affecting U.S. Medical Results

Unpaid Claims and Claim Expenses

Our unpaid claims and claim expenses liability was higher as of December 31, 2020 compared with December 31, 2019, primarily due to customer growth in our Medicare Advantage and U.S. Commercial insured businesses.

Medical Customers

Our medical customer base decreased at December 31, 2020 compared with December 31, 2019, reflecting a lower customer base in our Middle Markets and National Accounts segments and increased disenrollment resulting from the economic impacts of the COVID-19 pandemic; partially offset by growth in our Select segment and our Medicare Advantage business.

A medical customer is defined as a person meeting any one of the following criteria:

- is covered under a medical insurance policy, managed care arrangement or service agreement issued by us;
- has access to our provider network for covered services under their medical plan; or
- has medical claims that are administered by us.

International Markets Segment

As described in the introduction to Segment Reporting, performance of the International Markets segment is measured using pre-tax adjusted income from operations. Key factors affecting pre-tax adjusted income from operations for this segment are:

- premium growth, including new business and customer retention;
- benefit expenses as a percentage of premiums (loss ratio);
- selling, general and administrative expense as a percentage of revenues (expense ratio and acquisition cost ratio); and
- the impact of foreign currency movements.

Results of Operations

Financial Summary	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2020**	**2019**	**2018**	**2020 vs. 2019**		**2019 vs. 2018**	
Adjusted revenues	**$ 5,877**	$ 5,615	$ 5,366	$ 262	5 %	$ 249	5 %
Pre-tax adjusted income from operations	**$ 900**	$ 762	$ 735	$ 138	18 %	$ 27	4 %
Pre-tax adjusted margin	**15.3** %	13.6 %	13.7 %		170 bps		(10) bps
Loss ratio	**56.5** %	57.3 %	57.4 %		80 bps		10 bps
Acquisition cost ratio	**11.3** %	12.9 %	13.1 %		160 bps		20 bps
Expense ratio (excluding acquisition costs)	**20.2** %	19.5 %	18.9 %		(70) bps		(60) bps

2020 versus 2019

Adjusted revenues increased mainly due to business growth in Asia and Europe, partially offset by premium relief programs, primarily in Europe and unfavorable foreign currency movements.

Pre-tax adjusted income from operations increased reflecting lower acquisition and loss ratios and business growth, primarily in Asia, partially offset by higher expense ratios. The ratios in 2020 reflect the costs of actions to support clients; additionally, the expense ratio reflects actions to support employees and investments in the business for future growth.

The segment's ***loss ratio*** decreased reflecting lower medical utilization due to the COVID-19 pandemic, partially offset by premium relief programs.

The ***acquisition cost ratio*** decreased reflecting an update to our commission deferral process and lower acquisition expenses in Asia, partially offset by premium relief programs.

The ***expense ratio*** (excluding acquisition costs) increased, reflecting strategic investments and the unfavorable impact of premium relief programs.

Other Items Related to International Markets Results

South Korea is the single largest geographic market for our International Markets segment. For the year ended December 31, 2020, South Korea generated 38% of the segment's adjusted revenues and 60% of the segment's pre-tax adjusted income from operations.

Group Disability and Other

Group Disability and Other included for the period presented, Cigna's Group Disability and Life business which offered group long-term and short-term disability, and group life, accident, voluntary and specialty insurance products and services. Additionally, this segment includes Corporate Owned Life Insurance ("COLI") and the Company's run-off operations. As described in the introduction of Segment Reporting, performance of Group Disability and Other is measured using pre-tax adjusted income from operations. Key factors affecting pre-tax adjusted income from operations are:

- premium growth, including new business and customer retention;
- net investment income;
- benefit expenses as a percentage of premiums (loss ratio); and
- selling, general and administrative expense as a percentage of revenues excluding net investment income (expense ratio).

Results of Operations

Financial Summary	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2020**	**2019**	**2018**	**2020 vs. 2019**		**2019 vs. 2018**	
Adjusted revenues	**$ 5,264**	$ 5,182	$ 5,061	$ 82	2 %	$ 121	2 %
Pre-tax adjusted income from operations	**$ 290**	$ 501	$ 529	$ (211)	(42) %	$ (28)	(5) %
Pre-tax adjusted margin	**5.5 %**	9.7 %	10.5 %		(420) bps		(80) bps

2020 versus 2019

Adjusted revenues increased due to growth in disability, life and voluntary products, partially offset by lower investment income.

Pre-tax adjusted income from operations and margin decreased due to unfavorable life claims experience related to the COVID-19 pandemic, unfavorable disability claims experience and lower investment income, partially offset by favorable results in our voluntary products.

Sale of U.S. Group Disability and Life Business. As discussed further in the Executive Overview section of this MD&A, we sold our U.S. Group Disability and Life business on December 31, 2020. Because this business constituted the vast majority of the segment, going forward, we would expect a substantial decline in adjusted revenues and adjusted income from operations in this segment.

Corporate

Corporate reflects amounts not allocated to operating segments, including net interest expense (defined as interest on corporate debt less net investment income on investments not supporting segment and other operations), certain litigation matters, expense associated with our frozen pension plans, charitable contributions, severance, certain overhead and project costs and intersegment eliminations for products and services sold between segments.

Financial Summary	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	2020	2019	2018	2020 vs. 2019		2019 vs. 2018	
Pre-tax adjusted loss from operations	**$ (1,552)**	$ (1,824)	$ (403)	$ 272	15 %	$ (1,421)	N/M %

2020 versus 2019

Pre-tax adjusted loss from operations was lower, reflecting lower interest expense due to lower levels of debt.

INVESTMENT ASSETS

The following table presents our investment asset portfolio excluding separate account assets as of December 31, 2020 and December 31, 2019. Additional information regarding our investment assets is included in Notes 11, 12, 13 and 14 to the Consolidated Financial Statements.

(In millions)	December 31, 2020	December 31, 2019
Debt securities	**$ 18,131**	$ 23,755
Equity securities	**501**	303
Commercial mortgage loans	**1,419**	1,947
Policy loans	**1,351**	1,357
Other long-term investments	**2,832**	2,403
Short-term investments	**359**	423
Total		30,188
Investments classified as assets of business held for sale [(1)]		(7,709)
Investments per Consolidated Balance Sheets	**$ 24,593**	$ 22,479

(1) On December 31, 2020, Cigna completed the sale of its U.S. Group Disability and Life business and transferred a total of $8.4 billion of investments to New York Life Insurance Company as part of this divestiture. The investment assets transferred to New York Life were primarily debt securities and, to a lesser extent, commercial mortgage loans. The table above includes $7.7 billion as of December 31, 2019 of investments associated with this business that was previously held for sale.

Debt Securities

Investments in debt securities include publicly-traded and privately-placed bonds, mortgage and other asset-backed securities and preferred stocks redeemable by the investor. These investments are classified as available for sale and are carried at fair value on our balance sheet. Additional information regarding valuation methodologies, key inputs and controls is included in Note 12 to the Consolidated Financial Statements. More detailed information about debt securities by type of issuer and maturity dates is included in Note 11 to the Consolidated Financial Statements.

The following table reflects our portfolio of debt securities by type of issuer as of December 31, 2020 and December 31, 2019.

(In millions)	December 31, 2020	December 31, 2019
Federal government and agency	**$ 456**	$ 733
State and local government	**167**	810
Foreign government	**2,511**	2,256
Corporate	**14,562**	19,420
Mortgage and other asset-backed	**435**	536
Total	**$ 18,131**	$ 23,755

As a result of the U.S. Group Disability and Life business divestiture, $7.8 billion of debt securities were transferred to New York Life on December 31, 2020, see Note 5 to the Consolidated Financial Statements for further information. The debt securities transferred to New York Life were primarily Corporate and State and local government sectors. This decrease in our debt securities portfolio was partially offset by an increase in valuations due to decreasing yields and net purchase activity during the year.

As of December 31, 2020, $15.6 billion, or 86% of the debt securities in our investment portfolio were investment grade (Baa and above, or equivalent) and the remaining $2.5 billion were below investment grade. The majority of the bonds that are below investment grade are rated at the higher end of the non-investment grade spectrum. Although our allocation to below investment grade bonds has increased since the prior year, these quality characteristics have not otherwise changed materially from the prior year and remain consistent with our investment strategy.

Investments in debt securities are diversified by issuer, geography and industry as appropriate. On an aggregate basis, the debt securities portfolio continues to perform according to original investment expectations. However, due to the economic impacts of the COVID-19 pandemic, there are certain issuers, particularly within the aviation, energy and hospitality sectors, that are showing signs of distress, primarily in the form of requests for temporary covenant relief. There were no material unrealized losses in any of these sectors as of the reporting date. We continue to monitor the economic environment and its effect on our portfolio, and consider the impact of various factors in determining the allowance for credit losses on debt securities, which is discussed in Note 11 to the Consolidated Financial Statements.

Foreign government obligations are concentrated in Asia, primarily South Korea, consistent with our risk management practice and local regulatory requirements of our international business operations. Corporate debt securities include private placement assets of $6.0 billion. These investments are generally less marketable than publicly-traded bonds; however, yields on these investments tend to be higher than yields on publicly-traded bonds with comparable credit risk. We perform a credit analysis of each issuer and require financial and other covenants that allow us to monitor issuers for deteriorating financial strength and pursue remedial actions, if warranted.

Commercial Mortgage Loans

As of December 31, 2020, the $1.4 billion commercial mortgage loan portfolio consisted of approximately 45 loans that are in good standing. Our commercial mortgage loans are fixed rate loans, diversified by property type, location and borrower. Given the quality and diversity of the underlying real estate, positive debt service coverage and significant borrower cash invested generally ranging between 30 and 40%, we remain confident that the vast majority of borrowers will continue to perform as expected under their contract terms. For further discussion of the results and changes in key loan metrics, see Note 11 to the Consolidated Financial Statements.

As a result of the U.S. Group Disability and Life business divestiture, $0.6 billion of commercial mortgage loans were transferred to New York Life on December 31, 2020, see Note 5 to the Consolidated Financial Statements for further information. Loans are secured by high quality commercial properties, located in strong institutional markets, and are generally made at less than 65% of the property's value at origination of the loan. Property value, debt service coverage, quality, building tenancy and stability of cash flows are all important financial underwriting considerations. We hold no direct residential mortgage loans and do not originate or service securitized mortgage loans.

COVID-19 has negatively impacted commercial real estate fundamentals and capital market activity with concentrated weakness in hotels and regional malls. Our mortgage loan portfolio is well diversified by property type and geography with no material exposure to hotels and no exposure to regional shopping malls. We continue to monitor the long-term impacts on the office sector due to growing headwinds: expanded remote working flexibility, shorter term leases and corporate migration to lower cost states. Our mortgage loans secured by office properties are in good standing.

Other Long-term Investments

Other long-term investments of $2.8 billion as of December 31, 2020 included investments in securities limited partnerships and real estate limited partnerships, direct investments in real estate joint ventures and other deposit activity that is required to support various insurance and health services businesses. The increase in other long-term investments is driven by net new funding activity. These limited partnership entities typically invest in mezzanine debt or equity of privately-held companies and equity real estate. Given our subordinate position in the capital structure of these underlying entities, we assume a higher level of risk for higher expected returns. To mitigate risk, these investments are diversified across approximately 175 separate partnerships and approximately 90 general partners who manage one or more of these partnerships. Also, the underlying investments are diversified by industry sector or property type and geographic region. No single partnership investment exceeded 4% of our securities and real estate partnership portfolio.

Income from our limited partnership investments is generally reported on a one quarter lag due to the timing of when financial information is received from the general partner or manager of the investments. We could experience losses into future periods, but the magnitude of these losses will depend in part on the length and extent of the economic disruption, the speed of the recovery and the overall economic impacts.

We participate in an insurance joint venture in China with a 50% ownership interest. We account for this joint venture on the equity method of accounting and report our share of the net assets of $0.8 billion in Other assets. Our 50% share of the investment portfolio supporting the joint venture's business is approximately $5.6 billion, primarily invested in Chinese corporate and government debt securities diversified by issuer, industry and geography, as appropriate. To a lesser extent and consistent with its investment strategy, the joint venture is invested in Chinese equity investments comprised of approximately 50% equity mutual funds, with the remainder invested in equity securities and private equity partnerships. We participate in the approval of the joint venture's investment strategy and continuously review its execution. There were no investments with a material unrealized loss as of December 31, 2020.

Investment Outlook

The impact of COVID-19 on the economy, despite unprecedented monetary and fiscal support, and the uncertainty as to the strength and sustainability of the recovery prior to a widely available vaccine, continues to dominate financial markets. The low interest rate environment continues to pressure income from both short-term and longer-term investments. U.S. treasury rates remain near all-time lows and the wider market credit spreads experienced during the beginning of the second quarter of 2020 have meaningfully narrowed, resulting in historically low yields for investment grade assets. We continue to actively monitor the economic impact of the pandemic, as well as fiscal and monetary responses, and their potential impact on the portfolio. Net investment income projections into 2021 reflect continued market volatility and portfolio impacts, particularly in certain sectors such as aviation, hospitality and energy, as well as other areas most severely impacted by COVID-19. Future realized and unrealized investment results will be driven largely by market conditions that exist when a transaction occurs or at the reporting date. These future conditions are not reasonably predictable; however, we believe that the vast majority of our investments will continue to perform under their contractual terms. Based on our strategy to match the duration of invested assets to the duration of insurance and contractholder liabilities, we expect to hold a significant portion of these assets for the long-term. Although future impairment losses resulting from interest rate movements and credit deterioration due to both investment-specific and the global economic uncertainties discussed above remain possible, we do not expect these losses to have a material adverse effect on our financial condition or liquidity.

MARKET RISK

Financial Instruments

Our assets and liabilities include financial instruments subject to the risk of potential losses from adverse changes in market rates and prices. Consistent with disclosure requirements, the following items have been excluded from this consideration of market risk for financial instruments:

- changes in the fair values of insurance-related assets and liabilities because their primary risks are insurance rather than market risk;
- changes in the fair values of investments recorded using the equity method of accounting and liabilities for pension and other postretirement and postemployment benefit plans (and related assets); and
- changes in the fair values of other significant assets and liabilities, such as goodwill, deferred policy acquisition costs, taxes and various accrued liabilities. Because they are not financial instruments, their primary risks are other than market risk.

Excluding these items, our primary market risk exposures from financial instruments are:

- ***Interest-rate risk*** on fixed-rate, medium-term instruments. Changes in market interest rates affect the value of instruments that promise a fixed return.

- ***Foreign currency exchange rate risk*** of the U.S. dollar, net of derivatives used for hedging, is primarily to the South Korean won, Chinese yuan renminbi and New Zealand dollar. An unfavorable change in exchange rates reduces the carrying value of net assets denominated in foreign currencies.

Our Management of Market Risks

We predominantly rely on three techniques to manage our exposure to market risk:

- ***Investment/liability matching.*** We generally select investment assets with characteristics (such as duration, yield, currency and liquidity) that correspond to the underlying characteristics of our related insurance and contractholder liabilities so that we can match the investments to our obligations. Shorter-term investments generally support shorter-term life and health liabilities. Medium-term, fixed-rate investments support interest-sensitive and health liabilities. Longer-term investments generally support products with longer payout periods such as annuities.
- ***Use of local currencies for foreign operations.*** We generally conduct our international business through foreign operating entities that maintain assets and liabilities in local currencies. This technique limits exchange rate risk to our net assets.
- ***Use of derivatives.*** We use derivative financial instruments to reduce our primary market risks. See Note 11 to the Consolidated Financial Statements for additional information about derivative financial instruments.

Effect of Market Fluctuations

Assuming a 100 basis point increase in interest rates and 10% strengthening in the U.S. dollar to foreign currencies, the effect of hypothetical changes in market rates or prices on the fair value of certain financial instruments, subject to the exclusions noted above (particularly insurance liabilities), would have been as follows as of December 31:

Market scenario for certain non-insurance financial instruments	**Loss in Fair Value**	
(in billions)	**2020**	**2019**
100 basis point increase in interest rates (excluding long-term debt)	**$ 1.4**	$ 1.6
10% strengthening in U.S. dollar to foreign currencies	**$ 0.4**	$ 0.3

The effect of a hypothetical increase in interest rates, primarily on debt securities and commercial mortgage loans, was determined by estimating the present value of future cash flows using various models, primarily duration modeling. The decrease in our sensitivity to market interest rates since the prior year is primarily due to our decreased interest sensitive investment portfolio base, due to the transfer of debt securities and commercial mortgage loans to New York Life on December 31, 2020. See Note 5 to the Consolidated Financial Statements for additional information on the divestiture of our U.S. Group Disability and Life business.

In the event of a hypothetical 100 basis point increase in interest rates, the fair value of the Company's long-term debt would decrease approximately $3.0 billion at December 31, 2020 and $2.5 billion at December 31, 2019. Changes in the fair value of our long-term debt do not impact our financial position or operating results. See Note 7 to the Consolidated Financial Statements for additional information about the Company's debt.

The effect of a hypothetical strengthening of the U.S. dollar relative to the foreign currencies of certain financial instruments held by us was estimated to be 10% of the fair value of these instruments, translated to the U.S. dollar. Our foreign operations hold investment assets, such as debt securities, cash and cash equivalents that are generally invested in the currency of the related liabilities.

Item 7A. *QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK*

The information contained under the caption "Market Risk" in the MD&A section of this Form 10-K is incorporated by reference.

Item 8. ***FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA***

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of Cigna Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Cigna Corporation and its subsidiaries (the "Company") as of December 31, 2020 and 2019, and the related consolidated statements of income, comprehensive income, changes in total equity and cash flows for each of the three years in the period ended December 31, 2020, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Annual Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matter communicated below is a matter arising from the current period audit of the consolidated financial statements that was communicated or required to be communicated to the audit committee and that (i) relates to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Goodwill Impairment Assessment - Evernorth and U.S. Medical Reporting Units

As described in Note 17 to the consolidated financial statements, as of December 31, 2020, goodwill is primarily reported in the Evernorth segment ($33.8 billion), the U.S. Medical segment ($10.4 billion) and, to a lesser extent, the International Markets segment ($0.4 billion). Management conducts its annual quantitative evaluation for goodwill impairment during the third quarter at the reporting unit level and writes it down through shareholders' net income if impaired. On a quarterly basis, management performs a qualitative impairment assessment to determine if events or changes in circumstances indicate that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. Fair value of a reporting unit is generally estimated based on either a market approach or a discounted cash flow analysis using assumptions that management believes a hypothetical market participant would use to determine a current transaction price. The significant assumptions and estimates used in determining fair value include the discount rate and future cash flows. A discount rate is selected to correspond with each reporting unit's weighted average cost of capital, consistent with that used for investment decisions considering the specific and detailed operating plans and strategies within that reporting unit. Projections of future cash flows for each reporting unit are consistent with management's annual planning process for revenues, pharmacy costs, benefits expenses, operating expenses, taxes, capital levels and long-term growth rates.

The principal considerations for our determination that performing procedures relating to the goodwill impairment assessment of the Evernorth and U.S. Medical reporting units is a critical audit matter are the significant judgment by management when determining the fair value measurement of the reporting units. This in turn led to a high degree of auditor judgment, subjectivity, and effort in performing procedures and evaluating management's estimate of the reporting units' fair value related to the assumptions for the discount rate and projection of future cash flows. In addition, the audit effort involved the use of professionals with specialized skill and knowledge to assist in performing these procedures and evaluating the audit evidence obtained.
Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's goodwill impairment assessment, including controls over management's methodology, inputs and assumptions used in its goodwill impairment assessment of the Evernorth and U.S. Medical reporting units. These procedures also included, among others, testing management's process for determining the fair value estimate of the reporting units; evaluating the appropriateness of the discounted cash flow analysis; testing the completeness and accuracy of underlying data used in the discounted cash flow analysis; and evaluating the key inputs and significant assumptions related to the discount rate and the projections of future cash flows. The underlying inputs and assumptions used in the development of the discount rate and the projections of future cash flows that were evaluated related to the weighted average cost of capital, revenues, pharmacy costs, benefits expenses, operating expenses, capital levels and long-term growth rates. Evaluating the reasonableness of management's inputs and assumptions involved considering (i) the current and past performance of the reporting unit, (ii) the consistency of the discount rate and long-term growth rates with external market and industry data, and (iii) whether these assumptions were consistent with evidence obtained in other areas of the audit. Professionals with specialized skill and knowledge were used to assist in the evaluation of certain significant assumptions related to the discount rate.

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 25, 2021

We have served as the Company's auditor since 1983.

Cigna Corporation
Consolidated Statements of Income

(In millions, except per share amounts)	For the Years Ended December 31, 2020	2019	2018
Revenues			
Pharmacy revenues	**$ 107,769**	$ 103,099	$ 5,479
Premiums	**42,627**	39,714	36,113
Fees and other revenues	**8,761**	9,363	5,578
Net investment income	**1,244**	1,390	1,480
TOTAL REVENUES	**160,401**	153,566	48,650
Benefits and expenses			
Pharmacy and other service costs	**103,484**	97,668	4,793
Medical costs and other benefit expenses	**32,710**	30,819	27,528
Selling, general and administrative expenses	**14,072**	14,053	11,934
Amortization of acquired intangible assets	**1,982**	2,949	235
TOTAL BENEFITS AND EXPENSES	**152,248**	145,489	44,490
Income from operations	**8,153**	8,077	4,160
Interest expense and other	**(1,438)**	(1,682)	(498)
Debt extinguishment costs	**(199)**	(2)	—
Gain (loss) on sale of business	**4,203**	—	—
Net realized investment gains (losses)	**149**	177	(81)
Income before income taxes	**10,868**	6,570	3,581
TOTAL INCOME TAXES	**2,379**	1,450	935
Net income	**8,489**	5,120	2,646
Less: Net income attributable to noncontrolling interests	**31**	16	9
SHAREHOLDERS' NET INCOME	**$ 8,458**	$ 5,104	$ 2,637
Shareholders' net income per share			
Basic	**$ 23.17**	$ 13.58	$ 10.69
Diluted	**$ 22.96**	$ 13.44	$ 10.54

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Statements of Comprehensive Income

(In millions)	For the Years Ended December 31, 2020	2019	2018
Net income	**$ 8,489**	$ 5,120	$ 2,646
Other comprehensive income (loss), net of tax			
Net unrealized (depreciation) appreciation on securities and derivatives	**(75)**	957	(365)
Net translation gains (losses) on foreign currencies	**252**	(59)	(167)
Postretirement benefits liability adjustment	**(105)**	(133)	127
Other comprehensive income (loss), net of tax	**72**	765	(405)
Total comprehensive income	**8,561**	5,885	2,241
Comprehensive income (loss) attributable to noncontrolling interests			
Net income attributable to redeemable noncontrolling interest	**14**	11	9
Net income attributable to other noncontrolling interests	**17**	5	—
Other comprehensive (loss) attributable to redeemable noncontrolling interest	**(8)**	(5)	(15)
Total comprehensive income (loss) attributable to noncontrolling interests	**23**	11	(6)
SHAREHOLDERS' COMPREHENSIVE INCOME	**$ 8,538**	$ 5,874	$ 2,247

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Balance Sheets

(In millions)	As of December 31, 2020	2019
Assets		
Cash and cash equivalents	**$ 10,182**	$ 4,619
Investments	**1,331**	937
Accounts receivable, net	**12,191**	10,716
Inventories	**3,165**	2,661
Other current assets	**930**	1,400
Assets of business held for sale	**—**	9,512
Total current assets	**27,799**	29,845
Long-term investments	**23,262**	21,542
Reinsurance recoverables	**5,200**	5,100
Deferred policy acquisition costs	**3,385**	2,958
Property and equipment	**4,205**	4,417
Goodwill	**44,648**	44,602
Other intangible assets	**35,179**	36,562
Other assets	**2,687**	2,283
Separate account assets	**9,086**	8,465
TOTAL ASSETS	**$ 155,451**	$ 155,774
Liabilities		
Current insurance and contractholder liabilities	**$ 5,308**	$ 4,921
Pharmacy and other service costs payable	**13,347**	10,454
Accounts payable	**5,478**	5,090
Accrued expenses and other liabilities	**8,515**	7,347
Short-term debt	**3,374**	5,514
Liabilities of business held for sale	**—**	6,812
Total current liabilities	**36,022**	40,138
Non-current insurance and contractholder liabilities	**16,844**	16,052
Deferred tax liabilities, net	**8,939**	9,387
Other non-current liabilities	**4,629**	4,460
Long-term debt	**29,545**	31,893
Separate account liabilities	**9,086**	8,465
TOTAL LIABILITIES	**105,065**	110,395
Contingencies — Note 21		
Redeemable noncontrolling interests	**58**	35
Shareholders' equity		
Common stock [(1)]	**4**	4
Additional paid-in capital	**28,975**	28,306
Accumulated other comprehensive loss	**(861)**	(941)
Retained earnings	**28,575**	20,162
Less: treasury stock, at cost	**(6,372)**	(2,193)
TOTAL SHAREHOLDERS' EQUITY	**50,321**	45,338
Other noncontrolling interests	**7**	6
Total equity	**50,328**	45,344
Total liabilities and equity	**$ 155,451**	$ 155,774

(1) Par value per share, $0.01; shares issued, 390 million as of December 31, 2020 and 386 million as of December 31, 2019; authorized shares, 600 million.

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation

Consolidated Statements of Changes in Total Equity

(In millions)	Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive (Loss)	Retained Earnings	Treasury Stock	Shareholders' Equity	Other Non-controlling Interests	Total Equity	Redeemable Noncontrolling Interests
Balance at December 31, 2017	**$ 74**	**$ 2,940**	**$ (1,082)**	**$ 15,800**	**$ (4,021)**	**$ 13,711**	**$ —**	**$ 13,711**	**$ 49**
Cumulative effect of accounting for financial instruments and hedging			(10)	68		58		58	
Reclassification adjustment related to U.S. tax reform legislation			(229)	229		—		—	
Retirement of treasury stock	(13)	(529)		(3,498)	4,040	—		—	
Exchange of Old Cigna common stock	(58)	58				—		—	
Acquisition of Express Scripts (see Note 5)	1	25,223				25,224	7	25,231	
Effect of issuing stock for employee benefit plans		59		(138)	206	127		127	
Other comprehensive (loss)			(390)			(390)		(390)	(15)
Net income				2,637		2,637		2,637	9
Common dividends declared (per share: $0.04)				(10)		(10)		(10)	
Repurchase of common stock					(329)	(329)		(329)	
Other transactions impacting noncontrolling interests						—		—	(6)
Balance at December 31, 2018	**$ 4**	**$ 27,751**	**$ (1,711)**	**$ 15,088**	**$ (104)**	**$ 41,028**	**$ 7**	**$ 41,035**	**$ 37**
Cumulative effect of adopting new lease accounting guidance (ASU 2016-02)				(15)		(15)		(15)	
Effect of issuing stock for employee benefit plans		555			(104)	451		451	
Other comprehensive income (loss)			770			770		770	(5)
Net income				5,104		5,104	5	5,109	11
Common dividends declared (per share: $0.04)				(15)		(15)		(15)	
Repurchase of common stock					(1,985)	(1,985)		(1,985)	
Other transactions impacting noncontrolling interests						—	(6)	(6)	(8)
Balance at December 31, 2019	**$ 4**	**$ 28,306**	**$ (941)**	**$ 20,162**	**$ (2,193)**	**$ 45,338**	**$ 6**	**$ 45,344**	**$ 35**
Cumulative effect of adopting new credit loss guidance (ASU 2016-13) [(1)]				**(30)**		**(30)**		**(30)**	
Effect of issuing stock for employee benefit plans		**672**			**(90)**	**582**		**582**	
Other comprehensive income (loss)			**80**			**80**		**80**	**(8)**
Net income				**8,458**		**8,458**	**17**	**8,475**	**14**
Common dividends declared (per share: $0.04)				**(15)**		**(15)**		**(15)**	
Repurchase of common stock					**(4,089)**	**(4,089)**		**(4,089)**	
Other transactions impacting noncontrolling interests		**(3)**				**(3)**	**(16)**	**(19)**	**17**
Balance at December 31, 2020	**$ 4**	**$ 28,975**	**$ (861)**	**$ 28,575**	**$ (6,372)**	**$ 50,321**	**$ 7**	**$ 50,328**	**$ 58**

(1) See Note 3 for further information about the Company's adoption of new credit loss guidance (ASU 2016-13).

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Statements of Cash Flows

(In millions)	For the Years Ended December 31, 2020	2019	2018
Cash Flows from Operating Activities			
Net income	**$ 8,489**	$ 5,120	$ 2,646
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	**2,802**	3,651	695
Realized investment losses (gains), net	**(149)**	(177)	81
Deferred income tax (benefit)	**(386)**	(313)	(101)
Gain on sale of business	**(4,203)**	—	—
Debt extinguishment costs	**199**	2	—
Net changes in assets and liabilities, net of non-operating effects:			
Accounts receivable	**(1,496)**	(713)	705
Inventories	**(504)**	149	(107)
Deferred policy acquisition costs	**(307)**	(242)	(237)
Reinsurance recoverable and Other assets	**230**	(277)	(234)
Insurance liabilities	**841**	575	560
Pharmacy and other service costs payable	**2,891**	(192)	(842)
Accounts payable and Accrued expenses and other liabilities	**1,346**	1,343	332
Other, net	**597**	559	272
NET CASH PROVIDED BY OPERATING ACTIVITIES	**10,350**	9,485	3,770
Cash Flows from Investing Activities			
Proceeds from investments sold:			
Debt securities and equity securities	**2,283**	3,487	2,655
Investment maturities and repayments:			
Debt securities and equity securities	**1,519**	1,825	2,151
Commercial mortgage loans	**19**	199	215
Other sales, maturities and repayments (primarily short-term and other long-term investments)	**1,575**	1,311	734
Investments purchased or originated:			
Debt securities and equity securities	**(4,765)**	(4,282)	(5,637)
Commercial mortgage loans	**(113)**	(307)	(312)
Other (primarily short-term and other long-term investments)	**(1,924)**	(1,753)	(1,189)
Property and equipment purchases, net	**(1,094)**	(1,050)	(528)
Acquisitions, net of cash acquired	**(139)**	(153)	(24,455)
Divestiture, net of cash sold	**5,592**	—	—
Other, net	**23**	(11)	(12)
NET CASH PROVIDED BY (USED IN) INVESTING ACTIVITIES	**2,976**	(734)	(26,378)
Cash Flows from Financing Activities			
Deposits and interest credited to contractholder deposit funds	**1,023**	955	1,040
Withdrawals and benefit payments from contractholder deposit funds	**(979)**	(1,097)	(1,151)
Net change in short-term debt	**60**	(681)	1,487
Net proceeds on issuance of term loan	**1,398**	—	—
Repayment of term loan	**(1,400)**	—	—
Payments for debt extinguishment	**(212)**	(3)	—
Repayment of long-term debt	**(8,047)**	(4,491)	(131)
Net proceeds on issuance of long-term debt	**3,465**	—	22,856
Repurchase of common stock	**(4,042)**	(1,987)	(342)
Issuance of common stock	**376**	224	68
Other, net	**(175)**	(107)	(312)
NET CASH (USED IN) PROVIDED BY FINANCING ACTIVITIES	**(8,533)**	(7,187)	23,515
Effect of foreign currency rate changes on cash, cash equivalents and restricted cash	**41**	(8)	(24)
Net increase in cash, cash equivalents and restricted cash	**4,834**	1,556	883
Cash, cash equivalents and restricted cash January 1, [1]	**5,411**	3,855	2,972
Cash, cash equivalents and restricted cash, December 31,	**10,245**	5,411	3,855
Cash reclassified to assets of business held for sale	**—**	(743)	—
Cash, cash equivalents and restricted cash December 31, per Consolidated Balance Sheets [2]	**$ 10,245**	$ 4,668	$ 3,855
Supplemental Disclosure of Cash Information:			
Income taxes paid, net of refunds	**$ 1,837**	$ 1,776	$ 1,019
Interest paid	**$ 1,439**	$ 1,645	$ 267

(1) Includes $743 million reported in Assets of business held for sale as of January 1, 2020. See table below for Cash, cash equivalents and restricted cash reconciliation.
(2) See table below for Cash, cash equivalents and restricted cash reconciliation as of December 31, 2020 and December 31, 2019.

The following table provides a reconciliation of cash, cash equivalents and restricted cash and cash equivalents reported within the Consolidated Balance Sheets to the totals above:

	As of December 31,	
(In millions)	**2020**	**2019**
Cash and cash equivalents	**$ 10,182**	$ 4,619
Restricted cash and cash equivalents, included in other long-term investments	**63**	49
Total cash, cash equivalents, and restricted cash and cash equivalents	**$ 10,245**	$ 4,668

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

CIGNA CORPORATION

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

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Note 1 – Description of Business

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us") is a global health services organization with a mission of helping those we serve improve their health, well-being and peace of mind. We offer a differentiated set of pharmacy, medical, dental, disability, life and accident insurance and related products and services by our subsidiaries.

The majority of these products are offered through employers and other groups such as governmental and non-governmental organizations, unions and associations. Cigna also offers commercial health and dental insurance, Medicare and Medicaid products and health, life and accident insurance coverages to individuals in the United States and selected international markets. In addition to these ongoing operations, Cigna also has certain run-off operations.

The Company reports its results in the segments detailed below:

In connection with the launch of Evernorth in the third quarter 2020, two reporting segments were re-named: Health Services was renamed as Evernorth and Integrated Medical was renamed as U.S. Medical. In addition, two of our operating segments were re-named: Commercial and Government were renamed as U.S. Commercial and U.S. Government, respectively. There were no changes to the underlying businesses reported in the segments.

Evernorth includes a broad range of coordinated and point solution health services capabilities, as well as those from partners across the health care system in pharmacy solutions, benefits management solutions, care solutions and intelligence solutions, which are provided to health plans, employers, government organizations and health care providers.

U.S. Medical includes Cigna's U.S. Commercial and U.S. Government businesses that provide comprehensive medical and coordinated solutions to clients and customers. U.S. Commercial products and services include medical, pharmacy, behavioral health, dental, vision, health advocacy programs and other products and services for insured and self-insured clients. U.S. Government solutions include Medicare Advantage, Medicare Supplement, and Medicare Part D plans for seniors, Medicaid plans, and individual health insurance plans both on and off the public exchanges.

International Markets includes supplemental health, life and accident insurance products and health care coverage in our international markets, as well as health care benefits for globally mobile employees of multinational organizations.

The remainder of our business operations are reported in ***Group Disability and Other,*** consisting of the following:

- ***Group Disability and Life*** provides group long-term and short-term disability, group life, accident, voluntary and specialty insurance products and related services. On December 31, 2020, Cigna completed the sale of its U.S. Group Disability and Life business to New York Life Insurance Company. See Note 5 for additional information.
- ***Corporate-Owned Life Insurance ("COLI")*** offers permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for the purpose of financing employer-paid future benefit obligations.
- ***Run-off businesses:***
    - ***Reinsurance:*** predominantly comprised of guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("GMIB") business effectively exited through reinsurance with Berkshire Hathaway Life Insurance Company of Nebraska ("Berkshire") in 2013.
    - ***Settlement Annuity*** business in run-off.
    - ***Individual Life Insurance and Annuity and Retirement Benefits businesses:*** deferred gains from the sales of these businesses.

Corporate reflects amounts not allocated to operating segments, including net interest expense (defined as interest on corporate debt less net investment income on investments not supporting segment and other operations), certain litigation matters, expense associated with our frozen pension plans, charitable contributions, severance, certain overhead and project costs and intersegment eliminations for products and services sold between segments.

Note 2 – COVID-19 and Related Economic Impact

All aspects of our business were impacted in fiscal year 2020 by the ongoing coronavirus ("COVID-19") pandemic. The Company initiated several actions to assist our customers, clients, health care providers and employees in this time of crisis. As described below, management has taken a number of steps to assess the impact on our business, including the financial reporting implications associated with this pandemic.

The COVID-19 pandemic has pervasively impacted the economy, financial markets and the global health care delivery systems. The effects of the COVID-19 pandemic on the Company began to emerge in the United States at the end of the first quarter and were not material to the Company's results of operations or financial condition for that period.

Beginning in April, we experienced a significant deferral of care by our customers. The deferral of care moderated over the course of the second quarter with utilization levels eventually returning to nearly normal levels by the end of June. In the third quarter, we experienced increased medical utilization as we observed a reduction to the level of deferred care and our customers sought care for COVID-19 testing and treatment.

In the fourth quarter, as COVID-19 cases increased, the costs for testing and treatment exceeded the savings related to the deferral of care. These impacts were most prevalent in the U.S. Medical segment where fourth quarter earnings were adversely impacted by increased costs of COVID-19 care and decreased contributions from our specialty products. Full year U.S. Medical results reflect COVID-19 impacts of deferral of care by our customers partially offset by the cost of COVID-19 care, the cost of COVID-19 related actions including premium relief programs for employer clients, cost share waivers for customers, customer disenrollment and actions to support providers and employees.

Our Group Disability and Other results reflect significantly elevated life insurance claims related to the COVID-19 pandemic and its effects in the third and fourth quarters. Quarterly and year-to-date earnings in our Evernorth segment also reflected effects of the pandemic, specifically, a favorable mix of claims as a result of both the type of drugs dispensed as well as the distribution method used for dispensing and fulfilling, partially offset by lower 30-day retail script volume.

The Company conducted its annual quantitative evaluation of goodwill impairment during the third quarter of 2020. These evaluations were performed at the reporting unit level, based on discounted cash flow analyses and market data. The estimated fair value of each of our reporting units exceeded their carrying values by significant margins. During the fourth quarter of 2020, the Company conducted its normal quarterly qualitative assessment and concluded that the current economic and business conditions did not result in a triggering event requiring a quantitative analysis.

For all other long-lived assets, including intangible assets, the Company conducted its normal quarterly qualitative impairment assessment and concluded that the current economic and business conditions did not result in a triggering event requiring a quantitative impairment analysis. There were no material impairments recorded for the year ended December 31, 2020.

The Company reviewed all classes of financial instruments including investments, accounts receivable and reinsurance recoverables. The additional allowance for expected credit losses recorded was not material for the year ended December 31, 2020.

Note 3 – Summary of Significant Accounting Policies

Basis of Presentation

The Consolidated Financial Statements include the accounts of Cigna Corporation and its consolidated subsidiaries. Intercompany transactions and accounts have been eliminated in consolidation. These Consolidated Financial Statements were prepared in conformity with accounting principles generally accepted in the United States of America (“GAAP”).

Amounts recorded in the Consolidated Financial Statements necessarily reflect management’s estimates and assumptions about medical costs, investment and receivable valuations, interest rates and other factors. Significant estimates are discussed throughout these Notes; however, actual results could differ from those estimates. The impact of a change in estimate is generally included in earnings in the period of adjustment.

Recently Adopted Accounting Guidance

The Company adopted Accounting Standards Update (“ASU”) No. 2016-13, *Measurement of Credit Losses on Financial Instruments*, and its related amendments, as of January 1, 2020, using the modified retrospective transition method. The new standard requires the use of a current expected credit loss impairment model to develop and recognize credit losses for financial instruments at amortized cost when the asset is first originated or acquired, and each subsequent reporting period. The new standard also eliminates the concept

of other-than-temporary impairments and changes the criteria for impairment of available-for-sale debt securities. A cumulative effect adjustment of $30 million after-tax was recorded as a reduction to retained earnings as of January 1, 2020, reflecting an additional allowance for future expected credit losses required under the new model, primarily related to reinsurance recoverables. Subsequent changes in the allowance are reported in current period earnings. See additional information regarding the Company's accounting policy for establishing the allowance for credit losses in Accounts Receivable, Net (Note 4), Reinsurance (Note 10) and Investments (Note 11).

The Company adopted ASU 2017-04, *Simplifying the Test for Goodwill Impairment*, as of January 1, 2020, on a prospective basis. The new standard eliminates the need to determine the fair value of individual assets and liabilities of a reporting unit to measure a goodwill impairment. There was no impact of adopting this new standard to the Company's financial statements because our quarterly qualitative assessments did not result in a triggering event for impairment of goodwill, and the results of our annual quantitative evaluation performed in the third quarter of 2020 indicated that the estimated fair value of each of our reporting units exceeded their carrying values by significant margins.

Accounting Guidance Not Yet Adopted

Facilitation of the Effects of Reference Rate Reform on Financial Reporting (ASU 2020-04)

- Optional, effective upon issuance (March 12, 2020) through December 31, 2022.
- Provides temporary optional relief to ease the potential burden of accounting for reference rate reform under existing GAAP. Amendments are elective and apply to all entities that have contracts, hedging relationships and other transactions that reference interbank offered rates, including LIBOR, expected to be discontinued for new contracts by December 31, 2021.
- Permits optional expedients and exceptions to simplify the accounting for contract modifications, hedging arrangements and held-to-maturity investments, when certain changes are made to a contract or instrument to facilitate reference rate reform.
- An entity may elect to apply the amendments, by topic or subsection, at any point prospectively through December 31, 2022. When elected, the optional expedients must be applied consistently for all eligible contracts or transactions.

To date, the Company has identified minimal exposure to LIBOR and does not anticipate that LIBOR's phase-out will have a material impact on its operations or financial results.

Targeted Improvements to the Accounting for Long-Duration Contracts (ASU 2018-12)

- Effective date of January 1, 2023 for Cigna (early adoption permitted) and requires the following key provisions (for insurance entities that issue long-duration contracts)
- Changes to the measurement of the future policy benefits liability for traditional and limited-pay insurance contracts:
    - Assumptions used to measure cash flows (such as mortality, morbidity and lapse assumptions) to be updated at least annually with the effect of changes in those assumptions remeasured retrospectively and reflected in current period net income.
    - Discount rate assumptions to be updated quarterly based on an upper-medium grade fixed-income instrument yield that maximizes the use of observable market inputs, with any changes reflected in other comprehensive income.
- Deferred policy acquisition costs ("DAC") related to long-duration insurance contracts to be amortized on a constant-level basis over the expected term of the related contracts. Other related deferred or capitalized balances (such as unearned revenue liability and value of business acquired) may use this simplified amortization method.
- Market risk benefits (defined as protecting the contractholder from other-than-nominal capital market risk and exposing the insurer to that risk) to be measured at fair value, with changes in fair value recognized in net income each period, except for the effect of changes in the insurance entity’s credit risk to be recognized in other comprehensive income.
- Additional disclosures, including disaggregated rollforwards for the liability for future policy benefits, market risk benefits, separate account liabilities and deferred acquisition costs, as well as information about significant inputs, judgments, assumptions and methods used in measurement.
- Transition methods at adoption vary:
    - Changes to the liability for future policy benefits to use a modified retrospective approach applied to all outstanding contracts on the basis of their existing carrying amounts as of the beginning of the earliest period presented, with an option to elect a full retrospective transition under certain criteria. Remeasuring the future policy benefits liability for the discount rate to be recorded through accumulated other comprehensive income at transition.
    - DAC to follow the transition method used for future policyholder benefits.
    - Market risk benefits to be transitioned retrospectively and measured at fair value at the beginning of the earliest period presented. The difference between this fair value and carrying value to be recognized in the opening balance of retained earnings, excluding the effect of credit risk changes that are to be recognized in accumulated other comprehensive income.

Expected effects:

- The new guidance will apply to our long-duration insurance products predominantly within the International Markets and Other segments.
- The Company will adopt the standard on January 1, 2023, using the modified retrospective transition method for changes to the liability for future policy benefits and DAC.
- The Company has developed a cross-functional implementation project plan and expects to have significant changes to our processes, systems, controls and financial results and disclosures.
- Although we continue to evaluate the new requirements of the standard and model their impacts across various products, we are unable to project or estimate the magnitude or frequency of expected changes to our financial results. However, it is possible that our income recognition pattern could change for several reasons:
    - Applying periodic assumption updates, versus the current locked-in model, may change our timing of profit or loss recognition.
    - DAC amortization will be on a constant level basis over the expected term of the related contracts, and no longer tied to the emergence of profit on such contracts.
    - Features, such as the Company’s GMDB product, that provide market-risk benefits are not currently measured at fair value, so these liabilities and related reinsurance recoverables will become subject to market sensitivity, notably to interest rates.
- While not yet quantified, the cumulative effect of implementing this guidance may be material to the Company’s beginning shareholders' equity balance upon adoption.
- The Company continues to monitor developing implementation guidance, particularly with respect to reinsured blocks of business.

Significant Accounting Policies

The Company's accounting policies are described either in this Note or in the applicable Notes to the Consolidated Financial Statements as listed in the table of contents.

A. Cash and Cash Equivalents

Cash and cash equivalents are carried at cost that approximates fair value. Cash equivalents consist of short-term investments with maturities of three months or less from the time of purchase. The Company reclassifies cash overdraft positions to liabilities when the legal right of offset does not exist.

B. Inventories

Inventories consist of prescription drugs and medical supplies and are stated at the lower of first-in-first-out cost or net realizable value.

C. Deferred Policy Acquisition Costs

Costs eligible for deferral include incremental, direct costs of acquiring new or renewal insurance and investment contracts and other costs directly related to successful contract acquisition. Examples of deferrable costs include commissions, sales compensation and benefits, policy issuance and underwriting costs. The Company records acquisition costs differently depending on the product line. Acquisition costs for:

- ***Supplemental health, life and accident insurance products*** (primarily individual products) that comprise the majority of the Company's deferred policy acquisition costs and ***group health and accident insurance products*** are deferred and amortized, generally in proportion to the ratio of periodic revenue to the estimated total revenues over the contract periods.
- ***Universal life products*** are deferred and amortized in proportion to the present value of total estimated gross profits over the expected lives of the contracts.
- ***Other products*** are expensed as incurred.

Deferred policy acquisition costs also include the value of business acquired ("VOBA") for certain acquisitions with material long-duration insurance contracts. The Company recorded amortization of deferred policy acquisition costs of $502 million in 2020, $483 million in 2019 and $406 million in 2018 primarily in Selling, general and administrative expenses.

Each year, deferred policy acquisition costs are tested for recoverability. For universal life and other individual products, management estimates the present value of future revenues less expected payments. For group health and accident insurance products, management estimates the sum of unearned premiums and anticipated net investment income less future expected claims and related costs. If management's estimates of these sums are less than the deferred costs, the Company reduces deferred policy acquisition costs and records an additional expense.

D. Other Assets (Current and Non-Current)

Other current assets consist primarily of prepaid expenses, accrued investment income and the current portion of reinsurance recoverables. Other non-current assets consist primarily of GMIB assets, operating lease right-of-use assets and various other insurance-related assets. See Note 10 for the Company's accounting policy for GMIB assets and Note 18 for the Company's accounting policy related to leases. Additionally, other non-current assets include the carrying value of our equity-method investments in joint ventures in China, India, the U.S. and other foreign jurisdictions.

E. Assets and Liabilities of Business Held for Sale

The Company classifies assets and liabilities as held for sale ("disposal group") when management commits to a plan to sell the disposal group, the sale is probable within one year and the disposal group is available for immediate sale in its present condition. The Company considers various factors, particularly whether actions required to complete the plan indicate it is unlikely that significant changes to the plan will be made or the plan will be withdrawn. Assets held for sale are measured at the lower of carrying value or fair value less costs to sell. Any loss resulting from the measurement is recognized in the period the held for sale criteria are met. Conversely, gains are not recognized until the date of the sale. When the disposal group is classified as held for sale, depreciation and amortization ceases and the Company tests the assets for impairment.

F. Redeemable Noncontrolling Interest

Redeemable noncontrolling interest on our Consolidated Balance Sheets represents the noncontrolling shareholders preferred and common stock interests of the Company's consolidated less than fully owned subsidiaries. Those shareholders may choose to require the Company to purchase their redeemable noncontrolling interest. We also have the right to require those shareholders to sell their redeemable noncontrolling interest to us. The redeemable noncontrolling interest was recorded at fair value as of the date of purchase. When the estimated redemption value for a redeemable noncontrolling interest exceeds its carrying value, an adjustment to increase the redeemable noncontrolling interest is recorded with an offsetting reduction to retained earnings or additional paid-in capital in the absence of retained earnings. When an adjustment is made to the carrying value of the redeemable noncontrolling interest, the calculation of shareholders' net income per share will be adjusted if the redemption value exceeds fair value.

G. Accrued Expenses and Other Current and Non-Current Liabilities

Accrued expenses (current) primarily includes financial and performance guarantee liabilities under pharmacy contracts (see section I), management compensation and various insurance-related liabilities, including experience-rated refunds, reinsurance contracts and the risk adjustment and minimum medical loss ratio rebate accruals under The Patient Protection and Affordable Care Act (the "ACA"). Other non-current liabilities include obligations for pension (see Note 15), GMIB contract liabilities (see Note 10), lease liabilities (see Note 18) and self-insured exposures not expected to be settled within one year.

The Company accrues for legal and regulatory matters when a loss contingency is both probable and estimable. The estimated loss is generally recorded in Selling, general and administrative expenses and represents the Company's best estimate of the loss contingency. If the loss estimate is a range, the Company accrues the minimum amount in the range if no amount is better than any other estimated amount in the range. Legal costs to defend the Company's litigation and arbitration matters are expensed as incurred in cases that the Company cannot reasonably estimate the ultimate cost to defend. If the Company can reasonably estimate the cost to defend, a liability for these costs is accrued when the claim is reported. Litigation and legal or regulatory matters that the Company has identified with a reasonable possibility of material loss are described in Note 21.

H. Translation of Foreign Currencies

The Company generally conducts its international business through foreign operating entities that maintain assets and liabilities in local currencies that are their functional currencies. The Company uses exchange rates as of the balance sheet date to translate assets and liabilities into U.S. dollars. Translation gains or losses on functional currencies, net of applicable taxes, are recorded in Accumulated other comprehensive income (loss). The Company uses average monthly exchange rates during the year to translate revenues and expenses into U.S. dollars.

I. Pharmacy revenues and Costs

***Pharmacy revenues*.** Pharmacy revenues are primarily derived from providing pharmacy benefit management services to clients and customers. Pharmacy revenues are recognized when control of the promised goods or services is transferred to clients and customers, in an amount that reflects the consideration the Company expects to receive for those goods or services.

The Company provides or makes available various services supporting benefit management and claims administration and is generally obligated to provide prescription drugs to clients' members using multiple distribution methods including retail networks, home delivery and specialty pharmacies. These goods and services are integrated into a single performance obligation to process claims, dispense prescription drugs and provide other services over the contract period (generally three years). This performance obligation is satisfied as the business stands ready to fulfill its obligation.

Revenues for dispensing prescription drugs through retail pharmacies are reported gross and consist of the prescription price (ingredient cost and dispensing fee) contracted with clients, including the customer copayment, and any associated fees for services because the Company acts as the principal in these arrangements. When a prescription is presented to a retail network pharmacy, the Company is solely responsible for customer eligibility, drug utilization review, drug-to-drug interaction review, any required clinical intervention, plan provision information, payment to the pharmacy and client billing. These revenues are recognized based on the full prescription price when the pharmacy claim is processed and approved for payment. The Company also provides benefit design and formulary consultation services to clients and negotiates separate contractual relationships with clients and network pharmacies. These factors indicate that the Company has control over these transactions until the prescription is processed. Revenues are billed, due and recognized at contract rates either on a periodic basis or as services are provided (such as based on volume of claims processed). This recognition pattern aligns with the benefits from services provided.

Home delivery and specialty pharmacy revenues are due and recognized as each prescription is shipped, net of reserves for discounts and contractual allowances estimated based on historical experience. Any differences between estimates and actual collections are reflected in operations when payments are received. Historically, adjustments to original estimates and returns have not been material. The Company has elected the practical expedient to account for shipping and handling as a fulfillment activity.

We may also provide certain financial and performance guarantees, including a minimum level of discounts a client may receive, generic utilization rates and various service levels. Clients may be entitled to receive compensation if we fail to meet the guarantees. Actual performance is compared to the contractual guarantee for each measure throughout the period and the Company defers revenue for any estimated payouts within Accrued expenses and other liabilities (current). These estimates are adjusted at the end of the guarantee period. Historically, adjustments to original estimates have not been material. The performance guarantee liability was $1.1 billion as of December 31, 2020 and $1.0 billion as of December 31, 2019.

The Company administers programs through which we may receive rebates and other vendor consideration from pharmaceutical manufacturers. The amounts of such rebates or other vendor consideration shared with pharmacy benefit management services clients vary based on the contractual arrangement with the client and in some cases the type of consideration received from the pharmaceutical manufacturer. Rebates and other vendor consideration payable to pharmacy benefit management services clients are recorded as a reduction of Pharmacy revenues. Estimated amounts payable to clients are based on contractual sharing arrangements between the Company and the client and these amounts are adjusted when amounts are collected from pharmaceutical manufacturers in accordance with the contractual arrangement between the Company and the client. Historically, these adjustments have not been material.

In certain retail, home delivery and specialty transactions certain amounts may be collected from third-party payors. These are billed and collected subject to normal account receivable collections procedures.

Other pharmacy service revenues are earned by distributing specialty pharmaceuticals and medical supplies to providers, clinics and hospitals and services to specialty pharmacy manufacturers. These revenues are recognized as prescriptions and supplies are shipped and services are provided.

Pharmacy costs. Pharmacy costs include the cost of prescriptions sold, network pharmacy claim costs and copayments. Also included are direct costs of dispensing prescriptions including supplies, shipping and handling and direct costs associated with clinical programs, such as drug utilization management and medication adherence counseling. Home delivery and specialty pharmacy costs are recognized when the drug is shipped and retail network costs are recognized when the drug is processed and approved for payment. Rebates and other vendor consideration received when providing pharmacy benefit management services are recorded as a reduction of pharmacy costs. Rebates are recognized as prescriptions are shipped or processed and approved for payment. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material. The Company maintains reimbursement guarantees with certain retail network pharmacies. For each such guarantee, the Company records a pharmacy and other service costs payable or prepaid asset for applicable retail network claims based on our actual performance throughout the period against the contractual reimbursement rate. The Company's contracts with certain retail pharmacies give the Company the right to adjust reimbursement rates during the annual guarantee period.

Other. Incremental costs of obtaining service and pharmacy contracts for short-term arrangements are expensed as incurred.

J. Premiums and Related Expenses

Premiums for group life, accident and health insurance and managed care coverages are recognized as revenue on a pro rata basis over the contract period. Benefits and expenses are recognized when incurred and, for our U.S. Medical insured business, are presented net of pharmaceutical manufacturer rebates. For experience-rated contracts, premium revenue includes an adjustment for experience-rated refunds based on contract terms and calculated using the customer's experience (including estimates of incurred but not reported claims).

Premium revenue also includes an adjustment to reflect the estimated effect of rebates due to customers under the commercial minimum medical loss ratio provisions of the ACA. These rebates are settled in the subsequent calendar year.

Premiums received for the Company's Medicare Advantage plans and Medicare Part D products from the Centers for Medicare and Medicaid Services ("CMS") and customers are recognized as revenue ratably over the contract period. CMS provides risk-adjusted premium payments for Medicare Advantage Plans and Medicare Part D products based on our customer demographics and wellness. The Company recognizes periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured. Additionally, Medicare Part D premiums include payments from CMS for risk-sharing adjustments. These

adjustments are estimated quarterly based on claim experience by comparing actual incurred drug benefit costs to estimated costs submitted in original contracts. These adjustments may result in more or less revenue from CMS. Final revenue adjustments are determined and settled with CMS in the year following the contract year. Premium revenue may also include an adjustment to reflect the estimated effect of rebates due to CMS under the Medicare Advantage and Medicare Part D minimum medical loss ratio provisions of the ACA.

The ACA prescribed three programs to mitigate the risk for participating health insurance companies selling coverage on the public exchanges: risk adjustment, reinsurance and risk corridor. The reinsurance and ACA risk corridor programs expired at the end of 2016, while the permanent risk-adjustment program continues.

The risk-adjustment program reallocates funds from insurers with lower risk populations to insurers with higher risk populations based on the relative risk scores of participants in non-grandfathered plans in the individual and small group markets, both on and off the exchanges. We estimate our receivable or payable based on the risk of our customers compared to the risk of other customers in the same state and market, considering data obtained from industry studies and the United States Department of Health and Human Services ("HHS"). Receivables or payables are recorded as adjustments to premium revenue based on our year-to-date experience when the amounts are reasonably estimable and collection is reasonably assured. Final revenue adjustments are determined by HHS in the year following the policy year.

Premiums for individual life, accident and supplemental health insurance and annuity products, excluding universal life and investment-related products, are recognized as revenue when due. Benefits and expenses are matched with premiums.

Revenue for universal life products is recognized as follows:

- Investment income on assets supporting universal life products is recognized in Net investment income as earned.
- Charges for mortality, administration and policy surrender are recognized in premiums as earned. Administrative fees are considered earned when services are provided.

Benefits and expenses for universal life products consist of benefit claims in excess of policyholder account balances and income earned by policyholders. Expenses are recognized when claims are incurred, and income is credited to policyholders in accordance with contract provisions.

The unrecognized portion of premiums received is recorded as unearned premiums included in insurance and contractholder liabilities (see Note 9 for further information).

K. Fees and Related Expenses

The majority of the Company's service fees are derived from administrative services only ("ASO") arrangements, fee-for-service clinical solutions and health benefit management services.

ASO arrangements allow plan sponsors to self-fund claims and assume the risk of medical or other benefit costs. Most of the Company's ASO arrangements are for medical and specialty services, including pharmacy benefits. Generally, the Company's ASO arrangements are short-term. Contract modifications typically occur on renewal and are prospective in nature.

In return for fees from these clients, the Company provides access to our participating provider networks and other services supporting benefit management, including claims administration, behavioral health services, disease management, utilization management and cost containment programs. In general, the Company considers these services to be a combined performance obligation to provide cost effective administration of plan benefits over the contract period. Fees are billed, due and recognized monthly at contracted rates based on current membership or utilization. This recognition pattern aligns with the benefits from services provided to clients. These revenues are reported in Fees and other revenues in the Consolidated Statements of Income.

The Company may also provide performance guarantees that provide potential refunds to clients if certain service standards, clinical outcomes or financial metrics are not met. If these standards, outcomes and metrics are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. The Company defers revenue by recording a liability for estimated payouts associated with these guarantees within Accrued expenses and other liabilities. The amount of revenue deferred is estimated for each type of guarantee using either a most likely amount or expected value method depending on the nature of the guarantee and the information available to estimate refunds. Estimates are refined each reporting period as additional information on the Company's performance becomes available and upon final reconciliation and settlement at the end of the guarantee period. Amounts accrued and paid for these performance guarantees during the reporting periods were not material.

Rebates from pharmaceutical manufacturers for ASO client purchases at retail pharmacies, net of amounts payable to ASO clients, were considered compensation for use of the manufacturer's products and recorded in Fees and other revenues prior to transitioning U.S. Commercial customers to Express Scripts' retail pharmacy network in the third quarter of 2019. After this transition, these rebates are reflected as a reduction to pharmacy costs (See "Pharmacy Costs" above).

Expenses associated with administrative programs and services are recognized as incurred in Selling, general and administrative expenses.

The Company also earns revenue, as part of its integrated pharmacy benefits performance obligation, by offering fee-for-service clinical solutions to our clients, such as drug utilization management and medication adherence counseling. These clinical programs help clients to drive better health outcomes at a lower cost by identifying and addressing potentially unsafe or wasteful prescribing, dispensing and utilization of prescription drugs and communicating with, or supporting communications with physicians, pharmacies and patients. Fees are billed, due and recognized at contracted rates either on a periodic basis or as services are provided. This recognition pattern aligns with the benefits from services provided. These revenues are reported in Fees and other revenues in the Consolidated Statements of Income. Direct costs associated with these programs are recognized in Pharmacy and other service costs, and other related expenses are recorded as incurred in Selling, general and administrative expenses.

The Company also earns fees by providing health benefit management solutions that drive cost reductions and improve quality outcomes. Clients are primarily sponsors of health benefit plans and fees may be stated as a per-member-per-month fee or as a per-claim fee. The Company considers the services to be a single performance obligation to stand ready to provide utilization management services over the contract period (generally three years). In certain arrangements, the Company assumes the financial obligation for third-party provider costs for medical services provided to the health plan's customers. Fees are recorded gross in Fees and other revenues in the Consolidated Statements of Income because the Company is acting as a principal in arranging for and controlling the services provided by third-party network providers. Contractual fees vary based on enrollment and provider costs and are billed, due and recognized monthly. Direct costs associated with these programs are recognized in Pharmacy and other service costs, and other related expenses are recorded in Selling, general and administrative expenses as incurred.

Certain health benefit management contracts require the Company to share the results of medical cost experience that differ from specified targets. This variable consideration is estimated at contract inception and adjusted through the contract period. The estimated profits and costs are recognized net in Fees and other revenues.

Note 4 – Accounts Receivable, Net

Accounting policy. The Company's accounts receivable balances primarily include amounts due from clients, third-party payors, customers and pharmaceutical manufacturers, and are presented net of allowances. The Company's adoption of ASU 2016-13, *Measurement of Credit Losses on Financial Instruments* (ASU 2016-13), as of January 1, 2020 did not have a material impact on our accounts receivable credit loss allowance, as there were no substantive changes to our methodology for this class of assets. The allowance for expected credit losses for current accounts receivable is based primarily on past collections experience relative to the length of time receivables are past due; however, when available evidence reasonably supports an assumption that counterparty credit risk over the expected payment period will differ from current and historical payment collections, a forecasting adjustment is reflected in the allowance for expected credit losses.

All other (non-credit) allowances are based on the current status of each customer's receivable balance as well as current economic and market conditions and a variety of other factors, including the length of time the receivables are past due, the financial health of customers and our past experience. We bill pharmaceutical manufacturers based on management's interpretation of contractual terms and estimate a contractual allowance based on the best information available at the time a claim is processed. Contractual allowances for certain rebates receivable from pharmaceutical manufacturers are determined by reviewing payment experience and specific known items that could be adjusted under contract terms. The Company's estimation process for contractual allowances for pharmaceutical manufacturer receivables generally results in an allowance for balances outstanding greater than 90 days. Contractual allowances for certain receivables from third-party payors are based on their contractual terms and are estimates based on the Company's best information available at the time revenue is recognized.

Receivables and any associated allowance are written off only when all collection attempts have failed and such amounts are determined unrecoverable. We regularly review the adequacy of these allowances based on a variety of factors, including age of the outstanding receivable and collection history. When circumstances related to specific collection patterns change, estimates of the recoverability of receivables are adjusted.

The following amounts were included within Accounts receivable, net:

(In millions)	December 31, 2020	December 31, 2019
Noninsurance customer receivables	**$ 5,534**	$ 5,143
Pharmaceutical manufacturers receivable	**4,676**	3,439
Insurance customer receivables	**1,789**	2,321
Other receivables	**192**	334
Total		11,237
Accounts receivable, net classified as assets of business held for sale		(521)
Accounts receivable, net per Consolidated Balance Sheets	**$ 12,191**	$ 10,716

These receivables are reported net of our allowances of $1.2 billion as of December 31, 2020 and $778 million as of December 31, 2019. The allowances as of December 31, 2020 include contractual allowances for certain rebates receivable with pharmaceutical manufacturers of $757 million and contractual allowances from third-party payors of $208 million based upon the contractual payment terms. The remaining allowances of $224 million include allowances, discounts and claims adjustments issued to customers in the form of client credits, an allowance for current expected credit losses and other non-credit adjustments.

The Company's allowance for current expected credit losses was $65 million as of December 31, 2020 and $39 million as of January 1, 2020 (no change to allowance for credit losses from December 31, 2019).

Note 5 – Mergers, Acquisitions and Divestitures

A. Divestiture of Group Disability and Life business

On December 31, 2020, Cigna completed the sale of its U.S. Group Disability and Life business to New York Life Insurance Company for cash proceeds of $6.2 billion. The Company recognized a gain of $4.2 billion pre-tax ($3.2 billion after-tax), which includes recognition of previously unrealized capital gains on investments sold (see Note 14 for further information).

In December 2019, Cigna entered into a definitive agreement to sell this business and since the sale was expected to close in the fourth quarter of 2020 following applicable regulatory approvals and other customary closing conditions, the Company aggregated and classified the assets and liabilities directly associated with the pending sale of its Group Disability and Life business as held for sale and has reported them separately on our Consolidated Balance Sheet as of December 31, 2019.

The assets and liabilities of business held for sale were as follows:

(In millions)	December 31, 2019
Cash and cash equivalents	$ 743
Accounts receivable, net	521
Investments	7,709
Other assets	539
Total assets of business held for sale	9,512
Insurance and contractholder liabilities	6,308
Other liabilities	504
Total liabilities of business held for sale	$ 6,812

B. Acquisition of Express Scripts

On December 20, 2018, Cigna acquired Express Scripts Holding Company (“Express Scripts") through a series of mergers for a purchase price of $52.8 billion, which consisted of cash and stock consideration. The purchase price was allocated to the tangible and intangible net assets acquired based on management’s final estimates of their fair values. Total goodwill of $38.4 billion was recorded, of which $33.7 billion resides in the Company’s Evernorth segment, with the remainder in the Company’s U.S. Medical segment. The results of Express Scripts have been included in the Company’s Consolidated Financial Statements from the date of the acquisition. Revenues of Express Scripts included in the Company’s results for 2018 approximated $2.6 billion and Express Scripts’ results of operations were immaterial to Cigna’s net income.

C. Integration and Transaction-related Costs

The Company has incurred costs detailed in the table below related to the acquisition and integration of Express Scripts, the terminated merger with Anthem, Inc. (“Anthem”), the sale of the U.S. Group Disability and Life business and other transactions.

These costs consisted primarily of certain projects to integrate the Company's systems, products and services, fees for legal, advisory and other professional services and certain employment-related costs. Costs in 2018 also included charitable contributions and amortization of certain financing fees and interest expense on the debt issued in the third quarter of 2018 to fund the Express Scripts merger, net of investment income earned on proceeds of the debt issuance.

	2020		2019		2018	
(In millions)	**Before-tax**	**After-tax**	**Before-tax**	**After-tax**	**Before-tax**	**After-tax**
Interest expense on newly-issued debt	**$ —**	**$ —**	$ —	$ —	$ 227	$ 179
Net investment income on debt proceeds	**—**	**—**	—	—	(123)	(97)
Charitable contributions	**—**	**—**	—	—	200	158
Legal and advisory fees	**48**	**36**	53	41	204	185
Bridge facility fees	**—**	**—**	—	—	140	111
All other integration and transaction-related costs	**479**	**368**	499	386	204	133
Integration and transaction-related costs, net	**$ 527**	**$ 404**	$ 552	$ 427	$ 852	$ 669

Note 6 – Earnings Per Share ("EPS")

Accounting policy. The Company computes basic earnings per share using the weighted-average number of unrestricted common and deferred shares outstanding. Diluted earnings per share also includes the dilutive effect of outstanding employee stock options and restricted stock using the treasury stock method and the effect of strategic performance shares.

Basic and diluted earnings per share were computed as follows:

	2020			2019			2018		
(Shares in thousands, dollars in millions, except per share amounts)	**Basic**	**Effect of Dilution**	**Diluted**	**Basic**	**Effect of Dilution**	**Diluted**	**Basic**	**Effect of Dilution**	**Diluted**
Shareholders' net income	**$ 8,458**		**$ 8,458**	$ 5,104		$ 5,104	$ 2,637		$ 2,637
Shares:									
Weighted average	**364,979**		**364,979**	375,919		375,919	246,652		246,652
Common stock equivalents		**3,410**	**3,410**		3,898	3,898		3,573	3,573
Total shares	**364,979**	**3,410**	**368,389**	375,919	3,898	379,817	246,652	3,573	250,225
EPS	**$ 23.17**	**$ (0.21)**	**$ 22.96**	$ 13.58	$ (0.14)	$ 13.44	$ 10.69	$ (0.15)	$ 10.54

The following outstanding employee stock options were not included in the computation of diluted earnings per share because their effect was anti-dilutive.

(In millions)	**2020**	**2019**	**2018**
Anti-dilutive options	**4.1**	3.5	0.9

Note 7 – Debt

The outstanding amounts of debt and finance leases were as follows:

(In millions)	December 31, 2020	December 31, 2019
Short-term debt		
$1,000 million, Floating Rate Notes due 3/2020	**$ —**	$ 999
$300 million, 5.125% Notes due 6/2020	**—**	300
$1,750 million, 3.2% Notes due 9/2020	**—**	1,748
$349 million, 4.125% Notes due 9/2020	**—**	351
$500 million, 2.6% Notes due 11/2020	**—**	496
$400 million, Floating Rate Notes due 11/2020	**—**	400
$250 million, 4.375% Notes due 12/2020	**—**	249
$78 million, 6.37% Notes due 6/2021	**78**	—
$1,000 million, Floating Rate Notes due 9/2021	**999**	—
$1,250 million, 3.4% Notes due 9/2021	**1,249**	—
Commercial paper	**1,030**	944
Other, including finance leases	**18**	27
Total short-term debt	**$ 3,374**	$ 5,514
Long-term debt		
$500 million, 3.3% Notes due 2021	**$ —**	$ 499
$300 million, 4.5% Notes due 2021	**—**	298
$78 million, 6.37% Notes due 2021	**—**	78
$1,000 million, Floating Rate Notes due 2021	**—**	998
$1,250 million, 3.4% Notes due 2021	**—**	1,247
$1,248 million, 4.75% Notes due 2021	**—**	1,272
$277 million, 4% Notes due 2022	**276**	747
$973 million, 3.9% Notes due 2022	**972**	999
$500 million, 3.05% Notes due 2022	**490**	485
$17 million, 8.3% Notes due 2023	**17**	17
$63 million, 7.65% Notes due 2023	**63**	100
$700 million, Floating Rate Notes due 2023	**698**	698
$1,000 million, 3% Notes due 2023	**975**	966
$2,187 million, 3.75% Notes due 2023	**2,181**	3,088
$1,000 million, 3.5% Notes due 2024	**977**	970
$900 million, 3.25% Notes due 2025	**896**	895
$2,200 million, 4.125% Notes due 2025	**2,191**	2,188
$1,500 million, 4.5% Notes due 2026	**1,505**	1,506
$1,500 million, 3.4% Notes due 2027	**1,410**	1,396
$259 million, 7.875% Debentures due 2027	**259**	259
$600 million, 3.05% Notes due 2027	**595**	595
$3,800 million, 4.375% Notes due 2028	**3,780**	3,776
$1,500 million, 2.4% Notes due 2030	**1,489**	—
$45 million, 8.3% Step Down Notes due 2033	**45**	45
$190 million, 6.15% Notes due 2036	**190**	190
$2,200 million, 4.8% Notes due 2038	**2,180**	2,178
$750 million, 3.2% Notes due 2040	**742**	—
$121 million, 5.875% Notes due 2041	**119**	119
$448 million, 6.125% Notes due 2041	**490**	491
$317 million, 5.375% Notes due 2042	**315**	315
$1,500 million, 4.8% Notes due 2046	**1,465**	1,465
$1,000 million, 3.875% Notes due 2047	**988**	988
$3,000 million, 4.9% Notes due 2048	**2,966**	2,964
$1,250 million, 3.4% Notes due 2050	**1,235**	—
Other, including finance leases	**36**	61
Total long-term debt	**$ 29,545**	$ 31,893

Debt Issuance and Redemption. In order to decrease future interest expense and reduce future refinancing risk, the Company entered into the following transactions during 2020:

- Debt issuance: On March 16, 2020, the Company issued $3.5 billion of new senior notes. The proceeds of this issuance were mainly used to pay the consideration for the cash tender and redemption offer as described below. Interest on this debt is paid semi-annually.

Principal	Maturity Date	Interest Rate	Net Proceeds
$1,500 million	March 15, 2030	2.4%	$1,491 million
$750 million	March 15, 2040	3.2%	$743 million
$1,250 million	March 15, 2050	3.4%	$1,237 million

- Debt tender and redemption: In March and April 2020, the Company completed a tender offer and an optional redemption totaling $3.5 billion of aggregate principal amount of certain of its outstanding debt securities. The principal amount repurchased in this tender offer was $1.5 billion. Additionally, $2.0 billion of notes were repurchased via optional redemption. The Company recorded a pre-tax loss of $199 million ($151 million after-tax), consisting primarily of premium payments on the tender and optional redemption.

Debt Exchange. In the fourth quarter of 2019, the Company settled an exchange of approximately $12.7 billion of Notes issued by Express Scripts Holding Company, Medco Health Solutions, Inc. and Cigna Holding Company (formerly named Cigna Corporation) for privately placed Notes issued by Cigna with the same interest rates and maturities and comparable other terms. We initiated an exchange offer to register such debt in the second quarter of 2020 and completed the exchange in July 2020.

Debt Repayment. In 2020, the Company repaid $8.0 billion of long-term debt, including the $3.5 billion debt tender and redemption described above. On December 31, 2020 Cigna issued a notice of full redemption to the holders of Cigna's Senior Floating Rate Notes due 2021 (the "Notes") pursuant to which Cigna redeemed the entire $1.0 billion aggregate principal amount of the Notes outstanding on January 15, 2021 at a redemption price calculated in accordance with the terms and conditions of the indenture governing the Notes.

Revolving Credit Agreements. Cigna has a revolving credit and letter of credit agreement that matures in April 2023 and is diversified among 23 banks. Cigna can borrow up to $3.25 billion for general corporate purposes, with up to $500 million available for issuance of letters of credit. This revolving credit agreement also includes an option to increase the facility amount up to $500 million and an option to extend the termination date for additional one-year periods, subject to consent of the banks.

Additionally, Cigna has a 364-day $1.0 billion revolving credit agreement that will mature in October 2021. The agreement replaces the $1.0 billion 364-day revolving credit agreement that expired in October 2020. The agreement is diversified among 23 banks. Pursuant to this revolving credit agreement, Cigna can borrow up to $1.0 billion for general corporate purposes. The agreement includes the option to "term out" any revolving loans that are outstanding at maturity by converting them into a term loan maturing on the one year anniversary of conversion.

The revolving credit agreements contain customary covenants and restrictions including a financial covenant that the Company's leverage ratio may not exceed 60%. As of December 31, 2020, there were no outstanding balances under the revolving credit agreements.

Term Loan Credit Agreement. On April 1, 2020, the Company borrowed an aggregate principal amount of $1.4 billion under a new 364-Day Term Loan Credit Agreement. In connection with the sale of the Group Life and Disability business, on December 31, 2020 we repaid the entire $1.4 billion balance outstanding.

Commercial Paper. Under our commercial paper program we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time not to exceed $4.25 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The commercial paper program had approximately $1.0 billion outstanding at December 31, 2020 at an average interest rate of 0.2%.

The Company was in compliance with its debt covenants as of December 31, 2020.

Maturities of outstanding long-term debt are as follows:

(in millions)		Scheduled Maturities [1]
2021	$	2,328
2022	$	1,749
2023	$	3,967
2024	$	1,000
2025	$	3,100
Maturities after 2025	$	19,981

(1) Long-term debt maturity amounts include current maturities of long-term debt.

Interest expense on long-term and short-term debt was $1.4 billion in 2020, $1.6 billion in 2019 and $507 million in 2018.

Note 8 – Common and Preferred Stock

On December 20, 2018 Cigna acquired Express Scripts through a series of mergers (collectively, the "Merger"). Cigna Holding Company (formerly named Cigna Corporation and referred to as "Old Cigna") and Express Scripts each merged with and into a wholly-owned subsidiary of Cigna. As a result of these transactions, Cigna became the parent of the combined company. Old Cigna shareholders exchanged each of their shares for a share of Cigna common stock and shareholders of Express Scripts received 0.2434 of a share of Cigna (and $48.75 in cash) for each share of Express Scripts. Following the Merger, Old Cigna was de-listed and shares of Cigna were listed on the New York Stock Exchange for trading.

Cigna (and, prior to the Merger, Old Cigna) has a total of 25 million shares of $1 par value preferred stock authorized for issuance. No shares of preferred stock were outstanding at December 31, 2020, 2019 or 2018.

The following table presents the share activity of Cigna and Old Cigna for the years ended December 31, 2020, 2019 and 2018.

(Shares in thousands)	2020	2019	2018
Common: Par value $0.01; 600,000 shares authorized - Cigna			
Outstanding- January 1,	**372,531**	380,924	—
Shares issued to Old Cigna shareholders			243,785
Shares issued to Express Scripts shareholders			137,337
Issued for stock option exercises and other benefit plans	**4,142**	3,413	91
Repurchased common stock	**(21,902)**	(11,806)	(289)
Outstanding- December 31,	**354,771**	372,531	380,924
Treasury stock	**35,505**	13,012	570
Issued- December 31,	**390,276**	385,543	381,494
Common: Par value $0.25; 600,000 shares authorized - Old Cigna			
Outstanding- January 1,			243,967
Issued for stock option exercises and other benefit plans			1,118
Repurchased common stock			(1,300)
Balance, December 20, 2018 (Merger Date)			243,785
Exchange of Old Cigna shares for shares of Cigna			(243,785)
Outstanding- December 31,			—
Retirement of treasury stock on December 20, 2018			(52,358)
Exchange of Old Cigna certificated treasury stock for new Cigna certificated treasury stock			(2)
Treasury stock- December 31,			—
Issued- December 31,			—

Note 9 – Insurance and Contractholder Liabilities

A. Account Balances – Insurance and Contractholder Liabilities

As of December 31, 2020 and December 31, 2019, the Company's insurance and contractholder liabilities were comprised of the following:

	December 31, 2020			December 31, 2019		
(In millions)	**Current**	**Non-current**	**Total**	**Current**	**Non-current**	**Total**
Contractholder deposit funds	**$ 350**	**$ 6,823**	**$ 7,173**	$ 600	$ 7,139	$ 7,739
Future policy benefits	**327**	**9,317**	**9,644**	553	9,281	9,834
Unearned premiums	**485**	**394**	**879**	453	360	813
Unpaid claims and claim expenses						
U.S. Medical	**3,166**	**18**	**3,184**	2,875	17	2,892
Other segments	**980**	**292**	**1,272**	2,529	3,474	6,003
Total				7,010	20,271	27,281
Insurance and contractholder liabilities classified as liabilities of business held for sale [(1)]				(2,089)	(4,219)	(6,308)
Total insurance and contractholder liabilities	**$ 5,308**	**$ 16,844**	**$ 22,152**	$ 4,921	$ 16,052	$ 20,973

(1) Amounts classified as Liabilities of business held for sale primarily include $4.9 billion of unpaid claims, $717 million of contractholder deposit funds and $653 million of future policy benefits as of December 31, 2019.

Insurance and contractholder liabilities expected to be paid within one year are classified as current.

Accounting Policy - Contractholder Deposit Funds. Liabilities for contractholder deposit funds primarily include deposits received from customers for investment-related and universal life products and investment earnings on their fund balances. These liabilities are adjusted to reflect administrative charges and, for universal life fund balances, mortality charges. In addition, this caption includes: 1) premium stabilization reserves under group health insurance contracts representing experience refunds left with the Company to pay future premiums; 2) deposit administration funds used to fund non-pension retiree insurance programs; 3) retained asset accounts and 4) annuities or supplementary contracts without significant life contingencies. Interest credited on these funds is accrued ratably over the contract period.

Accounting Policy - Future Policy Benefits. Future policy benefits represent the present value of estimated future obligations under long-term life and supplemental health insurance policies and annuity products currently in force. These obligations are estimated using actuarial methods and consist primarily of reserves for annuity contracts, life insurance benefits, GMDB contracts (GMDB contracts are fully reinsured, see Note 10 for additional information) and certain health, life and accident insurance products of our International Markets segment.

Obligations for annuities represent specified periodic benefits to be paid to an individual or groups of individuals over their remaining lives. Obligations for life insurance policies and GMDB contracts represent benefits expected to be paid to policyholders, net of future premiums expected to be received. Management estimates these obligations based on assumptions as to premiums, interest rates, mortality or morbidity, future claim adjudication expenses and surrenders, allowing for adverse deviation as appropriate. Mortality, morbidity and surrender assumptions are based on the Company's own experience and published actuarial tables. Interest rate assumptions are based on management's judgment considering the Company's experience and future expectations, and range from 1% to 9%. Obligations for the direct and assumed run-off settlement annuity business include adjustments for realized and unrealized investment returns consistent with GAAP when a premium deficiency exists. As of December 31, 2020, approximately 20% of the liability for future policy benefits was supported by assets held in trust for the benefit of the ceding company under reinsurance agreements.

Accounting Policy - Unearned Premium. The unrecognized portion of premiums received is recorded as unearned premiums included in insurance and contractholder liabilities.

B. Unpaid Claims and Claim Expenses – U.S. Medical

This liability reflects estimates of the ultimate cost of claims that have been incurred but not reported, including expected development on reported claims, those that have been reported but not yet paid (reported claims in process) and other medical care expenses and services payable that are primarily comprised of accruals for incentives and other amounts payable to health care professionals and facilities.

Accounting policy. The Company uses actuarial principles and assumptions that are consistently applied each reporting period and recognizes the actuarial best estimate of the ultimate liability along with a margin for adverse deviation. This approach is consistent with actuarial standards of practice that the liabilities be adequate under moderately adverse conditions.

The Company compares key assumptions used to establish the medical costs payable to actual experience for each reporting period. The unpaid claims liability is adjusted through current period shareholders' net income when actual experience differs from these assumptions. Additionally, the Company evaluates expected future developments and emerging trends that may impact key assumptions. The process used to determine this liability requires the Company to make critical accounting estimates that involve considerable judgment, reflecting the variability inherent in forecasting future claim payments. These estimates are highly sensitive to changes in the Company's key assumptions, specifically completion factors and medical cost trend.

The liability is primarily calculated using "completion factors" developed by comparing the claim incurral date to the date claims were paid. Completion factors are impacted by several key items including changes in: 1) electronic (auto-adjudication) versus manual claim processing; 2) frequency and timeliness of provider claims submissions; 3) membership and 4) the mix of products. The Company uses historical completion factors combined with an analysis of current trends and operational factors to develop current estimates of completion factors. The Company estimates the liability for claims incurred in each month by applying the current estimates of completion factors to the current paid claims data. This approach implicitly assumes that historical completion rates will be a useful indicator for the current period.

The Company relies more heavily on medical cost trend analysis that reflects expected claim payment patterns and other relevant operational considerations for more recent months. Medical cost trend is primarily impacted by medical service utilization and unit costs that are affected by changes in the level and mix of health benefits offered, including inpatient, outpatient and pharmacy, the impact of copays and deductibles, changes in provider practices and changes in consumer demographics and consumption behavior.

The total of incurred but not reported liabilities plus expected development on reported claims, including reported claims in process, was $2.9 billion at December 31, 2020 and $2.7 billion at December 31, 2019.

Activity, net of intercompany transactions, in the unpaid claims liability for the U.S. Medical segment for the years ended December 31 was as follows:

(In millions)	2020	2019	2018
Beginning balance	**$ 2,892**	$ 2,697	$ 2,420
Less: Reinsurance and other amounts recoverable	**303**	264	262
Beginning balance, net	**2,589**	2,433	2,158
Acquired, net	**—**	—	40
Incurred costs related to:			
Current year	**25,889**	24,368	21,331
Prior years	**(115)**	(165)	(173)
Total incurred	**25,774**	24,203	21,158
Paid costs related to:			
Current year	**23,005**	21,851	18,978
Prior years	**2,398**	2,196	1,945
Total paid	**25,403**	24,047	20,923
Ending balance, net	**2,960**	2,589	2,433
Add: Reinsurance and other amounts recoverable	**224**	303	264
Ending balance	**$ 3,184**	$ 2,892	$ 2,697

Reinsurance and other amounts recoverable reflect amounts due from reinsurers and policyholders to cover incurred but not reported and pending claims of certain business for which the Company administers the plan benefits without any right of offset. See Note 10 for additional information on reinsurance.

Variances in incurred costs related to prior years' unpaid claims and claim expenses that resulted from the differences between actual experience and the Company's key assumptions for the years ended December 31 were as follows:

	Year Ended			
(Dollars in millions)	December 31, 2020		December 31, 2019	
	$	%[1]	$	%[2]
Actual completion factors	**$ 42**	**0.2 %**	$ 90	0.4 %
Medical cost trend	**73**	**0.3**	75	0.4
Total favorable variance	**$ 115**	**0.5 %**	$ 165	0.8 %

(1) Percentage of current year incurred costs as reported for the year ended December 31, 2019.
(2) Percentage of current year incurred costs as reported for the year ended December 31, 2018.

Favorable prior year development in both years reflects lower than expected utilization of medical services.

The following table depicts the incurred and paid claims development as of December 31, 2020 (net of reinsurance), claims frequency metrics and incurred but not reported liabilities reported in the U.S. Medical segment. The information about incurred and paid claims development for the year ended December 31, 2019 is presented as supplementary information and is unaudited.

	Incurred Costs			
Incurral Year	**2019 (Unaudited)**	**2020**	**Unpaid Claims & Claim Expenses**	**Claims Frequency**
(In millions)				
2019	$ 23,306	$ 23,211	60	3.5 million
2020		24,927	2,764	3.7 million
Cumulative incurred costs for the periods presented		$ 48,138		

	Cumulative Costs Paid	
Incurral Year	**2019 (Unaudited)**	**2020**
2019	$ 20,920	$ 23,151
2020		22,163
Cumulative paid costs for the periods presented		$ 45,314

Outstanding liabilities for the periods presented, net of reinsurance	$ 2,824
Other long-duration liabilities not included in development table above	136
Net unpaid claims and claims expenses - U.S. Medical	2,960
Reinsurance and other amounts recoverable	224
Unpaid claims and claim expenses - U.S. Medical	$ 3,184

More than 95% of health claims incurred in a calendar year are paid within one year of their incurred date.

There is no single or common claim frequency metric used in the health care industry. The Company believes a relevant metric for its health insurance business is the number of customers for whom an insured medical claim was paid. Customers for whom no insured medical claim was paid are excluded from the calculation. Claims that did not result in a liability are not included in the frequency metric.

C. Unpaid Claims and Claim Expenses – Group Disability and Other and International Markets

Accounting policy. Liabilities for unpaid claims and claim expenses are established by book of business within Group Disability and Other and International Markets. Unpaid claims and claim expenses within the Group Disability and Other and International Markets segments consist of (1) case or claims reserves for reported claims that are unpaid as of the balance sheet date; (2) incurred but not reported reserves for claims when the insured event has occurred but has not been reported to the Company and (3) loss adjustment expense reserves for the expected costs of settling these claims. The Company consistently estimates incurred but not yet reported losses using actuarial principles and assumptions based on historical and projected claim incidence patterns, claim size and the expected payment period. The Company recognizes the actuarial best estimate of the ultimate liability within a level of confidence, consistent with actuarial standards of practice that the liabilities be adequate under moderately adverse conditions. The Company immediately records an adjustment in Medical costs and other benefit expenses when estimates of these liabilities change.

See Note 5 for a discussion of the divestiture of the Group Disability and Life business on December 31, 2020. For the year ended December 31, 2019, liabilities for unpaid claims and claim expenses within the Group Disability and Life business reflect the following primary products: long-term and short-term disability, life insurance and accident coverages and the majority of the Company's liability for disability claims consisted of "disabled life reserves", measured as the present value of estimated future benefit payments, including expected development, for each reported claim that is currently receiving benefit payments over the expected disability period or pending a decision on eligibility for benefits. The Company projected the expected disability period by using historical resolution rates combined with an analysis of current trends and operational factors to develop current estimates of resolution rates. Expected claim resolution rates may vary based upon the Company's experience for the anticipated disability period, the covered benefit period, the cause of disability, the benefit design and the claimant's age, gender and income level. The gross monthly benefit is reduced (offset) by disability income received under other benefit programs, most commonly Social Security Disability Income, workers' compensation, statutory disability or other group benefit plans. The Company estimated the probability and amount of future offset awards and lapses based on the Company's experience for certain offsets not yet finalized.

The Company also establishes a liability for the expected present value of future benefit payments for known claims that have recently been resolved but may reopen in the future, based on Company experience. Prior to a claim becoming known, the Company establishes a liability for incurred but not reported claims using standard actuarial techniques and calculations based on completion factors and loss ratio assumptions using the Company's experience combined with an analysis of current trends and operational factors. Completion factors are impacted by several key items including changes in claim inventory levels, claim payment patterns, changes in business volume and other factors. Loss ratio assumptions are developed using historical Company experience, adjusted prospectively for expected changes in the underlying business including rate actions, persistency and inforce growth.

Liability balance details. The liability details for unpaid claims and claim expenses for the years ended December 31 are as follows:

(In millions)	**2020**	**2019** [1]
Group Disability and Other		
Group Disability and Life	**$ 150**	$ 4,972
Other Operations	**159**	187
Total Group Disability and Other	**309**	5,159
International Markets	**963**	844
Unpaid claims and claim expenses Group Disability and Other and International Markets	**$ 1,272**	$ 6,003

(1) Includes unpaid claim amounts classified as Liabilities of business held for sale, see Note 5.

Group Disability and Life balances as of December 31, 2020 include reserves associated with retained business and amounts reinsured to New York Life as part of the sale of the Group Disability and Life business.

The Company discounts certain liabilities, predominantly long-term disability liabilities, because benefits payments are made over extended periods. Discount rate assumptions for these liabilities are based on projected investment returns for the supporting asset portfolios.

Details of the Company's Group Disability and Life unpaid claim discounted liability balance as of December 31, 2019 were as follows:

(In billions)	**2019** [1]
Discounted liabilities	$ 4.5
Aggregate amount of discount	$ 1.2
Range of discount rates	4.0 % — 5.2 %

(1) Includes unpaid claims amounts classified as Liabilities held for sale.

Activity in the Company's liabilities for unpaid claims and claim expenses, excluding Other Operations, are presented in the following table. Liabilities associated with Other Operations are excluded because they pertain to obligations for long-duration insurance contracts or, if short-duration, the liabilities have been fully reinsured.

(In millions)	2020	2019 [1]	2018
Beginning balance	**$ 5,816**	$ 5,432	$ 5,274
Less: Reinsurance	**184**	156	140
Beginning balance, net	**5,632**	5,276	5,134
Incurred claims related to:			
Current year	**5,810**	5,616	5,350
Prior years:			
Interest accretion	**154**	152	156
All other incurred	**19**	(40)	(147)
Total incurred	**5,983**	5,728	5,359
Paid claims related to:			
Current year	**3,595**	3,488	3,391
Prior years	**2,015**	1,873	1,808
Total paid	**5,610**	5,361	5,199
Acquisitions	**—**	—	23
Foreign currency	**42**	(11)	(41)
Divestiture of Group Disability and Life business	**(5,093)**	—	—
Ending balance, net	**954**	5,632	5,276
Add: Reinsurance	**159**	184	156
Ending balance	**$ 1,113**	$ 5,816	$ 5,432

(1) Includes unpaid claims amounts classified as Liabilities of business held for sale.

Reinsurance in the table above reflects amounts due from reinsurers related to unpaid claims liabilities. The Company's insurance subsidiaries enter into agreements with other companies primarily to limit losses from large exposures and to permit recovery of a portion of incurred losses. See Note 10 for additional information on reinsurance.

Following the sale of the Company's Group Disability and Life business (see Note 5 for further information), the majority of the liability for unpaid claims and claim expenses relates to products sold in the International Markets segment. Prior to the sale, the majority of the liability for unpaid claims and claim expenses related to disability claims with long-tailed payouts. The rollforward above reflects activity inclusive of these reserves, which were sold on December 31, 2020. Interest earned on assets backing these liabilities is an integral part of pricing and reserving. Therefore, interest accreted on prior year balances is shown as a separate component of prior year incurred claims and reported in Medical costs and other benefit expenses in the Consolidated Statements of Income. This interest is calculated by applying the average discount rate used in determining the liability balance to the average liability balance over the period. The remaining prior year incurred claims amount primarily reflects updates to the Company's liability estimates and variances between actual experience during the period relative to the assumptions and expectations reflected in determining the liability. Assumptions reflect the Company's expectations over the life of the book of business and will vary from actual experience in any period, both favorably and unfavorably, with variation in resolution rates being the most significant driver for the long-term disability business. Favorable prior year incurred claims for the year ended December 31, 2019 primarily reflected favorable long-term disability resolution rate experience relative to expectations reflected in the prior year reserve and favorable reserve development for life, accident and voluntary driven by lower than expected incidence. Development for the year ended December 31, 2020 was immaterial.

Note 10 – Reinsurance

The Company's insurance subsidiaries enter into agreements with other insurance companies to assume and cede reinsurance. Reinsurance is ceded primarily in acquisition and disposition transactions when the underwriting company is not being acquired. Reinsurance is also used to limit losses from large exposures and to permit recovery of a portion of direct or assumed losses. Reinsurance does not relieve the originating insurer of liability. Therefore, reinsured liabilities must continue to be reported along with the related reinsurance recoverables. The Company regularly evaluates the financial condition of its reinsurers and monitors concentrations of its credit risk.

A. Reinsurance Recoverables

Accounting policy. Reinsurance recoverables represent amounts due from reinsurers for both paid and unpaid claims of the Company's insurance businesses. Most reinsurance recoverables are classified as non-current assets. The current portion of reinsurance recoverables is reported in Other current assets and consists primarily of recoverables on paid claims expected to be settled within one year. Reinsurance recoverables are presented net of allowances for uncollectible reinsurance that, effective with adopting ASU 2016-13 on January 1, 2020, consists primarily of an allowance for expected credit losses. $31 million was recorded as a cumulative effect adjustment to retained earnings at adoption. Estimates of the allowance for expected credit losses are based on internal and external data used to develop expected loss rates over the anticipated duration of the recoverable asset that vary by external credit rating and collateral level. The Company's allowance for credit losses on reinsurance recoverables was $32 million as of December 31, 2020, of which $31 million was recorded as a cumulative effect adjustment to retained earnings at adoption.

The majority of the Company's reinsurance recoverables resulted from acquisition and disposition transactions in which the underwriting company was not acquired. Included in the table below is $217 million of current reinsurance recoverables that are reported in Other current assets as of December 31, 2020; as of December 31, 2019 there was $222 million of current reinsurance recoverables reported in Other current assets. The Company's reinsurance recoverables are presented in the following table by range of external credit rating and collateral level.

(Dollars in millions)	Fair value of collateral contractually required to meet or exceed carrying value of recoverable	Collateral provisions exist that may mitigate risk of credit loss[3]	No collateral	Total
Ongoing Operations				
Upper-medium grade and higher [1]	**$ —**	**$ —**	**$ 173**	**$ 173**
Lower-medium grade [2]	**—**	**—**	**64**	**64**
Not rated	**92**	**—**	**29**	**121**
Total recoverables related to ongoing operations	**92**	**—**	**266**	**358**
Acquisition, disposition or runoff activities				
Upper-medium grade and higher [1]				
Lincoln National Life and Lincoln Life & Annuity of New York	**—**	**3,033**	**—**	**3,033**
Berkshire	**309**	**409**	**—**	**718**
Prudential Retirement Insurance and Annuity	**625**	**—**	**—**	**625**
Life Insurance Company of North America	**—**	**424**	**—**	**424**
Other	**232**	**18**	**20**	**270**
Not rated	**—**	**17**	**4**	**21**
Total recoverables related to acquisition, disposition or runoff activities	**1,166**	**3,901**	**24**	**5,091**
Total	**$ 1,258**	**$ 3,901**	**$ 290**	**$ 5,449**
Allowance for uncollectible reinsurance				**(32)**
Total reinsurance recoverables				**$ 5,417**

(1) Includes A- equivalent and higher current ratings certified by a nationally recognized statistical rating organization ("NRSRO")
(2) Includes BBB- to BBB+ equivalent current credit ratings certified by an NRSRO
(3) Includes collateral provisions requiring the reinsurer to fully collateralize its obligation if its external credit rating is downgraded to a specified level

Collateral levels are defined internally based on the fair value of the collateral relative to the carrying amount of the reinsurance recoverable, the frequency at which collateral is required to be replenished and the potential for volatility in the collateral's fair value.

The Company bears the risk of loss if its reinsurers and retrocessionaires do not meet or are unable to meet their reinsurance obligations to the Company. The Company reviews its reinsurance arrangements and establishes reserves against the recoverables, as further described above.

B. Effects of Reinsurance

The following table presents direct, assumed and ceded premiums for both short-duration and long-duration insurance contracts. It also presents reinsurance recoveries that have been netted against benefit expenses in the Company's Consolidated Statements of Income.

(In millions)	2020	2019	2018
Premiums			
Short-duration contracts			
Direct	**$ 38,425**	$ 35,690	$ 32,148
Assumed	**85**	64	77
Ceded	**(230)**	(203)	(182)
Total short-duration contract premiums	**38,280**	35,551	32,043
Long-duration contracts			
Direct	**4,517**	4,352	4,268
Assumed	**99**	105	116
Ceded			
Individual life insurance and annuity business sold	**(119)**	(126)	(133)
Other	**(150)**	(168)	(181)
Total long-duration contract premiums	**4,347**	4,163	4,070
Total premiums	**$ 42,627**	$ 39,714	$ 36,113
Reinsurance recoveries			
Individual life insurance and annuity business sold	**$ 240**	$ 238	$ 249
Other	**191**	157	203
Total reinsurance recoveries	**$ 431**	$ 395	$ 452

C. Effective Exit of GMDB and GMIB Business

The Company entered into an agreement with Berkshire to effectively exit the GMDB and GMIB business via a reinsurance transaction in 2013. Berkshire reinsured 100% of the Company's future claim payments in this business, net of other reinsurance arrangements existing at that time. The reinsurance agreement is subject to an overall limit with approximately $3.2 billion remaining at December 31, 2020.

GMDB is accounted for as assumed and ceded reinsurance and GMIB assets and liabilities are reported as derivatives at fair value as discussed below. GMIB assets are reported in Other current assets and Other assets, and GMIB liabilities are reported in Accrued expenses and other liabilities and Other non-current liabilities.

GMDB

The GMDB exposure arises under annuities written by ceding companies that guarantee the benefit received at death. The Company's exposure arises when the guaranteed minimum death benefit exceeds the fair value of the related mutual fund investments at the time of a contractholder's death.

Accounting policy. The Company estimates the gross liability and reinsurance recoverable with an internal model based on the Company's experience and future expectations over an extended period, consistent with the long-term nature of this product. As a result of the reinsurance transaction, reserve increases have a corresponding increase in the recorded reinsurance recoverable, provided the increased recoverable remains within the overall Berkshire limit (including the GMIB asset presented below).

The following table presents the account value, net amount at risk and the number of contractholders for guarantees assumed by the Company in the event of death. The net amount at risk is the amount that the Company would have to pay if all contractholders died as of the specified date. The Company should be reimbursed in full for these payments unless the Berkshire reinsurance limit is exceeded.

(Dollars in millions, excludes impact of reinsurance ceded)	December 31, 2020	December 31, 2019
Account value	**$ 9,523**	$ 9,110
Net amount at risk	**$ 1,570**	$ 1,764
Average attained age of contractholders (weighted by exposure)	**77**	76
Number of contractholders (estimated)	**185,000**	200,000

GMIB

The Company reinsured contracts with issuers of GMIB products. The Company's exposure represents the excess of a contractually guaranteed amount over the level of variable annuity account values. Payment by the Company depends on the actual account value in the related underlying mutual funds and the level of interest rates when the contractholders elect to receive minimum income payments that can only occur within 30 days of a policy anniversary after the appropriate waiting period. The Company has purchased retrocessional coverage ("GMIB assets") for these contracts including retrocessional coverage from Berkshire.

Accounting policy. The Company reports GMIB liabilities and assets as derivatives at fair value because cash flows of these liabilities and assets are affected by equity markets and interest rates, but are without significant life insurance risk and are settled in lump sum payments. The Company receives and pays fees periodically based on either contractholders' account values or deposits increased at a contractual rate. The Company will also pay and receive cash depending on changes in account values and interest rates when contractholders first elect to receive minimum income payments. Cash flows on these contracts are reported in operating activities.

Assumptions used in fair value measurement. GMIB assets and liabilities are established using capital market assumptions and assumptions related to future annuitant behavior (including mortality, lapse and annuity election rates). The Company classifies GMIB assets and liabilities in Level 3 of the fair value hierarchy described in Note 12 because assumptions related to future annuitant behavior are largely unobservable.

The only assumption expected to impact future shareholders' net income is non-performance risk. The non-performance risk adjustment reflects a market participant's view of nonpayment risk by adding an additional spread to the discount rate in the calculation of both (a) the GMIB liabilities to be paid by the Company, and (b) the GMIB assets to be paid by the reinsurers, after considering collateral. The impact of non-performance risk was immaterial for the years ended December 31, 2020 and December 31, 2019.

GMIB liabilities totaling $729 million as of December 31, 2020 and $688 million as of December 31, 2019 were reported in Accrued expenses and other liabilities and Other non-current liabilities. There were three reinsurers covering 100% of the GMIB exposures as of December 31, 2020 and December 31, 2019 as follows:

(In millions)

Line of Business	Reinsurer	December 31, 2020	December 31, 2019	Collateral and Other Terms at December 31, 2020
GMIB	Berkshire	**$ 353**	$ 332	100% were secured by assets in a trust.
	Sun Life Assurance Company of Canada	**215**	202	
	Liberty Re (Bermuda) Ltd.	**190**	179	100% were secured by assets in a trust.
Total GMIB recoverables reported in Other current assets and Other assets		**$ 758**	$ 713	

All reinsurers are rated A- equivalent and higher by an NRSRO.

Amounts included in shareholders' net income for GMIB assets and liabilities were not material in 2020, 2019 and 2018.

Note 11 – Investments

Cigna's investment portfolio consists of a broad range of investments including debt securities, equity securities, commercial mortgage loans, policy loans, other long-term investments, short-term investments and derivative financial instruments. The sections below provide more detail regarding our investment balances and realized investment gains and losses. See Note 12 for information about the valuation of the Company's investment portfolio. Debt securities, commercial mortgage loans, derivative financial instruments and short-term investments with contractual maturities during the next twelve months are classified on the balance sheet as current investments, unless they are held as statutory deposits or restricted for other purposes and then they are classified in Long-term investments. Equity securities may include exchange traded funds that are used in our cash management strategy and are classified as current investments. All other investments are classified as Long-term investments. The following table summarizes the Company's investments by category and current or long-term classification.

	December 31, 2020			December 31, 2019		
(In millions)	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt securities	**$ 959**	**$ 17,172**	**$ 18,131**	$ 928	$ 22,827	$ 23,755
Equity securities	**—**	**501**	**501**	—	303	303
Commercial mortgage loans	**13**	**1,406**	**1,419**	—	1,947	1,947
Policy loans	**—**	**1,351**	**1,351**	—	1,357	1,357
Other long-term investments	**—**	**2,832**	**2,832**	—	2,403	2,403
Short-term investments	**359**	**—**	**359**	423	—	423
Total				1,351	28,837	30,188
Investments classified as assets of business held for sale[(1)]				(414)	(7,295)	(7,709)
Investments per Consolidated Balance Sheets	**$ 1,331**	**$ 23,262**	**$ 24,593**	$ 937	$ 21,542	$ 22,479

(1) On December 31, 2020, Cigna completed the sale of its U.S. Group Disability and Life business and transferred a total of $8.4 billion of investments to New York Life Insurance Company as part of this divestiture. The table above includes $7.7 billion as of December 31, 2019 of investments associated with this business that was previously held for sale.

A. Investment Portfolio

Debt Securities

Accounting policy. Debt securities (including bonds, mortgage and other asset-backed securities and preferred stocks redeemable by the investor) are classified as available for sale and are carried at fair value with changes in fair value recorded either in Accumulated other comprehensive income (loss) within Shareholders' equity or in credit loss expense based on fluctuations in the allowance for credit losses, as further discussed below. Net unrealized appreciation on debt securities supporting the Company's run-off settlement annuity business is reported in Non-current insurance and contractholder liabilities rather than Accumulated other comprehensive income (loss). When the Company intends to sell or determines that it is more likely than not to be required to sell an impaired debt security, the excess of amortized cost over fair value is directly written down with a charge to Realized investment gains and losses. A portion of these investments are unconsolidated variable interest entities, see Note 13 for additional information.

As of January 1, 2020, the Company adopted ASU 2016-13 that included certain targeted improvements to the accounting for available-for-sale debt securities. The new guidance resulted in certain policy changes related to the process used by the Company to review declines in fair value from a security's amortized cost basis to determine whether a credit loss exists. For example, the length of time that a debt security has been impaired is no longer a criterion for this review. In addition, under this new guidance, the Company recognizes an allowance for credit loss with a corresponding charge to credit loss expense, presented in Realized investment gains and losses in the Company's income statement. Prior to this new guidance, the Company recorded a direct write-down of the instrument's amortized cost basis. The allowance for credit loss represents the excess of amortized cost over the greater of its fair value or the net present value of the debt security's projected future cash flows (based on qualitative and quantitative factors, including the probability of default, and the estimated timing and amount of recovery). Each period, the allowance for credit loss is adjusted through credit loss expense.

The Company elected the expedient to not measure an allowance for credit losses for accrued interest receivables. Consistent with prior practice, when interest payments are delinquent based on contractual terms or when certain terms (interest rate or maturity date) of the investment have been restructured, accrued interest, reported in Other current assets, is written off through a charge to Net investment income, and interest income is recognized on a cash basis.

Debt securities are classified as either Current or Long-term investments based on their contractual maturities.

The amortized cost and fair value by contractual maturity periods for debt securities were as follows at December 31, 2020:

(In millions)	Amortized Cost	Fair Value
Due in one year or less	**$ 991**	**$ 1,001**
Due after one year through five years	**5,412**	**5,699**
Due after five years through ten years	**5,581**	**6,178**
Due after ten years	**3,809**	**4,818**
Mortgage and other asset-backed securities	**427**	**435**
Total	**$ 16,220**	**$ 18,131**

Actual maturities of these securities could differ from their contractual maturities used in the table above because issuers may have the right to call or prepay obligations, with or without penalties.

Gross unrealized appreciation (depreciation) on debt securities by type of issuer is shown below. As a result of the U.S. Group Disability and Life business divestiture, debt securities with a fair value of $7.8 billion, primarily in the Corporate and State and local government sectors, were transferred to New York Life on December 31, 2020. These debt securities included unrealized appreciation of $864 million and unrealized depreciation of $2 million. See Note 5 for further information.

(In millions)	Amortized Cost	Allowance for Credit Loss	Unrealized Appreciation	Unrealized Depreciation	Fair Value
December 31, 2020					
Federal government and agency	**$ 334**	**$ —**	**$ 122**	**$ —**	**$ 456**
State and local government	**150**	**—**	**17**	**—**	**167**
Foreign government	**2,201**	**—**	**318**	**(8)**	**2,511**
Corporate	**13,108**	**(19)**	**1,506**	**(33)**	**14,562**
Mortgage and other asset-backed	**427**	**(7)**	**27**	**(12)**	**435**
Total	**$ 16,220**	**$ (26)**	**$ 1,990**	**$ (53)**	**$ 18,131**
Investments supporting liabilities of the Company's run-off settlement annuity business (included in total above) [1]	**$ 2,282**	**$ (5)**	**$ 838**	**$ (3)**	**$ 3,112**
December 31, 2019					
Federal government and agency	$ 498	$ —	$ 235	$ —	$ 733
State and local government	729	—	81	—	810
Foreign government	2,027	—	230	(1)	2,256
Corporate	18,149	—	1,299	(28)	19,420
Mortgage and other asset-backed	506	—	31	(1)	536
Total	$ 21,909	$ —	$ 1,876	$ (30)	$ 23,755
Investments supporting liabilities of the Company's run-off settlement annuity business (included in total above) [1]	$ 2,229	$ —	$ 740	$ (4)	$ 2,965

(1) Net unrealized appreciation for these investments is excluded from accumulated other comprehensive income.

The Company had commitments to purchase $149 million of debt securities as of December 31, 2020, bearing interest at a fixed market rate.

Review of declines in fair value. Management reviews impaired debt securities to determine whether a credit loss allowance is needed based on criteria that include:

- severity of decline;
- financial health and specific prospects of the issuer; and
- changes in the regulatory, economic or general market environment of the issuer's industry or geographic region.

The table below summarizes debt securities with a decline in fair value from amortized cost for which an allowance for credit losses has not been recorded, by investment grade and the length of time these securities have been in an unrealized loss position. These debt securities are primarily corporate securities with a decline in fair value that reflects an increase in market yields since purchase. See discussion of Realized Investment Gains and Losses below for further information on the credit loss expense recorded for the Company's investments.

	December 31, 2020				December 31, 2019			
(Dollars in millions)	Fair Value	Amortized Cost	Unrealized Depreciation	Number of Issues	Fair Value	Amortized Cost	Unrealized Depreciation	Number of Issues
One year or less								
Investment grade	**$ 1,026**	**$ 1,045**	**$ (19)**	**300**	$ 723	$ 729	$ (6)	267
Below investment grade	**$ 381**	**$ 405**	**$ (24)**	**232**	$ 340	$ 348	$ (8)	355
More than one year								
Investment grade	**$ 18**	**$ 18**	**$ —**	**6**	$ 366	$ 378	$ (12)	118
Below investment grade	**$ 90**	**$ 100**	**$ (10)**	**33**	$ 84	$ 88	$ (4)	93
Total	**$ 1,515**	**$ 1,568**	**$ (53)**	**571**	$ 1,513	$ 1,543	$ (30)	833

The table below presents a roll-forward of the allowance for credit losses on debt securities for the year ended December 31, 2020.

(In millions)	2020
Balance at beginning of period	**$ —**
Additions for debt securities where no credit loss has previously been recognized	**82**
Reductions for securities sold during the period	**(15)**
Decrease for debt securities where credit losses have previously been recorded	**(41)**
Balance December 31,	**$ 26**

Equity Securities

Accounting policy. Changes in the fair values of equity securities that have a readily determinable fair value are reported in Net realized investment gains (losses). Equity securities without a readily determinable fair value are carried at cost minus impairment, if any, plus or minus changes resulting from observable price changes. Equity securities also include hybrid investments consisting of preferred stock with call features that are carried at fair value with changes in fair value reported in Net realized investment gains (losses) and dividends reported in Net investment income.

Equity securities with a readily determinable fair value consist primarily of mutual funds that invest in fixed income debt securities while those without a readily determinable fair value consist of private equity investments. The amount of impairments or value changes resulting from observable price changes on equity securities still held was not material as of December 31, 2020 or 2019.

The following table provides the values of the Company's equity security investments as of December 31, 2020 and December 31, 2019.

	December 31, 2020		December 31, 2019	
(In millions)	Cost	Carrying Value	Cost	Carrying Value
Equity securities with readily determinable fair values	**$ 180**	**$ 202**	$ 61	$ 64
Equity securities with no readily determinable fair value	**$ 225**	**$ 255**	$ 183	$ 192
Hybrid equity securities	**$ 58**	**$ 44**	$ 58	$ 47
Total	**$ 463**	**$ 501**	$ 302	$ 303

Commercial Mortgage Loans

Accounting policy. Commercial mortgage loans are carried at unpaid principal balances. Beginning January 1, 2020 with the adoption of ASU 2016-13, unpaid principal balances are presented net of an allowance for expected credit losses. Changes in the allowance for expected credit losses are recognized as credit loss expense and presented in Realized investment gains and losses in the Company’s income statement. Each period, the Company establishes (or adjusts) its allowance for expected credit losses for commercial mortgage loans. The allowance for expected credit losses is based on a credit risk category that is assigned to each loan at origination using key credit quality indicators, including debt service coverage and loan-to-value ratios. Credit risk categories are updated as key credit quality indicators change. An expected loss rate, assigned based on the credit risk category, is applied to each loan's unpaid principal balance to develop an aggregate allowance for expected credit losses. Prior to adoption, impaired commercial mortgage loans were written down to the lower of unpaid principal or fair value of the underlying collateral when it became probable that the Company

would not collect all amounts due under its promissory note. The Company recorded an allowance of $7 million through a cumulative effect adjustment to retained earnings to reflect expected credit losses at adoption. The credit loss allowance for the Company's commercial mortgage loan investments was $6 million as of December 31, 2020.

Commercial mortgage loans are considered impaired and written off against the allowance when it is probable that the Company will not collect all amounts due per the terms of the promissory note. The Company elected the expedient to not measure an allowance for credit losses for accrued interest receivables. Consistent with our prior practice, accrued interest, reported in Other current assets, is written off through a charge to Net investment income; interest income on impaired loans is only recognized when a payment is received.

In the event of a foreclosure, the allowance for credit losses is based on the excess of the carrying value of the mortgage loan over the fair value of its underlying collateral.

Mortgage loans held by the Company are made exclusively to commercial borrowers and are diversified by property type, location and borrower. Loans are generally issued at fixed rates of interest and are secured by high quality, primarily completed and substantially leased operating properties. Commercial mortgage loans are classified as either current or long-term investments based on their contractual maturities.

***Credit quality*.** The Company regularly evaluates and monitors credit risk, beginning with the initial underwriting of a mortgage loan and continuing throughout the investment holding period. Mortgage origination professionals employ an internal credit quality rating system designed to evaluate the relative risk of the transaction at origination that is then updated each year as part of the annual portfolio loan review. The Company evaluates and monitors credit quality on a consistent and ongoing basis.

Quality ratings are based on our evaluation of a number of key inputs related to the loan, including real estate market-related factors such as rental rates and vacancies, and property-specific inputs such as growth rate assumptions and lease rollover statistics. However, the two most significant contributors to the credit quality rating are the debt service coverage and loan-to-value ratios. The debt service coverage ratio measures the amount of property cash flow available to meet annual interest and principal payments on debt, with a ratio below 1.0 indicating that there is not enough cash flow to cover the required loan payments. The loan-to-value ratio, commonly expressed as a percentage, compares the amount of the loan to the fair value of the underlying property collateralizing the loan.

The following table summarizes the credit risk profile of the Company's commercial mortgage loan portfolio based on loan-to-value and debt service coverage ratios as of December 31, 2020 and December 31, 2019. As a result of the U.S. Group Disability and Life business divestiture, $0.6 billion of commercial mortgage loans were transferred to New York Life on December 31, 2020, see Note 5 for further information.

(Dollars in millions)	**December 31, 2020**			**December 31, 2019**		
Loan-to-Value Ratio	**Carrying Value**	**Average Debt Service Coverage Ratio**	**Average Loan-to-Value Ratio**	**Carrying Value**	**Average Debt Service Coverage Ratio**	**Average Loan-to-Value Ratio**
Below 60%	**$ 533**	**2.28**		$ 1,136	2.19	
60% to 79%	**751**	**2.08**		723	1.98	
80% to 100%	**141**	**1.33**		88	1.62	
Allowance for credit losses	**(6)**					
Total	**$ 1,419**	**2.08**	**61 %**	$ 1,947	2.09	58 %

The Company's annual in-depth review of its commercial mortgage loan investments is the primary mechanism for identifying emerging risks in the portfolio. The Company's investment professionals completed the annual in-depth review in the second quarter of 2020 that included an analysis of each underlying property's most recent annual financial statements, rent rolls, operating plans, budgets, a physical inspection of the property and other pertinent factors. Based on historical results, current leases, lease expirations and rental conditions in each market, the Company estimated the current year and future stabilized property income and fair value for each loan.

The Company re-evaluates a loan's credit quality between annual reviews if new property information is received or an event such as delinquency or a borrower's request for restructure causes management to believe that the Company's estimate of financial performance, fair value or the risk profile of the underlying property has been impacted.

All commercial mortgage loans in the Company's portfolio are current as of December 31, 2020 and December 31, 2019.

Policy Loans

***Accounting policy*.** Policy loans, primarily associated with our corporate-owned life insurance business, are carried at unpaid principal balances plus accumulated interest, the total of which approximates fair value. These loans are collateralized by life insurance policy cash values and therefore have minimal exposure to credit loss. Interest rates are reset annually based on a rolling average of benchmark interest rates.

Other Long-Term Investments

Accounting policy. Other long-term investments include investments in unconsolidated entities, including certain limited partnerships and limited liability companies holding real estate, securities or loans. These investments are carried at cost plus the Company's ownership percentage of reporting income or loss, based on the financial statements of the underlying investments that are generally reported at fair value. Income or loss from these investments is reported on a one quarter lag due to the timing of when financial information is received from the general partner or manager of the investments.

Other long-term investments also include investment real estate carried at depreciated cost less any impairment write-downs to fair value when cash flows indicate that the carrying value may not be recoverable. Depreciation is generally recorded using the straight-line method based on the estimated useful life of each asset. Investment real estate as of December 31, 2020 and 2019 is expected to be held longer than one year and may include real estate acquired through the foreclosure of commercial mortgage loans.

Additionally, statutory and other restricted deposits, healthcare related investment partnerships and foreign currency swaps carried at fair value are reported in the table below as Other. See discussion below for information on the Company's accounting policies for derivative financial instruments.

Other long-term investments and related commitments are diversified by issuer, property type and geographic regions. A majority of these investments are unconsolidated variable entities, see Note 13 for additional information. The following table provides unfunded commitment and carrying value information for these investments. The Company expects to disburse approximately 38% of the committed amounts in 2021.

	Carrying value as of December 31,		Unfunded Commitments as of
(In millions)	**2020**	**2019**	**December 31, 2020**
Real estate investments	**$ 951**	$ 788	**$ 677**
Securities partnerships	**1,683**	1,409	**1,617**
Other	**198**	206	**31**
Total	**$ 2,832**	$ 2,403	**$ 2,325**

Short-Term Investments and Cash Equivalents

Accounting policy. Security investments with maturities of greater than three months to one year from time of purchase are classified as short-term, available for sale and carried at fair value that approximates cost. Cash equivalents consist of short-term investments with maturities of three months or less from the time of purchase and are carried at cost that approximates fair value.

Short-term investments and cash equivalents included the following types of issuers. The increase since prior year end is substantially attributable to proceeds received on December 31, 2020 from the U.S. Group Disability and Life business divestiture, see Note 5 for further information.

(In millions)	**December 31, 2020**	**December 31, 2019**
Corporate securities	**$ 2,669**	$ 1,985
Federal government securities	**$ 158**	$ 472
Foreign government securities	**$ 90**	$ 65
Money market funds	**$ 5,134**	$ 631

B. Derivative Financial Instruments

The Company uses derivative financial instruments to manage the characteristics of investment assets (such as duration, yield, currency and liquidity) to meet the varying demands of the related insurance and contract holder liabilities. The Company also uses derivative financial instruments to hedge the risk of changes in the net assets of certain of its foreign subsidiaries due to changes in foreign currency exchange rates. The Company has written and purchased GMIB reinsurance contracts in its run-off reinsurance business that are accounted for as freestanding derivatives as discussed in Note 10. Derivatives in the Company's separate accounts

are excluded from the following discussion because associated gains and losses generally accrue directly to separate account policyholders.

Derivative instruments used by the Company typically include foreign currency swap contracts and foreign currency forward contracts. Foreign currency swap contracts periodically exchange cash flows between two currencies for principal and interest. Foreign currency forward contracts require the Company to purchase a foreign currency in exchange for the functional currency of its operating unit at a future date.

The Company manages the credit risk of these derivative instruments by diversifying its portfolio among approved dealers of high credit quality and through routine monitoring of credit risk exposures. Certain of the Company's over-the-counter derivative instruments require either the Company or the counterparty to post collateral or demand immediate payment depending on the amount of the net liability position of the derivative instrument and predefined financial strength or credit rating thresholds. These collateral posting requirements vary by counterparty. The Company may incur a loss if dealers failed to perform under derivative contracts, however collateral has been posted by dealers to cover substantially all of the net fair values owed at December 31, 2020 and December 31, 2019. The fair value of collateral posted by the Company was not significant as of December 31, 2020 or December 31, 2019.

Accounting policy. Derivatives are recorded on our balance sheet at fair value and are classified as current or non-current according to their contractual maturities. Further information on our policies for determining fair value are discussed in Note 12. The Company applies hedge accounting when derivatives are designated, qualified and highly effective as hedges. Under hedge accounting, the changes in fair value of the derivative and the hedged risk are generally recognized together and offset each other when reported in Shareholders' net income. Various qualitative or quantitative methods appropriate for each hedge are used to formally assess and document hedge effectiveness at inception and each period throughout the life of a hedge.

The gross fair values of our derivative financial instruments are presented in Note 12. The following table summarizes the types and notional quantity of derivative instruments held by the Company. As of December 31, 2020 and December 31, 2019, the effects of these individual hedging strategies were not material to the Consolidated Financial Statements, including gains or losses reclassified from accumulated other comprehensive income into shareholders' net income, as well as amounts excluded from the assessment of hedge effectiveness.

(In millions)		Notional Value as of	
Purpose	**Type of Instrument**	**December 31, 2020**	**December 31, 2019**
Fair value hedge: To hedge the foreign exchange-related changes in fair values of certain foreign-denominated bonds. The notional value of these derivatives matches the amortized cost of the hedged bonds.	Foreign currency swap contracts	**$ 925**	$ 817
Net investment hedge: To reduce the risk of changes in net assets due to changes in foreign currency spot exchange rates for certain foreign subsidiaries that conduct their business principally in Euros, Korean Won and Taiwan Dollar. The notional value of hedging instruments matches the hedged amount of subsidiary net assets.	Foreign currency swap contracts	**$ 526**	$ 438
	Foreign currency forward contracts	**$ 636**	$ 406
Economic hedge: To hedge the foreign exchange-related changes in fair value of U.S. dollar-denominated investment assets to reflect the local currency for the Company's foreign subsidiary in South Korea. The notional value of hedging instruments generally aligns with the fair value of the hedged investments.	Foreign currency forward contracts	**$ 538**	$ 410

The Company's derivative financial instruments are presented as follows:

- Fair value hedges of the foreign exchange-related changes in fair values of certain foreign-denominated bonds: Swap fair values are reported in Long-term investments or Other non-current liabilities. Changes in fair values attributable to foreign exchange risk of the swap contracts and the hedged bonds are reported in Realized investment gains and losses. The portion of the swap contracts' changes in fair value excluded from the assessment of hedge effectiveness is recorded in Other comprehensive income and recognized in Net investment income as swap coupon payments are accrued, offsetting the foreign-denominated coupons received on the designated bonds. Net cash flows are reported in Operating activities, while exchanges of notional principal amounts are reported in Investing activities.
- Net investment hedges of certain foreign subsidiaries that conduct their business principally in currencies other than the U.S. dollar: The fair values of the foreign currency swap and forward contracts are reported in Other assets or Other liabilities. The changes in fair values of these instruments are reported in Other comprehensive income, specifically in translation of foreign currencies. The portion of the change in fair values relating to foreign exchange spot rates will be recognized in earnings upon deconsolidation of the hedged foreign subsidiaries. The remaining changes in fair value of these instruments are excluded from our effectiveness assessment and recognized in interest expense when coupon payments are accrued or ratably

over the term of the instrument. The notional value of hedging instruments matches the hedged amount of subsidiary net assets. Cash flows relating to these contracts are reported in Investing activities.

- Economic hedges for derivatives not designated as accounting hedges: Fair values of forward contracts are reported in Current investments or Accrued expenses and other liabilities. The changes in fair values are reported in Realized investment gains and losses. Cash flows relating to these contracts are reported in Investing activities.

Concentration of Risk

The Company did not have a concentration of investments in a single issuer or borrower exceeding 10% of shareholders' equity as of December 31, 2020 or 2019.

C. Net Investment Income

Accounting policy. When interest and principal payments on investments are current, the Company recognizes interest income when it is earned. The Company recognizes interest income on a cash basis when interest payments are delinquent based on contractual terms or when certain terms (interest rate or maturity date) of the investment have been restructured. For unconsolidated entities that are included in Other long-term investments, investment income is generally recognized according to the Company's share of the reported income or loss on the underlying investments. Investment income attributed to the Company's separate accounts is excluded from our earnings because associated gains and losses generally accrue directly to separate account policyholders.

The components of Net investment income for the years ended December 31 were as follows:

(In millions)	2020	2019	2018
Debt Securities	**$ 962**	$ 986	$ 1,009
Equity securities	**11**	5	28
Commercial mortgage loans	**80**	88	78
Policy loans	**64**	66	70
Other long-term investments	**127**	167	156
Short-term investments and cash	**52**	131	194
Total investment income	**1,296**	1,443	1,535
Less investment expenses	**52**	53	55
Net investment income	**$ 1,244**	$ 1,390	$ 1,480

D. Realized Investment Gains and Losses

Accounting policy. Realized investment gains and losses are based on specifically identified assets and result from sales, investment asset write-downs, change in the fair value of certain derivatives and equity securities and changes in valuation reserves on commercial mortgage loans. Commencing January 1, 2020, realized gains and losses also include credit loss expense resulting from the impact of changes in the allowances for credit losses on debt securities and commercial mortgage loan investments under ASU 2016-13.

Gains and losses relating to the transfers of investment assets associated with the divestiture of the U.S. Group Disability and Life business are excluded from the activity below, see Note 5 for further information. The following realized gains and losses on investments exclude amounts required to adjust future policy benefits for the run-off settlement annuity business (consistent with accounting for a premium deficiency, see Note 9 for further information), as well as realized gains and losses attributed to the Company's separate accounts because those gains and losses generally accrue directly to separate account policyholders.

(In millions)	2020	2019	2018
Net realized investment gains (losses), excluding credit loss expense and asset write-downs	**$ 186**	$ 189	$ (34)
Credit loss (expense) recoveries on invested assets	**(27)**	—	—
Other investment asset write-downs	**(10)**	(12)	(47)
Net realized investment gains (losses), before income taxes	**$ 149**	$ 177	$ (81)

Net realized investment gains, excluding credit loss expense and asset write-downs for the year ended December 31, 2020 was primarily driven by mark-to-market gains on equity securities and sales of debt securities, while this activity for the year ended December 31, 2019 was primarily driven by gains on the sales of real estate partnerships and debt securities. Net realized investment losses, excluding credit loss expense and asset write-downs in 2018 represented mark-to-market losses on equity securities and

derivatives, partially offset by gains on the sales of real estate partnerships. Credit loss (expense) recoveries on invested assets for the year ended December 31, 2020 reflects credit losses incurred primarily on debt securities due to uncertainty around issuers in certain industries that are particularly impacted by the global COVID-19 pandemic. Realized gains and losses on equity securities still held at December 31, 2020, 2019 and 2018 were not material.

The following table presents sales information for available-for-sale debt securities. Gross gains on sales and gross losses on sales exclude amounts required to adjust future policy benefits for the run-off settlement annuity business.

(In millions)	**2020**	**2019**	**2018**
Proceeds from sales	**$ 2,186**	$ 3,077	$ 2,625
Gross gains on sales	**$ 89**	$ 72	$ 28
Gross losses on sales	**$ (23)**	$ (19)	$ (47)

Note 12 – Fair Value Measurements

The Company carries certain financial instruments at fair value in the financial statements including debt securities, certain equity securities, short-term investments and derivatives. Other financial instruments are measured at fair value only under certain conditions, such as when impaired or when there are observable price changes for equity securities with no readily determinable fair value.

Fair value is defined as the price at which an asset could be exchanged in an orderly transaction between market participants at the balance sheet date. A liability's fair value is defined as the amount that would be paid to transfer the liability to a market participant, not the amount that would be paid to settle the liability with the creditor.

The Company's financial assets and liabilities carried at fair value have been classified based upon a hierarchy defined by GAAP. The hierarchy gives the highest ranking to fair values determined using unadjusted quoted prices in active markets for identical assets and liabilities (Level 1) and the lowest ranking to fair values determined using methodologies and models with unobservable inputs (Level 3). An asset's or a liability's classification is based on the lowest level of input that is significant to its measurement. For example, a financial asset or liability carried at fair value would be classified in Level 3 if unobservable inputs were significant to the instrument's fair value, even though the measurement may be derived using inputs that are both observable (Levels 1 and 2) and unobservable (Level 3).

The Company estimates fair values using prices from third parties or internal pricing methods. Fair value estimates received from third-party pricing services are based on reported trade activity and quoted market prices when available, and other market information that a market participant would use to estimate fair value. The internal pricing methods are performed by the Company's investment professionals and generally involve using discounted cash flow analyses, incorporating current market inputs for similar financial instruments with comparable terms and credit quality as well as other qualitative factors. In instances where there is little or no market activity for the same or similar instruments, fair value is estimated using methods, models and assumptions that the Company believes a hypothetical market participant would use to determine a current transaction price. These valuation techniques involve some level of estimation and judgment that becomes significant with increasingly complex instruments or pricing models.

The Company is responsible for determining fair value and for assigning the appropriate level within the fair value hierarchy based on the significance of unobservable inputs. The Company reviews methodologies, processes and controls of third-party pricing services and compares prices on a test basis to those obtained from other external pricing sources or internal estimates. The Company performs ongoing analyses of both prices received from third-party pricing services and those developed internally to determine that they represent appropriate estimates of fair value. The controls executed by the Company include evaluating changes in prices and monitoring for potentially stale valuations. The Company also performs sample testing of sales values to confirm the accuracy of prior fair value estimates. The minimal exceptions identified during these processes indicate that adjustments to prices are infrequent and do not significantly impact valuations. An annual due-diligence review of the most significant pricing service is conducted to review their processes, methodologies and controls. This review includes a walk-through of inputs for a sample of securities held across various asset types to validate the documented pricing process.

A. Financial Assets and Financial Liabilities Carried at Fair Value

The following table provides information as of December 31, 2020 and December 31, 2019 about the Company's financial assets and liabilities carried at fair value. As a result of the U.S. Group Disability and Life business divestiture, debt securities with a fair value of $7.8 billion, primarily classified in Level 2 of the fair value hierarchy, were transferred to New York Life on December 31, 2020. See Note 5 for further information. Separate account assets are also recorded at fair value on the Company's Consolidated Balance Sheets and are reported separately in the Separate Accounts section below as gains and losses related to these assets generally accrue directly to policyholders.

(In millions)	Quoted Prices in Active Markets for Identical Assets (Level 1)		Significant Other Observable Inputs (Level 2)		Significant Unobservable Inputs (Level 3)		Total	
	As of December 31, 2020	As of December 31, 2019	As of December 31, 2020	As of December 31, 2019	As of December 31, 2020	As of December 31, 2019	As of December 31, 2020	As of December 31, 2019
Financial assets at fair value								
Debt securities								
Federal government and agency	**$ 207**	$ 197	**$ 249**	$ 536	**$ —**	$ —	**$ 456**	$ 733
State and local government	**—**	—	**167**	810	**—**	—	**167**	810
Foreign government	**—**	—	**2,498**	2,228	**13**	28	**2,511**	2,256
Corporate	**—**	—	**13,878**	19,063	**684**	357	**14,562**	19,420
Mortgage and other asset-backed	**—**	—	**309**	398	**126**	138	**435**	536
Total debt securities	**207**	197	**17,101**	23,035	**823**	523	**18,131**	23,755
Equity securities [1]	**50**	7	**165**	72	**31**	32	**246**	111
Short-term investments	**—**	—	**325**	423	**—**	—	**325**	423
Derivative assets [3]	**—**	—	**72**	83	**—**	—	**72**	83
Real estate funds priced at NAV as a practical expedient [2]							**156**	184
Financial liabilities at fair value								
Derivative liabilities	**$ —**	$ —	**$ 108**	$ 18	**$ —**	$ —	**$ 108**	$ 18

(1) Excludes certain equity securities that have no readily determinable fair value.

(2) As a practical expedient, certain real estate funds are carried at fair value based on the Company's ownership share of the equity of the investee (Net Asset Value ("NAV")) including changes in the fair value of its underlying investments. The Company has $50 million in unfunded commitments in these funds as of December 31, 2020.

(3) Derivative assets above include $34 million that are presented in the Short-term investments category in Note 11. See Note 11 for more information on our accounting for Derivative Financial Instruments.

Level 1 Financial Assets

Inputs for instruments classified in Level 1 include unadjusted quoted prices for identical assets in active markets accessible at the measurement date. Active markets provide pricing data for trades occurring at least weekly and include exchanges and dealer markets.

Assets in Level 1 include actively-traded U.S. government bonds and exchange-listed equity securities. A relatively small portion of the Company's investment assets are classified in this category given the narrow definition of Level 1 and the Company's investment asset strategy to maximize investment returns.

Level 2 Financial Assets and Financial Liabilities

Inputs for instruments classified in Level 2 include quoted prices for similar assets or liabilities in active markets, quoted prices from those willing to trade in markets that are not active or other inputs that are market observable or can be corroborated by market data for the term of the instrument. Such other inputs include market interest rates and volatilities, spreads and yield curves. An instrument is classified in Level 2 if the Company determines that unobservable inputs are insignificant.

Debt and equity securities. Approximately 94% of the Company's investments in debt and equity securities are classified in Level 2 including most public and private corporate debt and hybrid equity securities, federal agency and municipal bonds, non-government mortgage-backed securities and preferred stocks. Third-party pricing services and internal methods often use recent trades of securities

with similar features and characteristics because many debt securities do not trade daily. Pricing models are used to determine these prices when recent trades are not available. These models calculate fair values by discounting future cash flows at estimated market interest rates. Such market rates are derived by calculating the appropriate spreads over comparable U.S. Treasury securities based on the credit quality, industry and structure of the asset. Typical inputs and assumptions to pricing models include, but are not limited to, a combination of benchmark yields, reported trades, issuer spreads, liquidity, benchmark securities, bids, offers, reference data and industry and economic events. For mortgage-backed securities, inputs and assumptions may also include characteristics of the issuer, collateral attributes, prepayment speeds and credit rating.

Nearly all of these instruments are valued using recent trades or pricing models. Less than 1% of the fair value of investments classified in Level 2 represents foreign bonds that are valued using a single, unadjusted market-observable input derived by averaging multiple broker-dealer quotes, consistent with local market practice.

Short-term investments are carried at fair value that approximates cost. The Company compares market prices for these securities to recorded amounts on a regular basis to validate that current carrying amounts approximate exit prices. The short-term nature of the investments and corroboration of the reported amounts over the holding period support their classification in Level 2.

Derivative assets and liabilities classified in Level 2 represent over-the-counter instruments such as foreign currency forward and swap contracts. Fair values for these instruments are determined using market observable inputs including forward currency and interest rate curves and widely published market observable indices. Credit risk related to the counterparty and the Company is considered when estimating the fair values of these derivatives. However, the Company is largely protected by collateral arrangements with counterparties and determined that no adjustments for credit risk were required as of December 31, 2020 or 2019. The nature and use of these derivative financial instruments are described in Note 11.

Level 3 Financial Assets and Financial Liabilities

Certain inputs for instruments classified in Level 3 are unobservable (supported by little or no market activity) and significant to their resulting fair value measurement. Unobservable inputs reflect the Company's best estimate of what hypothetical market participants would use to determine a transaction price for the asset or liability at the reporting date.

The Company classifies certain newly-issued, privately-placed, complex or illiquid securities in Level 3. Approximately 5% of debt and equity securities are priced using significant unobservable inputs and classified in this category.

Fair values of mortgage and other asset-backed securities, as well as corporate and government debt securities, are primarily determined using pricing models that incorporate the specific characteristics of each asset and related assumptions including the investment type and structure, credit quality, industry and maturity date in comparison to current market indices, spreads and liquidity of assets with similar characteristics. Inputs and assumptions for pricing may also include characteristics of the issuer, collateral attributes and prepayment speeds for mortgage and other asset-backed securities. Recent trades in the subject security or similar securities are assessed when available, and the Company may also review published research in its evaluation, as well as the issuer's financial statements.

Quantitative Information about Unobservable Inputs

The following table summarizes the fair value and significant unobservable inputs used in pricing the following debt securities that were developed directly by the Company as of December 31, 2020 and 2019. The range and weighted average basis point ("bps") amounts for liquidity and credit spreads (adjustment to discount rates) reflect the Company's best estimates of the unobservable adjustments a market participant would make to calculate these fair values. These liquidity and credit spreads have increased over the reported periods, resulting from continued uncertainty over the economic impacts related to COVID-19.

Corporate and government debt securities. The significant unobservable input used to value the following corporate and government debt securities is an adjustment for liquidity. This adjustment is needed to reflect current market conditions and issuer circumstances when there is limited trading activity for the security.

Mortgage and other asset-backed securities. The significant unobservable inputs used to value the following mortgage and other asset-backed securities are liquidity and weighting of credit spreads. An adjustment for liquidity is made as of the measurement date that considers current market conditions, issuer circumstances and complexity of the security structure when there is limited trading activity for the security. An adjustment to weight credit spreads is needed to value a more complex bond structure with multiple underlying collateral and no standard market valuation technique. The weighting of credit spreads is primarily based on the underlying collateral's characteristics and their proportional cash flows supporting the bond obligations.

	Fair Value as of			Unobservable Adjustment Range (Weighted Average by Quantity) as of	
(Fair value in millions)	**December 31, 2020**	**December 31, 2019**	**Unobservable input December 31, 2020**	**December 31, 2020**	**December 31, 2019**
Debt securities					
Corporate and government debt securities	**$ 696**	$ 385	**Liquidity**	**60 - 1370 (470) bps**	70 - 930 (280) bps
Mortgage and other asset-backed securities	**126**	138	**Liquidity**	**60 - 380 (80) bps**	60 - 370 (70) bps
			Weighting of credit spreads	**300 - 670 (480) bps**	240 - 460 (330) bps
Securities not priced by the Company [1]	**1**	—			
Total Level 3 debt securities	**$ 823**	$ 523			

(1) The fair values for these securities use single, unadjusted non-binding broker quotes not developed directly by the Company.

Significant increases in liquidity or credit spreads would result in lower fair value measurements while decreases in these inputs would result in higher fair value measurements. The unobservable inputs are generally not interrelated and a change in the assumption used for one unobservable input is not accompanied by a change in the other unobservable input.

Changes in Level 3 Financial Assets and Financial Liabilities Carried at Fair Value

The following tables summarize the changes in financial assets and financial liabilities classified in Level 3 for the years ended December 31, 2020 and 2019. Gains and losses reported in these tables may include net changes in fair value that are attributable to both observable and unobservable inputs.

(In millions)	**2020**	**2019**
Balance at beginning of period	**$ 555**	$ 410
Total gains (losses) included in shareholders' net income	**(7)**	(8)
Gains (losses) included in other comprehensive income	**(12)**	22
Gains (losses) required to adjust future policy benefits for settlement annuities [1]	**7**	2
Purchases, sales and settlements		
Purchases	**107**	72
Sales [2]	**(121)**	—
Settlements	**(89)**	(19)
Total purchases, sales and settlements	**$ (103)**	$ 53
Transfers into/(out of) Level 3		
Transfers into Level 3	**774**	170
Transfers out of Level 3	**(360)**	(94)
Total transfers into/(out of) Level 3	**$ 414**	$ 76
Balance at December 31,	**$ 854**	$ 555
Total gains (losses) included in shareholders' net income attributable to instruments held at the reporting date	**$ (17)**	$ (8)
Change in unrealized gains or losses included in other comprehensive income for assets held at the end of the reporting period	**$ (6)**	N/A

(1) Amounts do not accrue to shareholders.
(2) Sales in 2020 include $108 million of Level 3 debt securities transferred to New York Life Insurance Company on December 31, 2020 as part of the U.S. Group Disability and Life business divestiture. See Note 5 for further details.

Total gains and losses included in Shareholders' net income in the tables above are reflected in the Consolidated Statements of Income as Net realized investment gains (losses) and Net investment income.

Gains and losses included in Other comprehensive income in the tables above are reflected in Net unrealized (depreciation) appreciation on securities and derivatives in the Consolidated Statements of Comprehensive Income.

Transfers into or out of the Level 3 category occur when unobservable inputs, such as the Company's best estimate of what a market participant would use to determine a current transaction price, become more or less significant to the fair value measurement. Market

activity typically decreases during periods of economic uncertainty, and this decrease in activity reduces the availability of market observable data. As a result, the level of unobservable judgement that must be applied to the pricing of certain instruments increases, and is typically observed through the widening of liquidity and credit spreads. Transfers between Level 2 and Level 3 during 2020 and 2019 primarily reflected changes in liquidity and credit risk estimates for certain private placement issuers across several sectors. Transfers into and out of Level 3 are higher in 2020 due to fluctuations in liquidity and credit spreads over the reported periods, resulting from continued uncertainty over the economic impacts related to COVID-19. See discussion under Quantitative Information about Unobservable Inputs above for more information.

Separate Accounts

Accounting policy. Separate account assets and liabilities are contractholder funds maintained in accounts with specific investment objectives. The assets of these accounts are legally segregated and are not subject to claims that arise out of any of the Company's other businesses. These separate account assets are carried at fair value with equal amounts recorded for related separate account liabilities. The investment income and fair value gains and losses of separate account assets generally accrue directly to the contractholders and, together with their deposits and withdrawals, are excluded from the Company's Consolidated Statements of Income and Cash Flows. Fees and charges earned for mortality risks, asset management or administrative services are reported in either Premiums or Fees and other revenues. Investments that are measured using the practical expedient of NAV are excluded from the fair value hierarchy.

Fair values of separate account assets at December 31 were as follows:

(In millions)	**Quoted Prices in Active Markets for Identical Assets (Level 1)**		**Significant Other Observable Inputs (Level 2)**		**Significant Unobservable Inputs (Level 3)**		**Total**	
	2020	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**
Guaranteed separate accounts (See Note 21)	**$ 226**	$ 219	**$ 297**	$ 271	**$ —**	$ —	**$ 523**	$ 490
Non-guaranteed separate accounts [1]	**1,925**	1,450	**5,600**	5,522	**355**	263	**7,880**	7,235
Subtotal	**$ 2,151**	$ 1,669	**$ 5,897**	$ 5,793	**$ 355**	$ 263	**8,403**	7,725
Non-guaranteed separate accounts priced at NAV as a practical expedient [1]							**683**	756
Total								8,481
Separate account assets of business classified as held for sale								(16)
Separate account assets per Consolidated Balance Sheets							**$ 9,086**	$ 8,465

(1) Non-guaranteed separate accounts included $4.2 billion as of December 31, 2020 and $4.0 billion as of December 31, 2019 in assets supporting the Company's pension plans, including $0.3 billion classified in Level 3 as of December 31, 2020 and $0.2 billion classified in Level 3 as of December 31, 2019.

Separate account assets classified as Level 1 primarily include exchange-listed equity securities. Level 2 assets primarily include:

- corporate and structured bonds valued using recent trades of similar securities or pricing models that discount future cash flows at estimated market interest rates as described above; and
- actively-traded institutional and retail mutual fund investments.

Separate account assets classified in Level 3 primarily support Cigna's pension plans and include certain newly-issued, privately-placed, complex, or illiquid securities that are priced using methods discussed above, as well as commercial mortgage loans. Activity, including transfers into and out of Level 3, was not material in 2020 or 2019.

Separate account investments in securities partnerships, real estate and hedge funds are generally valued based on the separate account's ownership share of the equity of the investee (NAV as a practical expedient) including changes in the fair values of its underlying investments. Substantially all of these assets support the Cigna Pension Plans. The following table provides additional information on these investments.

	Fair Value as of				
(In millions)	**December 31, 2020**	**December 31, 2019**	**Unfunded Commitment as of December 31, 2020**	**Redemption Frequency (if currently eligible)**	**Redemption Notice Period**
Securities partnerships	**$ 463**	$ 531	**$ 272**	Not applicable	Not applicable
Real estate funds	**215**	220	—	Quarterly	30 - 90 days
Hedge funds	**5**	5	—	Up to annually, varying by fund	30 - 90 days
Total	**$ 683**	$ 756	**$ 272**		

As of December 31, 2020, the Company does not have plans to sell any of these assets at less than fair value. These investments are structured to satisfy longer-term investment objectives. Securities partnerships are contractually non-redeemable, and the underlying investment assets are expected to be liquidated by the fund managers within ten years after inception.

B. Assets and Liabilities Measured at Fair Value under Certain Conditions

Some financial assets and liabilities are not carried at fair value each reporting period, but may be measured using fair value only under certain conditions such as when investments become impaired, including investment real estate and commercial mortgage loans and certain equity securities with no readily determinable fair value. For 2020 and 2019, there were no such impairments. Equity securities with no readily determinable fair value are also measured at fair value when there are observable price changes from orderly transactions with the same issuer. There were $75 million in 2020 and $22 million in 2019 of realized investment gains relating to price changes for equity securities with no readily determinable fair value. Carrying values represented less than 1% of total investments as of both 2020 and 2019.

C. Fair Value Disclosures for Financial Instruments Not Carried at Fair Value

The following table includes the Company's financial instruments not recorded at fair value that are subject to fair value disclosure requirements at December 31, 2020 and 2019. In addition to universal life products and finance leases, financial instruments that are carried in the Company's Consolidated Financial Statements at amounts that approximate fair value are excluded from the following table.

		December 31, 2020		December 31, 2019	
(In millions)	**Classification in Fair Value Hierarchy**	**Fair Value**	**Carrying Value**	**Fair Value**	**Carrying Value**
Commercial mortgage loans	Level 3	**$ 1,456**	**$ 1,419**	$ 1,989	$ 1,947
Long-term debt, including current maturities, excluding finance leases	Level 2	**$ 37,676**	**$ 31,835**	$ 39,439	$ 36,375

Off-balance sheet financial instruments include commitments to purchase debt securities or fund commercial mortgage loans at fixed rates of interest. The fair values of off-balance sheet financial instruments were not material as of December 31, 2020 and 2019.

Note 13 – Variable Interest Entities

When the Company becomes involved with a variable interest entity and when there is a change in the Company's involvement with an entity, the Company must determine if it is the primary beneficiary and must consolidate the entity. The Company is considered the primary beneficiary if it has the power to direct the entity's most significant economic activities and has the right to receive benefits or obligation to absorb losses that could be significant to the entity. The Company evaluates the following criteria:

- the structure and purpose of the entity;
- the risks and rewards created by, and shared through, the entity; and
- the Company's ability to direct its activities, receive its benefits and absorb its losses relative to the other parties involved with the entity including its sponsors, equity holders, guarantors, creditors and servicers.

The Company determined it was not a primary beneficiary in any material variable interest entities as of December 31, 2020 or December 31, 2019. The Company's involvement in variable interest entities for which it is not the primary beneficiary is described below.

Securities limited partnerships and real estate limited partnerships. The Company owns interests in securities limited partnerships and real estate limited partnerships that are defined as unconsolidated variable interest entities. These partnerships invest in the equity or mezzanine debt of privately-held companies and real estate properties. General partners unaffiliated with the Company control decisions that most significantly impact the partnership's operations and the limited partners do not have substantive kick-out or participating rights. The Company's investments in approximately 150 limited partnerships that have a carrying value of $2.1 billion as of December 31, 2020 and are reported in Long-term investments. We have commitments to contribute an additional $1.9 billion to these entities. The Company's maximum exposure to loss from these investments is $4.0 billion, calculated as the sum of our carrying value and the additional funding commitments. Our noncontrolling interest in each of these limited partnerships is generally less than 15% of the partnership ownership interests. See Note 11 for further information on the Company's accounting policy for long-term investments.

Other asset-backed and corporate securities. In the normal course of its investing activities, the Company also makes passive investments in certain asset-backed and corporate securities that are issued by variable interest entities whose sponsors or issuers are unaffiliated with the Company. These investments provide the Company fixed-rate cash flows and are accounted for as debt securities. As of December 31, 2020 the carrying value of these investments is $0.5 billion, which represents the Company's maximum exposure related to these instruments. Our combined ownership interests are insignificant relative to the total principal amounts issued by these entities. See Note 11 for further information on the Company's accounting policy for debt securities.

The Company is involved in other types of variable interest entities, including real estate joint ventures that develop properties for residential and commercial use, independent physician associations (IPAs) that provide care management services and international healthcare joint ventures. The carrying values and maximum exposures for each of these types of unconsolidated variable interest entities was not material as of December 31, 2020.

The Company has not provided, and does not intend to provide, financial support to any of the variable interest entities in excess of its maximum exposure. We perform ongoing qualitative analyses of our involvement with these variable interest entities to determine if consolidation is required.

Note 14 – Accumulated Other Comprehensive Income (Loss) ("AOCI")

AOCI includes unrealized appreciation on securities and derivatives (excluding appreciation on investments supporting future policy benefit liabilities of the run-off settlement annuity business) (See Note 11), foreign currency translation and the net postretirement benefits liability adjustment. AOCI includes the Company's share from unconsolidated entities reported on the equity method. Generally, tax effects in AOCI are established at the currently enacted tax rate and reclassified to net income in the same period that the related pre-tax AOCI reclassifications are recognized. Changes in the components of AOCI were as follows:

	For the Years Ended December 31,		
(In millions)	**2020**	**2019**	**2018**
Securities and Derivatives			
Beginning balance	**$ 975**	$ 18	$ 328
Reclassification adjustment to retained earnings related to U.S. tax reform legislation	**—**	—	65
Reclassification adjustment to retained earnings related to new financial instruments guidance	**—**	—	(4)
Reclassification adjustment from retained earnings related to new hedging guidance	**—**	—	(6)
Adjusted beginning balance	**975**	18	383
Appreciation (depreciation) on securities and derivatives	**776**	1,266	(512)
Tax (expense) benefit	**(150)**	(270)	100
Net appreciation (depreciation) on securities and derivatives	**626**	996	(412)
Reclassification adjustment for (gains) included in shareholders' net income ((gain) loss on sale of business)	**(862)**	—	—
Reclassification adjustment for (gains) losses included in shareholders' net income (net realized investment (gains) losses)	**(26)**	(49)	60
Reclassification adjustment for tax expense (benefit) included in shareholders' net income	**187**	10	(13)
Net (gains) losses reclassified from AOCI to net income	**(701)**	(39)	47
Other comprehensive (loss) income, net of tax	**(75)**	957	(365)
Ending balance	**$ 900**	$ 975	$ 18
Translation of foreign currencies			
Beginning balance	**$ (275)**	$ (221)	$ (65)
Reclassification adjustment to retained earnings related to U.S. tax reform legislation	**—**	—	(4)
Adjusted beginning balance	**(275)**	(221)	(69)
Translation of foreign currencies	**232**	(57)	(167)
Tax (expense) benefit	**12**	(2)	—
Net translation of foreign currencies	**244**	(59)	(167)
Reclassification adjustment for losses included in shareholders' net income ((gain) loss on sale of business)	**11**	—	—
Reclassification adjustment for tax expense (benefit) included in shareholders' net income	**(3)**	—	—
Net translation losses reclassified from AOCI to net income	**8**	—	—
Other comprehensive income (loss), net of tax	**252**	(59)	(167)
Less: Net translation gain (loss) on foreign currencies attributable to noncontrolling interests	**(8)**	(5)	(15)
Shareholders' other comprehensive income (loss), net of tax	**260**	(54)	(152)
Ending balance	**$ (15)**	$ (275)	$ (221)
Postretirement benefits liability			
Beginning balance	**$ (1,641)**	$ (1,508)	$ (1,345)
Reclassification adjustment to retained earnings related to U.S. tax reform legislation	**—**	—	(290)
Adjusted beginning balance	**(1,641)**	(1,508)	(1,635)
Reclassification adjustment for amortization of net prior actuarial losses and prior service costs (interest expense and other)	**70**	62	69
Reclassification adjustment for settlement (interest expense and other)	**—**	10	—
Reclassification adjustment for tax expense (benefit) included in shareholders' net income	**(17)**	(15)	(15)
Net adjustments reclassified from AOCI to net income	**53**	57	54
Valuation update	**(206)**	(249)	93
Tax (expense) benefit	**48**	59	(20)
Net change due to valuation update	**(158)**	(190)	73
Other comprehensive (loss) income, net of tax	**(105)**	(133)	127
Ending balance	**$ (1,746)**	$ (1,641)	$ (1,508)

Note 15 – Pension

A. About Our Plans

The Company sponsors U.S. and non-U.S. defined benefit pension plans; future benefit accruals for the domestic plans are frozen.

Accounting policy. The Company measures the assets and liabilities of its domestic pension plans as of December 31. Benefit obligations are measured at the present value of estimated future payments based on actuarial assumptions. The Company uses the "corridor" method to account for changes in the benefit obligation when actual results differ from those assumed, or when assumptions change. These changes are called net unrecognized actuarial gains (losses). Under the corridor method, net unrecognized actuarial gains (losses) are initially recorded in accumulated other comprehensive income. When the unrecognized gain (loss) exceeds 10% of the benefit obligation, that excess is amortized to expense over the expected remaining lives of plan participants. The net plan expense is reported in Interest expense and other in the Consolidated Statements of Income.

For balance sheet purposes, we measure plan assets at fair value. When the actual return differs from the expected return, those differences are reflected in the net unrealized actuarial gain (loss) discussed above. However, to measure pension benefit costs, we use a "market-related" asset valuation that differs from the actual fair value for domestic pension plan assets invested in non-fixed income investments. The "market-related" value recognizes the difference between actual and expected long-term returns in the portfolio over five years, a method that reduces the short-term impact of market fluctuations on pension costs. The market-related asset value was approximately $4.4 billion, compared with a fair value of approximately $4.6 billion at December 31, 2020.

B. Funded Status and Amounts Included in Accumulated Other Comprehensive Income

The following table summarizes the projected benefit obligations and assets related to our U.S. and non-U.S. pension plans as of, and for the years ended December 31:

	Pension Benefits	
(In millions)	**2020**	**2019**
Change in benefit obligation		
Benefit obligation, January 1	**$ 5,314**	$ 4,741
Service cost	**2**	2
Interest cost	**168**	194
Litigation settlement	**—**	142
Actuarial losses, net [(1)]	**416**	574
Benefits paid from plan assets	**(285)**	(325)
Benefits paid — other	**(15)**	(14)
Benefit obligation, December 31	**5,600**	5,314
Change in plan assets		
Fair value of plan assets, January 1	**4,441**	4,151
Actual return on plan assets	**449**	594
Benefits paid	**(285)**	(325)
Contributions	**18**	21
Fair value of plan assets, December 31	**4,623**	4,441
Funded status	**$ (977)**	$ (873)
Liability in Consolidated Balance Sheets		
Accrued expenses and other liabilities	**$ (15)**	$ (18)
Other non-current liabilities	**$ (962)**	$ (855)

(1) 2020 Loss reflects a decrease in the discount rate, partially offset by a favorable change in the mortality assumption; 2019 loss reflects a decrease in the discount rate and an unfavorable change in the mortality assumption.

We fund our qualified pension plans at least at the minimum amount required by the Employee Retirement Income Security Act of 1974 and the Pension Protection Act of 2006. The Company made immaterial contributions to the qualified pension plans in 2020. For 2021, contributions to the qualified pension plans are expected to be immaterial. Future years' contributions will ultimately be based on a wide range of factors including but not limited to asset returns, discount rates and funding targets. Non-qualified pension and other postretirement benefit plans are generally funded on a pay-as-you-go basis as there are no plan assets for these plans.

Benefit payments. The following benefit payments are expected to be paid in:

(In millions)	Pension Benefits
2021	**$ 328**
2022	**$ 313**
2023	**$ 316**
2024	**$ 316**
2025	**$ 315**
2026-2030	**$ 1,551**

Amounts reflected in the pension liabilities shown above that have not yet been reported in net income and, therefore, have been included in Accumulated other comprehensive loss consisted of the following as of December 31:

	Pension Benefits	
(In millions)	**2020**	**2019**
Unrecognized net (losses)	**$ (2,277)**	$ (2,132)
Unrecognized prior service cost	**(5)**	(5)
Postretirement benefits liability adjustment	**$ (2,282)**	$ (2,137)

C. Cost of Our Plans

Net pension cost was as follows:

	Pension Benefits		
(In millions)	**2020**	**2019**	**2018**
Service cost	**$ 2**	$ 2	$ 3
Interest cost	**168**	194	169
Expected long-term return on plan assets	**(260)**	(245)	(257)
Amortization of:			
Prior actuarial losses, net	**78**	59	70
Prior service cost	**—**	—	—
Litigation settlement - plan amendment	**—**	142	32
Settlement loss	**—**	10	—
Net (benefit) cost	**$ (12)**	$ 162	$ 17

Old Cigna and the Cigna Pension Plan (the "Plan") were defendants in a class action lawsuit related to the Plan's conversion of certain employees from an annuity to a cash balance benefit in 1997. In the fourth quarter of 2018, the Plan was ordered to pay $32 million representing the attorney fee portion of the settlement. This payment was recognized as an expense in 2018. In the first quarter of 2019, the Plan implemented the court order resulting in an increase to the pension liability of $142 million. The Company reversed a litigation reserve for the expenses recognized for this matter in both 2019 and 2018 aggregating to the same amount resulting in no impact on net income.

D. Assumptions Used for Pension

	2020		**2019**	
Discount rate:				
Pension benefit obligation	**2.49**	**%**	3.30	%
Pension benefit cost	**3.30**	**%**	4.23	%
Expected long-term return on plan assets:				
Pension benefit cost	**6.75**	**%**	6.75	%
Mortality table for pension obligations	**White Collar mortality table with MP 2020 projection scale**		White Collar mortality table with MP 2019 projection scale	

The Company develops discount rates by applying actual annualized yields for high quality bonds by duration to the expected pension plan liability cash flows. The bond yields represent a diverse mix of actively traded high quality fixed-income securities that have an above average return at each duration as management believes this approach is representative of the yield achieved through plan asset investment strategy.

The expected long-term return on plan assets was developed considering historical long-term actual returns, expected long-term market conditions, plan asset mix and management's plan asset investment strategy.

E. Pension Plan Assets

As of December 31, 2020, pension assets included $4.2 billion invested in the separate accounts of Connecticut General Life Insurance Company, a subsidiary of the Company, as well as an additional $0.4 billion, primarily invested directly in funds offered by an unaffiliated insurance company.

The fair values of pension assets by category are as follows as of December 31, 2020 and 2019.

(In millions)	2020	2019
Debt securities:		
Federal government and agency	**$ 9**	$ —
Corporate	**1,680**	1,906
Asset-backed	**53**	41
Fund investments	**380**	460
Total debt securities	**2,122**	2,407
Equity securities:		
Domestic	**978**	582
International, including funds and pooled separate accounts (1)	**471**	419
Total equity securities	**1,449**	1,001
Securities partnerships	**463**	531
Real estate funds, including pooled separate accounts (1)	**219**	230
Commercial mortgage loans	**95**	96
Hedge funds	**1**	24
Guaranteed deposit account contract	**98**	100
Cash equivalents and other current assets, net	**176**	52
Total pension assets at fair value	**$ 4,623**	$ 4,441

(1) A pooled separate account has several participating benefit plans and each owns a share of the total pool of investments.

The Company’s current target investment allocation percentages (50% fixed income, 33% public equity securities and 17% in other investments, including private equity (securities partnerships) and real estate) are developed by management as guidelines, although the fair values of each asset category are expected to vary as a result of changes in market conditions. The Company will evaluate further allocation changes to equity securities, other investments and fixed income securities as funding levels change.

See Note 12 for further details regarding how fair value is determined, including the level within the fair value hierarchy and the procedures we use to validate fair value measurements. The Company classifies substantially all debt securities in Level 2 for pension plan assets. These assets are valued using recent trades of similar securities or are fund investments priced using their daily net asset value that is the exit price. A substantial portion of domestic equity securities within pension assets are classified as Level 1, while international equity funds within pension assets are predominantly classified in Level 2 using daily net asset value.

Securities partnerships, real estate and hedge funds are valued using NAV as a practical expedient and are excluded from the fair value hierarchy. See Note 12 for additional disclosures related to these assets invested in the separate accounts of the Company’s subsidiaries. Certain securities as described in Note 12, as well as commercial mortgage loans and guaranteed deposit account contracts, are classified in Level 3 because unobservable inputs used in their valuation are significant.

F. 401(k) Plans

The Company sponsors a 401(k) plan in which the Company matches a portion of employees' pre-tax contributions. Participants in the plan may invest in various funds that invest in the Company's common stock, several diversified stock funds, a bond fund or a fixed-income fund.

The Company may elect to increase its matching contributions if the Company's annual performance meets certain targets. The Company's annual expense for these plans was as follows:

(In millions)	**2020**	**2019**	**2018**
Expense	**$ 243**	$ 256	$ 196

Note 16 – Employee Incentive Plans

A. About Our Plans

The People Resources Committee (the "Committee") of the Board of Directors awards stock options, restricted stock grants, restricted stock units, deferred stock and strategic performance shares to certain employees.

Prior to the acquisition of Express Scripts, the Company issued shares from Treasury stock for these awards. Following the acquisition, original issue shares were used.

Awards of Express Scripts options and restricted stock units were rolled over to Cigna stock options and restricted stock units in connection with the Express Scripts acquisition on December 20, 2018. Information in this footnote includes the effect of the Express Scripts rollover awards unless otherwise indicated.

The Company records compensation expense for stock and option awards over their vesting periods primarily based on the estimated fair value at the grant date. Fair value is determined differently for each type of award as discussed below.

Shares of common stock available for award at December 31, were as follows:

(In millions)	**2020**	**2019**	**2018**
Common shares available for award	**20.6**	23.2	25.7

B. Stock Options

Accounting policy. The Company awards options to purchase Cigna common stock at the market price of the stock on the grant date except for rollover option awards issued to Express Scripts employees in connection with the acquisition. Options vest over periods ranging from one year to three years and expire no later than 10 years from grant date. Fair value is estimated using the Black-Scholes option-pricing model by applying the assumptions presented below. That fair value is reduced by options expected to be forfeited during the vesting period. The Company estimates forfeitures at the grant date based on our experience and adjusts the expense to reflect actual forfeitures over the vesting period. The fair value of options, net of forfeitures, is recognized in Selling, general and administrative expenses on a straight-line basis over the vesting period.

Black-Scholes option-pricing model assumptions and the resulting fair value of options are presented in the following table. The average fair value of options and the expected option life exclude the rollover options granted to Express Scripts employees in connection with the acquisition.

	2020	**2019**	**2018**
Dividend yield	**—** **%**	— %	— %
Expected volatility	**30.0** **%**	30.0 %	35.0 %
Risk-free interest rate	**1.4** **%**	2.5 %	2.5 %
Expected option life	**4.5 years**	4.4 years	4.4 years
Weighted average fair value of options	**$ 52.42**	$ 53.10	$ 64.18

The expected volatility reflects the past daily stock price volatility of Cigna stock. The Company does not consider volatility implied in the market prices of traded options to be a good indicator of future volatility because remaining traded options will expire within one year. The risk-free interest rate is derived using the four-year U.S. Treasury bond yield rate as of the award date for the primary annual grant. Expected option life reflects the Company's historical experience.

The following table shows the status of, and changes in, common stock options during the last three years.

(Options in thousands)	2020		2019		2018	
	Options	**Weighted Average Exercise Price**	**Options**	**Weighted Average Exercise Price**	**Options**	**Weighted Average Exercise Price**
Outstanding - January 1	**11,438**	**$ 136.19**	12,370	$ 125.46	6,156	$ 100.79
Granted	**1,851**	**$ 191.86**	1,569	$ 183.41	7,080	$ 143.62
Exercised	**(3,289)**	**$ 115.38**	(2,297)	$ 106.75	(771)	$ 88.35
Expired or canceled	**(258)**	**$ 188.79**	(204)	$ 180.08	(95)	$ 165.04
Outstanding - December 31	**9,742**	**$ 152.40**	11,438	$ 136.19	12,370	$ 125.46
Options exercisable at year-end	**6,837**	**$ 137.08**	8,874	$ 123.87	9,446	$ 114.22

Compensation expense of $66 million related to unvested stock options at December 31, 2020 will be recognized over the next two years (weighted average period).

The table below summarizes information for stock options exercised during the last three years:

(In millions)	2020	2019	2018
Intrinsic value of options exercised	**$ 304**	$ 180	$ 86
Cash received for options exercised	**$ 376**	$ 224	$ 68
Tax benefit from options exercised	**$ 57**	$ 34	$ 8

The following table summarizes information for outstanding common stock options at December 31, 2020:

	Options Outstanding	**Options Exercisable**
Number (in thousands)	**9,742**	**6,837**
Total intrinsic value (in millions)	**$ 543**	**$ 486**
Weighted average exercise price	**$ 152.40**	**$ 137.08**
Weighted average remaining contractual life	**5.8 years**	**4.6 years**

C. Restricted Stock

The Company awards restricted stock (grants and units) to the Company's employees that vest over periods ranging from one to three years. Recipients of restricted stock awards accumulate dividends during the vesting period, but forfeit their awards and accumulated dividends if their employment terminates before the vesting date.

Accounting policy. Fair value of restricted stock awards is equal to the market price of Cigna's common stock on the date of grant. This fair value is reduced by awards that are expected to forfeit. At the grant date, the Company estimates forfeitures based on experience and adjusts the expense to reflect actual forfeitures over the vesting period. This fair value, net of forfeitures, is recognized in Selling, general and administrative expenses over the vesting period on a straight-line basis.

The following table shows the status of, and changes in, restricted stock awards during the last three years.

(Awards in thousands)	2020		2019		2018	
	Grants/Units	**Weighted Average Fair Value at Award Date**	**Grants/Units**	**Weighted Average Fair Value at Award Date**	**Grants/Units**	**Weighted Average Fair Value at Award Date**
Outstanding - January 1	**1,945**	**$ 178.78**	2,138	$ 168.12	1,295	$ 126.44
Awarded	**791**	**$ 191.22**	870	$ 183.86	1,451	$ 183.29
Vested	**(1,026)**	**$ 161.58**	(964)	$ 160.74	(560)	$ 112.53
Forfeited	**(110)**	**$ 186.63**	(99)	$ 168.68	(48)	$ 150.84
Outstanding - December 31	**1,600**	**$ 186.12**	1,945	$ 178.78	2,138	$ 168.12

The fair value of vested restricted stock at the vesting date for the years ended December 31 was as follows:

(In millions)	2020	2019	2018
Fair value of vested restricted stock	**$ 190**	$ 171	$ 107

Approximately 10,300 employees held 1.6 million restricted stock awards at the end of 2020 with $152 million of related compensation expense to be recognized over the next two years (weighted average period).

D. Strategic Performance Shares ("SPS")

The Company awards SPSs to executives and certain other key employees generally with a performance period of three years. Half of these shares are subject to a market condition (total shareholder return relative to industry peer companies) and half are subject to a performance condition (cumulative adjusted net income). These targets are set by the Committee at the beginning of the performance period. Holders of these awards receive shares of Cigna common stock at the end of the performance period ranging anywhere from 0 to 200% of the original awards.

Accounting policy. Compensation expense for SPSs is recorded over the performance period. Fair value is determined at the grant date for "market condition" SPSs using a Monte Carlo simulation model and not subsequently adjusted regardless of the final outcome. Expense is initially accrued for "performance condition" SPSs based on the most likely outcome, but evaluated for adjustment each period for updates in the expected outcome. Expense is adjusted to the actual outcome (number of shares awarded times the share price at the grant date) at the end of the performance period.

The following table shows the status of, and changes in, SPSs during the last three years:

	2020		2019		2018	
(Awards in thousands)	Shares	Weighted Average Fair Value at Award Date	Shares	Weighted Average Fair Value at Award Date	Shares	Weighted Average Fair Value at Award Date
Outstanding - January 1	**818**	**$ 177.94**	707	$ 160.74	778	$ 136.57
Awarded	**362**	**$ 191.52**	389	$ 184.72	221	$ 197.51
Vested	**(309)**	**$ 159.67**	(244)	$ 139.27	(269)	$ 121.57
Forfeited	**(63)**	**$ 187.76**	(34)	$ 178.98	(23)	$ 158.16
Outstanding - December 31	**808**	**$ 190.02**	818	$ 177.94	707	$ 160.74

The fair value of vested SPSs at the vesting date for the years ended December 31 was as follows:

	2020		2019		2018	
(Shares in thousands; $ in millions)	Shares	Fair Value	Shares	Fair Value	Shares	Fair Value
Shares of Cigna common stock distributed upon SPS vesting	**306**	**$ 55**	254	$ 45	380	$ 73

Approximately 1,500 employees held 808,000 SPSs at the end of 2020 and $63 million of related compensation expense is expected to be recognized over the next two years. The amount of expense for "performance condition" SPSs will vary based on actual performance in 2021 and 2022.

E. Compensation Cost and Tax Effects of Share-based Compensation

The Company records tax benefits in shareholders' net income during the vesting period based on the amount of expense being recognized. The difference between tax benefits based on the expense and the actual tax benefit realized are also recorded in net income when stock options are exercised, or when restricted stock and SPSs vest.

(In millions)	2020	2019	2018
Total compensation cost for shared-based awards	**$ 289**	$ 299	$ 180
Tax benefits recognized	**$ 63**	$ 59	$ 36

Note 17 – Goodwill, Other Intangibles and Property and Equipment

A. Goodwill

Accounting policy. Goodwill represents the excess of the cost of businesses acquired over the fair value of their net assets. The resulting goodwill is assigned to those reporting units expected to realize cash flows from the acquisition, based on those reporting units' relative fair values. As a result, goodwill is primarily reported in the Evernorth segment ($33.8 billion), the U.S. Medical segment ($10.4 billion) and, to a lesser extent, the International Markets segment ($0.4 billion).

The Company conducts its annual quantitative evaluation for goodwill impairment during the third quarter at the reporting unit level and writes it down through shareholders' net income if impaired. On a quarterly basis, the Company performs a qualitative impairment assessment to determine if events or changes in circumstances indicate that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. Fair value of a reporting unit is generally estimated based on either a market approach or a discounted cash flow analysis using assumptions that the Company believes a hypothetical market participant would use to determine a current transaction price. The significant assumptions and estimates used in determining fair value include the discount rate and future cash flows. A discount rate is selected to correspond with each reporting unit's weighted average cost of capital, consistent with that used for investment decisions considering the specific and detailed operating plans and strategies within that reporting unit. Projections of future cash flows for each reporting unit are consistent with our annual planning process for revenues, pharmacy costs, benefits expenses, operating expenses, taxes, capital levels and long-term growth rates.

Goodwill activity. Goodwill activity during 2020 and 2019 was as follows:

(In millions)		2020		2019
Balance at January 1,	**$**	**44,602**	$	44,505
Goodwill acquired, net		**29**		103
Impact of foreign currency translation		**17**		(6)
Balance at December 31,	**$**	**44,648**	$	44,602

B. Other Intangibles

Accounting policy. The Company's other intangible assets primarily include purchased customer and producer relationships, provider networks and trademarks. The fair value of purchased customer relationships and the amortization method were determined as of the dates of purchase using an income approach that relies on projected future net cash flows including key assumptions for customer attrition and discount rates. The Company's definite-lived intangible assets are amortized on an accelerated or straight-line basis, reflecting their pattern of economic benefits, over periods from three to 39 years. Management revises amortization periods if it believes there has been a change in the length of time that an intangible asset will continue to have value. Costs incurred to renew or extend the terms of these intangible assets are generally expensed as incurred.

The Company's amortized intangible assets are tested for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. If the total of the expected future undiscounted cash flows generated by the underlying asset group is less than the carrying amount of the asset group, the Company recognizes an impairment charge equal to the difference between the carrying value of the asset group and its estimated fair value. The Company's indefinite-lived intangible assets are each reviewed for impairment at least annually by comparing their fair value with their carrying value. If the carrying value exceeds fair value, that excess is recognized as an impairment loss.

There were no material impairments in the years ended December 31, 2020, 2019 or 2018.

Components of other assets, including other intangibles. Other intangible assets were comprised of the following at December 31:

(In millions)	Cost	Accumulated Amortization	Net Carrying Value
2020			
Customer relationships	**$ 29,432**	**3,024**	**26,408**
Trade Name - Express Scripts	**8,400**		**8,400**
Other	**475**	**104**	**371**
Other intangible assets	**38,307**	**3,128**	**35,179**
Value of business acquired (reported in Deferred policy acquisition costs)	**670**	**152**	**518**
Total	**$ 38,977**	**3,280**	**35,697**
2019			
Customer relationships	$ 31,184	3,319	27,865
Trade Name - Express Scripts	8,400		8,400
Other	383	86	297
Other intangible assets	39,967	3,405	36,562
Value of business acquired (reported in Deferred policy acquisition costs)	643	122	521
Total	$ 40,610	3,527	37,083

The Company has indefinite-lived intangible assets totaling $8.5 billion at December 31, 2020 and $8.4 billion at December 31, 2019, largely consisting of trade names and licenses.

C. Property and Equipment

Accounting policy. Property and equipment is carried at cost less accumulated depreciation. Cost includes interest, real estate taxes and other costs incurred during construction when applicable. Internal-use software that is acquired, developed or modified solely to meet the Company's internal needs, with no plan to market externally, is also included in this category. Costs directly related to acquiring, developing or modifying internal-use software are capitalized.

The Company calculates depreciation and amortization principally using the straight-line method generally based on the estimated useful life of each asset as follows: buildings and improvements, 10 to 40 years; purchased software, three to five years; internally developed software, three to seven years and furniture and equipment (including computer equipment), three to 10 years. Improvements to leased facilities are depreciated over the lesser of the remaining lease term or the estimated life of the improvement. The Company considers events and circumstances that would indicate the carrying value of property, equipment or capitalized software might not be recoverable. An impairment charge is recorded if the Company determines the carrying value of any of these assets is not recoverable. The Company also reviews and shortens the estimated useful lives of these assets, if necessary.

Components of property and equipment. Property and equipment was comprised of the following as of December 31:

(In millions)	Cost	Accumulated Amortization	Net Carrying Value
2020			
Internal-use software	**$ 7,061**	**$ 4,048**	**$ 3,013**
Other property and equipment	**2,719**	**1,527**	**1,192**
Total property and equipment	**$ 9,780**	**$ 5,575**	**$ 4,205**
2019			
Internal-use software	$ 6,578	$ 3,282	$ 3,296
Other property and equipment	2,569	1,353	1,216
Total property and equipment	9,147	4,635	4,512
Property and equipment classified as Assets held for sale	(226)	(131)	(95)
Total property and equipment per Consolidated Balance Sheet	$ 8,921	$ 4,504	$ 4,417

Components of depreciation and amortization. Depreciation and amortization expense was comprised of the following for the years ended December 31:

(In millions)	2020	2019	2018
Internal-use software	**$ 971**	$ 850	$ 323
Other property and equipment	**276**	284	146
Value of business acquired (reported in deferred policy acquisition costs)	**28**	34	16
Other intangibles	**1,527**	2,483	210
Total depreciation and amortization	**$ 2,802**	$ 3,651	$ 695

The Company estimates annual pre-tax amortization for intangible assets, including internal-use software, over the next five calendar years to be as follows:

(In millions)	Pre-tax Amortization
2021	**$ 2,719**
2022	**$ 2,236**
2023	**$ 2,014**
2024	**$ 1,821**
2025	**$ 1,760**

Note 18 – Leases

Cigna adopted ASU 2016-2, *Leases,* as of January 1, 2019. As permitted by the standard, the Company did not restate its Consolidated Financial Statements for periods prior to the adoption date and the required disclosures presented below are prospective from the date of adoption. The Company's leases are primarily for office space and certain computer and other equipment, and have terms of up to 34 years.

Accounting policy. The Company determines if an arrangement is a lease and its lease classification (operating or finance) at inception. Beginning in the first quarter of 2019, both operating and finance leases result in (1) a right-of-use ("ROU") asset that represents our right to use the underlying asset for the lease term and (2) a lease liability that represents our obligation to make lease payments arising from the lease. ROU assets and lease liabilities are reflected in the following lines in the Company's Consolidated Balance Sheet:

	ROU Asset	Current Lease Liability	Non-Current Lease Liability
Operating lease	Other assets	Accrued expenses and other liabilities (current)	Other liabilities (non-current)
Finance lease	Property and equipment	Short-term debt	Long-term debt

These lease assets and liabilities are recognized at the lease commencement date based on the present value of the lease payments over the lease term. Most of the Company's leases do not provide an implicit rate, so the Company uses its incremental borrowing rate based on the information available at commencement date in determining the present value of lease payments. The ROU asset also includes any lease pre-payments made and excludes lease incentives for operating leases. The Company's expected life of a lease may consider options to extend or terminate a lease when it is reasonably certain that the Company will exercise that option.

The Company has lease agreements with lease and non-lease components that are accounted for as a single lease component. Variable lease payments are expensed as incurred and represent amounts that are neither fixed in nature, such as maintenance and other services provided by the lessor, nor tied to an index or rate.

The components of lease expense were as follows:

(In millions)	For the Years Ended December 31, 2020	2019
Operating lease cost	**$ 190**	$ 188
Finance lease cost:		
Amortization of ROU assets	**28**	28
Interest on lease liabilities	**3**	3
Total finance lease cost	**31**	31
Variable lease cost	**48**	50
Total lease cost	**$ 269**	$ 269

Rental expense under operating lease agreements was $162 million for the year ended December 31, 2018.

Supplemental cash flow information related to leases was as follows:

(In millions)	For the Years Ended December 31, 2020	2019
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash outflows from operating leases	**$ 189**	$ 173
Operating cash outflows from finance leases	**$ 3**	$ 3
Financing cash outflows from finance leases	**$ 26**	$ 25
ROU assets obtained in exchange for lease obligations:		
Operating leases	**$ 189**	$ 89
Finance leases	**$ 9**	$ 68

The non-cash impact of adopting the new lease guidance in 2019 was an increase of Other assets of $615 million and an increase to Accrued expenses and other liabilities of $630 million.

Operating and finance lease ROU assets and lease liabilities were as follows:

(In millions)	December 31, 2020	December 31, 2019
Operating leases:		
Operating lease ROU assets	**$ 552**	$ 536
Accrued expenses and other liabilities	**$ 152**	$ 166
Other non-current liabilities	**491**	465
Total operating lease liabilities	**$ 643**	$ 631
Finance leases:		
Property and equipment, gross	**$ 98**	$ 110
Accumulated depreciation	**(46)**	(23)
Property and equipment, net	**$ 52**	$ 87
Short-term debt	**$ 18**	$ 27
Long-term debt	**36**	61
Total finance lease liabilities	**$ 54**	$ 88

As of December 31, 2020, the weighted average remaining lease term was five years for operating leases and four years for finance leases, and the weighted average discount rate was 3.51% for operating leases and 3.95% for finance leases.

Maturities of lease liabilities as of December 31, 2020 were as follows:

(In millions)	Operating Leases	Finance Leases
2021	**$ 150**	**$ 20**
2022	**170**	**18**
2023	**118**	**6**
2024	**89**	**3**
2025	**57**	**3**
Thereafter	**121**	**10**
Total lease payments	**705**	**60**
Less: imputed interest	**62**	**6**
Total	**$ 643**	**$ 54**

Note 19 – Shareholders' Equity and Dividend Restrictions

State insurance departments and foreign jurisdictions that regulate certain of the Company's subsidiaries prescribe accounting practices (differing in some respects from GAAP) to determine statutory net income and surplus. The Company's life, accident and health insurance and Health Maintenance Organization ("HMO") subsidiaries are regulated by such statutory requirements. The statutory net income of the Company's life, accident and health insurance and HMO subsidiaries for the years ended, and their statutory surplus as of December 31, were as follows:

(In billions)	2020	2019	2018
Net income	**$ 4.0**	$ 3.8	$ 3.4
Surplus	**$ 12.9**	$ 13.8	$ 12.2

The Company's HMO and life, accident and health insurance subsidiaries are also subject to minimum statutory surplus requirements and may be required to maintain investments on deposit with state departments of insurance or other regulatory bodies. Additionally, these subsidiaries may be subject to regulatory restrictions on the amount of annual dividends or other distributions (such as loans or cash advances) that insurance companies may extend to their parent companies without prior approval. As of December 31, 2020, these amounts, including restricted GAAP net assets of the Company's subsidiaries, were as follows:

(In billions)	2020
Minimum statutory surplus required by regulators	**$ 4.9**
Investments on deposit with regulatory bodies	**$ 0.4**
Maximum dividend distributions permitted in 2021 without regulatory approval	**$ 2.5**
Maximum loans to the parent company permitted without regulatory approval	**$ 0.8**
Restricted GAAP net assets of Cigna Corporation's subsidiaries	**$ 13.5**

Permitted practices used by the Company's insurance subsidiaries in 2020 that differed from prescribed regulatory accounting had an immaterial impact on statutory surplus.

Note 20 – Income Taxes

Accounting policy. Deferred income taxes are reflected in the Consolidated Balance Sheets for differences between the financial and income tax reporting bases of the Company's underlying assets and liabilities, and established based upon enacted tax rates and laws. Deferred income tax assets are recognized when available evidence indicates that realization is more likely than not, and a valuation allowance is established to the extent this standard is not met. The deferred income tax provision generally represents the net change in deferred income tax assets and liabilities during the reporting period excluding adjustments to accumulated other comprehensive income or amounts recorded in connection with a business combination. The current income tax provision generally represents estimated amounts due on income tax returns for the year reported to various jurisdictions plus the effect of any uncertain tax positions. The Company recognizes a liability for uncertain tax positions if management believes the probability that the positions will be sustained is 50% or less. For uncertain positions that management believes are more likely than not to be sustained, the Company recognizes a liability based upon management's estimate of the most likely settlement outcome with the taxing authority. The

liabilities for uncertain tax positions are classified as current when the position is expected to be settled within 12 months or the statute of limitation expires within 12 months.

Income taxes attributable to the Company's foreign operations are generally provided using the respective foreign jurisdictions' tax rate.

The liquidity and regulatory capital requirements of our foreign operations and certain international growth initiatives are supported by retaining overseas a significant portion of the earnings generated by our foreign operations. This strategy does not materially limit Cigna's ability to meet the Company's liquidity and capital needs in the United States. The Company generally does not intend to repatriate these earnings.

A. Income Tax Expense

The components of income taxes for the years ended December 31 were as follows:

(In millions)	2020	2019	2018
Current taxes			
U.S. income taxes	**$ 2,128**	$ 1,476	$ 804
Foreign income taxes	**334**	173	185
State income taxes	**303**	114	47
Total current taxes	**2,765**	1,763	1,036
Deferred taxes (benefits)			
U.S. income taxes (benefits)	**(217)**	(236)	(75)
Foreign income taxes	**11**	16	8
State income tax (benefits)	**(180)**	(93)	(34)
Total deferred taxes (benefits)	**(386)**	(313)	(101)
Total income taxes	**$ 2,379**	$ 1,450	$ 935

Total income taxes for the years ended December 31 were different from the amount computed using the nominal federal income tax rate for the following reasons:

	2020		2019		2018	
(In millions)	$	%	$	%	$	%
Tax expense at nominal rate	**$ 2,282**	**21.0 %**	$ 1,380	21.0 %	$ 752	21.0 %
Effect of U.S. tax reform legislation	**—**	**—**	—	—	(4)	(0.1)
Impact of sale of business	**104**	**1.0**	—	—	—	—
Effect of foreign earnings	**(61)**	**(0.6)**	24	0.4	74	2.1
Health insurance industry tax	**93**	**0.9**	—	—	78	2.2
State income tax (net of federal income tax benefit)	**24**	**0.2**	32	0.5	10	0.3
Other	**(63)**	**(0.6)**	14	0.2	25	0.6
Total income taxes	**$ 2,379**	**21.9 %**	$ 1,450	22.1 %	$ 935	26.1 %

Consolidated pre-tax income from the Company's foreign operations was approximately 14% of the Company's pre-tax income in 2020, 12% in 2019 and 15% in 2018.

B. Deferred Income Taxes

Deferred income tax assets and liabilities as of December 31, were as follows:

(In millions)	2020	2019
Deferred tax assets		
Employee and retiree benefit plans	**$ 477**	$ 511
Other insurance and contractholder liabilities	**278**	282
Loss carryforwards	**177**	260
Other accrued liabilities	**358**	183
Other	**209**	218
Deferred tax assets before valuation allowance	**1,499**	1,454
Valuation allowance for deferred tax assets	**(207)**	(196)
Deferred tax assets, net of valuation allowance	**1,292**	1,258
Deferred tax liabilities		
Depreciation and amortization	**660**	630
Acquisition-related basis differences	**8,989**	9,386
Policy acquisition expenses	**289**	113
Unrealized appreciation on investments and foreign currency translation	**171**	223
Other	**122**	293
Total deferred tax liabilities	**10,231**	10,645
Net deferred income tax (liabilities) assets	**$ (8,939)**	$ (9,387)

Management believes that future results will be sufficient to realize a majority of the Company's gross deferred tax assets. Valuation allowances are established against deferred tax assets when it is determined that it is more likely than not that the asset will not be recognized. Valuation allowances have been established against certain federal, state and foreign tax attributes. There are multiple expiration dates associated with these tax attributes.

C. Uncertain Tax Positions and Other Tax Matters

Reconciliations of unrecognized tax benefits for the years ended December 31 follow:

(In millions)	2020	2019	2018
Balance at January 1,	**$ 1,018**	$ 928	$ 35
Increase due to prior year positions	**128**	68	40
Increase due to business combinations	**—**	—	860
Increase due to current year positions	**88**	29	6
Reduction related to settlements with taxing authorities	**—**	—	(1)
Reduction related to lapse of applicable statute of limitations	**(24)**	(7)	(12)
Balance at December 31,	**$ 1,210**	$ 1,018	$ 928

Substantially all unrecognized tax benefits would impact shareholders' net income if recognized.

The Company classifies net interest expense on uncertain tax positions as a component of income tax expense and in Accrued expenses and other liabilities on the balance sheet. In addition to the amounts in the table above, the liability for net interest expense on uncertain tax positions was approximately $127 million as of December 31, 2020, $100 million as of December 31, 2019 and immaterial for 2018.

D. Other Tax Matters

The statute of limitations for Cigna's consolidated federal income tax returns through 2015 have closed. However, Cigna filed an amended return for the 2015 tax year, and it is being reviewed by the Internal Revenue Service (IRS). Additionally, the IRS has opened an examination of Cigna's 2017 return. It is expected that the IRS will add tax years 2016 and 2018 to the existing Cigna cycle. The IRS has examined Express Scripts' tax returns for 2010 through 2012, for which there is a significant disputed tax matter, and is currently examining returns for 2013 through 2017. In addition, the Company has pending refund claims for various years.

The Company conducts business in a number of state and foreign jurisdictions and may be engaged in multiple audit proceedings at any given time. Generally, no further state or foreign audit activity is expected for tax years prior to 2012 for Cigna's entities and 2006 for Express Scripts' entities.

Note 21 – Contingencies and Other Matters

The Company, through its subsidiaries, is contingently liable for various guarantees provided in the ordinary course of business.

A. Financial Guarantees: Retiree and Life Insurance Benefits

The Company guarantees that separate account assets will be sufficient to pay certain life insurance or retiree benefits. For the majority of these benefits, the sponsoring employers are primarily responsible for ensuring that assets are sufficient to pay these benefits and are required to maintain assets that exceed a certain percentage of benefit obligations. If employers fail to do so, the Company or an affiliate of the buyer of the retirement benefits business has the right to redirect the management of the related assets to provide for benefit payments. As of December 31, 2020, employers maintained assets that generally exceeded the benefit obligations under these arrangements of approximately $450 million. An additional liability is established if management believes that the Company will be required to make payments under the guarantees; there were no additional liabilities required for these guarantees, net of reinsurance, as of December 31, 2020. Separate account assets supporting these guarantees are classified in Levels 1 and 2 of the GAAP fair value hierarchy.

The Company does not expect that these financial guarantees will have a material effect on the Company's consolidated results of operations, liquidity or financial condition.

B. Certain Other Guarantees

The Company had indemnification obligations as of December 31, 2020 in connection with acquisition and disposition transactions. These indemnification obligations are triggered by the breach of representations or covenants provided by the Company, such as representations for the presentation of financial statements, filing of tax returns, compliance with law or identification of outstanding litigation. These obligations are typically subject to various time limitations, defined by the contract or by operation of law, such as statutes of limitation. In some cases, the maximum potential amount due is subject to contractual limitations based on a percentage of the transaction purchase price, while in other cases limitations are not specified or applicable. The Company does not believe that it is possible to determine the maximum potential amount due under these obligations because not all amounts due under these indemnification obligations are subject to limitation. There were no liabilities for these indemnification obligations as of December 31, 2020.

C. Guaranty Fund Assessments

The Company operates in a regulatory environment that may require its participation in assessments under state insurance guaranty association laws. The Company's exposure to assessments for certain obligations of insolvent insurance companies to policyholders and claimants is based on its share of business written in the relevant jurisdictions.

There were no material effects for existing or new guaranty fund assessments for the year ended December 31, 2020.

D. Legal and Regulatory Matters

The Company is routinely involved in numerous claims, lawsuits, regulatory inquiries and audits, government investigations, including under the federal False Claims Act and state false claims acts initiated by a government investigating body or by a qui tam relator's filing of a complaint under court seal, and other legal matters arising, for the most part, in the ordinary course of managing a global health service business. Additionally, the Company has received and is cooperating with subpoenas or similar processes from various governmental agencies requesting information, all arising in the normal course of its business. Disputed tax matters arising from audits by the Internal Revenue Service or other state and foreign jurisdictions, including those resulting in litigation, are accounted for under GAAP guidance for uncertain tax positions. See Note 20 for additional information on income tax matters.

Pending litigation and legal or regulatory matters that the Company has identified with a reasonably possible material loss and certain other material litigation matters are described below. For those matters that the Company has identified with a reasonably possible material loss, the Company provides disclosure in the aggregate of accruals and range of loss, or a statement that such information cannot be estimated. The Company's accruals for the matters discussed below under "Litigation Matters" and "Regulatory Matters" are not material. Due to numerous uncertain factors presented in these cases, it is not possible to estimate an aggregate range of loss (if any) for these matters at this time. In light of the uncertainties involved in these matters, there is no assurance that their ultimate

resolution will not exceed the amounts currently accrued by the Company. An adverse outcome in one or more of these matters could be material to the Company's results of operations, financial condition or liquidity for any particular period. The outcomes of lawsuits are inherently unpredictable and we may be unsuccessful in these ongoing litigation matters or any future claims or litigation.

Litigation Matters

Risk Corridors and CSR Litigation with the Federal Government. As a result of a Supreme Court decision in April 2020, the Company filed suit in early May 2020 against the United States in the U.S. Court of Federal Claims seeking to recover two types of payments the Federal Government owes Cigna under the risk corridors and cost-sharing reduction ("CSR") programs of The Patient Protection and Affordable Care Act. In aggregate, the complaint seeks to recover more than $315 million: $120 million in risk corridors payments and more than $195 million in CSR payments. We received $120 million in payments in September 2020, which resolved our risk corridors claim. Our claim seeking recovery for CSR payments is stayed until either the Federal Circuit's judgments in the CSR appeals become final and non-appealable or the Supreme Court resolves any petition for writ of certiorari.

Cigna Litigation with Anthem. In February 2017, the Company filed suit against Anthem, Inc. in the Delaware Court of Chancery (the "Chancery Court") seeking, among other relief, payment of the $1.85 billion reverse termination fee under the parties' 2015 merger agreement and damages. Anthem countersued, alleging its own claims for damages. A trial was held during the first quarter of 2019. In August 2020, the Chancery Court issued an opinion finding that, although Cigna breached its contractual obligation to use reasonable best efforts to support the Anthem/Cigna merger, its actions did not cause the merger to fail. The Court denied claims by both parties for damages and further denied Cigna's claim for the reverse termination fee. The Company filed a Notice of Appeal with the Delaware Supreme Court on October 30, 2020, and seeks reversal of the portion of the Chancery Court's decision denying Cigna the reverse termination fee. Briefing on the appeal was completed on January 29, 2021 and oral arguments are scheduled for April 14, 2021.

Express Scripts Litigation with Anthem. In March 2016, Anthem filed a lawsuit in the United States District Court for the Southern District of New York alleging various breach of contract claims against Express Scripts relating to the parties' rights and obligations under the periodic pricing review section of the pharmacy benefit management agreement between the parties including allegations that Express Scripts failed to negotiate new pricing concessions in good faith, as well as various alleged service issues. Anthem also requested that the court enter declaratory judgment that Express Scripts is required to provide Anthem competitive benchmark pricing, that Anthem can terminate the agreement and that Express Scripts is required to provide Anthem with post-termination services at competitive benchmark pricing for one year following any termination by Anthem. Anthem claims it is entitled to $13 billion in additional pricing concessions over the remaining term of the agreement, as well as $1.8 billion for one year following any contract termination by Anthem and $150 million damages for service issues ("Anthem's Allegations"). On April 19, 2016, in response to Anthem's complaint, Express Scripts filed its answer denying Anthem's Allegations in their entirety and asserting affirmative defenses and counterclaims against Anthem. The court subsequently granted Anthem's motion to dismiss two of six counts of Express Scripts' amended counterclaims. The current scheduling order runs through the completion of summary judgment briefing in August 2021. There is no tentative trial date.

Regulatory Matters

Civil Investigative Demand. The U.S. Department of Justice ("DOJ") is conducting an industry-wide investigation of Medicare Advantage organizations' risk adjustment practices under Medicare Parts C and D including medical chart reviews and health exams. For certain other Medicare Advantage organizations, the investigation has resulted in litigation. The Company is currently responding to information requests (civil investigative demands) received from the DOJ (U.S. Attorney's Offices for the Eastern District of Pennsylvania and the Southern District of New York ("SDNY")). We will continue to cooperate with the DOJ's investigation. Additionally, in relation to the SDNY's pending investigation, a *qui tam* action that was filed by a relator in the United States District Court for the Southern District of New York in 2017 was unsealed on August 6, 2020. The action asserts claims related to risk adjustment practices arising from certain health exams conducted as part of Cigna's Medicare Advantage business. The DOJ has not intervened in the case at this time.

Note 22 – Segment Information

See Note 1 for a description of our segments. A description of our basis for reporting segment operating results is outlined below. Intersegment revenues primarily reflect pharmacy related transactions between the Evernorth and U.S. Medical segments. Effective with the first quarter of 2019, the Company began allocating compensation cost for stock options to segments. Prior year segment information was not restated for this change. A description of our basis for reporting segment operating results is outlined below.

The Company uses "pre-tax adjusted income from operations" and "adjusted revenues" as its principal financial measures of segment operating performance because management believes they best reflect the underlying results of business operations and permit

analysis of trends in underlying revenue, expenses and profitability. Pre-tax adjusted income from operations is defined as income before taxes excluding realized investment results, amortization of acquired intangible assets, special items and, for periods prior to 2020, earnings contribution from transitioning clients Anthem Inc. and Coventry Health Care, Inc. (the "transitioning clients"). As of December 31, 2019, the transition of these clients was substantially complete; therefore, beginning in 2020, we no longer exclude results of transitioning clients from our adjusted revenues and adjusted income from operations. Income or expense amounts that are excluded from adjusted income from operations because they are not indicative of underlying performance or the responsibility of operating segment management include:

- Realized investment gains (losses) including changes in market values of certain financial instruments between balance sheet dates, as well as gains and losses associated with invested asset sales.
- Amortization of acquired intangible assets because these relate to costs incurred for acquisitions.
- Results of transitioning clients, for periods prior to 2020, because those results were not indicative of ongoing results.
- Special items, if any, that management believes are not representative of the underlying results of operations due to the nature or size of these matters.

The Company does not report total assets by segment because this is not a metric used to allocate resources or evaluate segment performance.

Adjusted revenues is defined as revenues excluding: 1) revenue contribution from transitioning clients for periods prior to 2020; 2) the Company's share of certain realized investment results of its joint ventures reported in the International Markets segment using the equity method of accounting; and 3) special items, if any.

The following tables present the special items recorded by the Company in 2020, 2019 and 2018.

	Three Months Ended					
(In millions)	**2020**		**2019**		**2018**	
Description of Special Item Charges (Benefits) and Financial Statement Line Item(s)	**After-tax**	**Before-tax**	**After-tax**	**Before-tax**	**After-tax**	**Before-tax**
Integration and transaction-related costs:						
- Selling, general and administrative expenses	**$ 404**	**$ 527**	$ 427	$ 552	$ 587	$ 748
- Interest expense and other	**—**	**—**	—	—	179	227
- Net investment income	**—**	**—**	—	—	(97)	(123)
Integration and transaction-related costs	**$ 404**	**$ 527**	$ 427	$ 552	$ 669	$ 852
Debt extinguishment costs	**$ 151**	**$ 199**	$ —	$ —	$ —	$ —
Charge for organizational efficiency plan (Selling, general and administrative expenses)	**24**	**31**	162	207	—	—
Charges associated with litigation matters (Selling, general and administrative expenses)	**19**	**25**	41	51	19	25
Risk corridors recovery (Selling, general and administrative expenses)	**(76)**	**(101)**	—	—	—	—
Contractual adjustment for a former client (Pharmacy revenues)	**(155)**	**(204)**	—	—	—	—
(Gain) on sale of business	**(3,217)**	**(4,203)**	—	—	—	—
Charges (benefits) associated with tax reform:						
- Selling, general and administrative expenses	**$ —**	**$ —**	$ —	$ —	$ 1	$ 2
- Tax (benefit)	**—**	**—**	—	—	(3)	—
Charges (benefits) associated with tax reform	**$ —**	**$ —**	$ —	$ —	$ (2)	$ 2
Total impact from special items	**$ (2,850)**	**$ (3,726)**	$ 630	$ 810	$ 686	$ 879

Summarized segment financial information for the years ended December 31 was as follows:

(In millions)	Evernorth	U.S. Medical	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2020						
Revenues from external customers	**$ 112,647**	**$ 36,027**	**$ 5,853**	**$ 4,630**	**$ —**	**$ 159,157**
Inter-segment revenues	**3,655**	**1,977**	**—**	**23**	**(5,655)**	
Net investment income	**32**	**447**	**154**	**611**	**—**	**1,244**
Total revenues	**$ 116,334**	**$ 38,451**	**$ 6,007**	**$ 5,264**	**$ (5,655)**	**$ 160,401**
Net realized investment results from certain equity method investments	**—**	**—**	**(130)**	**—**	**—**	**(130)**
Special item related to contractual adjustment for a former client	**(204)**	**—**	**—**	**—**	**—**	**(204)**
Adjusted revenues	**$ 116,130**	**$ 38,451**	**$ 5,877**	**$ 5,264**	**$ (5,655)**	**$ 160,067**
Depreciation and amortization	**$ 2,248**	**$ 426**	**$ 68**	**$ 35**	**$ 25**	**$ 2,802**
Income (loss) before taxes	**$ 3,684**	**$ 3,956**	**$ 1,048**	**$ 4,514**	**$ (2,334)**	**$ 10,868**
Pre-tax adjustments to reconcile to adjusted income from operations						
(Income) attributable to noncontrolling interests	**(17)**	**—**	**(20)**	**—**	**—**	**(37)**
Net realized investment (gains) losses [1]	**(17)**	**(77)**	**(161)**	**(24)**	**—**	**(279)**
Amortization of acquired intangible assets	**1,917**	**29**	**33**	**3**	**—**	**1,982**
Special items						
Integration and transaction-related costs	**—**	**—**	**—**	**—**	**527**	**527**
Debt extinguishment costs	**—**	**—**	**—**	**—**	**199**	**199**
Charge for organizational efficiency plan	**—**	**—**	**—**	**—**	**31**	**31**
Charges associated with litigation matters	**—**	**—**	**—**	**—**	**25**	**25**
Risk corridors recovery	**—**	**(101)**	**—**	**—**	**—**	**(101)**
Contractual adjustment for a former client	**(204)**	**—**	**—**	**—**	**—**	**(204)**
(Gain) on sale of business	**—**	**—**	**—**	**(4,203)**	**—**	**(4,203)**
Pre-tax adjusted income (loss) from operations	**$ 5,363**	**$ 3,807**	**$ 900**	**$ 290**	**$ (1,552)**	**$ 8,808**

(In millions)	Evernorth	U.S. Medical	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2019						
Revenues from external customers	$ 107,354	$ 34,861	$ 5,500	$ 4,461	$ —	$ 152,176
Inter-segment revenues	2,380	1,180	—	26	(3,586)	
Net investment income (loss)	60	478	159	695	(2)	1,390
Total revenues	$ 109,794	$ 36,519	$ 5,659	$ 5,182	$ (3,588)	$ 153,566
Revenue contribution from transitioning clients	(13,347)	—	—	—	—	(13,347)
Net realized investment results from certain equity method investments	—	—	(44)	—	—	(44)
Adjusted revenues	$ 96,447	$ 36,519	$ 5,615	$ 5,182	$ (3,588)	$ 140,175
Depreciation and amortization	$ 3,071	$ 449	$ 87	$ 41	$ 3	$ 3,651
Income (loss) before taxes	$ 3,983	$ 3,904	$ 785	$ 562	$ (2,664)	$ 6,570
Pre-tax adjustments to reconcile to adjusted income from operations						
Adjustment for transitioning clients	(1,726)	—	—	—	—	(1,726)
(Income) attributable to noncontrolling interests	(4)	—	(16)	—	—	(20)
Net realized investment (gains) losses [1]	—	(112)	(43)	(66)	—	(221)
Amortization of acquired intangible assets	2,839	69	36	5	—	2,949
Special items						
Integration and transaction-related costs	—	—	—	—	552	552
Charge for organizational efficiency plan	—	—	—	—	207	207
Charges associated with litigation matters	—	(30)	—	—	81	51
Pre-tax adjusted income (loss) from operations	$ 5,092	$ 3,831	$ 762	$ 501	$ (1,824)	$ 8,362

(1) Includes the Company's share of certain realized investment gains (losses) of its joint ventures reported using the equity method of accounting.

(In millions)	Evernorth	U.S. Medical	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2018						
Revenues from external customers	$ 5,902	$ 31,759	$ 5,174	$ 4,335	$ —	$ 47,170
Inter-segment revenues	1,154	573	—	14	(1,741)	
Net investment income (loss)	9	459	149	712	151	1,480
Total revenues	$ 7,065	$ 32,791	$ 5,323	$ 5,061	$ (1,590)	$ 48,650
Revenue contributions from transitioning clients	(459)	—	—	—	—	(459)
Net realized investment results from certain equity method investments	—	—	43	—	—	43
Special items reported in integration and transaction-related costs	—	—	—	—	(123)	(123)
Adjusted revenues	$ 6,606	$ 32,791	$ 5,366	$ 5,061	$ (1,713)	$ 48,111
Depreciation and amortization	$ 120	$ 466	$ 55	$ 53	$ 1	$ 695
Income (loss) before taxes	$ 329	$ 3,342	$ 670	$ 497	$ (1,257)	$ 3,581
Pre-tax adjustments to reconcile to adjusted income from operations						
Adjustment for transitioning clients	(62)	—	—	—	—	(62)
(Income) attributable to noncontrolling interests	—	—	(14)	—	—	(14)
Net realized investment (gains) losses [(1)]	—	36	61	25	2	124
Amortization of acquired intangible assets	113	99	18	5	—	235
Special items						
Integration and transaction-related costs	—	—	—	—	852	852
Charges associated with litigation matters	—	25	—	—	—	25
Charges (benefits) associated with tax reform	—	—	—	2	—	2
Pre-tax adjusted income (loss) from operations	$ 380	$ 3,502	$ 735	$ 529	$ (403)	$ 4,743

(1) Includes the Company's share of certain realized investment gains (losses) of its joint ventures reported using the equity method of accounting.

Revenue from external customers includes pharmacy revenues, premiums and fees and other revenues. The following table presents these revenues by product, premium and service type for the years ended December 31:

(In millions)	2020	2019	2018
Products (Pharmacy revenues) (ASC 606)			
Network revenues	**$ 53,574**	$ 50,431	$ 1,415
Home delivery and specialty revenues	**48,792**	47,768	3,997
Other	**5,403**	4,900	67
Total pharmacy revenues	**$ 107,769**	$ 103,099	$ 5,479
Insurance premiums (ASC 944)			
U.S. Medical premiums			
U.S. Commercial			
Health Insurance	**13,389**	12,523	10,710
Stop loss	**4,614**	4,328	4,008
Other	**1,135**	1,040	1,038
U.S. Government			
Medicare Advantage	**7,565**	6,314	5,832
Medicare Part D	**1,593**	1,699	764
Other	**4,301**	4,185	4,496
Total U.S. Medical premiums	**32,597**	30,089	26,848
International Markets premiums	**5,511**	5,266	5,043
Domestic disability, life and accident premiums	**4,423**	4,225	4,000
Other premiums	**96**	134	222
Total premiums	**42,627**	39,714	36,113
Services (ASC 606)			
Fees	**8,532**	9,229	5,558
Other external revenues	**229**	134	20
Total services	**8,761**	9,363	5,578
Total revenues from external customers	**$ 159,157**	$ 152,176	$ 47,170

Foreign and U.S. revenues from external customers for the three years ended December 31 are shown below. The Company's foreign revenues are generated by its foreign operating entities. In the periods shown, no foreign country contributed more than 5% of consolidated revenues from external customers.

(In millions)	2020	2019	2018
United States	**$ 154,042**	$ 147,332	$ 42,773
South Korea	**2,123**	2,022	2,093
All other foreign countries	**2,992**	2,822	2,304
Total	**$ 159,157**	$ 152,176	$ 47,170

Revenues from U.S. Federal Government agencies, under a number of contracts, were 15% of consolidated revenues in 2020, 14% in 2019 and 16% in 2018.

Item 9. ***CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE***

None.

Item 9A. ***CONTROLS AND PROCEDURES***

A. Disclosure Controls and Procedures

Based on an evaluation of the effectiveness of Cigna's disclosure controls and procedures conducted under the supervision and with the participation of Cigna's management (including Cigna's Chief Executive Officer and Chief Financial Officer), Cigna's Chief Executive Officer and Chief Financial Officer concluded that, as of the end of the period covered by this report, Cigna's disclosure controls and procedures are effective to ensure that information required to be disclosed by Cigna in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the Securities and Exchange Commission's rules and forms and is accumulated and communicated to Cigna's management, including Cigna's Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

B. Internal Control Over Financial Reporting

Management's Annual Report on Internal Control over Financial Reporting

Management of Cigna Corporation is responsible for establishing and maintaining adequate internal controls over financial reporting. The Company's internal controls were designed to provide reasonable assurance that the Company's consolidated published financial statements for external purposes were prepared in accordance with accounting principles generally accepted in the United States. The Company's internal control over financial reporting includes those policies and procedures that:

(i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company;
(ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with accounting principles generally accepted in the United States, and that receipts and expenditures of the Company are being made only in accordance with authorization of management and directors of the Company; and
(iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisitions, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements.

Management assessed the effectiveness of the Company's internal controls over financial reporting as of December 31, 2020. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework (2013).* Based on management's assessment and the criteria set forth by COSO, it was determined that the Company's internal controls over financial reporting are effective as of December 31, 2020.

The Company's independent registered public accounting firm, PricewaterhouseCoopers LLP, has audited the effectiveness of the Company's internal control over financial reporting, as stated in their report located in Item 8 of this Form 10-K.

Change in Internal Control over Financial Reporting

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2020 that have materially affected, or are reasonably likely to materially affect, Cigna's internal control over financial reporting.

Item 9B. ***OTHER INFORMATION***

None.

PART III

Item 10. ***DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE***

A. Directors of the Registrant

The information under the captions "Corporate Governance Matters – Board of Directors' Nominees" and "– Board Meetings and Committees" (as it relates to Audit Committee disclosure) in Cigna's definitive proxy statement related to the 2021 annual meeting of shareholders is incorporated herein by reference.

B. Executive Officers of the Registrant

See PART I – "Information about our Executive Officers" in this Form 10-K.

C. Code of Ethics and Other Corporate Governance Disclosures

The information under the caption "Corporate Governance Matters – Codes of Ethics" in Cigna's definitive proxy statement related to the 2021 annual meeting of shareholders is incorporated herein by reference. We intend to promptly disclose on our website, in accordance with applicable rules, any required disclosure of changes to or waivers, if any, of our Code of Ethics or our Director Code of Business Conduct and Ethics.

D. Delinquent Section 16(a) Reports

The information under the caption "Ownership of Cigna Common Stock – Delinquent Section 16(a) Reports", if included in Cigna's definitive proxy statement related to the 2021 annual meeting of shareholders, is incorporated herein by reference.

Item 11. ***EXECUTIVE COMPENSATION***

The information under the captions "Corporate Governance Matters – Non-Employee Director Compensation," "Certain Transactions – Compensation Committee Interlocks and Inside Participation," "Compensation Matters – Compensation Discussion and Analysis," "– Report of the People Resources Committee" and "– Executive Compensation Tables" in Cigna's definitive proxy statement related to the 2021 annual meeting of shareholders is incorporated herein by reference.

Item 12. ***SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS***

The following table presents information regarding Cigna's equity compensation plans as of December 31, 2020:

Plan Category	(a)[1] Securities To Be Issued Upon Exercise Of Outstanding Options, Warrants And Rights	(b)[2] Weighted Average Exercise Price Of Outstanding Options, Warrants And Rights	(c)[3] Securities Remaining Available For Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected In Column (a))
Equity Compensation Plans Approved by Security Holders	**11,725,097**	**$ 152.40**	**23,618,311**
Equity Compensation Plans Not Approved by Security Holders	—	—	—
Total	**11,725,097**	**$ 152.40**	**23,618,311**

(1) Includes, in addition to outstanding stock options:
(i) 82,426 restricted stock units, 122,887 deferred shares and 1,615,392 strategic performance shares that are reported at the maximum 200% payout rate granted under the Cigna Long-Term Incentive Plan, the Corporation Stock Plan and the Cigna Corporation Director Equity Plan; and
(ii) 637,546 shares of common stock underlying stock option awards and 153,959 restricted stock units granted under the Express Scripts Holding Company 2016 Long-Term Incentive Plan, 5,728 deferred shares granted under the Express Scripts, Inc. Executive Deferred Compensation Plan of 2005, 1,327,353 shares of common stock underlying stock option awards granted under the Express Scripts, Inc. 2011 Long-Term Incentive Plan, 1,091,220 shares of common stock underlying stock option awards and 3,300 restricted stock units granted under the Medco Health Solutions, Inc. 2002 Stock Incentive Plan, and 43,737 shares of common stock underlying stock option awards granted under the Accredo Health, Incorporated 2002 Long-Term Incentive Plan that were all approved by the applicable company's shareholders before Cigna's acquisition of Express Scripts in December 2018.

(2) The weighted-average exercise price is based only on outstanding stock options. The outstanding stock options assumed due to Cigna's acquisition of Express Scripts, in aggregate, have a weighted-average exercise price of $143.21. Excluding the assumed options from this acquisition results in a weighted-average exercise price of $156.69.

(3) Includes 213,471 shares of common stock available as of the close of business December 31, 2020 for future issuance under the Cigna Corporation Director Equity Plan, 20,591,667 shares of common stock available as of the close of business on December 31, 2020 for future issuance under the Cigna Long-Term Incentive Plan that includes 10,728,281 shares of common stock available assumed from the Express Scripts, Inc. 2016 Long-Term Incentive Plan, and 2,813,173 shares of common stock available as of the close of business December 31, 2020 for future issuance under the Express Scripts, Inc. Executive Deferred Compensation Plan of 2005. Because no further grants may be made under the Express Scripts, Inc. 2011 Long-Term Incentive Plan, the Medco Health Solutions, Inc. 2002 Stock Incentive Plan and the Accredo Health, Incorporated 2002 Long-Term Incentive Plan, shares available for issuance under these plans are not included.

The information under the captions "Ownership of Cigna Common Stock – Stock Held by Directors, Nominees and Executive Officers" and "Ownership of Cigna Common Stock – Stock Held by Certain Beneficial Owners" in Cigna's definitive proxy statement related to the 2021 annual meeting of shareholders is incorporated herein by reference.

Item 13. ***CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE***

The information under the captions "Corporate Governance Matters – Director Independence" and "– Certain Transactions" in Cigna's definitive proxy statement related to the 2021 annual meeting of shareholders is incorporated herein by reference.

Item 14. ***PRINCIPAL ACCOUNTANT FEES AND SERVICES***

The information under the captions "Audit Matters – Policy for the Pre-Approval of Audit and Non-Audit Services" and "– Fees to Independent Registered Public Accounting Firm" in Cigna's definitive proxy statement related to the 2021 annual meeting of shareholders is incorporated herein by reference.

PART IV

Item 15. ***EXHIBITS AND FINANCIAL STATEMENT SCHEDULES***

(a) (1) The following Financial Statements can be found under Part II Item 8 of this Form 10-K:

Report of Independent Registered Public Accounting Firm.
Consolidated Statements of Income for the years ended December 31, 2020, 2019 and 2018.
Consolidated Statements of Comprehensive Income for the years ended December 31, 2020, 2019 and 2018.
Consolidated Balance Sheets as of December 31, 2020 and 2019.
Consolidated Statements of Changes in Total Equity for the years ended December 31, 2020, 2019 and 2018.
Consolidated Statements of Cash Flows for the years ended December 31, 2020, 2019 and 2018.
Notes to the Consolidated Financial Statements.

(2) The financial statement schedules listed in the Index to Financial Statement Schedules on page FS-1 which list is incorporated herein.

(3) Set forth in this Item 15 is a list of exhibits filed or incorporated by reference as part of this Annual Report on Form 10-K.

(b) The exhibits listed in the accompanying "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K.

(c) The financial statement schedules listed in the Index to Financial Statement Schedules on page FS-1 are filed as part of this Annual Report on Form 10-K.

INDEX TO EXHIBITS

Number	Description	Method of Filing
2.1(a)	Agreement and Plan of Merger, dated as of March 8, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Express Scripts Holding Company, Cigna Holding Company (formerly Cigna Corporation), Halfmoon I, Inc. and Halfmoon II, Inc.	Filed by Cigna Holding Company ("CHC") as Exhibit 2.1 to the Current Report on Form 8-K on March 13, 2018 and incorporated herein by reference.
2.1(b)	Amendment No. 1, dated as of June 27, 2018, to the Agreement and Plan of Merger, dated as of March 8, 2018, by and among Cigna Corporation, Express Scripts Holding Company, Cigna Holding Company, Halfmoon I, Inc. and Halfmoon II, Inc.	Filed by CHC as Exhibit 2.1 to the Current Report on Form 8-K on July 2, 2018 and incorporated herein by reference.
3.1	Amended and Restated Certificate of Incorporation of the registrant as last amended December 20, 2018	Filed by the registrant as Exhibit 3.1 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
3.2	Amended and Restated By-Laws of the registrant as last amended February 26, 2020.	Filed by the registrant as Exhibit 3.1 to the Current Report on Form 8-K on February 27, 2020 and incorporated herein by reference.
4.1(a)	Indenture, dated as of September 17, 2018, between Cigna Corporation (formerly Halfmoon Parent, Inc.) and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on September 21, 2018 and incorporated herein by reference.
4.1(b)	Supplemental Indenture, dated as of September 17, 2018, between Cigna Corporation (formerly Halfmoon Parent, Inc.) and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.2 to the Current Report on Form 8-K on September 21, 2018 and incorporated herein by reference.
4.1(c)	Second Supplemental Indenture dated as of December 20, 2018, by and among Express Scripts Holding Company, Cigna Holding Company and U.S. Bank National Association, as Trustee	Filed by the registrant as Exhibit 4.7 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.1(d)	Third Supplemental Indenture, dated as of October 11, 2019, by and among Cigna Corporation, as the Issuer, Cigna Holding Company and Express Scripts Holding Company, each as guarantors, and U.S. Bank, National Association, as trustee	Filed by the registrant as Exhibit 4.1 to the Current Report on Form 8-K on October 11, 2019 and incorporated herein by reference.
4.1(e)	Fourth Supplemental Indenture, dated as of March 16, 2020, between Cigna Corporation and U.S. Bank, National Association, as trustee	Filed by the registrant as Exhibit 4.1 to the Current Report on Form 8-K on March 16, 2020 and incorporated herein by reference.
4.2	Registration Rights Agreement, dated as of October 11, 2019, by and among Cigna Corporation, as the Issuer, Cigna Holding Company and Express Scripts Holding Company, each as guarantors, and J.P. Morgan Securities LLC, Deutsche Bank Securities Inc., and Wells Fargo Securities, LLC, each as dealer managers	Filed by the registrant as Exhibit 4.2 to the Current Report on Form 8-K on October 11, 2019 and incorporated herein by reference.
4.3(a)	Senior Indenture dated August 16, 2006 between Cigna Holding Company (formerly Cigna Corporation) and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(a) to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
4.3(b)	Supplemental Indenture No. 1 dated November 10, 2006 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(b) to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
4.3(c)	Supplemental Indenture No. 2 dated March 15, 2007 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(c) to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2011 and incorporated herein by reference.
4.3(d)	Supplemental Indenture No. 3 dated March 7, 2008 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on March 10, 2008 and incorporated herein by reference.
4.3(e)	Supplemental Indenture No. 5 dated May 17, 2010 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on May 28, 2010 and incorporated herein by reference.

4.3(f)	Supplemental Indenture No. 6 dated December 8, 2010 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on December 9, 2010 and incorporated herein by reference.
4.3(g)	Supplemental Indenture No. 7 dated March 7, 2011 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on March 8, 2011 and incorporated herein by reference.
4.3(h)	Supplemental Indenture No. 8 dated November 10, 2011 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on November 14, 2011 and incorporated herein by reference.
4.3(i)	Supplemental Indenture No. 9 dated as of March 20, 2015, between Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on March 26, 2015 and incorporated herein by reference.
4.3(j)	Supplemental Indenture No. 10 dated as of September 14, 2017 between Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K filed September 14, 2017 and incorporated herein by reference.
4.3(k)	Supplemental Indenture No. 11 dated as of December 20, 2018, by and among Cigna Corporation, Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by the registrant as Exhibit 4.1 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.3(l)	Supplemental Indenture No. 12, dated as of October 11, 2019, among Cigna Holding Company, as Issuer, Cigna Corporation, as parent guarantor, and U.S. Bank National Association, as trustee	Filed by the registrant as Exhibit 4.3 to the Current Report on Form 8-K on October 11, 2019 and incorporated herein by reference.
4.4(a)	Indenture dated January 1, 1994 between Cigna Holding Company (formerly Cigna Corporation) and Marine Midland Bank	Filed by CHC as Exhibit 4.2 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
4.4(b)	Supplemental Indenture No. 1 dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Cigna Holding Company and HSBC Bank USA, National Association (as successor to Marine Midland Bank, N.A.), as Trustee	Filed by the registrant as Exhibit 4.2 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.4(c)	Supplemental Indenture No. 2, dated as of October 11, 2019, among Cigna Holding Company, as Issuer, Cigna Corporation, as parent guarantor, and HSBC Bank USA, National Association, as trustee	Filed by the registrant as Exhibit 4.4 to the Current Report on Form 8-K on October 11, 2019 and incorporated herein by reference.
4.5(a)	Indenture dated June 30, 1988 between Cigna Holding Company (formerly Cigna Corporation) and Bankers Trust Company	Filed by CHC as Exhibit 4.3 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
4.5(b)	Supplemental Indenture No. 1 dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Cigna Holding Company and Deutsche Bank Trust Company Americas, a New York banking corporation (as successor to Bankers Trust Company), as Trustee	Filed by the registrant as Exhibit 4.3 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.6(a)	Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company (formerly Aristotle Holding, Inc.), the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by Express Scripts, Inc. ("ESI") as Exhibit 4.1 to the Current Report on Form 8-K filed November 25, 2011 and incorporated herein by reference.
4.6(b)	Third Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESI as Exhibit 4.4 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.6(c)	Fourth Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESI as Exhibit 4.5 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.6(d)	Seventh Supplemental Indenture, dated as of February 9, 2012, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee, related to Express Scripts Holding Company's 3.900% senior notes due 2022	Filed by ESI as Exhibit 4.3 to the Current Report on Form 8-K filed February 10, 2012 and incorporated herein by reference.

4.6(e)	Eighth Supplemental Indenture, dated as of April 2, 2012, among Express Scripts, Inc., Express Scripts Holding Company, Medco Health Solutions, Inc., the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by Express Scripts Holding Company ("ESRX") as Exhibit 4.1 to the Current Report on Form 8-K on April 6, 2012 and incorporated herein by reference.
4.6(f)	Eleventh Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(g)	Twelfth Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(h)	Thirteenth Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(i)	Sixteenth Supplemental Indenture, dated as of February 25, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on February 25, 2016 and incorporated herein by reference.
4.6(j)	Seventeenth Supplemental Indenture, dated as of February 25, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on February 25, 2016 and incorporated herein by reference.
4.6(k)	Eighteenth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(l)	Nineteenth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(m)	Twentieth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(n)	Twenty-Second Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(o)	Twenty-Third Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee and Calculation Agent	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(p)	Twenty-Fourth Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(q)	Twenty-Fifth Supplemental Indenture dated as of December 20, 2018, by and among Cigna Corporation, Express Scripts Holding Company and Wells Fargo Bank, National Association, as Trustee	Filed by the registrant as Exhibit 4.4 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.6(r)	Twenty-Sixth Supplemental Indenture, dated as of October 11, 2019, among Express Scripts Holding Company, as Issuer, Cigna Corporation, as parent guarantor, and Wells Fargo Bank, National Association, as trustee	Filed by the registrant as Exhibit 4.5 to the Current Report on Form 8-K on October 11, 2019 and incorporated herein by reference.
4.7(a)	Indenture, dated as of June 9, 2009, among Express Scripts, Inc., the Subsidiary Guarantors party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.1 to the Current Report on Form 8-K on June 10, 2009 and incorporated herein by reference.
4.7(b)	Third Supplemental Indenture, dated as of June 9, 2009, among Express Scripts, Inc., the Subsidiary Guarantors party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.4 to the Current Report on Form 8-K on June 10, 2009 and incorporated herein by reference.

4.7(c)	Seventh Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.6 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.7(d)	Eighth Supplemental Indenture, dated as of April 2, 2012, among Express Scripts, Inc., Express Scripts Holding Company, Medco Health Solutions, Inc., the other subsidiaries of Express Scripts Holding Company party thereto and Union Bank, N.A., as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on April 6, 2012 and incorporated herein by reference.
4.7(e)	Ninth Supplemental Indenture dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Express Scripts, Inc. and MUFG Union Bank, N.A. (as successor to Union Bank, N.A.), as Trustee	Filed by the registrant as Exhibit 4.5 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.8	Description of Securities	Filed herewith

Exhibits 10.1 through 10.37 are identified as compensatory plans, management contracts or arrangements pursuant to Item 15 of Form 10-K.

10.1(a)	Cigna Long-Term Incentive Plan as amended and restated effective as of April 26, 2017 (the "Cigna LTIP")	Filed by the registrant as Exhibit 10.1 to the Current Report on Form 8-K on May 1, 2017 and incorporated herein by reference.
10.1(b)	Amendment No. 1, effective January 25, 2018, to the Cigna LTIP	Filed by CHC as Exhibit 10.3 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2018 and incorporated herein by reference.
10.1(c)	Form of Cigna LTIP: Nonqualified Stock Option and Grant Letter	Filed by CHC as Exhibit 10.21 to Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.1(d)	Form of Cigna LTIP: Nonqualified Stock Option Grant Agreement	Filed by CHC as Exhibit 10.2 to Form 10-Q for the period ended March 31, 2014 and incorporated herein by
10.1(e)	Form of Cigna LTIP: Nonqualified Stock Option Grant Agreement	Filed by CHC as Exhibit 10.3 to Form 10-Q for the period ended March 31, 2015 and incorporated herein by
10.1(f)	Form of Cigna LTIP: Nonqualified Stock Option Grant Agreement	Filed by CHC as Exhibit 10.3 to Form 10-Q for the period ended March 31, 2017 and incorporated herein by reference.
10.1(g)	Form of Cigna LTIP: Strategic Performance Share Grant Agreement	Filed by CHC as Exhibit 10.4 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.1(h)	Form of Cigna LTIP: Restricted Stock Grant Agreement	Filed by CHC as Exhibit 10.6 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference
10.1(i)	Form of Cigna LTIP: Nonqualified Stock Option Grant Agreement	Filed by CHC as Exhibit 10.5 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.1(j)	Form of Cigna LTIP: Strategic Performance Share Grant Agreement	Filed by the registrant as Exhibit 10.1 to Quarterly Report on Form 10-Q for the period ended March 31, 2019 and incorporated herein by reference.
10.1(k)	Form of Cigna LTIP: Nonqualified Stock Option Grant Agreement	Filed by the registrant as Exhibit 10.2 to Quarterly Report on Form 10-Q for the period ended March 31, 2019 and incorporated herein by reference.

10.1(l)	Form of Cigna LTIP: Restricted Stock Grant Agreement	Filed by the registrant as Exhibit 10.3 to Quarterly Report on Form 10-Q for the period ended March 31, 2019 and incorporated herein by reference.
10.1(m)	Form of Cigna LTIP: Strategic Performance Share Grant Agreement	Filed by the registrant as Exhibit 10.1 to Quarterly Report on Form 10-Q for the period ended March 31, 2020 and incorporated herein by reference.
10.1(n)	Form of Cigna LTIP: Nonqualified Stock Option Grant Agreement	Filed by the registrant as Exhibit 10.2 to Quarterly Report on Form 10-Q for the period ended March 31, 2020 and incorporated herein by reference.
10.1(o)	Form of Cigna LTIP: Restricted Stock Grant Agreement	Filed by the registrant as Exhibit 10.3 to Quarterly Report on Form 10-Q for the period ended March 31, 2020 and incorporated herein by reference.
10.1(p)	Form of Cigna LTIP: Covenant Agreement	Filed by the registrant as Exhibit 10.5 to Quarterly Report on Form 10-Q for the period ended March 31, 2020 and incorporated herein by reference.
10.2	Cigna Corporation Stock Plan, as amended through July 2000	Filed by CHC as Exhibit 10.7 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.3	Cigna Stock Unit Plan, as amended and restated effective February 22, 2017	Filed by CHC as Exhibit 10.5 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2017 and incorporated herein by reference.
10.4(a)	Express Scripts Holding Company 2016 Long-Term Incentive Plan (the "ESRX LTIP")	Filed by ESRX as Appendix A to ESRX's Definitive Proxy Statement on Schedule 14A for its 2016 Annual Meeting of Stockholders, filed March 21, 2016 and incorporated herein by reference.
10.4(b)	Form of Stock Option Grant Notice for Non-Employee Directors used with respect to grants of stock options by Express Scripts Holding Company to non-employee directors under the ESRX LTIP	Filed by ESRX as Exhibit 10.4 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.4(c)	Form of Restricted Stock Unit Grant Notice used with respect to grants of restricted stock units by Express Scripts Holding Company under the ESRX LTIP	Filed by ESRX as Exhibit 10.5 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.4(d)	Form of Stock Option Grant Notice used with respect to grants of stock options by Express Scripts Holding Company under the ESRX LTIP	Filed by ESRX as Exhibit 10.7 to Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.5(a)	Express Scripts, Inc. 2011 Long-Term Incentive Plan (as amended and restated effective April 2, 2012) (the "ESI LTIP")	Filed by the registrant as Exhibit 4.10 to the Registration Statement on Form S-8 (No. 333- 228930) on December 20, 2018 and incorporated herein by reference.
10.5(b)	Form of Stock Option Grant Notice for Non-Employee Directors used with respect to grants of stock options by Express Scripts Holding Company under the ESI LTIP	Filed by ESRX as Exhibit 10.6 to Quarterly Report on Form 10-Q for the quarter ended June 30, 2012 and incorporated herein by reference.
10.5(c)	Form of Stock Option Grant Notice used with respect to certain grants of stock options by Express Scripts Holding Company prior to 2013 under the ESI LTIP	Filed by ESRX as Exhibit 10.14 to the Current Report on Form 8-K on April 2, 2012 and incorporated herein by reference.
10.5(d)	Form of Stock Option Grant Notice used with respect to grants of stock options by Express Scripts Holding Company under the ESI LTIP	Filed by ESRX as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarter ended March 31, 2013 and incorporated herein by reference.

10.6(a)	Medco Health Solutions, Inc. 2002 Stock Incentive Plan (as amended and restated effective April 2, 2012).	Filed by the registrant as Exhibit 4.11 to the Registration Statement on Form S-8 (No. 333- 228930) on December 20, 2018 and incorporated herein by reference.
10.6(b)	Form of terms and conditions for director stock option and restricted stock unit awards	Filed by Medco as Exhibit 10.2 to the Current Report on Form 8-K on February 8, 2005 and incorporated herein by reference.
10.7	Accredo Health, Incorporated 2002 Long-Term Incentive Plan	Filed by the registrant as Exhibit 4.12 to the Registration Statement on Form S-8 (No. 333- 228930) on December 20, 2018 and incorporated herein by reference.
10.8	Deferred Compensation Plan for Directors of Cigna Corporation, as amended and restated January 1, 1997	Filed by CHC as Exhibit 10.1 the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.9	Cigna Deferred Compensation Plan, as amended and restated October 24, 2001	Filed by CHC as Exhibit 10.14 to the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.10	Cigna Deferred Compensation Plan of 2005 effective as of January 1, 2005	Filed by the registrant as Exhibit 4.6 to the Registration Statement on Form S-8 (No. 333- 228930) on December 20, 2018 and incorporated herein by reference.
10.11	Express Scripts, Inc. Amended and Restated Executive Deferred Compensation Plan (effective December 31, 2004 and grandfathered for the purposes of Section 409A of the Code)	Filed by ESI as Exhibit No. 10.1 to the Current Report on Form 8-K on May 25, 2007 and incorporated herein by reference.
10.12(a)	Express Scripts, Inc. Executive Deferred Compensation Plan of 2005 (as amended and restated effective December 20, 2018)	Filed by the registrant as Exhibit 4.13 to the Registration Statement on Form S-8 (No. 333- 228930) on December 20, 2018 and incorporated herein by reference.
10.12(b)	Amendment No. 1 to the Express Scripts, Inc. Executive Deferred Compensation Plan of 2005	Filed by the registrant as Exhibit 10.12(b) to the Annual Report on Form 10-K for the year ended December 31, 2019 and incorporated herein by reference.
10.13(a)	Cigna Supplemental Pension Plan as amended and restated effective August 1, 1998	Filed by CHC as Exhibit 10.15(a) to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.13(b)	Amendment No. 1 to the Cigna Supplemental Pension Plan, amended and restated effective as of September 1, 1999	Filed by CHC as Exhibit 10.15(b) to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.13(c)	Amendment No. 2 dated December 6, 2000 to the Cigna Supplemental Pension	Filed by CHC as Exhibit 10.16(c) to the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.14(a)	Cigna Supplemental Pension Plan of 2005 effective as of January 1, 2005	Filed by CHC as Exhibit 10.15 to the Annual Report on Form 10-K for the year ended December 31, 2007 and incorporated herein by reference.
10.14(b)	Amendment No. 1 to the Cigna Supplemental Pension Plan of 2005	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2009 and incorporated herein by reference.
10.15(a)	Cigna Supplemental 401(k) Plan effective January 1, 2010	Filed by the registrant as Exhibit 4.7 to the Registration Statement on Form S-8 (No. 333- 228930) on December 20, 2018 and incorporated herein by reference.

10.15(b)	Amendment No. 1 to the Cigna Supplemental 401(k) Plan	Filed by the registrant as Exhibit 10.15(b) to the Annual Report on Form 10-K for the year ended December 31, 2019 and incorporated herein by reference.
10.15(c)	Amendment No. 2 to the Cigna Supplemental 401(k) Plan	Filed by the registrant as Exhibit 10.15(c) to the Annual Report on Form 10-K for the year ended December 31, 2019 and incorporated herein by reference.
10.15(d)	Amendment No. 3 to the Cigna Supplemental 401(k) Plan	Filed by the registrant as Exhibit 10.15(d) to the Annual Report on Form 10-K for the year ended December 31, 2019 and incorporated herein by reference.
10.16	Cigna Corporation Non-Employee Director Compensation Program amended and restated effective February 26, 2014	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2014 and incorporated herein by reference.
10.17	Cigna Corporation Non-Employee Director Compensation Program, amended and restated effective January 1, 2019	Filed by the registrant as Exhibit 10.18 to the Annual Report on Form 10-K for the year ended December 31, 2018 and incorporated herein by reference.
10.18	Cigna Corporation Director Equity Plan, as amended December 4, 2020	Filed herewith.
10.19	Cigna Restricted Share Equivalent Plan for Non-Employee Directors as amended and restated effective January 1, 2008	Filed by CHC as Exhibit 10.4 to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
10.20	Deferred Compensation Plan of 2005 for Directors of Cigna Corporation, Amended and Restated effective April 28, 2010	Filed by the registrant as Exhibit 4.8 to the Registration Statement on Form S-8 (No. 333- 228930) on December 20, 2018 and incorporated herein by reference.
10.21	Form of Indemnification Agreement with Express Scripts Holding Company's executive officers and former members of the Express Scripts Holding Company's board of directors	Filed by ESRX as Exhibit 10.1 to the Current Report on Form 8-K on March 5, 2014 and incorporated herein by reference.
10.22	Cigna Executive Severance Benefits Plan as amended and restated effective December 21, 2020	Filed by the registrant as Exhibit 10.1 to the Current Report on Form 8-K on October 30, 2020 and incorporated herein by reference.
10.23	Description of Severance Benefits for Executives in Non-Change of Control Circumstances	Filed by CHC as Exhibit 10.10 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.24	Cigna Executive Incentive Plan amended and restated as of January 1, 2012	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2012 and incorporated herein by reference.
10.25	Description of Cigna Corporation Financial Services Program	Filed by CHC as Exhibit 10.18 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.26	Offer Letter for Eric P. Palmer dated June 16, 2017	Filed by CHC as Exhibit 10.1 to the Current Report on Form 8-K on June 19, 2017 and incorporated herein by reference.
10.27	Nicole Jones' Offer of Employment dated April 27, 2011	Filed by CHC as Exhibit 10.2 to the Quarterly Report on Form 10-Q for the period ended March 31, 2012 and incorporated herein by reference.

10.28	Employment Agreement for Jason D. Sadler dated May 7, 2010	Filed by CHC as Exhibit 10.1(a) to the Quarterly Report on Form 10-Q for the period ended March 31, 2015 and incorporated herein by reference.
10.29	Promotion letter for Jason Sadler dated June 2, 2014	Filed by CHC as Exhibit 10.1(b) to the Quarterly Report on Form 10-Q for the period ended March 31, 2015 and incorporated herein by reference.
10.30	Retention Agreement by and between Cigna Corporation and Mr. Timothy Wentworth, dated as of May 12, 2018.	Filed by the registrant as Exhibit 10.1 to Amendment No. 1 to the Registration Statement on Form S-4 (No. 333-224960) on June 20, 2018 and incorporated herein by reference.
10.31	Express Scripts Holding Company Executive Employment Agreement with Timothy Wentworth dated May 4, 2016	Filed by ESRX as Exhibit 10.1 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.32	Schedule regarding Amended Deferred Stock Unit Agreements effective December 31, 2008 with John M. Murabito and Form of Amended Deferred Stock Unit Agreement	Filed by CHC as Exhibit 10.20 to the Annual Report on Form 10-K for the year ended December 31, 2008 and incorporated herein by reference.
10.33	Retention Agreement between the Cigna Corporation and Steven B. Miller dated October 9, 2018	Filed by the registrant as Exhibit 10.34 to the Annual Report on Form 10-K for the year ended December 31, 2018 and incorporated herein by reference.
10.34	Agreement and Release between the Company and Matthew G. Manders dated October 16, 2017	Filed by CHC as Exhibit 10.1 to the Current Report on Form 8-K on October 18, 2017 and incorporated herein by reference.
10.35	Offer letter for Eric Palmer dated December 6, 2020	Filed herewith.
10.36	Offer letter for Matthew Manders dated December 6, 2020	Filed herewith.
10.37	Offer letter for Brian Evanko dated December 6, 2020	Filed herewith.
10.38	Revolving Credit and Letter of Credit Agreement, dated as of April 6, 2018	Filed by CHC as Exhibit 10.1 to Current Report on Form 8-K on April 12, 2018 and incorporated herein by reference.
10.39	Master Transaction Agreement, dated February 4, 2013 among Connecticut General Life Insurance Company, Berkshire Hathaway Life Insurance Company of Nebraska and, solely for purposes of Sections 3.10, 6.1, 6.3, 6.4, 6.6, 6.9 and Articles II, V, VII and VIII, thereof, National Indemnity Company (including the Forms of Retrocession Agreement, the Collateral Trust Agreement, the Security and Control Agreement, the Surety Policy and the ALC Model Purchase Option Agreement as exhibits)	Filed by CHC as Exhibit 10.29 to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
21	Subsidiaries of the Registrant	Filed herewith.
23	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Certification of Chief Executive Officer of Cigna Corporation pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934	Filed herewith.
31.2	Certification of Chief Financial Officer of Cigna Corporation pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934	Filed herewith.
32.1	Certification of Chief Executive Officer of Cigna Corporation pursuant to Rule 13a-14(b) or Rule 15d-14(b) and 18 U.S.C. Section 1350	Furnished herewith.
32.2	Certification of Chief Financial Officer of Cigna Corporation pursuant to Rule 13a-14(b) or Rule 15d-14(b) and 18 U.S.C. Section 1350	Furnished herewith.

101	The following materials from Cigna Corporation's Annual Report on Form 10-K for the year ended December 31, 2020, formatted in inline XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Changes in Total Equity; (vi) the Notes to Consolidated Financial Statements; and (vii) Financial Statement Schedules I and II.	Filed herewith.
104	Cover Page Interactive Data File (formatted as inline XBRL and contained in Exhibit 101)	Filed herewith.

The agreements and other documents filed as exhibits to this report are not intended to provide factual information or other disclosure other than the terms of the agreements or other documents themselves, and you should not rely on them for that purpose. In particular, any representations and warranties made by the Company in these agreements or other documents were made solely within the specific context of the relevant agreement or document and may not describe the actual state of affairs at the date they were made or at any other time.

Item 16. ***FORM 10-K SUMMARY***

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: February 25, 2021

CIGNA CORPORATION

By: /s/ Brian C. Evanko
Brian C. Evanko
Executive Vice President and
Chief Financial Officer
(Principal Financial Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated as of February 25, 2021.

Signature	**Title**
/s/ David M. Cordani David M. Cordani	Chief Executive Officer and Director (Principal Executive Officer)
/s/ Brian C. Evanko Brian C. Evanko	Executive Vice President and Chief Financial Officer (Principal Financial Officer)
/s/ Mary T. Agoglia Hoeltzel Mary T. Agoglia Hoeltzel	Senior Vice President, Tax and Chief Accounting Officer (Principal Accounting Officer)
/s/ William J. DeLaney William J. DeLaney	Director
/s/ Eric J. Foss Eric J. Foss	Director
/s/ Elder Granger, M.D. Elder Granger, M.D.	Director
/s/ Isaiah Harris, Jr. Isaiah Harris, Jr.	Chairman of the Board

/s/ Kathleen M. Mazzarella Kathleen M. Mazzarella	Director
/s/ Mark McClellan, M.D. Mark McClellan, M.D.	Director
/s/ John M. Partridge John M. Partridge	Director
/s/ William L. Roper, M.D. William L. Roper, M.D.	Director
/s/ Kimberly A. Ross Kimberly A. Ross	Director
/s/ Eric C. Wiseman Eric C. Wiseman	Director
/s/ Donna F. Zarcone Donna F. Zarcone	Director

CIGNA CORPORATION AND SUBSIDIARIES

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Schedules other than those listed above are omitted because they are not required or are not applicable, or the required information is shown in the financial statements or notes thereto.

Report of Independent Registered Public Accounting Firm on Financial Statement Schedules

To the Board of Directors and Shareholders of Cigna Corporation

Our audits of the consolidated financial statements referred to in our report dated February 25, 2021 (which report and consolidated financial statements are included under Item 8 in this Annual Report on Form 10-K) also included an audit of the financial statement schedules listed on page FS-1 in Item 15 of this Form 10-K. In our opinion, these financial statement schedules present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements.

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 25, 2021

CIGNA CORPORATION AND SUBSIDIARIES

SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF CIGNA CORPORATION
(REGISTRANT)
STATEMENTS OF INCOME

	For the years ended December 31,		
(in millions)	**Cigna 2020**	**Cigna 2019**	**Cigna 2018**
Revenues			
Net investment income	**$ 1**	$ —	$ 123
Intercompany interest income	**475**	6	—
Total revenues	**476**	6	123
Operating expenses			
Selling, general and administrative expenses	**4**	(85)	200
Total operating expenses	**4**	(85)	200
Income (loss) from operations	**472**	91	(77)
Interest and other (expense)	**(1,324)**	(1,032)	(244)
Intercompany interest (expense)	**(48)**	(127)	(5)
Debt extinguishment costs	**(171)**	—	—
Realized investment (loss)	**—**	—	(1)
Loss before taxes	**(1,071)**	(1,068)	(327)
Income tax (benefit)	**(234)**	(251)	(74)
Loss of Parent Company	**(837)**	(817)	(253)
Equity in income of subsidiaries	**9,295**	5,921	2,890
Shareholders' net income	**8,458**	5,104	2,637
Shareholders' other comprehensive income (loss), net of tax			
Net unrealized appreciation (depreciation) on securities and derivatives	**(75)**	957	(365)
Net translation (losses) gains of foreign currencies	**260**	(54)	(152)
Postretirement benefits liability adjustment	**(105)**	(133)	127
Shareholders' other comprehensive income (loss), net of tax	**80**	770	(390)
Shareholders' comprehensive income	**$ 8,538**	$ 5,874	$ 2,247

See Notes to Financial Statements on the following pages.

CIGNA CORPORATION AND SUBSIDIARIES

SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF CIGNA CORPORATION
(REGISTRANT)
BALANCE SHEETS

(in millions)	As of December 31, 2020	2019
Assets		
Cash and cash equivalents	**$ 4,157**	$ —
Short-term investments	**49**	30
Other current assets	**4**	4
Total current assets	**4,210**	34
Intercompany receivable	**1,666**	4,111
Investments in subsidiaries	**76,040**	77,380
Other noncurrent assets	**22**	19
TOTAL ASSETS	**$ 81,938**	$ 81,544
Liabilities		
Short-term debt	**$ 3,278**	$ 4,043
Other current liabilities	**616**	457
Total current liabilities	**3,894**	4,500
Intercompany payable	**5**	2,341
Long-term debt	**27,718**	29,365
TOTAL LIABILITIES	**31,617**	36,206
Shareholders' Equity		
Common stock (shares issued, 390 and 386; authorized, 600)	**4**	4
Additional paid-in capital	**28,975**	28,306
Accumulated other comprehensive loss	**(861)**	(941)
Retained earnings	**28,575**	20,162
Less treasury stock, at cost	**(6,372)**	(2,193)
TOTAL SHAREHOLDERS' EQUITY	**50,321**	45,338
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	**$ 81,938**	$ 81,544

See Notes to Financial Statements on the following pages.

CIGNA CORPORATION AND SUBSIDIARIES

SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF CIGNA CORPORATION
(REGISTRANT)
STATEMENTS OF CASH FLOWS

(in millions)	For the years ended December 31, Cigna 2020	Cigna 2019	Cigna 2018
Cash Flows from Operating Activities			
Shareholders' net income	**$ 8,458**	$ 5,104	$ 2,637
Adjustments to reconcile shareholders' net income to net cash provided by operating activities			
Equity in income of subsidiaries	**(9,295)**	(5,921)	(2,890)
Debt extinguishment costs	**171**	—	—
Dividends received from subsidiaries	**8,627**	2,457	—
Other liabilities	**112**	43	412
Other, net	**500**	20	(14)
NET CASH PROVIDED BY OPERATING ACTIVITIES	**8,573**	1,703	145
Cash Flows from Investing Activities			
Net change in loans due to (from) affiliates	**(265)**	**—**	—
Short-term investment purchased, net	**(19)**	(30)	—
Other, net	**—**	**—**	(27,115)
NET CASH (USED IN) INVESTING ACTIVITIES	**(284)**	**(30)**	**(27,115)**
Cash Flows from Financing Activities			
Net change in amounts due to affiliates	**2,262**	2,015	4,437
Proceeds on issuance of commercial paper	**86**	944	—
Payments for debt extinguishment	**(181)**	—	—
Repayment of long-term debt	**(5,996)**	(3,002)	—
Net proceeds on issuance of long-term debt	**3,465**	—	22,856
Issuance of common stock	**376**	224	1
Common dividends paid	**(15)**	(15)	—
Repurchase of common stock	**(4,042)**	(1,987)	(32)
Tax withholding on stock compensation and other	**(87)**	(82)	(49)
Other	**—**	**(13)**	—
NET CASH (USED IN) PROVIDED BY FINANCING ACTIVITIES	**(4,132)**	**(1,916)**	**27,213**
Net increase (decrease) in cash and cash equivalents	**4,157**	(243)	243
Cash and cash equivalents, beginning of year	**—**	243	—
Cash and cash equivalents, end of year	**4,157**	—	243

See Notes to Financial Statements on the following pages.

CIGNA CORPORATION AND SUBSIDIARIES

SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF CIGNA CORPORATION
(REGISTRANT)

NOTES TO CONDENSED FINANCIAL STATEMENTS

The accompanying condensed financial statements should be read in conjunction with the Consolidated Financial Statements and the accompanying notes thereto contained in this Annual Report on Form 10-K ("Form 10-K").

Note 1 — Cigna Holding Company (formerly Cigna Corporation) was incorporated in Delaware in 1981. Halfmoon Parent, Inc. was incorporated in Delaware in March 2018. Halfmoon Parent, Inc. was renamed Cigna Corporation and Cigna Holding Company became its subsidiary concurrent with the consummation of the combination with Express Scripts on December 20, 2018.

For purposes of these condensed financial statements, Cigna Corporation's (the "Company") wholly-owned and majority-owned subsidiaries are recorded using the equity method of accounting.

Note 2 — See Note 7 – Debt included in Part II, Item 8 of this Form 10-K for a description of the short-term and long-term debt obligations of Cigna Corporation and its subsidiaries.

Debt Issuance and Redemption. In order to decrease future interest expense and reduce future refinancing risk, the Company entered into the following transactions during 2020:

- Debt issuance: On March 16, 2020, the Company issued $3.5 billion of new senior notes. The proceeds of this issuance were mainly used to pay the consideration for the cash tender and redemption offer as described below. Interest on this debt is paid semi-annually.

Principal	Maturity Date	Interest Rate	Net Proceeds
$1,500 million	March 15, 2030	2.4%	$1,491 million
$750 million	March 15, 2040	3.2%	$743 million
$1,250 million	March 15, 2050	3.4%	$1,237 million

- Debt tender and redemption: In March and April 2020, the Company completed a tender offer and an optional redemption totaling $2.9 billion of aggregate principal amount of certain of its outstanding debt securities. The principal amount repurchased in this tender offer was $1.3 billion. Additionally, $1.6 billion of notes were repurchased via optional redemption. The Company recorded a pre-tax loss of $171 million ($124 million after-tax), consisting primarily of premium payments on the tender and optional redemption.

Debt Exchange. In the fourth quarter of 2019, the Company settled an exchange of approximately $12.7 billion of Notes issued by Express Scripts Holding Company, Medco Health Solutions, Inc. and Cigna Holding Company for privately placed Notes issued by Cigna with the same interest rates and maturities and comparable other terms. We initiated an exchange offer to register such debt in the second quarter of 2020 and completed the exchange in July 2020.

Debt Repayment. In 2020, the Company repaid $6.0 billion of long-term debt, including the $2.9 billion debt tender and redemption described above. On December 31, 2020 Cigna issued a notice of full redemption to the holders of Cigna's Senior Floating Rate Notes due 2021 (the "Notes") pursuant to which Cigna redeemed the entire $1.0 billion aggregate principal amount of the Notes outstanding on January 15, 2021 at a redemption price calculated in accordance with the terms and conditions of the indenture governing the Notes.

Revolving Credit Agreements. Cigna has a revolving credit and letter of credit agreement that matures in April 2023 and is diversified among 23 banks. Cigna can borrow up to $3.25 billion for general corporate purposes, with up to $500 million available for issuance of letters of credit. This revolving credit agreement also includes an option to increase the facility amount up to $500 million and an option to extend the termination date for additional one-year periods, subject to consent of the banks.

Additionally, Cigna has a 364-day $1.0 billion revolving credit agreement that will mature in October 2021. The agreement replaces the $1.0 billion 364-day revolving credit agreement that expired in October 2020. The agreement is diversified among 23 banks. Pursuant to this revolving credit agreement, Cigna can borrow up to $1.0 billion for general corporate purposes. The agreement includes the option to "term out" any revolving loans that are outstanding at maturity by converting them into a term loan maturing on the one year anniversary of conversion.

The revolving credit agreements contain customary covenants and restrictions including a financial covenant that the Company's leverage ratio may not exceed 60%. As of December 31, 2020, there were no outstanding balances under the revolving credit agreements.

Term Loan Credit Agreement. On April 1, 2020, the Company borrowed an aggregate principal amount of $1.4 billion under a new 364-Day Term Loan Credit Agreement. In connection with the sale of the Group Life and Disability business, on December 31, 2020 we repaid the entire $1.4 billion balance outstanding.

Commercial Paper. Under our commercial paper program we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time not to exceed $4.25 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The commercial paper program had approximately $1.0 billion outstanding at December 31, 2020 at an average interest rate of 0.2%.

The Company was in compliance with its debt covenants as of December 31, 2020.

Maturity of the Company's long-term debt is as follows:

(in millions)		
2021	$	2,250
2022	$	1,378
2023	$	3,754
2024	$	714
2025	$	2,957
Maturities after 2025	$	19,182

Note 3 — Intercompany receivables of the Company consist primarily of net amounts due from Express Scripts Holdings of $1.4 billion (consisting of an $8.2 billion receivable offset by a $6.8 billion payable) as of December 31, 2020 and $3.9 billion (consisting of an $8.2 billion receivable offset by a $4.3 billion payable) as of December 31, 2019. Interest income on the receivable was accrued at an annual fixed rate of 5.50%. Interest expense on the payable was accrued at an average rate of 0.97% in 2020.

Note 4 — The Company had guarantees of approximately $87 million as of December 31, 2020. These guarantees are primarily related to outstanding letters of credit. In 2020, no payments have been made on these guarantees.

CIGNA CORPORATION AND SUBSIDIARIES

SCHEDULE II
VALUATION AND QUALIFYING ACCOUNTS AND RESERVES

(in millions) **Description**	**Balance at beginning of year**	**Charged (Credited) to costs and expenses**	**Charged (Credited) to other accounts**	**Other deductions**	**Balance at end of year**
2020					
Investment asset valuation reserves					
Available-for-sale debt securities	**$ —**	**$ 82**	**$ —**	**$ (56)**	**$ 26**
Accounts receivable, net	**$ 252**	**$ (50)**	**$ (12)**	**$ (34)**	**$ 156**
Deferred tax asset valuation allowance	**$ 196**	**$ 10**	**$ 1**	**$ —**	**$ 207**
Reinsurance recoverables [1]	**$ 2**	**$ (1)**	**$ 31**	**$ —**	**$ 32**
2019					
Accounts receivable, net	$ 217	$ 51	$ —	$ (16)	$ 252
Deferred tax asset valuation allowance	$ 199	$ (6)	$ 3	$ —	$ 196
Reinsurance recoverables	$ 2	$ —	$ —	$ —	$ 2
2018					
Accounts receivable, net	$ 207	$ 18	$ (3)	$ (5)	$ 217
Deferred tax asset valuation allowance [2]	$ 72	$ (5)	$ 132	$ —	$ 199
Reinsurance recoverables	$ 3	$ (1)	$ —	$ —	$ 2

(1) The Company recorded an additional allowance of $31 million on January 1, 2020 upon the adoption of ASU 2016-13
(2) Deferred tax valuation allowance amount includes amount assumed from Express Scripts in 2018.

DESCRIPTION OF THE REGISTRANT'S SECURITIES REGISTERED
PURSUANT TO SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934

The following is a summary of the material terms of the Common Stock, par value $0.01 per share of Cigna Corporation ("Cigna" or the "Company"). This summary is not complete and is qualified by *Cigna's amended and restated certificate of incorporation, which we refer to as the certificate of incorporation, and Cigna's amended and restated bylaws, which we refer to as the bylaws, each of which is incorporated by reference as an exhibit to the Annual Report on Form 10-K of which this Exhibit is a part, and the applicable provisions of the General Corporation Law of the State of Delaware, which we refer to as the DGCL.*

Authorized Capital Stock

The aggregate number of shares which Cigna has the authority to issue is (1) 600,000,000 shares of Cigna common stock, par value $0.01 per share, and (2) 25,000,000 shares of Cigna preferred stock, par value $1.00 per share. The board of directors is expressly authorized to provide for the issue of all or any shares of the preferred stock, in one or more series, and to fix for each such series such voting powers, full or limited, or no voting powers, and such designations, preferences and relative, participating, optional or other special rights and such qualifications, limitations or restrictions thereof.

As of the date of the Annual Report of which this Exhibit is a part, no shares of Cigna preferred stock are outstanding.

Common Stock

Holders of Cigna common stock will be entitled to receive dividends when, as and if declared by Cigna's board of directors out of funds legally available for payment. If Cigna issues preferred stock in the future, payment of dividends to holders of Cigna common stock may be subject to the rights of holders of Cigna preferred stock with respect to payment of preferential dividends, if any.

Subject to the rights, if any, of the holders of any series of preferred stock if and when issued and subject to applicable law, each holder of Cigna common stock is entitled to one vote per share and all voting rights are vested in the Cigna common stock. Holders of shares of Cigna common stock have noncumulative voting rights, which means that the holders of more than 50% of the shares voting for the election of directors can elect 100% of the directors and the holders of the remaining shares are not able to elect any directors.

In the event of a voluntary or involuntary liquidation, dissolution or winding up of Cigna, the holders of Cigna common stock will be entitled to share equally in any of the assets available for distribution after Cigna has paid in full all of its debts and after the holders of all series of outstanding Cigna preferred stock, if any, have received their liquidation preferences in full.

The shares of Cigna common stock outstanding are validly issued, fully paid and nonassessable. Holders of shares of Cigna common stock are not entitled to preemptive rights. Shares of Cigna common stock are not convertible into shares of any other class of capital stock.

Transfer Agent and Registrar

Computershare Inc. is the transfer agent for the Cigna common stock. Cigna may from time to time engage another transfer agent for its stock as business circumstances warrant.

Listing

Cigna's common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "CI."

Preferred Stock

Under the Cigna certificate of incorporation, without further stockholder action, the Cigna board of directors is authorized to provide, by resolution of the Cigna board of directors, for the issuance of all or any shares Cigna preferred stock in one or more series, and to fix the voting powers, designations, preferences and relative, participating, optional or other special rights and such qualifications, limitations or restrictions of such series including, without limitation, the authority to provide that any such series may be (1) subject to redemption at such time or times and at such price or prices; (2) entitled to receive dividends (which may be cumulative or non-cumulative) at such rates, on such conditions, and at such times, and payable in preference to, or in such relation to, the dividends payable on any other class or any other series; (3) entitled to such rights upon the dissolution of, or upon any distribution of the assets of, Cigna; or (4) convertible into, or exchangeable for, shares of any other class of stock, or of any other series of the same or any other class of stock, of Cigna at such price or prices or at such rates of exchange and with such adjustments.

Number and Election of Directors

The Cigna board of directors must consist of no less than eight and no more than sixteen directors. The number of directors may be fixed, from time to time, by the affirmative vote of a majority of the entire board of directors. Any decrease in the number of directors will be effective at the time of the next succeeding annual meeting of stockholders unless there will be vacancies in the board of directors, in which case such decrease may become effective at any time prior to the next succeeding annual meeting to the extent of the number of such vacancies.

A nominee for director is elected to the board of directors if the votes cast for election exceed the votes cast against; however, if the number of director nominees exceeds the number of directors to be elected, which we refer to as a contested election, directors are elected by a plurality of the votes. Stockholders cannot vote against a nominee in a contested election. A contested election will be deemed to exist at any meeting of stockholders for which (1) the Corporate Secretary of receives a notice that a stockholder has nominated a person for election to the board of directors in compliance with the bylaws and (2) such nomination has not been withdrawn by such stockholder on or prior to the day next preceding the date Cigna first mails its notice of meeting for such meeting to the stockholders.

Vacancies on the Board of Directors and Removal of Directors

The bylaws of Cigna provide that, any vacancy in the board of directors may be filled by the majority vote of the directors then in office (even if less than quorum) or by the sole remaining director. Each director so elected will hold office for a term expiring at the next annual meeting of stockholders and will hold office until his or her successor will have been elected and qualified, or until death, or until such director will have resigned, or will have been removed, as provided in the bylaws.

Any director may be removed, with or without cause, at any time, by a majority of the voting power of the issued and outstanding capital stock of Cigna entitled to vote at an election for directors. Neither the certificate of incorporation nor the bylaws of Cigna authorize the Cigna board of directors to remove any members of the Cigna board of directors.

Amendments to Certificates of Incorporation

The certificate of incorporation grants Cigna the right to amend, alter, change or repeal any provision in the Cigna certificate of incorporation in the manner prescribed by statute. Under Section 242 of the DGCL, unless the certificate of incorporation requires a greater vote, a proposed amendment to the certificate of incorporation must be approved by the affirmative vote of a majority of the voting power of the outstanding stock entitled to vote thereon and a majority of the outstanding stock of each class entitled to vote as a class.

Amendments to Bylaws

The Cigna bylaws may be adopted, amended or repealed by majority vote of the capital stock of Cigna outstanding and entitled to vote thereon, or by the Cigna board of directors without any vote of the stockholders.

Ability to Call Special Meeting of Stockholders

Special meetings of Cigna stockholders, unless otherwise prescribed by statute, may be called at any time by the board of directors or the Chief Executive Officer or may be called by the Corporate Secretary upon the valid request of one or more shareholders that have net long beneficial ownership (as defined in the bylaws) for a period of at least one full year prior to the date of the request, of capital stock of Cigna representing at least 25% of the voting power of the issued and outstanding capital stock of Cigna entitled to vote on the matters to be presented at the special meeting. The right to call a special meeting is subject to specified information, timing and other requirements as set forth in the bylaws. .At any special meeting of the stockholders, only such business will be conducted as will have been brought before the meeting by or at the direction of the board of directors or pursuant to valid request by shareholders.

Notice Required for Stockholder Nominations and other Proposals

Nominations: A stockholder's notice must be received by the Corporate Secretary at the principal executive offices of Cigna not less than 90 days nor more than 120 days prior to the first anniversary of the date of the preceding year's annual meeting of stockholder; provided, however, that in the event that the annual meeting of stockholder is more than 30 days before or 60 days after such anniversary date or if no such meeting was held in the preceding year, notice by a stockholder will be timely only if received (1) not earlier than 120 days prior to such annual meeting and (2) not less than 90 days before such annual meeting or, if later, within 10 days after the first public announcement of the date of such annual meeting. In no event will any adjournment or postponement of an annual meeting or the announcement thereof commence a new time period (or extend any time period) for the giving of a stockholder's notice as described above.

Other Proposals: A stockholder's notice pursuant to this section must be delivered to or mailed and received by the Corporate Secretary at the principal executive offices of Cigna, not less than 90 days nor more than 120 days prior to the first anniversary of the date of the preceding year's annual meeting of stockholder; provided, however, that in the event that the annual meeting of stockholder is more than 30 days before or 60 days after such anniversary date or if no such meeting was held in the preceding year, notice by a stockholder will be timely only if received (1) not earlier than 120 days prior to such annual meeting and (2) not less than 90 days before such annual meeting or, if later, within 10 days after the first public announcement of the date of such annual meeting. In no event will any adjournment or postponement of an annual meeting or the announcement thereof commence a new time period (or extend any time period) for the giving of a stockholder's notice as described above.

Proxy Access

The Cigna bylaws provide that if the board of directors solicits proxies with respect to the election of directors of Cigna at an annual meeting, a stockholder or a group of up to 20 stockholders owning 3% or more of the aggregate number of shares of Cigna's outstanding common stock continuously for at least three years is permitted to nominate and include in Cigna's proxy materials director nominees constituting up to the greater of 20% of the board of directors or two individuals, provided the stockholder(s) and the nominee(s) satisfy the requirements specified in the bylaws, including by providing Cigna with advance notice of the nomination.

Notice must be addressed to and received by the Corporate Secretary not less than 120 days nor more than 150 days prior to the first anniversary of the date on which Cigna's definitive proxy statement was released to stockholders in connection with the prior year's annual meeting; provided, however, that if the annual meeting is convened more than 30 days prior to or delayed by more than 60 days after the first anniversary of the date of the preceding year's annual meeting, the information must be so received not earlier than 120 days prior to such annual meeting and not later than the close of business on the later of (1) the 90th day prior to such annual

meeting or (2) the 10th day following the day on which a public announcement of the date of the annual meeting is first made.

State Anti-Takeover Statutes

Cigna has elected not to be governed by Section 203 of the DGCL, which provisions generally prohibit "business combinations," including mergers, sales and leases of assets, issuances of securities and similar transactions by a corporation or a subsidiary with an interested stockholder who beneficially owns 15% or more of a corporation's voting stock within three years after the person or entity becomes an interested stockholder, unless: (1) the board of directors of the target corporation has approved, before the acquisition time, either the business combination or the transaction that resulted in the person becoming an interested stockholder; (2) upon consummation of the transaction that resulted in the person becoming an interested stockholder, the person owns at least 85% of the corporation's voting stock (excluding shares owned by directors who are officers and shares owned by employee stock plans in which participants do not have the right to determine confidentially whether shares will be tendered in a tender or exchange offer); or (3) after the person or entity becomes an interested stockholder, the business combination is approved by the board of directors and authorized by the vote of at least 66 2/3% of the outstanding voting stock not owned by the interested stockholder at an annual or special meeting.

Transactions Involving Officers or Directors

Section 143 of the DGCL provides that a corporation may lend money to, or guarantee any obligation incurred by, its officers or directors if, in the judgment of the board of directors, the loan or guarantee may reasonably be expected to benefit the corporation. Section 144 of the DGCL provides that any other contract or transaction between the corporation and one or more of its directors or officers is neither void nor voidable solely because the interested director or officer was present, participates or votes at the board of directors or board committee meeting that authorizes the contract or transaction, if either: (1) the director's or officer's interest is made known to the disinterested directors or the stockholders of the corporation, who thereafter approve the transaction in good faith; or (2) the contract or transaction is fair to the corporation as of the time it is approved or ratified by either the board of directors, a committee thereof, or the stockholders.

Exclusive Forum

The Cigna bylaws provide that, unless Cigna consents in writing to the selection of an alternative forum, the sole and exclusive forum for (1) any derivative action or proceeding brought on behalf of Cigna, (2) any action asserting a claim for or based on a breach of a fiduciary duty owed by any current or former director or officer or other employee of Cigna to Cigna or Cigna's stockholders, including a claim alleging the aiding and abetting of such a breach of fiduciary duty, (3) any action asserting a claim against Cigna or any current or former director or officer or other employee of Cigna arising pursuant to any provision of the DGCL or the certificate of incorporation or the bylaws, (4) any action asserting a claim related to or involving Cigna that is governed by the internal affairs doctrine, or (5) any action asserting an "internal corporate claim" as that term is defined in Section 115 of the DGCL will be a state court in Delaware (or, if no state court located within Delaware has jurisdiction, the federal district court for the District of Delaware).

Limitation of Personal Liability of Directors and Officers

The DGCL provides that the certificate of incorporation of Cigna may include provisions which limits or eliminates personal liability of directors to the corporation or its stockholders for monetary damages for breach of fiduciary duty as a director, provided that such liability does not arise from (1) any breach of the director's duty of loyalty to Cigna or its stockholders; (2) acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law; (3) unlawful payments of dividends, certain stock repurchases or redemptions; or (4) any transaction from which the director derived an improper personal benefit. The certificate of incorporation of Cigna limits director liability to the extent permitted by the DGCL.

Indemnification of Directors and Officers

The Cigna bylaws provide that Cigna will indemnify each person who was or is made a party or is threatened to be made a party to or is otherwise involved in any action, suit or proceeding, whether civil, criminal, administrative or investigative, which we refer to as a proceeding, because he or she (1) is or was a director or an officer of Cigna or (2) is or was serving at the request of Cigna as a director, officer, employee, agent, partner or trustee of another company or of a partnership, joint venture, trust or other enterprise, including service with respect to an employee benefit plan (we refer to the persons in clauses (1) and (2) hereinafter each as an indemnitee), to the fullest extent permitted by Delaware law, against all expense, liability and loss (including attorneys' fees, judgments, fines, ERISA excise taxes or penalties and amounts paid in settlement) reasonably incurred or suffered by such indemnitee in connection therewith. However, except with respect to proceedings to enforce rights to indemnification, Cigna will indemnify any such indemnitee in connection with a proceeding (or part thereof) initiated by such indemnitee only if such proceeding (or part thereof) was authorized by the Cigna board of directors.

Cigna may, to the extent authorized from time to time by the Cigna board of directors, grant rights to indemnification and to the advancement of expenses to any employee or agent of Cigna to the fullest extent of indemnification and advancement of expenses of directors and officers of Cigna.

CIGNA CORPORATION DIRECTORS EQUITY PLAN
(As Amended December 4, 2020)

Article 1. Establishment and Purposes

1.1 Purpose. The Cigna Corporation Directors Equity Plan (the "Plan") is intended to (a) encourage ownership of the Company's common stock by members of the Board of Directors of the Company (the "Board") who are not employees or officers of the Company and thereby align such directors' interests more closely with the interests of the shareholders of the Company, and (b) enhance the Company's ability to attract and retain directors of outstanding competence.

1.2 Establishment. Cigna Corporation has adopted this Cigna Corporation Directors Equity Plan, effective as of January 1, 2010 (the "Effective Date").

Article 2. Definitions

Whenever used herein, the following terms shall have the meanings set forth below, and, when the defined meaning is intended, the term is capitalized:

2.1 "Administrator" means the Committee or any subcommittee authorized to administer the Plan pursuant to Section 3.1 below.

2.2 "Award" means any Shares, Deferred Stock Units, Restricted Stock, Restricted Stock Units or Stock Options granted to a Participant pursuant to the provisions of the Plan. Stock Options granted pursuant to the Plan do not qualify as incentive stock options under Section 422 of the Code.

2.3 "**Award Agreement**" means a written or electronic document or agreement setting forth the terms and conditions of a specific Award. An Award Agreement (including any amendment thereto) may be in the form of an agreement to be executed by both the Participant and the Company (or an authorized representative of the Company) or terms, certificates, program documents, notices or similar instruments as approved and designated as being an Award Agreement (or amendment or portion thereof) by the Administrator.

2.4 "Board Fees" means annual retainer fees payable to a Director at such rate as shall be established by the Board from time to time for serving as a member of the Board and, if and to the extent provided by the Administrator, may include fees payable to a Director for serving as Board chair or vice-chair and/or as chair, vice-chair or member of a committee of the Board.

2.5 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.6 "Committee" means the Corporate Governance Committee of the Board.

2.7 "Common Stock" means the common stock, par value $0.01 per share, of the Company.

2.8 "Company" means Cigna Corporation, a Delaware corporation, and any successors or companies into which Cigna Corporation may merge.

2.9 "Deferred Compensation Plan" means the Deferred Compensation Plan of 2005 for Directors of Cigna Corporation (effective January 1, 2005), or any successor plan.

2.10 "Deferred Stock Unit" or **"DSU"** means a unit that represents a right to receive one Share, or a cash payment equal to the Fair Market Value of one Share.

2.11 "Director" means a member of the Board who is neither an employee nor an officer of the Company.

2.12 "Equity Grant" means an award of Common Stock or Deferred Stock Units.

2.13 "Exchange Act" means the Securities Exchange Act of 1934, as amended.

2.14 "Fair Market Value" means, unless the Administrator provides otherwise, as of any date, the closing price of a share of Common Stock as reported on the Composite Tape (or any method of publishing stock prices determined by the Administrator) as of the close of the regular trading session on the New York Stock Exchange. If the Composite Tape (or any alternative source) is not published on that date, the determination will be made on the next preceding date of publication. In the absence of reported Common Stock sales, the Administrator will determine Fair Market Value by taking into account all facts and circumstances the Administrator deems relevant, subject to the requirements of Code Section 409A.

2.15 "Participant" means any person who is eligible for an Award under the Plan in consideration for his or her service as a Director.

2.16 "Restricted Stock" means an award of Shares made under the Plan, the grant, issuance, retention, vesting and/or transferability of which is subject to such conditions as are expressed in an Award Agreement.

2.17 "Restricted Stock Unit" or **"RSU"** means an award granted to a Participant pursuant to which Shares or cash in lieu thereof may be issued in the future on such terms and conditions as are specified in or determined pursuant to an Award Agreement.

2.18 "Share" means a share of Common Stock, subject to adjustment as provided in Section 7.2.

2.19 "Stock Option" means a right granted under the Plan to purchase a number of Shares at such exercise price, at such times, and on such other terms and conditions as are specified in or determined pursuant to an Award Agreement.

2.20 "Year" means a calendar year.

Article 3. Administration

3.1 Administrator of the Plan. The Plan shall be administered by the Committee. Subject to the terms of the Plan, the Committee may appoint a subcommittee, composed of one or more directors of the Company, and may delegate to any such subcommittee all or any of the authority of the Administrator as set forth in Section 3.2 and to take all or any other actions determined appropriate to administer the Plan or any aspect of it. Any action by any such subcommittee within the scope of such

delegation shall be deemed for all purposes to have been taken by the Committee. Notwithstanding any provision of the Plan, the Board may at any time limit the authority of the Committee or any subcommittee to administer the Plan.

3.2 Authority of the Administrator. Subject to the express provisions of the Plan and the delegation of any responsibilities by the Board, the Administrator shall be authorized and empowered to do all things necessary or desirable in connection with the administration of the Plan, including, without limitation: (a) to prescribe, amend and waive rules relating to the Plan and to define terms not otherwise defined herein; (b) to establish the terms and conditions of Awards made under the Plan and to prescribe the form of documentation used to evidence any Awards hereunder; (c) to establish and verify the extent of satisfaction of any conditions to receipt or vesting of Awards; (d) to determine whether, and the extent to which, adjustments are required pursuant to Section 7.2 hereof; (e) to interpret and construe the Plan, any rules and regulations under the Plan and the terms and conditions of any Awards hereunder, and to make exceptions to any procedural provisions in good faith and for the benefit of the Company; (f) to amend (subject to the provisions of Section 9.1 herein) the terms and conditions of the Plan, any Awards and any agreement entered into under the Plan; and (g) to make other determinations which may be necessary or advisable for the administration of the Plan.

3.3 Decisions Binding. All decisions, determinations and interpretations by the Board or the Administrator, any rules and regulations under the Plan or the terms and conditions of any Awards hereunder, including questions of construction and interpretation, shall be final, conclusive, and binding on all persons claiming benefits under the Plan and shall be given the maximum possible deference allowed by law. The Board and the Administrator may consider such factors as it deems relevant, in its sole and absolute discretion, in making such decisions, determinations and interpretations including, without limitation, the recommendations or advice of any officer or other employee of the Company and such attorneys, consultants and accountants as it may select.

Article 4. Participation

4.1 Participation. Any person who is a Director shall be eligible to receive Awards under the Plan.

Article 5. Deferred Stock Units; Equity Grants in Lieu of Cash Board Fees

5.1 Deferred Stock Units. DSUs represent an unfunded and unsecured obligation of the Company, except as otherwise provided for by the Administrator, with each DSU being a bookkeeping entry representing an amount equivalent to one Share. DSUs may be granted at any time and from time to time prior to the termination of the Plan to Participants as determined by the Administrator. Each award of DSUs shall be evidenced by an Award Agreement. Subject to such terms and conditions as the Administrator may establish, a DSU may be settled through the delivery of a Share or through the payment in cash of an amount equal to the Fair Market Value of a Share as of the date for which the amount of such payment is determined, as established by the Administrator.

5.2 Payment of Board Fees in Equity. Subject to such terms and conditions as may be established from time to time by the Administrator, including without limitation any minimum standards or requirements for participation established by the Administrator, a Director may receive Equity Grants in lieu of all or a portion of the cash Board Fees otherwise payable to such Director each Year (or, if applicable, any portion thereof) for his or her service as a Director. The number of Shares subject to any

Equity Grant made pursuant to this Section 5.2 shall be determined by dividing the amount of Board Fees to be paid or awarded in the form of Equity Grants, as determined by the Administrator or elected by the Director, by the Fair Market Value of a Share as of the date such Equity Grant is made. The date on which Equity Grants are made shall be determined by or pursuant to rules established by the Administrator.

5.3 Settlement of Outstanding DSUs. Subject to such terms and conditions as the Administrator may establish, a Director may elect to have his or her outstanding DSUs granted or credited prior to 2010 (including any dividend equivalents thereon) in respect of Board Fees treated as Awards for purposes of this Plan and distributed in Shares.

5.4 Voting Rights. Participants who receive Awards under this Article 5 shall have no voting rights with respect to Shares of Common Stock or Shares underlying DSUs and dividend equivalents unless and until such Shares are reflected as issued and outstanding shares on the Company's stock ledger.

5.5 Dividend Equivalents. Unless provided otherwise by the Administrator, any DSUs awarded under this Article 5 and any Shares awarded under this Article 5, the receipt of which is deferred pursuant to a Deferred Compensation Plan, as well as any dividend equivalent Shares accrued pursuant to this Section 5.5, shall until paid or distributed to a Participant accrue dividend equivalent Shares. Dividend equivalent Shares represent the right to receive additional Shares and shall be credited as of the dividend payment date for Shares. Unless otherwise provided by the Administrator or, if allowed, elected by a Participant, Shares shall be issued in payment and satisfaction of dividend equivalents on the date that the Equity Grants as to which such dividend equivalents accrued are paid or distributed.

5.6 Deferral Opportunity. The Administrator may permit deferrals of awards under this Plan in accordance with such terms and conditions as it specifies. Any deferral election shall be made in accordance with, and subject to the terms and conditions set forth in, the Deferred Compensation Plan.

Article 6. Other Awards

6.1 Restricted Stock

(a) Restricted Stock Award. Restricted Stock may be granted at any time and from time to time prior to the termination of the Plan to Participants as determined by the Administrator. Each award of Restricted Stock shall be evidenced by an Award Agreement.

(b) Award Agreement. Each Award Agreement evidencing an award of Restricted Stock shall contain provisions regarding (a) the number of Shares subject to such award of Restricted Stock or a formula for determining such, (b) the purchase price of the Shares, if any, and the means of payments, (c) the length of the restrictive period over which the Restricted Stock shall vest or may ratably vest, if any, (d) forfeiture provisions, if any, (e) restrictions on the transferability of the Shares, if any, and (f) such further terms and conditions, in each case not inconsistent with the Plan as may be determined from time to time by the Administrator. Shares subject to any Restricted Stock award shall not be transferable within less than one (1) year from the date of grant, except upon such separation of service events as specified by the Administrator. Shares issued under an award of Restricted Stock may be issued in the name of the Participant and held by the Participant or held by the Company, in each case as the Administrator may provide.

(c) Voting Rights. Unless otherwise determined by the Administrator, Participants holding shares of Restricted Stock granted hereunder may exercise full voting rights with respect to those shares during the period of restrictions.

(d) Dividends and Distributions. Participants in whose name Restricted Stock is granted shall be entitled to receive all dividends and other distributions paid with respect to those Shares, unless determined otherwise by the Administrator. The Administrator will determine whether any such dividends or distributions will be automatically reinvested in additional shares of Restricted Stock and subject to the same restrictions on transferability as the Restricted Stock with respect to which they were distributed or whether such dividends or distributions will be paid in cash and whether such cash payments will be made currently or deferred.

6.2 Restricted Stock Units

(a) **RSU Award.** RSUs may be granted at any time and from time to time prior to the termination of the Plan to Participants as determined by the Administrator. Each grant of RSUs shall be evidenced by an Award Agreement.

(b) **Award Agreement.** Each Award Agreement evidencing an award of RSUs shall contain provisions regarding (a) the number of RSUs subject to such award or a formula for determining such, (b) the purchase price of the Shares, if any, and the means of payments, (c) the length of the restrictive period over which the RSUs shall vest or may ratably vest, if any, (d) forfeiture provisions, if any, (e) restrictions on the transferability of the RSUs, and (f) such further terms and conditions, in each case not inconsistent with the Plan as may be determined from time to time by the Administrator. No shares shall be issued or cash paid in settlement of an RSU within less than one (1) year from the date of grant, except upon such separation of service events as specified by the Administrator.

(c) **Bookkeeping Entry.** A RSU is a bookkeeping entry representing an amount equivalent to one Share. RSUs represent an unfunded and unsecured obligation of the Company, except as otherwise provided for by the Administrator. Subject to such terms and conditions as the Administrator may establish, a RSU may be settled through the delivery of a Share or through the payment in cash of an amount equal to the Fair Market Value of a Share as of the date for which the amount of such payment is determined, as established by the Administrator.

(d) **Voting Rights.** Participants shall have no voting rights with respect to Shares underlying RSUs unless and until such Shares are reflected as issued and outstanding shares on the Company's stock ledger.

(e) Dividend Equivalents. Participants who are granted RSUs shall be entitled to dividend equivalents only to the extent provided by the Administrator. The Administrator will determine whether any such dividend equivalents will be automatically reinvested in additional RSUs and subject to the same terms and conditions as the RSUs with respect to which they were distributed or whether such dividend equivalents will be paid in cash and whether such cash payments will be made currently or deferred.

6.3 Stock Options

(a) Stock Option Awards. Stock Options may be granted at any time and from time to time prior to the termination of the Plan to Participants as determined by the Administrator. No

Participant shall have any rights as a shareholder with respect to any Shares subject to a Stock Option hereunder until said Shares have been issued. Each Stock Option shall be evidenced by an Award Agreement.

(b) Award Agreement. Each Award Agreement evidencing a Stock Option shall contain provisions regarding (a) the number of Shares which may be issued upon exercise of the Stock Option, (b) the exercise price of the Shares and the means of payment for the Shares, (c) the term of the Stock Option, (d) such terms and conditions of exercisability as may be determined from time to time by the Administrator, (e) restrictions on the transfer of the Stock Option and forfeiture provisions, and (f) such further terms and conditions, in each case not inconsistent with the Plan, as may be determined from time to time by the Administrator.

(c) Stock Option Price. The exercise price per share of the Shares subject to each Stock Option granted under the Plan shall equal or exceed 100 percent (100%) of the Fair Market Value of such Shares on the date the Stock Option is granted.

(d) Minimum Vesting. No Stock Option shall be exercisable within less than one (1) year from the date of grant, except upon such separation of service events as specified by the Administrator.

(e) Stock Option Term. The "Term" of each Stock Option granted under the Plan shall not exceed ten (10) years from the date of its grant.

(f) Stock Option Exercise

(1) ***Partial Exercise.*** An exercisable Stock Option may be exercised in whole or in part. However, a Stock Option shall not be exercisable with respect to fractional Shares and the Administrator may require, by the terms of the applicable Award Agreement, a partial exercise to include a minimum number of Shares.

(2) ***Manner of Exercise***. All or a portion of an exercisable Stock Option shall be deemed exercised upon delivery to the representative of the Company designated for such purpose by the Administrator all of the following: (i) notice of exercise in such form as the Administrator authorizes specifying the number of Shares to be purchased by the Participant, (ii) payment or provision for payment of the exercise price for such number of Shares, (iii) such representations and documents as the Administrator, in its sole discretion, deems necessary or advisable to effect compliance with all applicable provisions of the Securities Act of 1933, as amended, and any other federal, state or foreign securities laws or regulations, and (iv) such other representations and documents as the Administrator, in its sole discretion, deems necessary or advisable. Unless provided otherwise by the Administrator, no Participant shall have any right as a shareholder with respect to any Shares purchased pursuant to any Stock Option until the registration of Shares in the name of such person, and no adjustment shall be made for dividends (ordinary or extraordinary, whether in cash, securities or other property) or distributions or other rights for which the record date is prior to the date such Shares are so registered.

(3) ***Payment of Exercise Price.*** To the extent authorized by the Administrator, the exercise price of a Stock Option may be paid in the form of one of more of the following, either through the terms of the applicable Award Agreement or at the time of exercise of a Stock Option: (i) cash or certified or cashiers' check, (ii) Shares that have been held by the Participant for such period of time as the Administrator may specify, (iii) other property deemed acceptable by the

Administrator, (iv) a reduction in the number of Shares or other property otherwise issuable pursuant to such Stock Option, or (v) any combination of (i) through (iv).

(g) No Repricing; No Automatic Option Grants (Reloads). Without prior approval of stockholders, the Administrator may not:

(1) Cancel a previously granted Stock Option in exchange for cash or a replacement Award with a lower (or no) exercise price;

(2) Provide for any automatic grant of a new Stock Option upon a Participant's exercise of any Stock Option granted under the Plan; or

(3) Amend a Stock Option to lower the exercise price, except for adjustments required or otherwise made under Article 7.2, or take any other action that could constitute a repricing.

Article 7. Shares Subject to the Plan

7.1 Number of Shares. Subject to adjustment as provided in this Article 7, the aggregate number of Shares issued pursuant to the Plan shall not exceed an aggregate of 500,000 shares of Common Stock. The aggregate number of Shares issued under the Plan at any time shall equal the number of Shares actually issued upon grant or settlement of an Award and pursuant to dividend equivalents, less any Shares retained or returned to the Company upon cash settlement, cancellation, expiration or forfeiture of an Award or from dividend equivalents and less any Shares retained by or delivered to the Company by or on behalf of a Participant (either actually or by attestation) in payment or satisfaction of any purchase price or tax obligation respecting an Award. Shares may be issued from authorized but unissued shares or out of shares held in the Company's treasury, or both.

7.2 Adjustment and Changes in Shares. If the outstanding securities of the class then subject to the Plan are increased, decreased or exchanged for or converted into cash, property or a different number or kind of shares or securities, or if cash, property or shares or securities are distributed in respect of such outstanding securities, in either case as a result of a reorganization, reclassification, dividend (other than a regular, periodic cash dividend) or other distribution, stock split, reverse stock split, spin-off or the like, then the maximum number and type of shares or other securities that may be issued under the Plan and that are subject to outstanding Awards (including awards of Common Stock the receipt of which has been deferred) shall be appropriately adjusted. The Administrator shall determine in its sole discretion the appropriate adjustment to be effected pursuant to the immediately preceding sentence and in doing so shall take into account the provisions of any applicable Award Agreement. In addition, in connection with any such change in the class of securities then subject to the Plan, the Administrator shall make equitable adjustments in the number and type of shares or other securities or cash or other property that may be acquired pursuant to stock options and stock grants theretofore awarded under the Plan and the exercise price of such stock options or price, if any, of such stock grants; however no adjustment to an option shall be made in a manner that will be treated under Code Section 409A as the grant of a new option.

Article 8. Term of the Plan

Unless earlier suspended or terminated by the Board, no Award may be initially awarded after the date of the Company's 2021 Annual Meeting of Shareholders.

Article 9. Miscellaneous

9.1 Amendment and Termination. The Board or the Committee may from time to time amend the Plan; provided, however, that no amendment may without shareholder approval (a) materially increase the benefits accruing to participants under the Plan, (b) materially increase the number of shares of Common Stock which may be issued under the Plan, or (c) materially modify the requirements as to eligibility for participation in the Plan. In addition, except for an amendment adopted pursuant to Section 9.6, no amendment or alteration to the Plan shall be made which would in any material manner adversely affect any Participant's rights to any Award or Shares theretofore accrued or granted to him or her hereunder, without the consent of the Participant.

9.2 Compliance with Securities Laws, Listing Requirements, and Other Laws and Obligations. The Company shall not be obligated to deliver any shares of Common Stock under the Plan, (a) until, in the opinion of the Company's counsel, all applicable federal and state laws and regulations have been complied with, (b) if the outstanding Common Stock is at the time listed on any stock exchange, or quoted on any automated quotation system, until the shares to be delivered have been listed or authorized to be listed or quoted on such exchange or system upon official notice of issuance, and (c) until all other legal matters in connection with the issuance and delivery of such shares have been approved by the Company's counsel. If the sale of Common Stock has not been registered under the Securities Act of 1933, as amended, the Company may require, as a condition to the payment of Common Stock, such representations or agreements as counsel for the Company may consider appropriate to avoid violation of such Act and may require that the certificates evidencing such Stock bear an appropriate legend restricting transfer. In addition, the Company may, in its discretion, withhold a portion of the Shares that otherwise would be issued under the Plan to a Participant or make other such arrangements as it determines appropriate to satisfy Federal, state and local withholding tax requirements, if any.

9.3 Successors. All obligations of the Company under the Plan shall be binding on any successor to the Company, whether the existence of such successor is the result of a direct or indirect purchase, merger, consolidation, or otherwise, of all or substantially all of the business and/or assets of the Company.

9.4 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Delaware without regard to Delaware conflict of laws rules, to the extent not preempted by federal law, which shall otherwise control.

9.5 Severability. In the event any provision of the Plan shall be held illegal or invalid for any reason, the illegality or invalidity shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the illegal or invalid provision had not been included.

9.6 Compliance with Code Section 409A. To the extent that a benefit under the Plan is subject to the requirements of Code Section 409A, it is intended that the Plan, as applied to that benefit, comply with the requirements of Code Section 409A, and the Plan shall be so administered and interpreted. The Administrator may make any changes required to conform the Plan and any option agreements or other grants with applicable Code provisions and regulations relating to deferral of compensation under Code Section 409A.

David M. Cordani
President and CEO



Routing W2SLT
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.7482
Facsimile 860.226.3099

December 6, 2020

Eric P. Palmer

Dear Eric:

I am pleased to offer the following compensation package in connection with your assumption of the role of President, Chief Operating Officer, Evernorth, reporting to Tim Wentworth, effective January 1, 2021, subject to your written acceptance below:

- **Base Salary** – will increase to a pre-tax annualized rate of **$950,000**.
- **Annual Incentive** – your annual target will increase to **$950,000** for the 2021 performance year.
- **Long-Term Incentive** – your annual long-term incentive target will increase to **$4,300,000** for the 2021 annual grant.

NEW TOTAL ANNUAL COMPENSATION OPPORTUNITY: $6,200,000

The changes above have no impact on previously awarded bonuses, stock options, or SPS grants. As an executive of the company, your compensation will be subject to any future program changes.

Eric, I look forward to continuing to partner with you.

Sincerely,

/s/ David M. Cordani

David M. Cordani

cc: K. Gorodetzer
J. Murabito

Please indicate your acceptance of our offer by signing below and returning a copy to me no later than Tuesday, December 8, 2020.

Acceptance: /s/ Eric P. Palmer

Date: December 8, 2020

Exhibit 10.36

David M. Cordani
President and CEO

Routing W2SLT
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.7482
Facsimile 860.226.3099

December 6, 2020

Matthew Manders

Dear Matt:

I am pleased to offer the following compensation package in connection with your assumption of the role of President, Government Business and Enterprise Solutions, reporting to me, effective January 1, 2021, subject to your written acceptance below:

- **Base Salary** – will increase to a pre-tax annualized rate of **$1,000,000**.
- **Annual Incentive** – your annual target will increase to **$1,250,000** for the 2021 performance year.
- **Long-Term Incentive** – your annual long-term incentive target will increase to **$4,250,000** for the 2021 annual grant.

NEW TOTAL ANNUAL COMPENSATION OPPORTUNITY: $6,500,000

The changes above have no impact on previously awarded bonuses, stock options, or SPS grants. As an executive of the company, your compensation will be subject to any future program changes.

Matt, I look forward to continuing to partner with you.

Sincerely,

/s/ David M. Cordani

David M. Cordani

cc: K. Gorodetzer
J. Murabito

Please indicate your acceptance of our offer by signing below and returning a copy to me no later than Tuesday, December 8, 2020.

Acceptance: /s/ Matthew Manders

Date: December 8, 2020

David M. Cordani
President and CEO



Routing W2SLT

900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.7482
Facsimile 860.226.3099

December 6, 2020

Brian Evanko

Dear Brian:

I am pleased to offer the following compensation package in connection with your assumption of the role of EVP & Chief Financial Officer, reporting to me, effective January 1, 2021, subject to your written acceptance below:

- **Base Salary** – will increase to a pre-tax annualized rate of **$800,000**.
- **Annual Incentive** – your annual target will increase to **$900,000** for the 2021 performance year.
- **Long-Term Incentive** – your annual long-term incentive target will increase to **$2,800,000** for the 2021 annual grant.

NEW TOTAL ANNUAL COMPENSATION OPPORTUNITY: $4,500,000

The changes above have no impact on previously awarded bonuses, stock options, or SPS grants. As an executive of the company, your compensation will be subject to any future program changes.

Brian, I look forward to continuing to partner with you.

Sincerely,

/s/ David M. Cordani

David M. Cordani

cc: K. Gorodetzer
J. Murabito

Please indicate your acceptance of our offer by signing below and returning a copy to me no later than Tuesday, December 8, 2020.

Acceptance: /s/ Brian Evanko

Date: December 8, 2020

Exhibit 21 – Subsidiaries of the Registrant

Listed below are subsidiaries of Cigna Corporation as of December 31, 2020 with their jurisdictions of organization. Those subsidiaries not listed would not, in the aggregate, constitute a "significant subsidiary" of Cigna Corporation, as that term is defined in Rule 1-02(w) of Regulation S-X.

Entity Name	Jurisdiction
Accredo Health Group, Inc.	Delaware
Accredo Health, Incorporated	Delaware
Allegiance Life & Health Insurance Company	Montana
American Retirement Life Insurance Company	Ohio
Bravo Health Mid-Atlantic, Inc.	Maryland
Bravo Health Pennsylvania, Inc.	Pennsylvania
Care Continuum, Inc.	Kentucky
CareCore National, LLC	New York
CareCore NJ, LLC	New Jersey
Chiro Alliance Corporation	Florida
Cigna & CMB Life Insurance Company Limited	China
Cigna Arbor Life Insurance Company	Connecticut
Cigna Brokerage & Marketing (Thailand) Limited	Thailand
Cigna Dental Health Of California, Inc.	California
Cigna Dental Health Of Colorado, Inc.	Colorado
Cigna Dental Health Of Delaware, Inc.	Delaware
Cigna Dental Health Of Florida, Inc.	Florida
Cigna Dental Health of Illinois, Inc.	Illinois
Cigna Dental Health Of Kansas, Inc.	Kansas
Cigna Dental Health Of Kentucky, Inc.	Kentucky
Cigna Dental Health Of Maryland, Inc.	Maryland
Cigna Dental Health Of Missouri, Inc.	Missouri
Cigna Dental Health Of New Jersey, Inc.	New Jersey
Cigna Dental Health Of North Carolina, Inc.	North Carolina
Cigna Dental Health Of Ohio, Inc.	Ohio
Cigna Dental Health Of Pennsylvania, Inc.	Pennsylvania
Cigna Dental Health Of Texas, Inc.	Texas
Cigna Dental Health Of Virginia, Inc.	Virginia
Cigna Dental Health Plan Of Arizona, Inc.	Arizona
Cigna Europe Insurance Company S.A.-N.V.	Belgium
Cigna Global Insurance Company Limited	Guernsey
Cigna Global Reinsurance Company, Ltd.	Bermuda
Cigna Health and Life Insurance Company	Connecticut
Cigna HealthCare Mid-Atlantic, Inc.	Maryland
Cigna HealthCare of Arizona, Inc.	Arizona
Cigna HealthCare of California, Inc.	California

Cigna HealthCare of Colorado, Inc.	Colorado
Cigna HealthCare of Connecticut, Inc.	Connecticut
Cigna HealthCare of Florida, Inc.	Florida
Cigna HealthCare of Georgia, Inc.	Georgia
Cigna HealthCare of Illinois, Inc.	Illinois
Cigna HealthCare of Indiana, Inc.	Indiana
Cigna HealthCare of Maine, Inc.	Maine
Cigna HealthCare of Massachusetts, Inc.	Massachusetts
Cigna HealthCare of New Hampshire, Inc.	New Hampshire
Cigna HealthCare of New Jersey, Inc.	New Jersey
Cigna HealthCare of North Carolina, Inc.	North Carolina
Cigna HealthCare of Pennsylvania, Inc.	Pennsylvania
Cigna HealthCare of South Carolina, Inc.	South Carolina
Cigna HealthCare of St. Louis, Inc.	Missouri
Cigna HealthCare of Tennessee, Inc.	Tennessee
Cigna HealthCare of Texas, Inc.	Texas
Cigna HealthCare of Utah, Inc.	Utah
Cigna Holding Company	Delaware
Cigna Holdings, Inc.	Delaware
Cigna Insurance Middle East S.A.L.	Lebanon
Cigna Insurance Public Company Limited	Thailand
Cigna Insurance Services (Europe) Limited	United Kingdom
Cigna Life Insurance Company of Canada	Canada
Cigna Life Insurance Company of Europe S.A.-N.V.	Belgium
Cigna Life Insurance New Zealand Limited	New Zealand
Cigna National Health Insurance Company	Ohio
Cigna Saglik Hayat ve Emeklilik A.S.	Turkey
Cigna Taiwan Life Assurance Company Limited	Taiwan
Cigna Worldwide Life Insurance Company Limited	Hong Kong
Connecticut General Corporation	Connecticut
Connecticut General Life Insurance Company	Connecticut
CuraScript, Inc.	Delaware
ESI Mail Pharmacy Service, Inc.	Delaware
Evernorth Health, Inc.	Delaware
eviCore healthcare MSI, LLC	Tennessee
Express Reinsurance Company	Missouri
Express Scripts Administrators LLC	Delaware
Express Scripts Pharmaceutical Procurement, LLC	Delaware
Express Scripts Strategic Development, Inc.	New Jersey
Express Scripts Utilization Management Company	Delaware
Express Scripts, Inc.	Delaware
HealthSpring Life & Health Insurance Company, Inc.	Texas
HealthSpring of Florida, Inc.	Florida

Inside RX, LLC	Delaware
LINA Life Insurance Company of Korea	South Korea
Loyal American Life Insurance Company	Ohio
ManipalCigna Health Insurance Company Limited	India
Matrix Healthcare Services, Inc.	Florida
Medco Containment Insurance Company of NY	New York
Medco Containment Life Insurance Company	Pennsylvania
Medco Health Services, Inc.	Delaware
Medco Health Solutions, Inc.	Delaware
MSI Health Organization of Texas, Inc.	Texas
Provident American Life & Health Insurance Company	Ohio
PT Asuransi Cigna	Indonesia
Sterling Life Insurance Company	Illinois
Temple Insurance Company Limited	Bermuda
United Benefit Life Insurance Company	Ohio

Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-3 (No. 333-236877) and Form S-8 (Nos. 333-228930 and 333-228931) of Cigna Corporation of our reports dated February 25, 2021 relating to the financial statements and financial statement schedules and the effectiveness of internal control over financial reporting, which appear in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 25, 2021

Exhibit 31.1

CERTIFICATION

I, DAVID M. CORDANI, certify that:

1. I have reviewed this Annual Report on Form 10-K of Cigna Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2021

/s/ David M. Cordani
Chief Executive Officer

Exhibit 31.2

CERTIFICATION

I, BRIAN C. EVANKO, certify that:

1. I have reviewed this Annual Report on Form 10-K of Cigna Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2021

/s/ Brian C. Evanko

Chief Financial Officer

Exhibit 32.1

Certification of Chief Executive Officer of
Cigna Corporation pursuant to 18 U.S.C. Section 1350

I certify that, to the best of my knowledge and belief, the Annual Report on Form 10-K of Cigna Corporation for the fiscal period ending December 31, 2020 (the "Report"):

(1) complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Cigna Corporation.

/s/ David M. Cordani

David M. Cordani
Chief Executive Officer
February 25, 2021

Exhibit 32.2

Certification of Chief Financial Officer of
Cigna Corporation pursuant to 18 U.S.C. Section 1350

I certify that, to the best of my knowledge and belief, the Annual Report on Form 10-K of Cigna Corporation for the fiscal period ending December 31, 2020 (the "Report"):

(1) complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Cigna Corporation.

/s/ Brian C. Evanko

Brian C. Evanko
Chief Financial Officer
February 25, 2021