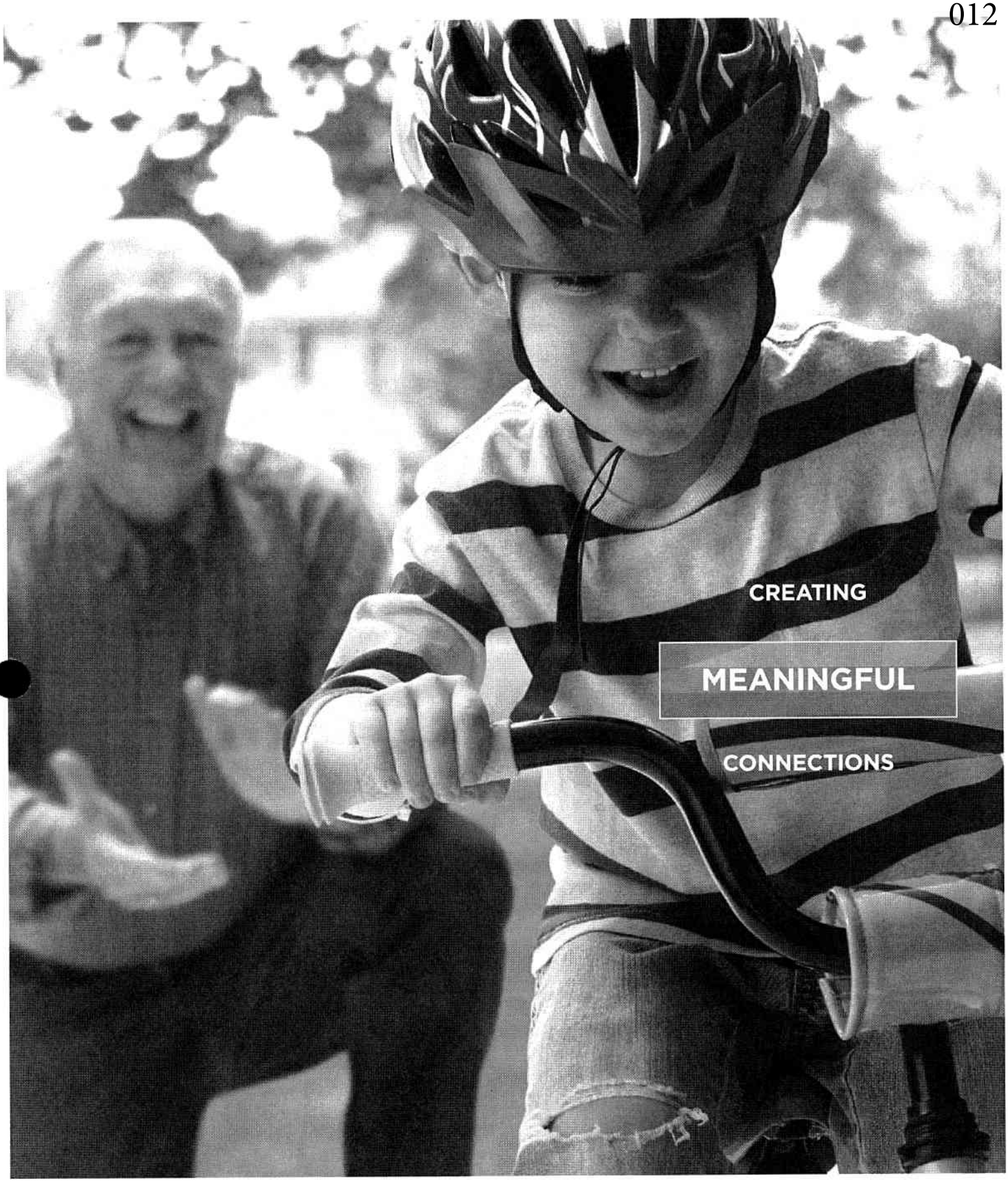
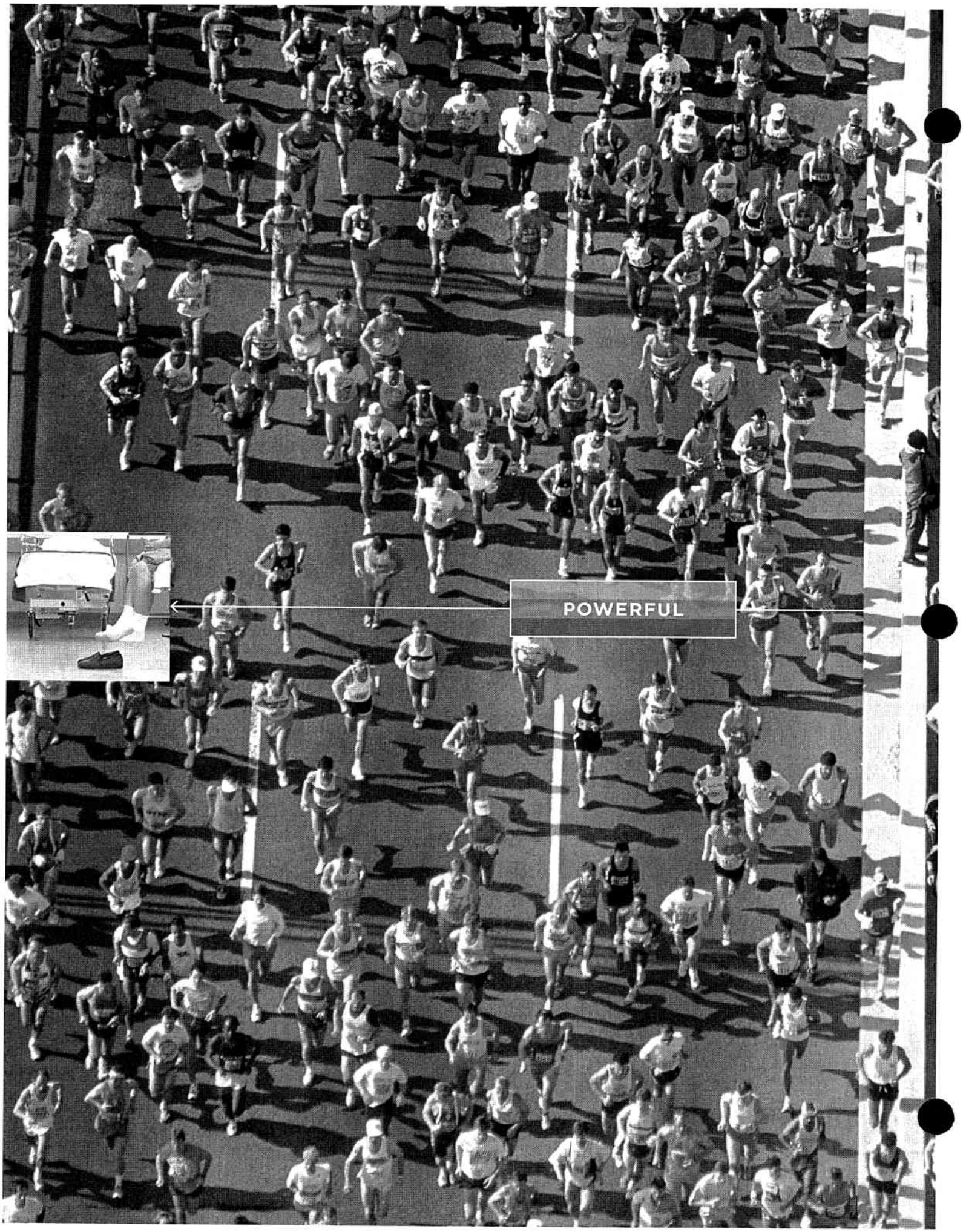
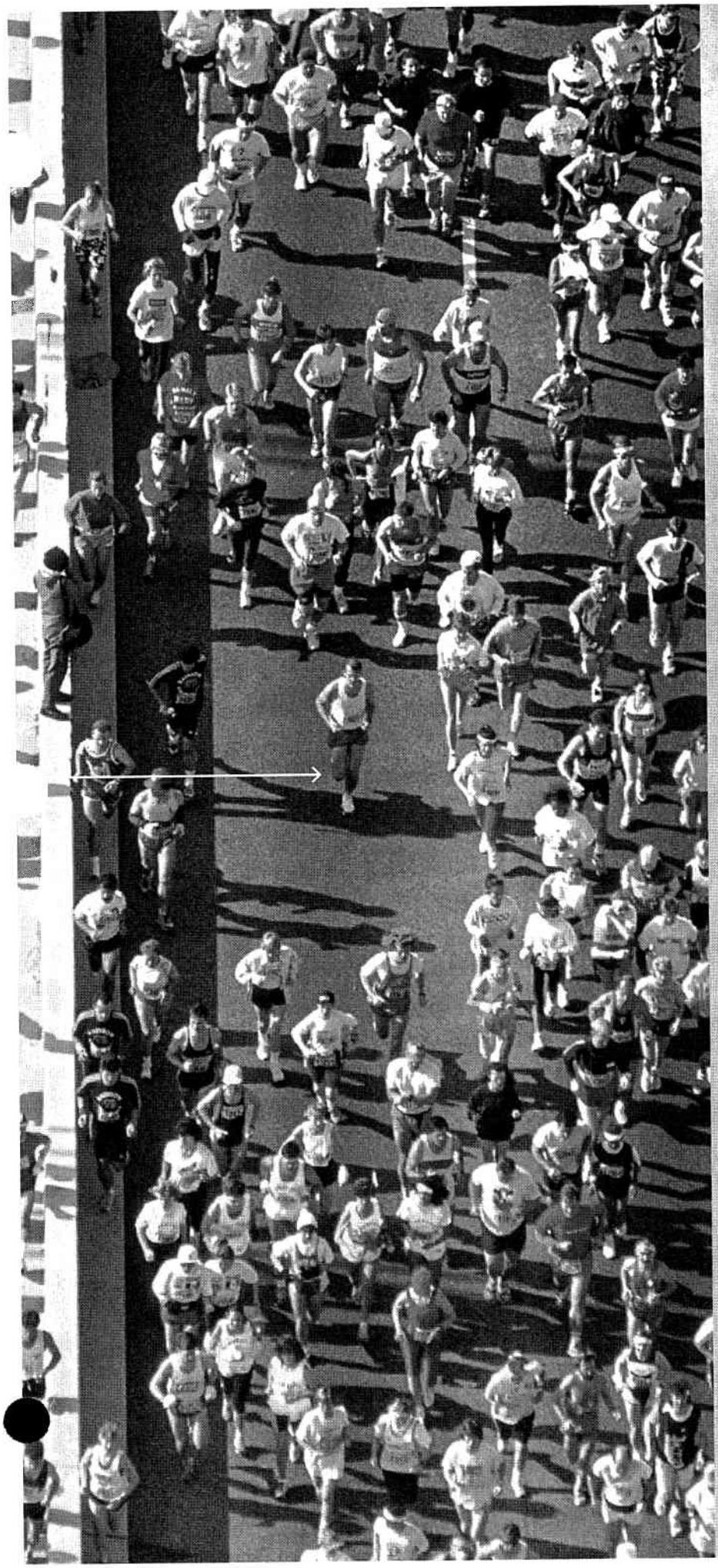


Cigna®

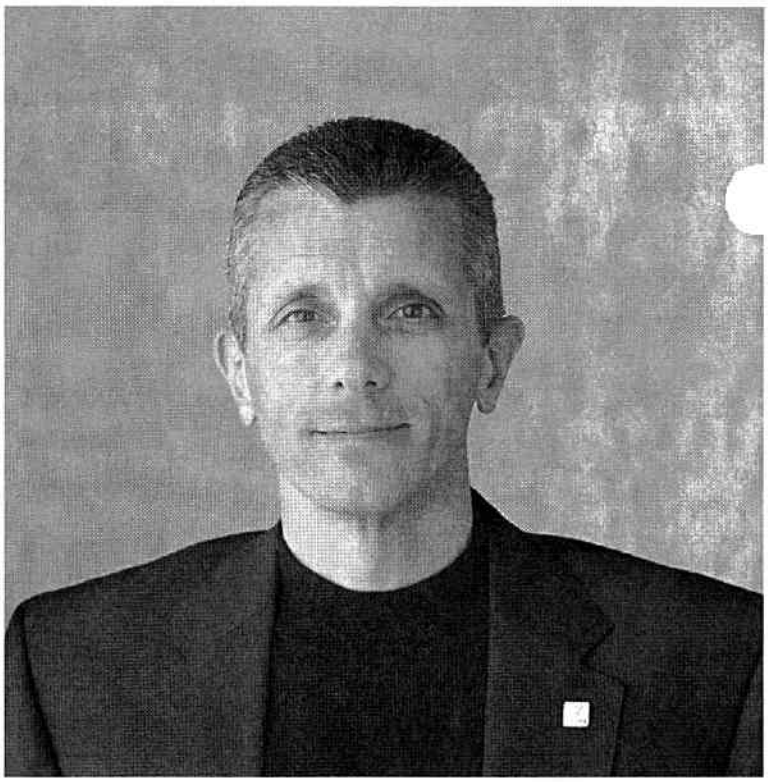

POWERFUL



THE POWER OF CONNECTIONS It isn't easy to be healthy and secure on your own. Meaningful connections are what help you be your best – physically, emotionally, financially – on your journey through life.

At Cigna, we're creating powerful connections with you and around you – connections that spark ideas, strengthen partnerships and sustain trust. Connections that channel the best in you, helping you take first steps after surgeries or final steps over finish lines.

Through meaningful connections, we're joining you together with the people, programs and services that help you achieve what matters most to your health, well-being and sense of security.



TO OUR SHAREHOLDERS In the face of a dynamic and challenging global environment, Cigna has demonstrated consistent success by addressing our customers' desire for affordable and personalized solutions which – consistent with Cigna's mission – help improve their health, well-being and sense of security.

This remained the case in 2014 when, for the fifth consecutive year, Cigna delivered competitively attractive financial results to our shareholders.

This outstanding track record continues to be driven by the disciplined execution of our "Go Deep, Go Global, Go Individual" strategy, as we continue to invest in new capabilities, personalize our product and service offerings, and expand our geographic footprint.

OUR STRATEGY:

GO DEEP
WITHIN TARGETED GEOGRAPHIES AND BUYING SEGMENTS

GO GLOBAL
TO LEVERAGE OUR CAPABILITIES IN A BORDERLESS FASHION

GO INDIVIDUAL
TO ENGAGE AND SERVE THE NEEDS OF INDIVIDUALS

David M. Cordani
President and
Chief Executive Officer
Cigna Corporation

"CIGNA WILL DOUBLE THE SIZE OF OUR BUSINESS IN 7 TO 8 YEARS."

We also continue to innovate through meaningful investments ranging from new clinical programs and aligned customer incentives, to the expanded use of enabling technologies and programs for health care professionals.

We believe that Cigna has the right strategy and growth framework to continue meeting and exceeding the needs of our customers and clients – giving us the foundation to achieve our goals, including:

- Growing revenues by eight to ten percent in 2015;
- Doubling the size of our business over the next seven to eight years and;
- Delivering on our long-term Earnings Per Share objective of 10 to 13 percent compound growth on an annual basis.

2014 Performance Highlights: Another Year of Strong Results

First, let's review Cigna's 2014 financial performance.

Cigna's full-year consolidated revenue increased by eight percent, to approximately $35 billion. Adjusted income from operations* was $2 billion, or $7.43 per share – representing a per-share increase of nine percent compared with 2013. Cigna reported shareholders' net income for the full- year of $2.1 billion.

In the five years since implementing our "Go Deep, Go Global, Go Individual" strategy, Cigna has delivered compound annual growth of 14 percent for revenues and 14 percent for adjusted income from operations* on a per share basis.

Further, over the past five years, we have continued to deliver industry leading medical cost trend results.

* Adjusted Income from Operations and Adjusted Income from Operations per share are non-GAAP measures used to describe the Company's financial results. Definitions of Adjusted Income from Operations on a consolidated and segment basis are contained in Management's Discussion and Analysis of Financial Condition and Results of Operations (MD&A) on page 32 and 45, respectively, of the Form 10-K included in this annual report. The MD&A also includes reconciliations of Adjusted Income from Operations to the most directly comparable GAAP measures.

Business Segment Performance Highlights

Each of Cigna's business segments – Global Health Care, Global Supplemental Benefits, and Group Disability and Life – delivered strong growth in 2014 over the prior year, as we grew our number of customer relationships to more than 85 million worldwide.

GLOBAL HEALTH CARE

Cigna's Global Health Care business segment provides health care, wellness and preventive solutions to individuals and employers around the world. In another strong year for this segment, we grew premiums and fees by seven percent, to $24.5 billion, reflecting growth in all of our Global Health Care businesses, including continued growth in our fast-growing self-funded and specialty products businesses. We ended 2014 with 14.5 million global medical customers, representing an increase of approximately 380,000 customers during the year (excluding limited benefits customers).

We continue to effectively manage medical costs that reflect better health outcomes and strong clinical excellence for our customers and clients, as a result of our deep, collaborative relationships with physicians and our focus on the personalization of care.

For example, in 2014 we surpassed our goal of 100 Collaborative Accountable Care Organization arrangements with large physician groups, serving more than 1.4 million customers. Cigna also introduced a new suite of value-based initiatives, which we refer to as Cigna Collaborative Care, to include small physician groups, specialists and hospitals, all with an eye to improving care for our customers.

GLOBAL SUPPLEMENTAL BENEFITS

Cigna's Global Supplemental Benefits business segment, which provides supplemental health, life and accident insurance in several markets around the world – including Medicare supplement coverage in the United States – once again delivered attractive growth and profitability for our shareholders. Our highlights included formally launching our Cigna Health Insurance joint venture in India, and continued success in Korea, where we continue to innovate and grow, serving millions of customers.

Premiums and fees for this segment grew by 14 percent year-over-year, with adjusted income from operations* of $230 million – reflecting attractive operating margins, and continued strategic investments to drive future growth.

GROUP DISABILITY AND LIFE

Our Group Disability and Life business segment – which provides life, accident and disability insurance, along with back-to-work programs – delivered solid results, with premiums and fees increasing by six percent over 2013, and full-year adjusted income from operations* of $317 million. These results reflected favorable claims experience in Cigna's life insurance business and a lower operating expense ratio. Cigna continues to be a leader in group disability product sales, and we maintain a strong share of the market for group disability, life and accident solutions as well as for leave of absence programs such as Family and Medical Leave Act (FMLA) administration.

Creating a more sustainable health care environment

We are proud of the results we've generated for our shareholders as well as for those we serve around the world.

Market by market, the global environment is a challenging one for those of us in the health service sector. It's far more so for the millions of individuals trying to manage their health, and the health of their families, in a way that's effective, affordable and relevant to their personal needs.

The anxiety and confusion of consumers surrounding their health care is easy to understand.

For example, in the United States, health care costs have grown faster than the economy over the past three decades, with health care expenditures on pace to represent $1 of every $5 produced by the United States economy by 2021.

Further, chronic diseases – many of them preventable with better lifestyle and behavior choices – represent about 75 percent of United States health care spending. Chronic diseases are the leading cause of death and disability in the United States, accounting for seven out of every ten deaths each year.

At the same time, there's a significant "disconnect" between individuals and their medical costs, with too many people acting as passive consumers of health care, in large part because of the difficulty in navigating and engaging with a high-cost, fragmented system. Yet, these same consumers of health care are expected to understand and select from more choices than ever before.

Ultimately, these individuals want peace of mind. Fulfilling these needs is a dynamic process, as customer needs evolve and vary over time due to life and health stage changes.

PERSONAL

"OUR GUIDING FRAMEWORK DRIVES DIFFERENTIATED VALUE FOR CUSTOMERS AND STAKEHOLDERS."

It is clear that, as a society, we are long past due for a reasoned dialogue on health care in the United States, exploring how employer groups, government and health care suppliers can work together to build a sustainable system better equipped to provide quality, affordable care over the long term – a system which transcends its historic focus on sick care and addressing existing illness, to one more adequately focused on the preventive care, and lifestyle and behavior improvements, that help people avoid getting sick in the first place.

At Cigna, we believe consumers of health care services deserve more choice, higher quality, transparency and affordability.

No single entity has all of the answers to get us there. From Cigna's perspective, we believe we can take major steps toward a sustainable health care system by increasing the effectiveness of what we already know is working today and for which Cigna strongly advocates, including:

- Access to quality medical care through employer-sponsored plans, a robust individual market and a variety of safety nets available to those in need;
- Improved affordability, which includes rewarding doctors and hospitals based on quality outcomes;
- Broadening choice for all purchasers of health care insurance and services;
- Making costs and quality of care as transparent as possible, and
- Engaging individual customers of health care as important partners.

"CIGNA WILL CONTINUE TO GROW THROUGH AFFORDABILITY AND PERSONALIZATION."

Society's desire for improvement is evident.

From an employer-group perspective, Cigna sees our clients increasingly focused on engaging their workforces to drive improved health outcomes. To continue doing so, they require choices of effective and efficient health and productivity services, including more benefit choices that are valued by their employees, ranging from employer-funded base offerings to employee-paid voluntary benefits; and innovative engagement tools, including incentive and network programs that yield superior value from both a quality and affordability perspective.

Similarly, as government funding of health costs continues to grow, governments across the globe are seeking paths to better drive improved quality and health outcomes at affordable costs – including high-value based social programs for the neediest members of the population as well as innovative programs for the higher risk/higher complexity populations, such as Medicare/Medicaid dual eligible individuals in the United States, and the aged, blind and disabled populations.

Finally, health care professionals are seeking new partnerships that leverage information, incentives and care resources to help them navigate to a value-based performance and reimbursement environment. We're seeing this approach gain momentum in the United States.

Affordability and personalization

For Cigna, market needs and expectations are framed in the context of two strategic imperatives that guide our approach as we respond to, engage and interact with our customers: affordability and the personalization of services.

There's an inherent and natural tension involved in striking the right balance between affordability and personalization – a balance which Cigna aims to strike by:

- Understanding our customers' unique needs, in part by leveraging data analytics and insights;
- Localizing our operations to meet the needs of a specific market or country;
- Fulfilling our brand promise of helping individuals in a personally relevant way, and
- Harnessing our breadth of talent – more than 35,000 team members around the world.

Cigna is committed to continuing to participate in, and play a convening role in prompting constructive dialogue on how we can best create a sustainable health care system. At the same time, we will continue to incorporate these elements in our own organization, and ensure we are positioned to rise to these opportunities and challenges.

Converting challenges into growth opportunities

To achieve our growth goals in a disruptive global environment for health care, Cigna has built a guiding framework – comprising three main components:

- Leveraging our core capabilities in existing businesses;
- Effectively deploying capital;
- Pursuing new and emerging opportunities.

Taken together, Cigna believes this framework will enable us to continue driving differentiated value for our customers and shareholders over time.

LEVERAGING OUR CORE CAPABILITIES

As part of this first component, we see significant opportunity to leverage the three pillars of our "Go Deep, Go Global, Go Individual" strategy, to focus on markets and segments where we are well-positioned to continue winning in the market.

Our existing portfolio, along with our focused execution, will play a significant role in doubling the size of business over the next seven to eight years, which will result in an average annual revenue growth rate of eight to ten percent. Our 2015 outlook is consistent with this goal.

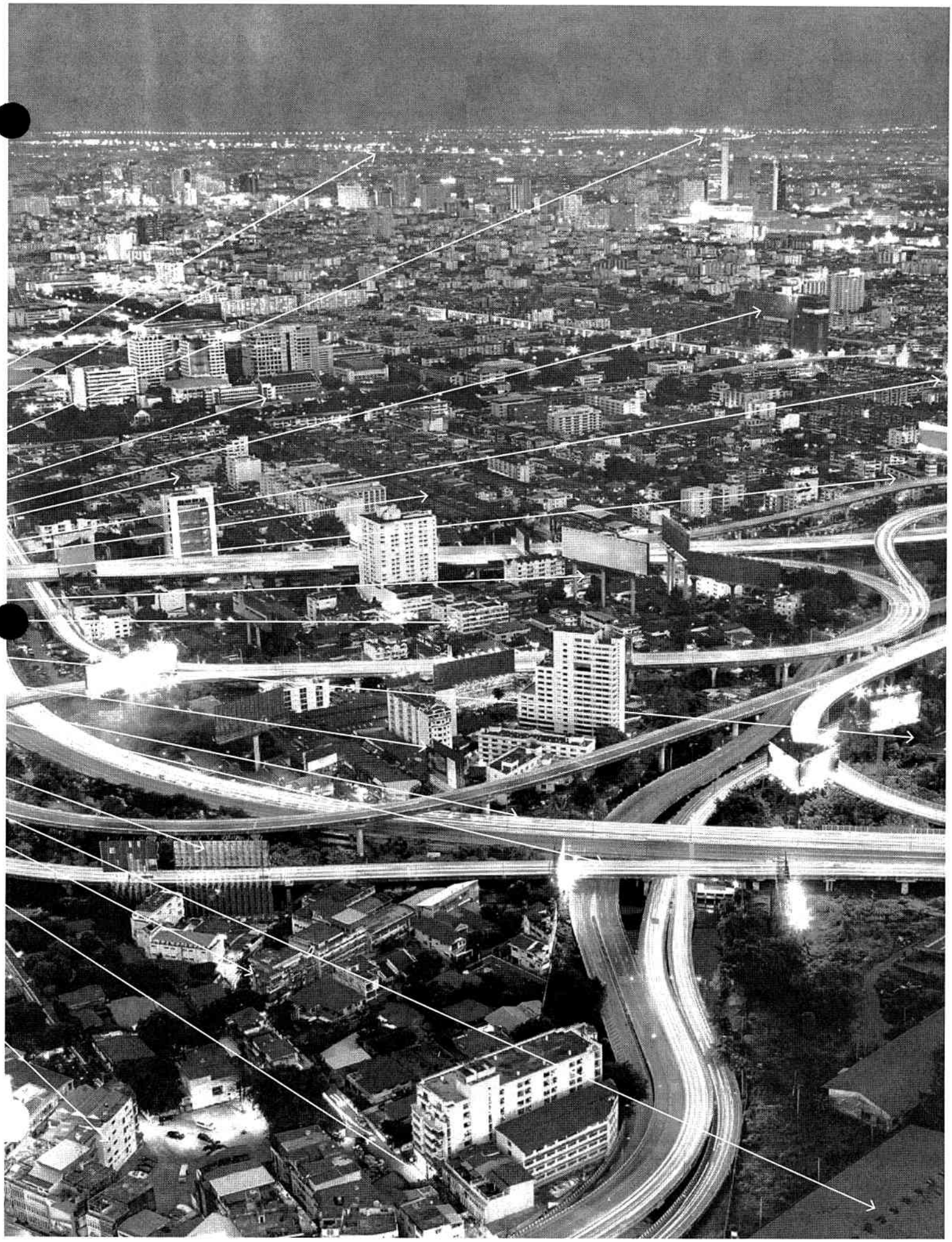
CAPITAL DEPLOYMENT

Relative to the second part of our framework – targeted and effective capital deployment – our portfolio of businesses continued to contribute significant free cash flow for shareholders.

Over the past five years, we have effectively deployed capital through a balance of investments in our business portfolio, strategic mergers and acquisitions, and share repurchase. A good, recent example of this is our agreement to purchase QualCare Alliance Networks – an acquisition directly aligned with our Go Deep strategy, and our physician-partnership strategy.

We also have a strong track record of generating high levels of free cash flow, which provides us with financial flexibility, and the opportunity to deploy capital to create additional value for our shareholders. And given the health of our balance sheet and underlying capitalization levels of our subsidiaries, we expect to have $1.8 billion dollars of capital available for deployment in 2015.

ACCESSIBLE



NEW AND EMERGING OPPORTUNITIES

The third component of our framework where we will seek to drive additional value for our shareholders is through new and emerging opportunities.

These opportunities include:

- New distribution marketplaces such as public and private exchanges;
- Geographic expansion, such as new Medicare Advantage markets in the United States and expanding international opportunities;
- New buying segments and service expansions, such as Medical Service Organization offerings for the benefit of integrated health care professionals.

Cigna is well-positioned to pursue each of these potentially attractive future growth opportunities that are aligned with our strategy. As such, we have dedicated resources to fuel future expansion in these areas.

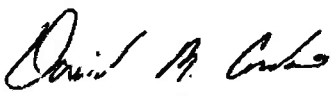
Conclusion

Cigna remains confident in the strength of our product and service portfolio, our financial flexibility, and our ability to build on our current markets and segments as well as to create new opportunities in target geographies.

The proven effectiveness of our "Go Deep, Go Global, Go Individual" strategy, along with our framework for longer-term growth, puts us in a strong position to meet our goals of:

- Growing revenues by eight to ten percent in 2015;
- Doubling the size of our business over the next seven to eight years and
- Delivering on our long-term Earnings Per Share growth objective of between 10 to 13 percent compound growth on an annual basis.

Our 35,000-plus employees around the world remain committed, day in and day out, to living Cigna's mission of helping the people we serve improve their health, well-being and sense of security. On behalf of our entire organization, I thank you for your support of Cigna.



David M. Cordani
President and
Chief Executive Officer
Cigna Corporation


PRODUCTIVE

Cigna uses its deep insights to connect customers with innovative, personalized products, programs and services.

In 2014, Cigna launched a new brand campaign with a promise to customers to work together with them to lead healthier, more secure lives. Our brand promise, Together, all the way.℠ is based on insights rooted in research and experience, which tell us that customers want us to work as their partners. When it comes to staying well – physically, financially, emotionally – we're with our customers all the way.

Affordability and personalization

Affordability and personalization are central to our brand promise. Affordability means helping customers find the right care, at the right price. Affordability also compels us to help customers get the most value from their benefit plans – and to help them lower their costs as their health improves. One important way we do this is through maximizing the relationship between our customers and health care professionals to help customers get quality, cost-effective care.

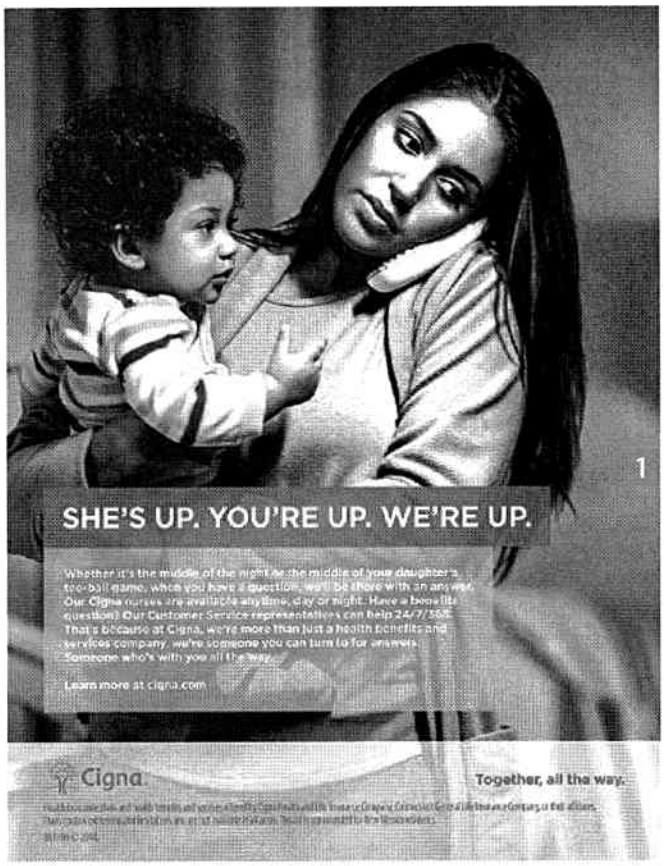
Personalization means we use the insights we've gleaned from customers to segment individuals into groups with common needs. This allows us to deliver personally relevant products and services to each group of customers.

Keeping our promise

Evidence of how we provide affordability and personalization can be found in the United States and around the world. For example, during the 2014 fall benefits enrollment period, millions of United States Cigna customers were introduced to Cigna Health Matters℠, a way to make health management more interesting by combining our health coaches, mobile applications, social media and games to help customers and their families evaluate their health, find tools to improve their health, track their progress and earn rewards.

Additionally, Cigna and Samsung teamed up to create a digital health coaching tool that fits in the palm of customers' hands. "Coach by Cigna" is available at no additional charge to Samsung Galaxy S®5 smartphone and Note®4 users around the globe. This app helps customers collect and evaluate their health and wellness progress, create a personalized lifestyle improvement program, and ultimately achieve their health and wellness goals.

Another example of how we live the brand promise is through the work of Cigna-HealthSpring®, which serves our Medicare and Medicaid customers. After a successful pilot in Tennessee, we're expanding our heart



1 Cigna's new brand expression, Together, all the way.℠ focuses on being a partner to our customers.

2 Hazel, a customer with Cigna-HealthSpring®, stays active through ballroom dancing.

3 Cigna helped to create a new handicapped parking icon focused on ability rather than disability.

failure remote patient monitoring program in collaboration with Intel-GE Care Innovations™. Patients with a prior admission to the hospital for heart failure receive a tablet to assess their health for at least 90 days. The tablet helps customers interact with a Cigna-HealthSpring® nurse practitioner, track their health metrics and learn how to manage their condition at home. Customers know they have easy and direct access to someone who cares about them and their health.

Further demonstrating our understanding of customers, Cigna led an effort to replace the International Symbol of Access – the iconic "wheelchair" symbol, created in 1969 – with a new icon. Led by Cigna's People With Different Abilities Colleague Resource Group, a support and networking group within Cigna, the new image shows a more active figure that emphasizes ability rather than disability. The icon serves as affirmation of our commitment to help our customers achieve their full potential both inside and outside of the workplace. Through Cigna's efforts, Phoenix, AZ became the latest city to approve the new symbol for use in business parking areas.

In international markets

In China, the first-ever Cigna and CMB Home Shopping Channel aired recently on Jia You-Hyundai Home Shopping Channel, and replicated the success we've had in distributing direct-to-consumer products in Korea. In Turkey, as part of our joint venture with Finansbank, a leading Turkish bank, Cigna Finans Pension and Insurance Advisors are available in banks to help educate customers and encourage them to consider their future needs.

In India, Cigna TTK is developing prevention and wellness programs for a country with diverse needs and an explosive growth in the rates of chronic disease, where 60 million people struggle with diabetes. And in Korea, where more than 33 percent of the Korean population is over 50 years old, Cigna Korea launched "Heyday," the first health care membership program in Korea. Through Heyday, seniors enjoy various health and wellness programs and services with no membership fee.

Wherever Cigna customers are, we're showing that we listen and we care, connecting them to the people, products and programs that help them improve their health, well-being and sense of security.

Inspired by the work of others, the Cigna Foundation is connecting with nonprofit partners to work together to create a healthier, more secure world.

In 2014, the Cigna Foundation created a new grant-making platform focused on impact investing – moving beyond financial support to creating strong partnerships with nonprofits. The partnerships also mean involving Cigna employees to share their skills and talents with the community.

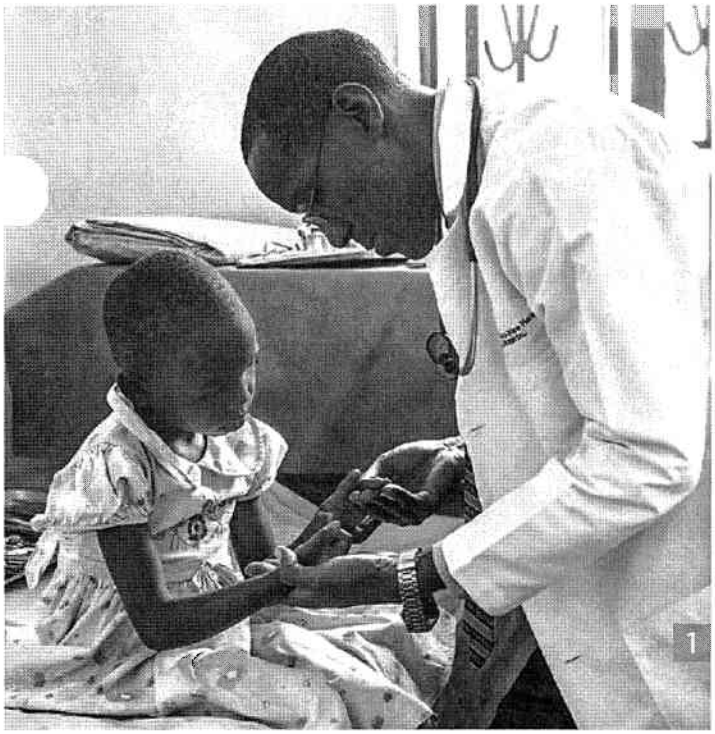
This approach to grants brought the Cigna Foundation together with change agents far and wide. Arogya World, for example, is a nonprofit partner in engaging people in India to improve their health. With the Cigna Foundation's support, Arogya is creating a mobile app that will house heart and kidney disease education, awareness and prevention information. The mobile app will be distributed to India's workforce through employers.

In New York, with the help of the Cigna Foundation, the New York Botanical Garden is conducting world-class research to improve health outcomes for Latino and Caribbean populations living in New York City through a new discipline known as urban ethnobotany. This program is teaching health professionals how to understand and communicate with their patients who use plant-based remedies. We expect this research will be of importance to the medical community around the world.

In the northeast neighborhood of Hartford, CT, the Cigna Foundation's work with Community Solutions is designed to turn around the health of a neighborhood ravaged by poverty, in an area where life expectancy is 10 years lower than in other surrounding neighborhoods. This work involves looking at the root causes of high emergency room use by residents, as well as how home visits and better housing and employment options can improve health.

Additionally in 2014, Cigna employees organized the company's largest-ever volunteer effort, with 1,000 Connecticut employees packing 250,000 meals for Feeding Children Everywhere. The meals were delivered to needy children in Kenya.

All of this work expresses the Cigna Foundation's passion for removing the barriers people face in their daily lives so that everyone has a chance to achieve their best health.



INSPIRING

1 Samahope raises funds to help the needy get life-saving surgeries around the world.

2 The New York Botanical Garden helps doctors understand their patients' use of plant-based remedies.

3 Cigna employees in Hartford, CT run for the March of Dimes®.

4 Community Solutions improves health and wellness in a Hartford neighborhood.

5 Achilles studies the impact of running to help children with autism.

6 Girls on the Run helps girls learn to be healthy and self-confident.

7 Arogya World helps prevent chronic disease in India through mobile phone messages.

8 Children in Memphis, TN receive food for the weekends through Blessings in a Backpack.

9 Stylists with the University of Maryland HAIR program teach clients about the importance of cancer prevention.

Cigna connections make an impact worldwide. We strive to be a positive force for change in the lives of customers, clients and communities.

The impact we have on those we serve can be life-changing, and is measured in statistics as well as by the individual stories from our customers and clients.

A proven difference

Within Cigna, for example, 94 percent of employees and families are tobacco-free, and nearly 70 percent of employees and families report they're at a healthy weight.

Through our collaboration with physicians and other health care professionals, we're improving health care costs and quality. Among our 23 Cigna Collaborative Care arrangements with two or more years of experience, 91 percent are having success controlling total medical costs, while 78 percent are having success with improving the quality of health care – and 74 percent are having success with both total medical costs and quality.

Research with customers

Our studies with customers tell a similar story of lowering costs and improving health. For example, Cigna research shows that a single phone call from a nurse to high-risk heart and respiratory patients, after they've been discharged from the hospital, can reduce future readmissions by 22 percent. This is significant from a cost perspective, as readmissions represent 30 percent of total inpatient costs.

Cigna also monitored the health outcomes of customers with hepatitis C who have undergone treatment using Sovaldi® as part of a combination prescription therapy, and found that 91 percent of our customers were cured after completing treatment.

And for the eighth year in a row, a Cigna Choice Fund® study demonstrated that an account-based approach – in which customers use savings and reimbursement accounts in higher deductible plans – is helping millions of customers reduce their health care expenses without compromising their care. When compared with customers in other types of health plans, our Choice Fund customers are more likely to use health improvement programs, comply with evidence-based medicine best practices, and

1 GOAL
FEEDING CHILDREN EVERYWHERE

1,000
CIGNA VOLUNTEERS PACKING MEALS

250,000
MEALS DELIVERED TO KENYA

access information on quality and cost, resulting in improved health risk profiles and lower total medical expenses. For example, Choice Fund customers used the emergency room at a five percent lower rate than individuals enrolled in HMO and PPO plans.

Choice Fund products provide tools and information accessible online and via mobile devices to empower customers to make cost-conscious decisions about their health and health spending.

Personal stories and recognition

Around the world, our individual stories are compelling. For example, we helped a family who moved from the United States to Sweden, whose five-year-old needed her anti-seizure medicine. The family hadn't yet become a part of Sweden's health care system. A Cigna nurse case manager took charge and made sure that the child received the medicine she needed. Another example is the businessman who suffered from chronic kidney failure, whose job required him to travel around the world. His Cigna nurse case manager stepped up and arranged his dialysis for him wherever he was in the world.

We're proud of this level of service to customers, which led to a 2014 International Employee Benefits Provider of the Year award, given to Cigna Global Health Benefits® for overall excellence by the Expatriate Management and Mobility Awards. This is the third time in four years that Cigna has won the recognition.


COLLABORATIVE

Committed to corporate responsibility and the environment

Our success depends on earning trust through responsible business practices, corporate citizenship and service that meets our customers' needs, all through a unique approach to corporate responsibility called Cigna Connects. In 2014, Cigna took its commitment to corporate responsibility (CR) to the next level by issuing the 2013 Cigna Connects Corporate Responsibility Report, available online at **Cigna.com/CorporateResponsibility**. Cigna's first CR report provides a detailed look at the company's environmental, social and governance policies and priorities, and explores how they support the company's core businesses and benefit Cigna stakeholders and society. The report provides relevant facts, figures and stories about CR initiatives at Cigna, including the company's new 2017 environmental targets: a nine percent reduction in greenhouse gas emissions, a nine percent reduction in energy use, and a three percent reduction in water consumption.

Additionally, representative of our continuous improvement, Cigna's score on the 2014 CDP Climate Change Information Request improved from a disclosure score of 59/100 in 2013 to 86/100, and our performance band moved from C to B.

Through Cigna Connects, the company aims to serve as a catalyst for change and a convener of stakeholders in the more than 30 countries in which we operate. With more than 35,000 colleagues, we're united by the goal of building a better world for today and for future generations.

Cigna is a global health service leader that provides medical, dental, disability, life and accident insurance, and related products and services to customers in the United States and around the globe.

Global Health Care

Global Health Care includes a commercial line of business encompassing United States and international operations. Commercial offers a broad line of insured and self-insured medical, dental, behavioral health, vision, prescription drug benefit plans, health coaching programs and other products and services that may be integrated to provide comprehensive global health care benefit programs to employers and their employees, including globally mobile individuals.

Global Health Care also includes a government line of business that offers Medicare Advantage, Medicare Part D and Medicaid plans for Medicare or Medicaid-eligible individuals, primarily seniors. A significant portion of our Medicare Advantage customers are served by physicians in innovative plan models designed to improve health outcomes and lower medical costs. Cigna offers Medicare Advantage plans in 16 states and the District of Columbia, Medicare Part D plans in all 50 states and the District of Columbia, and Medicaid plans in select markets in Texas and Illinois. In 2015, we expect to expand Medicaid operations.

Global Supplemental Benefits

Global Supplemental Benefits offers supplemental health, life and accident insurance products in select international markets and the United States. With licenses and partnerships across Asia-Pacific, Europe and North America, Cigna offers products and services to local citizens and globally mobile individuals. Global Supplemental Benefits also offers Medicare supplement coverage.

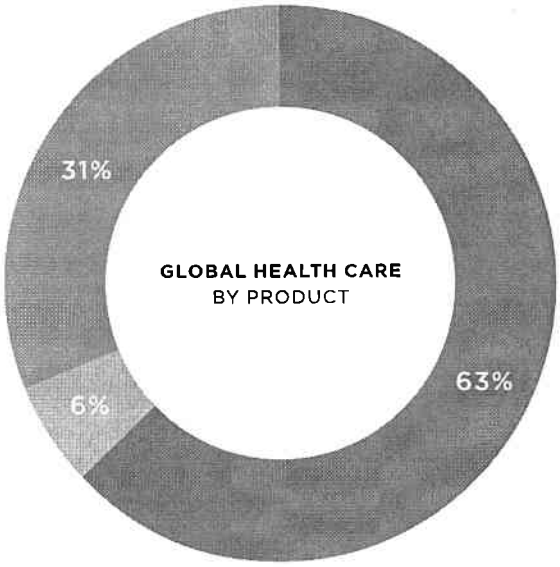
Group Disability and Life

Group Disability and Life provides insurance products and related services for group long- and short-term disability insurance, group life insurance, and accident and specialty insurance. Cigna markets products in all 50 states, the District of Columbia, Puerto Rico, the United States Virgin Islands and Canada. Group disability programs are designed to help improve employee productivity and lower employers' overall absence costs. Products are coupled with comprehensive tools and services for easy benefit management.

- Government – 31%

COMMERCIAL SEGMENT

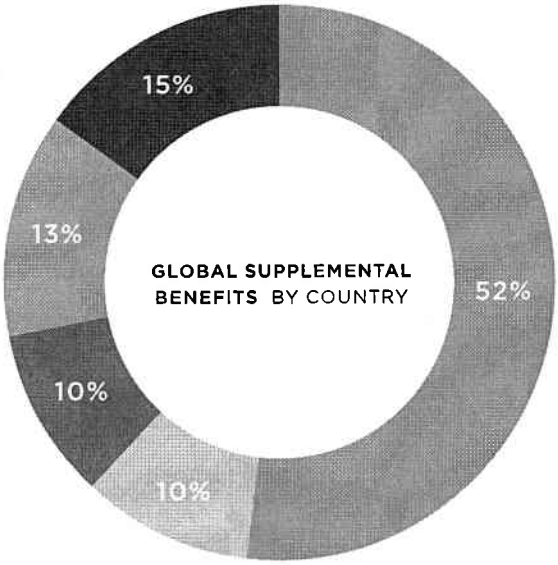
- Medical – 63%
- Dental – 6%



GLOBAL HEALTH CARE
BY PRODUCT

PREMIUMS AND FEES AND OTHER REVENUES
IN MILLIONS
$24,714

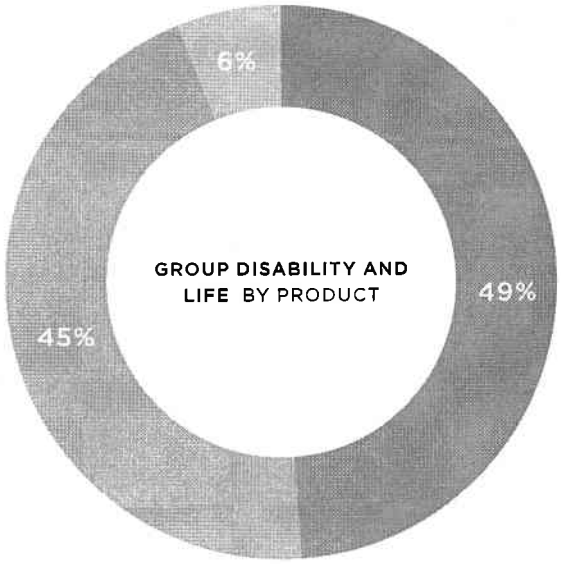
- South Korea – 52%
- Taiwan – 10%
- Europe – 10%
- United States – 13%
- Other – 15%



GLOBAL SUPPLEMENTAL BENEFITS BY COUNTRY

PREMIUMS AND FEES AND OTHER REVENUES
IN MILLIONS
$2,896

- Disability – 49%
- Life – 45%
- Other – 6%



GROUP DISABILITY AND LIFE BY PRODUCT

PREMIUMS AND FEES AND OTHER REVENUES
IN MILLIONS
$3,635

BOARD OF DIRECTORS

Isaiah Harris, Jr.
Independent Chairman of the Board,
Former President and Chief Executive Officer
AT&T Advertising and Publishing – East, a
communications services company

David M. Cordani
President and Chief Executive Officer
Cigna Corporation

Eric J. Foss
Chairman, President and Chief Executive Officer
ARAMARK Corporation, a provider of
food services, facilities management and
uniform services

Michelle D. Gass
Chief Customer Officer
Kohl's Department Stores, a retailer

Jane E. Henney, MD
Former Senior Vice President
Provost and Professor of Medicine,
University of Cincinnati College of Medicine,
an educational institution

Roman Martinez IV
Private Investor

John M. Partridge
Former President
Visa Inc., a consumer credit company

James E. Rogers
Former Chairman, President and
Chief Executive Officer
Duke Energy Corporation, an electric
power company

Eric C. Wiseman
Chairman, President and Chief Executive Officer
VF Corporation, an apparel and footwear company

Donna F. Zarcone
President and Chief Executive Officer
The Economic Club of Chicago, a civic and
business leadership organization

William D. Zollars
Former Chairman, President and
Chief Executive Officer
YRC Worldwide Inc., a transportation and
related services holding company

EXECUTIVE COMMITTEE

Isaiah Harris, Jr.
Chair

David M. Cordani
Jane E. Henney, MD
John M. Partridge
Donna F. Zarcone
William D. Zollars

AUDIT COMMITTEE

Donna F. Zarcone
Chair

Michelle D. Gass
Roman Martinez IV
James E. Rogers

CORPORATE GOVERNANCE COMMITTEE

Jane E. Henney, MD
Chair

Eric J. Foss
Michelle D. Gass
William D. Zollars

FINANCE COMMITTEE

John M. Partridge
Chair

Roman Martinez IV
James E. Rogers
Eric C. Wiseman
Donna F. Zarcone

PEOPLE RESOURCES COMMITTEE

William D. Zollars
Chair

Eric J. Foss
Jane E. Henney, MD
John M. Partridge
Eric C. Wiseman

EXECUTIVE OFFICERS

David M. Cordani
President and
Chief Executive Officer

Lisa R. Bacus
Executive Vice President and
Global Chief Marketing Officer

Mark L. Boxer
Executive Vice President and
Global Chief Information Officer

Herbert A. Fritch
President,
Cigna-HealthSpring®

Nicole S. Jones
Executive Vice President
and General Counsel

Matthew G. Manders
President, U.S. Commercial
Markets and Global Health
Care Operations

Thomas A. McCarthy
Executive Vice President
and Chief Financial Officer

John M. Murabito
Executive Vice President
of Human Resources
and Services

Jason D. Sadler
President,
International Markets

OTHER OFFICERS

Neil Boyden Tanner
Vice President, Chief Counsel
and Corporate Secretary

Timothy D. Buckley
Vice President and Treasurer

Mary T. Hoeltzel
Vice President and
Chief Accounting Officer

2015 ANNUAL MEETING

Wednesday, April 22 at 8:00 am
Windsor Marriott Hotel
Ballroom 4
28 Day Hill Road
Windsor, CT 06095

Proxies and proxy statements have been made available to shareholders of record as of February 23, 2015. On December 31, 2014, there were 7,129 common shareholders of record.

FINANCIAL INFORMATION

Cigna's Form 10-K is available online at **Cigna.com**. For a copy of Cigna's quarterly earnings news releases, visit our website at **Cigna.com** and click on "News."

OFFICES AND PRINCIPAL SUBSIDIARIES

Cigna Corporation
900 Cottage Grove Road
Bloomfield, CT 06002
860.226.6000

and

Two Liberty Place
1601 Chestnut Street
Philadelphia, PA 19192-1550
215.761.1000

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

900 Cottage Grove Road
Bloomfield, CT 06002
860.226.6000

CIGNA HEALTH AND LIFE INSURANCE COMPANY

900 Cottage Grove Road
Bloomfield, CT 06002
860.226.6000

LIFE INSURANCE COMPANY OF NORTH AMERICA

Two Liberty Place
1601 Chestnut Street
Philadelphia, PA 19192-1550
215.761.1000

DIRECT STOCK PURCHASE PLAN

Shareholders can automatically reinvest their annual dividends and make optional cash purchases of common shares. For information on these services, please contact:

Computershare
PO Box 30170
College Station, TX 77842-3170
Toll-free: **800.760.8864**.
Outside the United States and Canada: **201.680.6535**.

SHAREHOLDER ACCOUNT ACCESS

You can access your Cigna shareholder account online through the Computershare website: **Computershare.com**. Or, call **800.760.8864**.

DIRECT DEPOSIT OF DIVIDENDS

Direct deposit of dividends provides a prompt, efficient way to have your dividends electronically deposited into your checking or savings account. It avoids the possibility of lost or delayed dividend checks. The deposit is made electronically on the payment date. For more information and an enrollment authorization form, contact Computershare at **800.760.8864**, or outside the United States and Canada at **201.680.6535**. You can access your account online through the Computershare website: **Computershare.com**.

STOCK LISTING

Cigna's common shares are listed on the New York Stock Exchange. The ticker symbol is CI.

TRANSFER AGENT

Computershare
PO Box 30170
College Station, TX 77842-3170
Toll-free: **800.760.8864**.
Outside the United States and Canada: **201.680.6535**.
Hearing impaired, TDD: **800.231.5469**. Website: **Computershare.com**.

CIGNA ONLINE

To access online information about Cigna, our products and services, visit **Cigna.com**.

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, 2014

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 1-8323

CIGNA CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	06-1059331
(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
(860) 226-6741
Registrant's facsimile number, including area code

SECURITIES REGISTERED PURSUANT TO SECTION 12(B) OF THE ACT:	
Title of each class	Name of each exchange on which registered
Common Stock, Par Value $0.25	**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 and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted 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 and post such files).	☑	☐
• if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.	☑	☐

• whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See definitions of "large accelerated filer", "accelerated filer", and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑	Accelerated filer ☐	Non-accelerated filer ☐	Smaller Reporting Company ☐

• whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).	☐	☑

The aggregate market value of the voting stock held by non-affiliates of the registrant as of June 30, 2014 was approximately $24.3 billion.

As of January 31, 2015, 258,442,718 shares of the registrant's Common Stock were outstanding.

Part III of this Form 10-K incorporates by reference information from the registrant's definitive proxy statement related to the 2015 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 our business strategy, strategic or operational initiatives, including our ability to deliver improved health services outcomes and productivity for our customers and clients while lowering the costs of health care; future growth and expansion; future financial or operating performance; economic, regulatory or competitive environments; and our projected cash position, future pension funding and financing or capital deployment plans. 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 financial, strategic and operational plans or initiatives; our ability to predict and manage medical costs and price effectively and develop and maintain good relationships with physicians, hospitals and other health care providers; our ability to identify potential strategic acquisitions or transactions or realize the expected benefits of such strategic transactions; 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; the outcome of litigation, regulatory audits, investigations and actions and/or guaranty fund assessments; uncertainties surrounding participation in government-sponsored programs such as Medicare; and unfavorable industry, economic or political conditions, 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. 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 services organization dedicated to a **mission** of helping individuals **improve their health, well-being and sense of security**. To execute on our mission, Cigna's **strategy** is to "Go Deep", "Go Global" and "Go Individual" with a differentiated set of medical, dental, disability, life and accident insurance and related products and services offered by our subsidiaries. We:

- **GO DEEP** by targeting key segments and geographies;
- **GO GLOBAL** with solutions that leverage our capabilities in a borderless environment; and
- **GO INDIVIDUAL** to better understand and satisfy the holistic needs of each person we serve.

In an increasingly retail oriented marketplace, we deliver **affordable** and **personalized** products and services to customers through employer-based, government-sponsored and individual coverage arrangements. We increasingly collaborate with health care providers to transition from volume-based fee for service arrangements toward a more value-based system designed to increase quality of care, lower costs and improve health outcomes. We operate a customer-centric organization enabled by keen **insights** regarding customer needs, **localized** decision-making and **talented** professionals committed to bringing our "Together All the Way" **brand** promise to life.

As of December 31, 2014, our consolidated shareholders' equity was $10.8 billion, assets were $55.9 billion and we reported revenues of $34.9 billion for 2014. Our revenues are derived principally from premiums on insured products, fees from self-insured products and services, mail-order pharmacy sales and investment income.

As explained in Note 22 to the Consolidated Financial Statements, effective with the first quarter of 2014, we began combining the results of our run-off reinsurance business with other immaterial operating segments in Other Operations for segment reporting purposes. Prior year segment information has been conformed to the current year presentation.

We present the financial results of our businesses in the following three reportable segments:

Segment	% of revenues	Description
Global Health Care	78%	Aggregates the Commercial and Government operating segments: *Commercial* • Encompasses both our U.S. commercial and certain international health care businesses. • Serves employers and their employees, including globally mobile individuals, and other groups (e.g., governmental and non-governmental organizations, unions and associations). In addition, our U.S. commercial health care business also serves individuals. • Offers our insured and self-insured customers medical, dental, behavioral health, vision, and prescription drug benefit plans, health advocacy programs and other products and services that may be integrated as part of a comprehensive global health care benefit program. *Government* • Offers Medicare Advantage, Medicare Part D and Medicaid plans.
Global Supplemental Benefits	9%	Offers supplemental health, life and accident insurance products in selected international markets and the U.S.
Group Disability and Life	11%	Provides group long-term and short-term disability, group life, accident and specialty insurance products and related services.

We present the remainder of our segment results in ***Other Operations,*** consisting of the corporate-owned life insurance business ("COLI"), run-off reinsurance and settlement annuity businesses and deferred gains associated with the sales of the individual life insurance and annuity and retirement benefits businesses.

Key Transactions

Over the past three years, we have entered into a number of transactions that are helping us to achieve our strategic goals by: (1) repositioning the portfolio for growth in targeted geographies, product lines, buying segments and distribution channels; (2) improving our strategic and financial flexibility; and (3) pursuing additional opportunities in high growth markets with particular focus on individuals. Specifically:

- In June 2013, we entered into a ten-year pharmacy benefit management services agreement with Catamaran Corporation ("Catamaran"). Under this agreement, we utilize Catamaran's technology and service platforms, retail network contracting and claims processing services.
- In February 2013, we effectively exited our Run-off guaranteed minimum death benefit ("GMDB" also known as "VADBe") and guaranteed minimum income benefit ("GMIB") reinsurance businesses by entering into an agreement with Berkshire Hathaway Life Insurance Company of Nebraska ("Berkshire") to reinsure 100% of our future exposures for these businesses, net of retrocessional arrangements in place as of February 4, 2013, up to a specified limit.
- In 2012, we entered into three strategically significant transactions targeting several key markets: seniors, individual and global supplemental benefits:
  - We acquired HealthSpring, a Medicare Advantage provider, to assist us in serving individuals across their life stages and deepen our presence in a number of geographic markets. This acquisition brought us industry-leading physician partnership capabilities, deepened our existing client and customer relationships, and facilitated a broader deployment of our range of health and wellness capabilities and product offerings.
  - We acquired Great American Supplemental Benefits to both strengthen our capabilities in the individual market and facilitate our expansion into the Medicare supplement business.
  - We entered into a joint venture with Finansbank to expand our global footprint in Turkey.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively referred to throughout this Form 10-K as "Health Care Reform" or "PPACA") continues to have a significant impact on our business operations. The effects of Health Care Reform are discussed throughout this Form 10-K where appropriate, including in the Global Health Care business description, Regulation, Risk Factors, Management's Discussion and Analysis of Financial Condition and Results of Operations, and the Notes to the Consolidated Financial Statements.

Other Information

The financial information included in this Annual Report on Form 10-K for the fiscal year ended December 31, 2014 ("Form 10-K") is in conformity with accounting principles generally accepted in the United States of America ("GAAP"), unless otherwise indicated. Industry rankings and percentages set forth herein are for the year ended December 31, 2014 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 Corporation was incorporated in Delaware in 1981. Our annual, quarterly and current reports, proxy statements and other filings, and any amendments to these filings, are made available free of charge on 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 (the "SEC"). We use our website as a channel of distribution for material company information. Important information, including news releases, analyst presentations and financial information regarding Cigna is routinely posted on and accessible at www.cigna.com. See "Code of Ethics and Other Corporate Governance Disclosures" in Part III, Item 10 beginning on page 117 of this Form 10-K for additional available information.

Global Health Care

The Global Health Care segment constitutes approximately 80% of our revenues and aggregates the Commercial and Government operating segments due to their similar economic characteristics, products and services and regulatory environment. We seek to differentiate ourselves through deep customer insights, resulting in personalized solutions and service, and high quality physician partnerships to optimize quality and affordability of care for our customers and clients. We expect to accomplish these goals, in part, by targeting selected geographies and market segments and by accelerating our engagement with employers and individuals. The health care delivery system is moving away from a volume-based reimbursement system to a value orientation. We are actively driving this "volume-to-value" transition through our continued partnership with preferred health care professionals and our internal investment in people, process and technology.

Our Commercial operating segment encompasses both our U.S. commercial and certain international health care businesses serving employers and their employees, including globally mobile individuals, and other groups (e.g., governmental and non-governmental organizations, unions and associations). In addition, our U.S. commercial health care business also serves individuals through our product offerings both on and off the public health insurance exchanges. Through this segment, we offer our insured and self-insured customers medical, dental, behavioral health, vision, and prescription drug benefit plans, health advocacy programs and other products and services that may be integrated as part of a comprehensive global health care benefit program. Our Government operating segment offers Medicare Advantage, Medicare Part D and Medicaid plans.

Principal Products and Services

Commercial Medical Health Plans – U.S. and International

The Commercial operating segment, either directly or through its partners, offers some or all of its products in all 50 states, the District of Columbia, the U.S. Virgin Islands, Canada, Europe, the Middle East, and Asia. We offer a variety of medical plans including:

- *Managed Care Plans including Network, Network Open Access and Open Access Plus.* We offer a product line of Health Maintenance Organization ("HMO") and indemnity managed care benefit plans that use meaningful cost-sharing incentives to encourage the use of "in-network" versus "out-of-network" health care providers and provide the option to select a primary care physician. The national provider network for Managed Care Plans is somewhat smaller than the national network used with the preferred provider ("PPO") plan product line. Generally, customers may use non-participating health care professionals, but the customers' cost-sharing obligation is usually greater for out-of-network care.
- *PPO Plans.* Our PPO product line features a network with broader provider access than the Managed Care Plans. The preferred provider product line may be at a higher medical cost than our Managed Care Plans.
- *Choice Fund® Suite of Consumer-Driven Products.* Our medical plans are often integrated with the Cigna Choice Fund suite of products, including Health Reimbursement Accounts ("HRA"), Health Savings Accounts ("HSA") and Flexible Spending Accounts ("FSA") that are designed to encourage customers to play an active role in understanding and managing their health and associated expenses. Customers can use these accounts to finance eligible health care expenses and other approved services. In most cases, these products are combined with a high deductible medical plan. We continue to experience strong growth in these products and they represent a rapidly growing percentage of our overall medical customer base.

Approximately 90% of our commercial medical customers are in funding arrangements where lower medical costs directly benefit our corporate clients and employees who share in the cost of their coverage. The funding arrangements available for our commercial medical and dental health plans are as follows:

Funding Arrangement	% of Commercial Medical Customers	Description
Administrative Services Only ("ASO" or "self-insured")	82%	• ASO plan sponsors are responsible for self-funding all claims, but may purchase stop loss insurance to limit exposure for claims in excess of a predetermined amount. • 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; disease management; utilization management; cost containment; dental; and pharmacy benefit management. • In some cases, we provide performance guarantees associated with meeting certain service standards, clinical outcomes or financial metrics.
Insured – Experience Rated	6%	• Premium charged during the policy period ("initial premium") may be adjusted following the policy period for actual claim, and in some cases, administrative cost experience of the policyholder. • When claims and expenses are less than the initial premium charged (an "experience surplus"), the policyholder may be retrospectively credited for a portion of this premium. • However, if claims and expenses exceed the initial premium (an "experience deficit"), we generally bear the risk. In certain cases, experience deficits may be recovered through future year experience surpluses if the policyholder renews.
Insured – Guaranteed Cost	12%	• We establish the cost to the policyholder at the beginning of a policy period and generally cannot subsequently adjust premiums to reflect actual claim experience until the next annual renewal. • Employers and other groups with guaranteed cost policies are generally smaller than those with experience-rated group policies; accordingly, our claim and expense assumptions may be based in whole or in part on prior experience of the policyholder or on a pool of policyholders, depending on the policyholder's size and the statistical credibility of their experience. • HMO and individual plans (medical and dental) are offered on a guaranteed cost basis only.

We offer stop loss insurance coverage for ASO plans that provides reimbursement for claims in excess of a predetermined amount for individuals ("specific"), the entire group ("aggregate"), or both. Our experience rated group medical insurance policies include funding options similar to stop loss coverage.

In most states, individual and group insurance premium rates must be approved by the applicable state regulatory agency (typically department of insurance) and state laws may restrict or limit the use of rating methods. Premium rates for groups and individuals are subject to state review for reasonableness. In addition, Health Care Reform 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. In our individual business, premiums may also be adjusted as a result of the government risk mitigation programs. The MLR represents the percentage of premiums used to pay medical claims and expenses for activities that improve the quality of care. See the "Regulation" section of this Form 10-K for additional information on the commercial MLR requirements and the risk mitigation programs of Health Care Reform.

Government Health Plans

Medicare Advantage

We offer Medicare Advantage plans in 16 states and the District of Columbia through our Cigna-HealthSpring brand. Under a Medicare Advantage plan, Medicare-eligible beneficiaries may receive health care benefits, including prescription drugs, through a managed care health plan such as our coordinated care plans. A significant portion of our Medicare Advantage customers receive medical care from our innovative plan models that focus on developing highly engaged physician networks, aligning payment incentives to improved health outcomes, and using timely and transparent data sharing. We are focused on continuing to expand these models in the future.

We receive revenue from the Centers for Medicare and Medicaid Services ("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 "Medicare Stars"). Additional premiums may be received from customers, representing the difference between CMS subsidy payments and the revenue determined as part of our annual Medicare Advantage bid submissions. Beginning in 2014, Health Care Reform requires Medicare Advantage and Medicare Part D 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 subject to additional sanctions if the MLR continues to be less than 85% for successive years.

Medicare Part D

Our Medicare Part D prescription drug program provides a number of plan options, as well as service and information support to Medicare and Medicaid eligible customers. Our plans are available in all 50 states and the District of Columbia and offer the savings of Medicare combined with the flexibility to provide enhanced benefits and a drug list tailored to individuals' specific needs. Retirees benefit from broad network access and value-added services intended to help keep them well and save them money.

Medicaid

We offer Medicaid coverage to low income individuals in selected markets in Texas and Illinois. Our Medicaid customers benefit from many of the coordinated care aspects of our Medicare Advantage programs. We expect to further expand our Medicaid operations during 2015 under existing contracts.

Specialty Products

Our specialty products and services described below are designed to improve the quality of and lower the cost of medical services and help customers achieve better health outcomes. The vast majority of these products can be sold on a standalone basis, but we believe they are most effective when integrated with a Cigna-administered health plan. Our specialty products are focused in the areas of medical, behavioral, pharmacy management, dental and vision.

Medical Specialty

- *Cost-Containment Service.* We administer cost-containment programs on behalf of our clients and customers for health care services and supplies that are covered under health benefit plans. These programs may involve vendors who perform activities designed to control health costs by reducing out-of-network utilization, including educating customers regarding the availability of lower cost, in-network services, reviewing provider bills, and recovering overpayments from other payers or health care providers. We charge fees for providing or arranging for these services.
- *Health Advocacy.* We offer a wide array of medical management, disease management, and other health advocacy services to employers and other plan sponsors to help individuals improve their health, well-being and sense of security. These services are offered to customers covered under plans that we administer, as well as plans insured or administered by competing insurers or third-party administrators. Our health advocacy programs and services include early intervention in the treatment of chronic conditions. We also offer online tools and software to help customers manage their health and an array of health coaching programs designed to address lifestyle management issues such as stress, weight, and tobacco cessation.

Behavioral Health

We arrange for behavioral health care services for customers through our network of approximately 89,000 participating behavioral health care professionals and 11,400 facilities and clinics. We offer behavioral health care case management services, employee assistance programs ("EAP"), and work/life programs to employers, government entities and other groups sponsoring health benefit plans. We focus on integrating our programs and services with medical, pharmacy and disability programs to facilitate customized, holistic care.

Pharmacy Management

We offer prescription drug plans to our commercial and government (Medicare/Medicaid) customers both in conjunction with our medical products and on a stand-alone basis. With a network of over 74,000 pharmacies, Cigna Pharmacy Management is a comprehensive pharmacy benefits manager ("PBM") offering clinical integration programs and specialty pharmacy solutions. We also offer high quality, efficient, and cost-effective mail order, telephone and on-line pharmaceutical fulfillment services through our home delivery operation.

Our medical and pharmacy coverage can meet the needs of customers with complex medical conditions requiring specialty pharmaceuticals. These types of medications are covered under both pharmacy and medical benefits and can be expensive, often requiring associated lab work and administration by a health care professional. Therefore, coordination is critical in improving affordability and outcomes. Clients with Cigna-administered medical and pharmacy coverage benefit from continuity of care, integrated reporting, and aggressive unit cost discounts on all specialty drugs.

Dental

We offer a variety of dental care products including dental health maintenance organization plans ("Dental HMO") in 37 states, dental preferred provider organization ("Dental PPO") plans in 48 states and the District of Columbia, exclusive dental provider organization plans, traditional dental indemnity plans and a dental discount program. Employers and other groups can purchase our products as stand-alone products or integrated with medical products. Additionally, individual customers can purchase Dental PPO plans in conjunction with individual medical policies.

As of December 31, 2014, our dental customers totaled approximately 12.9 million, most of whom are in self-insured plans. Our customers access care from one of the largest Dental PPO networks and Dental HMO networks in the U.S., with approximately 134,000 Dental PPO health care professionals and 20,000 Dental HMO health care professionals.

Vision

Cigna Vision offers flexible, cost-effective PPO coverage that includes a range of both in and out-of-network benefits for routine vision services offered in conjunction with our medical and dental product offerings. Our national vision care network, consisting of approximately 69,700 health care providers in over 24,800 locations, includes private practice ophthalmologist and optometrist offices, as well as retail eye care centers.

Service and Quality

Customer Service

For U.S.-based customers, we operate 18 service centers that together processed approximately 158 million medical claims in 2014. As of December 31, 2014, we operated 15 call centers, and provide service to customers 24 hours a day, 365 days a year.

In our international health care business, we have a service model dedicated to the unique needs of our 1.3 million customers around the world. We service them from 8 service centers that are available 24 hours a day, 365 days a year.

Technology

Technology continues to play a significant role in the execution of our Go Deep, Go Global, Go Individual strategy. Our information technology (IT) investments and priorities are focused on building a retail-centric IT infrastructure and developing innovative business capabilities that support affordable health solutions and create a personalized customer experience. We continue to leverage technology, information and analytics globally to engage our customers in more meaningful, relevant and customized methods, guided by their needs, preferences, likes and interests. Our investments in digital, mobile, gamification, social media and big data enable us to create solutions that improve health and wellness. With increased engagement across the health care ecosystem, we believe that technology can significantly upgrade the customer experience and improve care delivery through collaboration with delivery systems, enabling the transition from a volume based fee-for-service system to a value based health care marketplace. While focusing on innovation, we will remain focused on the delivery of strong foundational IT capabilities including optimization and resilience of the core infrastructure; building appropriate business continuity and disaster recovery capabilities; and developing layered information protection and strengthened cybersecurity solutions. We will also continue to seek opportunities to expand the role technology plays in delivering value to our customers and partners.

Quality Medical Care

Our commitment to promoting quality medical care to the people we serve is reflected in a variety of activities.

Health Improvement through Delivery System Engagement

Cigna is committed to developing innovative solutions that span the delivery system. We are focused on executing our connected care strategy that engages providers and customers to achieve affordability and access at the local market level. We continue to increase our engagement with physicians and hospitals by rapidly developing the types of arrangements discussed below. More than one million medical customers are currently serviced by more than 48,000 health care providers in these types of arrangements.

- ***Collaborative Accountable Care Organizations ("CACs").*** We increasingly collaborate with physicians and other health care professionals and facilities to improve the quality of care and patient satisfaction while lowering medical costs, resulting in improved overall value. This collaboration is illustrated by our 114 CAC arrangements, spanning 28 states and reaching 1.2 million customers and by our commitment to continue increasing the number of CACs over the next several years. Our goal is to reach 135 of these programs in 2015.

We continue to grow Cigna's National Hospital Quality Incentive Program with compensation to 195 hospitals tied to quality metrics and we expect to add an additional 100 hospitals over the next two years. Additionally, we continue to develop our arrangements with specialists through innovative programs such as National Ob/Gyn and our episode-of-care program focused on deliveries along with hip and knee replacements.

Our Patient Care Collaboration program will put the small physician practice first by providing them with key actionable patient information to improve outcomes in a way that fits their practice needs. The program is newly developed and we anticipate piloting with select physicians in a few markets in 2015.

- ***Delivery System Alliances.*** We are now forming alliances with hospitals and hospital systems that will provide access to quality, value-based care in local communities.
- ***Independent Practice Associations – Cigna-HealthSpring.*** With the innovative physician engagement models in our Cigna-HealthSpring business, we utilize a variety of business arrangements that shift the physician's reimbursement from the traditional fee-for-service model to one that is focused on rewarding quality medical outcomes and an enhanced patient experience at a lower cost. In these arrangements, the physician groups share financial outcomes with us. The Cigna-HealthSpring 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 professionals, 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 (e.g., Tufts Health Plan, HealthPartners, Inc., Health Alliance Plan, and MVP Health Plan) to gain access to their provider networks and discounts.

We credential physicians, hospitals and other health care professionals in our participating provider networks using quality criteria that meet or exceed the standards of external accreditation or state regulatory agencies, or both. Typically, most health care professionals are re-credentialed every three years.

The *Cigna Care Network,* a benefit design option available in 70 service areas across the U.S., is a subset of participating specialist physicians so designated based on specific clinical quality and cost-efficiency criteria. Customers pay reduced co-payments or co-insurance when they receive care from a specialist designated as a Cigna Care Network physician. Participating specialists are evaluated regularly for the Cigna Care Network designation.

LocalPlus® is a select network of local, quality doctors and hospitals designed to offer clients greater affordability, by limiting the network to a subset of quality, cost-efficient physicians and hospitals. We currently offer LocalPlus in 12 markets and will expand this approach in additional markets in 2015.

Onsite Medical Care

- ***Cigna Medical Group*** is a multi-specialty medical group practice that delivers primary care and certain specialty care services through 23 medical facilities and approximately 150 employed clinicians in the Phoenix, Arizona metropolitan area. All of the these health care centers have received accreditation as a Patient Centered Medical Home from the National Committee for Quality Assurance ("NCQA") a private, nonprofit organization dedicated to improving health care quality. Cigna Medical Group holds the highest level of this accreditation (level 3). Cigna Medical Group has the greatest number of practices and physicians in the state of Arizona with this accreditation.
- ***Cigna Onsite Health.*** Our onsite services include more than 150 health centers at various employer sites that offer health coaching, wellness seminars and biometric screenings.
- ***LivingWell Health Centers.*** Our Medicare Advantage customers may receive care from a team of physicians, nurse practitioners and pharmacists. We operate seven free-standing clinics and six "embedded" clinics that incorporate the principles and resources of stand-alone clinics while allowing the customer to continue local office visits to his or her primary care physician.

External Validation

We continue to demonstrate our commitment to quality and have a broad scope of quality programs validated through nationally recognized external accreditation organizations. We retained Health Plan accreditation from the NCQA in 36 of our markets. Additional NCQA recognitions include Full Accreditation for Managed Behavioral Healthcare Organization for Cigna Behavioral Health, accreditation with Performance Reporting for Wellness & Health Promotion, accreditation for our wellness programs and Physician & Hospital Quality Certification for our provider transparency program. We have Full Accreditation for Health Utilization Management, Case Management and Pharmacy Benefit Management from URAC, an independent, nonprofit health care accrediting organization dedicated to promoting health care quality through accreditation, certification and commendation.

We participate in the NCQA's Health Plan Employer Data and Information Set ("HEDIS®") Quality Compass Report, whose Effectiveness of Care measures are a standard set of metrics to evaluate the effectiveness of managed care clinical programs. Our national results compare favorably to industry averages.

Markets and Distribution

We offer health care and related products and services in the following customer segments or markets:

		% of Medical Customers
National	Multi-state employers with 5,000 or more U.S.-based, full-time employees. We primarily offer ASO funding solutions in this market segment.	26%
Middle Market	Employers generally with 250 to 4,999 U.S.-based, full-time employees. This segment also includes single-site employers with more than 5,000 employees, Taft-Hartley plans and other third party payers. We offer ASO, experience-rated and guaranteed cost funding solutions in this market segment.	52%
Select	Employers generally with 51-249 eligible employees. We offer ASO and guaranteed cost funding solutions in this market segment.	8%
Individual	Individuals in ten states: Arizona, California, Colorado, Connecticut, Florida, Georgia, North Carolina, South Carolina, Tennessee and Texas. In 2014 we offered coverage on the state-run public health insurance exchange in Colorado, as well as the federally facilitated exchanges in Arizona, Florida, Tennessee and Texas. In 2015 we will expand our public exchange participation to include the state-run exchange in Maryland and the federally facilitated exchanges in Georgia and Missouri. Consistent with the regulations for Individual PPACA compliant plans, we offer plans only on a guaranteed cost basis in this market segment.	2%
Government	Offers Medicare Advantage (both to individuals who are post-65 retirees, as well as employer group sponsored pre- and post-65 retirees), Prescription Drug programs, and Medicaid products.	3%
International	Focused on the needs of local and multinational companies and organizations and their local and globally mobile employees and dependents. We offer guaranteed cost, experience-rated and ASO funding solutions in this market segment.	9%

Cigna Guided Solutions[SM], is our proprietary retail health insurance exchange targeting clients that value fully integrated solutions, and focusing on engaging employees in their health and their health spending. It leverages Cigna's ability to provide a fully integrated solution with our broad spectrum of plans and services, and broad suite of funding options, focused on improving total cost, health, and improved productivity. Together with integrated robust decision-support tools, employees will be able to make appropriate trade-off decisions and select plans that best fit them and their families.

In addition, Cigna participates on many third party private exchanges. 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. To date, we have committed to participate with numerous private exchanges for both active employees and retirees.

We employ sales representatives to distribute our products and services through insurance brokers and insurance consultants or directly to employers, unions and other groups or individuals. We also employ representatives to sell utilization review services, behavioral health care and pharmacy management, and employee assistance services directly to insurance companies, HMOs, third party administrators and employer groups. As of December 31, 2014, our field sales force consisted of over 1,250 sales representatives in more than 132 field locations. In our Cigna-HealthSpring business, Medicare Advantage enrollment is generally a decision made individually by the customer, and accordingly, sales agents and representatives focus their efforts on in-person contacts with potential enrollees, as well as telephonic and group selling venues.

Competition and Industry Developments

Our business is subject to intense competition and continuing industry consolidation that has created an even more competitive business environment. In certain geographic locations, some health care companies may have significant market share positions, but no one competitor dominates the health care market nationally. We expect a continuing trend of consolidation in the industry given the current economic and political environment. We also expect continued vertical integration, with the line blurring between clinicians and hospitals, and traditional insurers.

Competition in the health care market exists both for employers and other groups sponsoring plans and for the employees in those instances where the employer offers its employees a choice of products from more than one health care company. Most group policies are subject to annual review by the policyholder, who may seek competitive quotations prior to renewal. We expect competition to increase in the individual market as a result of the growth in the public health insurance exchanges under Health Care Reform. Given the relatively immature individual market and limited data around claim experience, we expect some uncertainty and competitive volatility through the initial years of the exchange roll out. Some of the risk is mitigated by the government risk mitigation programs.

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 of the insurer, as indicated by ratings issued by nationally recognized rating agencies, is also a competitive factor. We believe that our health advocacy capabilities, holistic approach to consumer engagement, breadth of product offerings, clinical care and medical management capabilities and array of product funding options are competitive advantages in meeting the diverse needs of our customer base. We also believe that our focus on helping to improve the health, well-being and sense of security of the customers we serve will allow us to differentiate ourselves from our competitors.

Our principal competitors in the U.S.-based business are:

- other large insurance companies that provide group health and life insurance products;
- Blue Cross and Blue Shield organizations;
- stand-alone HMOs and PPOs;
- HMOs affiliated with major insurance companies and hospitals; and
- national managed pharmacy, behavioral health and utilization review services companies.

The primary competitors of the international health care business include U.S. and European health insurance companies with global health benefits operations. The primary competitors for our international health care operations in the United Kingdom and Spain are regional and local insurers.

Competition also arises from smaller regional or specialty companies with strength in a particular geographic area or product line, administrative service firms and, indirectly, self-insurers. In addition to these traditional competitors, a new group of competitors has emerged. Some of these newer competitors, such as hospitals and companies that offer web-based tools for employers and employees, are focused on delivering employee benefits and services through internet-enabled technology that allows consumers to take a more active role in the management of their health. This can be accomplished through financial incentives, access to enhanced quality medical data and other information sharing. The effective use of our health advocacy, customer insight and physician engagement capabilities, along with decision support tools (some of which are web-based) and enabling technology are critical to success in the health care industry, and we believe our capabilities in these areas will be competitive differentiators.

The health insurance marketplace will continue to be shaped by Health Care Reform. In 2016, Health Care Reform expands the small group market definition to employers with 100 or less employees, subjecting insurers in this market to community rating. The results of the 2014 Congressional elections add additional uncertainty as to the effects that Health Care Reform may have going forward. See the "Regulation" section of this Form 10-K for additional information regarding Health Care Reform.

On February 20, 2015, CMS issued its Advance Notice of Methodological Changes for Calendar Year 2016 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (the "Notice"). The final terms are expected to be published on April 6, 2015. While the terms contained within the Notice are within the range of our expectations, there remain numerous open issues and substantial uncertainties regarding the final terms of the Notice. We expect that CMS will receive a significant number of comments from interested parties (including Cigna) prior to issuing the final terms; however, there can be no assurance that CMS will amend its current positions. Given the uncertainty regarding the final terms of the Notice, we cannot reliably estimate the impact on our business, revenues or results of operations in 2016 and beyond; under certain circumstances, it is possible that the impact could be materially adverse. In addition, we expect to adjust our programs and services in response to the proposed 2016 terms.

Global Supplemental Benefits

Our Global Supplemental Benefits segment offers supplemental health, life and accident insurance products primarily in Asia, Europe and the United States. With local licenses and partnerships in approximately 15 countries and jurisdictions, we are able to offer products and services to local citizens and globally mobile individuals. In China, Turkey, and India, we offer products and services through joint ventures. This segment constituted 9% of our consolidated revenues for the year ended December 31, 2014.

We continue to distinguish ourselves in the global supplemental health, life and accident businesses through our differentiated direct-to-consumer distribution, customer insights and marketing capabilities. We enter new markets when the opportunity to bring our product and health solutions is attractive. Over the past several years, we have continued to extend our product offerings and geographic reach. For example, in 2014, we began offering products in India through our joint venture with TTK Group. In 2012, we extended our reach in Turkey through the joint venture with Finansbank and expanded into the U.S. Medigap and supplemental lines of business through the acquisition of Great American Supplemental Benefits.

Principal Products and Services

Supplemental Health, Life and Accident Insurance

Supplemental health, life and accident insurance products generally provide simple, affordable coverage of risks for the health and financial security of individuals. Supplemental health products provide specified payments for a variety of health risks and include personal accident, accidental death, critical illness, hospitalization, travel, dental, cancer and other dread disease coverages. We also offer customers individual private medical insurance, term and variable universal life insurance, and certain savings products.

Medicare Supplement Plans

We offer individual Medicare Supplement plans that provide retirees with federally standardized Medigap-style plans. Retirees 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 professional or facility that accepts Medicare throughout the United States.

Pricing and Reinsurance

Premium rates for our global supplemental benefits products are based on assumptions about mortality, morbidity, customer acquisition and retention, customer demographics, expenses and target profit margins, as well as interest rates. For 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 for 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 per life, per risk, and per event (catastrophe) bases.

Markets and Distribution

Our supplemental health, life and accident insurance products sold in foreign countries are generally marketed through distribution partners with whom the individual insured has an affinity relationship. These products are sold primarily through direct marketing channels, such as outbound telemarketing, and in-branch bancassurance (where we partner with a bank and use the bank's sales channels to sell our insurance products). Marketing campaigns are conducted through these channels under a variety of arrangements with affinity partners, including banks, credit card companies and other financial and non-financial institutions. We also market directly to consumers via direct response television and the Internet. In certain countries, we market our products through captive and third party brokers. Our Medicare supplement product line is distributed primarily through independent agents and telemarketing directly to the consumer.

South Korea represents our single largest geographic market for Global Supplemental Benefits. For information on this concentration of risk for the Global Supplemental Benefits segment's business in South Korea, see "Other Items Affecting Results of Global Supplemental Benefits" in the Global Supplemental Benefits section of the MD&A beginning on page 52 of this Form 10-K.

For our supplemental health, life and accident insurance products sold in foreign markets we are increasingly exposed to geopolitical, currency and other risks inherent in foreign operations. Also, given that we bill and collect a significant portion of premiums through credit cards, a substantial contraction in consumer credit could impact our ability to retain existing policies and sell new policies. A decline in customer retention would result in both a reduction of revenue and an acceleration of the amortization of acquisition-related costs. Changes in regulation for permitted distribution channels also may impact our business or results.

Competition

We expect that the competitive environment for global supplemental benefits will continue to intensify as U.S., Europe and other regional-based insurance and financial services providers more aggressively pursue expansion opportunities across geographies, especially in Asia. We believe competitive factors will include branding, product and distribution innovation and differentiation, efficient management of marketing processes and costs, commission levels paid to distribution partners, the quality of claims, local network coverage, customer services and talent acquisition and retention. Additionally, in most overseas markets, perception of financial strength also will likely continue to be an important competitive factor.

Our competitors are primarily locally-based insurance companies, including insurance subsidiaries of banks primarily in Asia and Europe and multi-national companies. Insurance company competitors in this segment primarily focus on traditional product distribution through captive agents, with direct marketing being secondary channels. We estimate that we have less than 2% market share of the total insurance premiums in any given market in which we operate.

In the Medicare supplement business, the principal competitive factors are underwriting and pricing, relative operating efficiency, broker relations, and the quality of claims and customer service. Our primary competitors in this business include U.S.-based health insurance companies.

Industry Developments

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 products providing health insurance and financial security. 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. Recent Asian affinity deals have involved multinational insurers making large upfront payments to financial institutions for long term (over 10 years) exclusive regional distribution rights throughout their retail operations.

Data privacy regulation has tightened in all markets, in the wake of data privacy news scandals, impacting affinity partner and customer attitudes toward direct marketing of insurance and other financial services.

Group Disability and Life

Our Group Disability and Life segment provides group long-term and short-term disability insurance, group life insurance, accident and specialty insurance and related services. We market these products and services in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Canada. All products and services are offered by subsidiaries of Cigna Corporation.

Products and Services

Group Disability

Long-term and short-term group disability insurance products generally provide a fixed level of income to replace a portion of wages lost because of disability. Group disability coverage is typically employer-paid or a combination of employer and employee-paid, but also may include coverage paid for entirely by employees. As part of our group disability insurance products, we also provide assistance to employees in returning to work and assistance to their employers in managing the cost of employee disability. We are an industry leader in helping employees return to work quickly, resulting in higher productivity and lower cost for employers and a better quality of life for their employees.

We seek to integrate our disability insurance products with other disability benefit programs, behavioral programs, medical programs, social security advocacy, and administration of federal and state Family and Medical Leave Act (FMLA) laws and other leave of absence programs. We believe this integration provides our customers with increased efficiency and effectiveness in disability claims management, enhances productivity and reduces overall costs to employers. This integration also provides early insight into employees at risk for future disability claims. Coordinating the administration of these disability programs with medical programs offered by our health care business provides enhanced opportunities to influence outcomes, reduce the cost of both medical and disability events and improve the return to work rate. The benefits of this integrated approach also include:

- using information from the health care and disability databases to help identify, treat and manage disabilities before they become chronic, longer in duration and more costly; and
- proactively reaching out to assist employees suffering from a mental health or chronic condition, either as a primary condition or as a result of another condition.

Our disability products and services are offered on a fully insured, experience-rated and ASO basis, although most are fully insured. As measured by 2014 premiums and fees, disability constituted approximately 49% of this segment's business. Approximately 13,800 insured disability policies covering over 7.5 million lives were in force as of December 31, 2014.

Group Life Insurance

Group life insurance products offered include term life and universal life. Group term life insurance may be employer-paid basic life insurance, employee-paid supplemental life insurance or a combination thereof. Group universal life insurance is an employee-paid, voluntary life insurance product in which the owner may accumulate a cash value. The cash value earns interest at rates declared from time to time, subject to a minimum guaranteed contracted rate, and may be borrowed, withdrawn, or, within certain limits, used to fund future life insurance coverage.

As measured by 2014 premiums and fees, group life insurance constituted approximately 45% of this segment's business. Approximately 8,700 group life insurance policies covering over 6 million lives were in force as of December 31, 2014.

Other Products and Services

We also offer personal accident insurance coverage, consisting primarily of accidental death and dismemberment and travel accident insurance to employers. Group accident insurance may be employer-paid or employee-paid. In addition, we offer specialty insurance services that consist primarily of disability and life, accident, and hospital indemnity products to professional or trade associations and financial institutions.

We also provide a number of voluntary products and services that are typically paid by the employee and offered at the employer's worksite. Our plans provide employers with administrative solutions designed to provide employers with a complete and simple way to manage their benefits program. Recently, we have brought to market two additional voluntary offerings – accidental injury insurance and critical illness coverage. Both products provide additional dollar payouts to employees for unexpected accidents or more serious illnesses.

Pricing and Reinsurance

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 and 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.

Premiums for group universal life insurance products consist of mortality and administrative charges assessed against the policyholder's fund balance. Interest credited and mortality charges for group universal life may be adjusted prospectively to reflect expected interest and mortality experience. Mortality charges are subject to maximum guaranteed rates and interest credited on cash values is subject to minimum guaranteed rates as stated in the policy.

The effectiveness of return to work programs and morbidity levels will impact the profitability of disability insurance products. Our previous claim experience and industry data indicate a correlation between disability claim incidence levels and economic conditions, with submitted claims rising under adverse economic conditions, although this impact is not clear. For life insurance products, the degree to which future experience deviates from mortality and expense assumptions also affects profitability.

To reduce our exposure to large individual and catastrophic losses under group life, disability and accidental death policies, we purchase reinsurance from a diverse group of unaffiliated reinsurers. Our comprehensive reinsurance program consists of excess of loss treaties and catastrophe coverage designed to mitigate earnings volatility and provide surplus protection.

Markets and Distribution

We market our group disability and life insurance products and services to employers, employees, professional and other associations and groups in the National, Middle Market and Select segments. In marketing these products, we primarily sell through insurance brokers and consultants and employ a direct sales force consisting of approximately 235 sales professionals in 27 office locations as of December 31, 2014.

Competition

The principal competitive factors that affect the Group Disability and Life segment are underwriting and pricing, the quality and effectiveness of claims management, relative operating efficiency, investment and risk management, distribution methodologies and producer relations, the breadth and variety of products and services offered, and the quality of customer service. For certain products with longer-term liabilities, such as group long-term disability insurance, the financial strength of the insurer, as indicated by ratings issued by nationally recognized rating agencies, also is a competitive factor.

The principal competitors of our group disability, life and accident businesses are other large and regional insurance companies that market and distribute these or similar types of products. As of December 31, 2014, we are one of the top five providers of group disability, life and accident insurance in the United States, based on premiums.

Industry Developments

Employers are expressing a growing interest in employee wellness, absence management and productivity and likewise are recognizing a strong link between employee health, productivity and their profitability. As this interest grows, we believe our healthy lifestyle and return-to-work programs and integrated family medical leave, disability and health care programs position us to deliver integrated solutions for employers and employees. We also believe that our strong disability management portfolio and fully integrated programs provide employers and employees tools to improve health status. This focus on managing the employee's total absence enables us to increase the number and likelihood of interventions and minimize disabling events.

The group insurance market remains highly competitive as the rising cost of providing medical coverage to employees has forced companies to re-evaluate their overall employee benefit spending, resulting in lower volumes of group disability and life insurance business and more competitive pricing. Demographic shifts have further driven demand for products and services that are sufficiently flexible to meet the evolving needs of employers and employees who want innovative, cost-effective solutions to their insurance needs. Employers continue to shift towards greater employee participatory coverage and voluntary purchases. With our broad suite of voluntary offerings and continued focus on developing additional voluntary products and service capabilities, we believe we are well positioned to meet the needs of both employers and employees as the market shifts to become more retail-focused.

Over the past few years, there has been heightened review by state regulators of the claims handling practices within the disability and life insurance industry. This has resulted in an increase in coordinated, multi-state examinations that target specific market practices in addition to regularly recurring examinations of an insurer's overall operations conducted by an individual state's regulators. We have been recently subject to such an examination. See Note 23 to the Consolidated Financial Statements for additional information.

Other Operations

As discussed in the "Overview" section on page 1 of this Form 10-K, beginning in 2014, we combined the results of the Run-off Reinsurance segment with other immaterial segments in Other Operations. Throughout this Form 10-K, prior year information has been conformed to the current year presentation. Other Operations includes the following four businesses:

Corporate-owned Life Insurance ("COLI")

The principal products of the COLI business are 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. 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 and catastrophe losses, we purchase reinsurance from unaffiliated reinsurers.

Run-off Reinsurance

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

In February 2013, we effectively exited the GMDB and GMIB businesses 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, see Note 7 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 sale of these businesses and the arrangements that secure our reinsurance recoverables for the retirement benefits business, see Note 7 of the Consolidated Financial Statements.

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 23% of the liabilities associated with payments that are guaranteed and not contingent on survivorship. For contracts that involve non-guaranteed payments, such payments are contingent on the survival of one or more parties involved in the settlement.

Investments and Investment Income

General Accounts

Our investment operations provide investment management and related services for our corporate invested assets and 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. 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 segment earnings for each of our reporting segments and Corporate. Realized investment gains (losses) are reported by segment but excluded from segment earnings. For additional information about invested assets, see the "Investment Assets" section of the MD&A beginning on page 55 and Notes 10 to 14 of our 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 disability and 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 strategy and results are affected by the amount and timing of cash available for investment, competition for investments, economic conditions, interest rates 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/or property-specific information.

Separate Accounts

Our subsidiaries or external advisors manage Separate Account assets on behalf of contractholders. 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. As of December 31, 2014, our Separate Account assets consisted of:

- $3.8 billion in separate account assets that constitute a portion of the assets of the Cigna Pension Plan;
- $3.5 billion in separate account assets that support Variable Universal Life products sold as a part of our corporate-owned life insurance business, as well as through our Global Supplemental Benefits segment; and
- $1.0 billion in separate account assets that support primarily health care and other disability and life products.

Regulation

The laws and regulations governing our business continue to increase each year and are subject to frequent change. We are regulated by state, federal and international regulatory agencies that 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 that could materially impact the health care system. See "Regulatory and Legislative Developments" on page 13.

Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. These subsidiaries are subject to numerous state, federal and international regulations related to their business operations, including, but not limited to:

- the form and content of customer contracts including benefit mandates (including special requirements for small groups);
- premium rates and medical loss ratios;
- the content of agreements with participating providers of covered services;
- producer appointment and compensation;
- claims processing and appeals;
- underwriting practices;

- reinsurance arrangements;
- solvency/financial reporting;
- unfair trade and claim practices;
- protecting the privacy and confidentiality of the information received from customers;
- risk sharing arrangements with providers;
- reimbursement or payment levels for Medicare services;
- advertising; and
- the operation of consumer-directed plans (including health savings accounts, health reimbursement accounts, flexible spending accounts and debit cards).

In addition, our international subsidiaries are subject to regulations in international jurisdictions where foreign insurers may be faced with more onerous regulations than their domestic competitors. The broader regulatory environment may include anti-corruption laws, economic sanctions laws, various insurance, tax, tariff and trade laws and regulations, corporate governance, employment, intellectual property and investment laws and regulation, discriminatory licensing procedures, compulsory cessions of reinsurance, required localization of records and funds, higher premium and income taxes, and requirements for local participation in an insurer's ownership. In addition, the expansion of our operations into foreign countries increases our exposure to certain U.S. laws, such as the Foreign Corrupt Practices Act of 1977 ("FCPA"). See page 15 for further discussion of international regulations.

The business of administering and insuring employee benefit programs in the United States, particularly health care programs, is heavily regulated by state and federal laws and administrative agencies, such as state departments of insurance, and federal agencies including HHS, CMS, the Internal Revenue Service ("IRS") and the Departments of Labor, Treasury and Justice, as well as the courts. Health savings accounts, health reimbursement accounts and flexible spending accounts also are regulated by the Department of the Treasury and the IRS.

Our operations, accounts and other books and records are subject to examination at regular intervals by regulatory agencies, including state insurance and health and welfare departments, state boards of pharmacy and CMS to assess compliance with applicable laws and regulations. In addition, our current and past business practices are subject to review by, and from time to time we receive subpoenas and other requests of information from, various state insurance and health care regulatory authorities, attorneys general, the Office of Inspector General ("OIG"), the Department of Labor and other state and federal authorities, including inquiries by, and testimony before committees and subcommittees of the U.S. Congress regarding certain of our business practices. These examinations, reviews, subpoenas and requests may result in changes to or clarifications of our business practices, as well as fines, penalties or other sanctions.

Regulatory and Legislative Developments

The federal and state governments in the United States as well as governments in other countries where we do business continue to enact and consider many broad-based legislative and regulatory proposals that could materially impact various aspects of our business.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively referred to as "Health Care Reform") mandates broad changes affecting insured and self-insured health benefit plans that impact our current business model, including our relationship with current and future customers, producers and health care providers, products, services, processes and technology. Most of the key provisions of Health Care Reform are now effective. Health Care Reform left many details to be established through regulations. While federal agencies have published proposed and final regulations with respect to most provisions, many issues remain uncertain. In addition, certain provisions of Health Care Reform have been subject to legal challenge, including the case currently pending before the U.S. Supreme Court as to whether premium subsidies are available for eligible residents in states that have not established state-based exchanges. Other provisions of Health Care Reform have been amended or delayed, such as the employer mandate, which will be phased in during 2015 and 2016 based on employer size. The employer mandate requires employers with 50 or more full-time employees to offer health insurance that is affordable and provides minimum value (each as defined under Health Care Reform) to full-time employees and children up to age 26 or be subject to penalties.

Key Provisions of Health Care Reform in Effect

Various fees, including ***the health insurance industry tax*** and the ***reinsurance fee,*** were assessed beginning in 2014. The health insurance industry assessment, totaling $8.0 billion for the industry in 2014 and increasing to $13.9 billion by 2017, is not tax deductible. Our share of this industry tax is determined based on our proportion of premiums for both our commercial and government risk businesses to the industry total. The reinsurance fee is a temporary (2014-2016) fixed dollar per customer levy on all insurers, HMOs and self-insured group health plans and is tax deductible.

The ***health insurance exchange enrollment process*** began on October 1, 2013 with coverage first effective in 2014. Each state has a state-based, a state and federal partnership, or a federally-facilitated health insurance exchange for individuals and small employer groups to purchase insurance coverage.

Because individuals seeking to purchase health insurance coverage beginning in 2014 either on or off the exchanges are guaranteed to be issued a policy, Health Care Reform provides programs designed to reduce the risk for participating health insurance companies including: 1) a temporary (2014-2016) reinsurance program; and (2) a premium stabilization program comprised of two components: a temporary program (2014-2016) limiting insurer gains and losses, and a permanent program that adjusts premiums based on the relative health status of the customer base. See Note 2 to the Consolidated Financial Statements and the Introduction to the MD&A contained in this Form 10-K for additional information on these programs.

Commercial minimum medical loss ratio requirements, as prescribed by HHS, became effective in January 2011 and require payment of premium rebates to group and individual policyholders if certain annual MLRs are not met in our commercial business. In December 2014, the federal government enacted legislation that provides permanent relief from certain Health Care Reform requirements for expatriate health coverage (including the MLR requirements). For the financial impact of the commercial MLR requirements on our results, see the "Overview" section of our MD&A in this Form 10-K.

Other provisions already in effect include reduced Medicare Advantage premium 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 and extending coverage of dependents to the age of 26. Health Care Reform also changed certain tax laws that effectively limit tax deductions for certain employee compensation paid by health insurers.

Our Medicare Advantage and Medicare Part D prescription drug plan businesses also have been impacted by Health Care Reform in a variety of additional ways beginning in 2014, including mandated minimum reductions to risk scores, transition of Medicare Advantage "benchmark" rates to Medicare fee-for-service parity, reduced enrollment periods and limitations on disenrollment, providing "quality bonuses" for Medicare Advantage plans with a rating for four or five stars from CMS and mandated consumer discounts on brand name and generic prescription drugs for Medicare Part D plan participants in the coverage gap. Beginning in 2014, Health Care Reform requires Medicare Advantage and Medicare Part D plans to meet a minimum MLR of 85%. Under the finalized regulations promulgated by HHS, if the MLR for a CMS contract is less than 85%, we are required to pay a penalty to CMS and could be subject to additional sanctions if the MLR continues to be less than 85% for successive years. Through Health Care Reform and other federal legislation, funding for Medicare Advantage plans has been and may continue to be altered.

We have substantially implemented the key provisions of Health Care Reform. Management continues to be actively engaged with regulators and policymakers with respect to rule-making. For the financial effects of certain Health Care Reform provisions, see the Overview section of our MD&A beginning on page 32 of this Form 10-K. In addition, accounting policies around the government's risk mitigation programs are further disclosed in Note 2 to the Consolidated Financial Statements.

Regulation of Insurance Companies

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 accounts are subject to examination by such agencies. We expect states to expand regulations relating to corporate governance and internal control activities of insurance and HMO subsidiaries as a result of an amendment by the National Association of Insurance Commissioners ("NAIC") to its Annual Financial Reporting Model Regulation that has elements similar to corporate governance and risk oversight disclosure requirements under federal securities laws. The NAIC formally adopted these requirements in late 2014, which apply to all U.S. insurers beginning in 2016.

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. In the United States, to pay such claims, these associations levy assessments on member insurers licensed in a particular state. Certain states require HMOs to participate in guaranty funds, special risk pools and administrative funds. For additional information about guaranty fund and other assessments, see Note 23 to our 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 Health Care Reform.

Solvency and Capital Requirements

Many states have adopted some form of the NAIC model solvency-related laws and risk-based capital rules ("RBC rules") for life and health insurance companies. 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 risk-based capital falls below statutory 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. During 2014, our HMOs and life and health insurance subsidiaries, as well as non-U.S. insurance subsidiaries, were compliant with applicable RBC and non-U.S. surplus rules.

In 2012, the NAIC adopted the Risk Management and Own Risk and Solvency Assessment Model Act ("ORSA"). ORSA 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, which includes a

requirement to file an annual ORSA Summary Report in the lead state of domicile, now must be adopted into law by each state. Our insurance business in the United States will be subject to these requirements that are expected to become effective in 2015. We will be prepared to file an ORSA Summary Report with our lead state regulator consistent with the requirements.

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 or an HMO subsidiary and its affiliates may require notification to, or approval by, one or more state insurance commissioners.

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 Requirements

Certain of our subsidiaries are pharmacies that dispense prescription drugs to participants of benefit plans administered or insured by our HMO and insurance company subsidiaries. These pharmacy-subsidiaries are subject to state licensing requirements and regulation as well as U.S. Drug Enforcement Agency registration requirements. Other laws and regulation affecting our pharmacy-subsidiaries include federal and state laws concerning labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances.

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.

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 financial and other disclosures, corporate governance, privacy, data protection, data mining, data transfer, labor and employment, consumer protection, direct-to-consumer communications activities, 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 in the locations in which our subsidiaries conduct business,
- in some cases, are subject to regulations in the locations of customers, and
- in all cases, are subject to the FCPA.

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. In many countries outside of the United States, health care professionals are employed by the government. 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 Department of Justice 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.

If our employees or agents fail to comply with applicable laws governing our international operations, we may face investigations, prosecutions and other legal proceedings and actions that could result in civil penalties, administrative remedies and criminal sanctions. See the Risk Factors section beginning on page 18 for a discussion of risks related to operating globally.

Federal Regulations

Employee Retirement Income Security Act and the Public Health Service Act

Our domestic subsidiaries sell most of their products and services to sponsors of employee benefit plans that are governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA is a complex set of federal laws and regulations enforced by the IRS and the Department of Labor, as well as the courts. Our domestic subsidiaries are 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. 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.

Many provisions of Health Care Reform impacting insured and self-insured group health plans were incorporated into ERISA. The health insurance reform provisions under ERISA were also incorporated into the Public Health Service Act and are directly applicable to health insurance issuers (i.e., health insurers and HMOs).

Plans subject to ERISA also can be subject to state laws and the legal question of whether and to what extent ERISA preempts a state law has been, and will continue to be, subject to court interpretation.

Medicare Regulations

Several of our subsidiaries engage in businesses that are subject to federal Medicare regulations, such as:

- those offering individual and group Medicare Advantage (HMO) coverage;
- those offering Medicare Pharmacy (Part D) products that are subject to federal Medicare regulations; and
- billing of Medicare Part B claims on behalf of providers with whom we have contractual management agreements.

In our Medicare Advantage business, we contract with CMS to provide services to Medicare beneficiaries pursuant to the Medicare program. As a result, our right to obtain payment (and the determination of the amount of such payments), enroll and retain members 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. Marketing and sales activities (including those of third-party brokers and agents) are also heavily regulated by CMS and other governmental agencies, including applicable state departments of insurance. We expect to continue to allocate significant resources to our compliance, ethics and fraud, waste and abuse programs to comply with the laws and regulations governing Medicare Advantage and prescription drug plan programs.

Several of our subsidiaries are also subject to reporting requirements pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

Federal Audits of Government Sponsored Health Care Programs

Participation in government sponsored health care programs subjects us to a variety of federal laws and regulations and risks associated with audits conducted under these programs. These audits may occur in years subsequent to our providing the relevant services under audit. These risks may include reimbursement claims as well as potential fines and penalties. For example, with respect to our Medicare Advantage business, CMS and the Office of the Inspector General perform audits to determine a health plan's compliance with federal regulations and contractual obligations, including compliance with proper coding practices (sometimes referred to as "Risk Adjustment Data Validation Audits" or "RADV audits") and compliance with fraud and abuse enforcement practices through Recovery Audit Contractor ("RAC") audits in which third-party contractors conduct post-payment reviews on a contingency fee basis to detect and correct improper payments. See "Business – Global Health Care" beginning on page 2 of this Form 10-K for additional information about our participation in government health-related programs.

The federal government has made investigating and prosecuting health care 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 violation of patient privacy rights. The regulations and contractual requirements in this area are complex, are frequently modified, and are subject to administrative discretion. We expect to continue to allocate significant resources to comply with these regulations and requirements and to maintain audit readiness.

Privacy, Security and Data Standards Regulations

The federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") imposes minimum standards on health insurers, HMOs, health plans, health care providers and clearinghouses for the privacy and security of protected health information. HIPAA also established rules that standardize the format and content of certain electronic transactions, including, but not limited to, eligibility and claims. ICD-9 is the current electronic code system for diagnosis and procedures for hospital claims. Entities subject to HIPAA are required to update their transaction formats for electronic data interchange standards and convert to new ICD-10 diagnosis and procedure codes. The effective date for ICD-10 conversion is October 1, 2015.

HIPAA's privacy and security requirements were expanded by the Health Information Technology for Economic and Clinical Health Act ("HITECH") through 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.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public 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.

A number of states have adopted data security laws and regulations, regulating data security and requiring security breach notification that may apply to us in certain circumstances. Neither HIPAA nor the Gramm-Leach-Bliley privacy regulations preempt more stringent state laws and regulations.

Dodd-Frank Act and Investment-Related Regulations

The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act") provides for a number of reforms and regulations in the corporate governance, financial reporting and disclosure, investments, tax and enforcement areas. The Dodd-Frank Act established a Federal Insurance Office (the "FIO") to develop federal policy on insurance matters. While the FIO does not have authority over health insurance, it may have authority over other parts of our business, such as life insurance. Additional rulemaking by the SEC and other regulatory authorities continues. We are closely monitoring how these regulations might impact us; however, the full impact may not be known for several years until regulations become fully effective.

Depending upon their nature, our investment management activities are subject to U.S. federal securities laws, ERISA and other federal and state laws governing investment related activities. In many cases, the

investment management activities and investments of individual insurance companies are subject to regulation by multiple jurisdictions.

Office of Foreign Assets Control Sanctions and Anti-Money Laundering

We also are subject to regulation by the Office of Foreign Assets Control of the Department of the Treasury, which administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes.

Certain of our products are subject to Department of the Treasury anti-money laundering regulations under the Bank Secrecy Act.

In addition, we may be subject to similar regulations in non-U.S. jurisdictions in which we operate.

Miscellaneous

Premiums and fees from CMS represented 21% of our total consolidated revenues for the year ended December 31, 2014 under a number of contracts. We are not dependent on business from one or a few customers. Other than CMS, no one customer accounted for 10% or more of our consolidated revenues in 2014. We are 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.

We had approximately 37,200 employees as of December 31, 2014; 36,500 employees as of December 31, 2013; and 35,800 employees as of December 31, 2012.

Item 1A. Risk Factors

As a large company operating in a complex industry, we encounter a variety of risks and uncertainties that could have a material adverse effect on our business, liquidity, results of operations or financial condition. You should carefully consider each of the risks and uncertainties discussed below, in Management's Discussion and Analysis of Results of Operations and Financial Condition and information contained elsewhere in this Annual Report on Form 10-K. 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.

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, including, among others, those associated with Health Care Reform, are increasing in number and complexity, are subject to frequent change and can be inconsistent or in conflict with each other. As a public company with global operations, we are subject to the laws of multiple jurisdictions and the rules and regulations of various governing bodies, such as those related to financial and other disclosures, corporate governance, privacy, data protection, labor and employment, consumer protection, tax and anti-corruption.

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. Existing or future laws, rules, regulatory interpretations or judgments could force us to change how we conduct our business, restrict revenue and enrollment growth, increase health care, technology and administrative costs, including capital requirements, and require enhancements to our compliance infrastructure and internal controls environment. Existing or future laws and rules also could require us to take other actions such as changing our business practices, thereby increasing our liability in federal and state courts for coverage determinations, contract interpretation and other actions.

In the foreseeable future, the impact of existing regulations and future regulatory and legislative changes could materially adversely affect our business, results of operations, financial condition and cash flows by, among other things:

- reducing the potential for growth in revenues and customers by disrupting the employer-based market (currently the primary market for our Commercial operating segment) if employers cease to offer health care coverage for their employees;
- restricting revenue, premium and customer growth in certain products and markets or expansion into new markets;
- increasing health care or other benefit costs through enhanced or guaranteed coverage requirements;
- increasing operating costs through the imposition of new regulatory requirements, increased taxes and other financial assessments;
- restricting our ability to increase premium rates to meet costs (including denial or delays in approval and implementation of those rates);
- limiting the level of margin we can earn on premiums through mandated minimum medical loss ratios and required rebates in the event we do not meet mandated minimum ratios;
- restricting our ability to participate in and derive revenue from government-sponsored programs; and
- significantly reducing the level of Medicare program payments.

Specifically, in the United States, significant changes are occurring in the health care system as a result of Health Care Reform. Substantially all of the key provisions of Health Care Reform are now effective. While federal agencies have published interim and final regulations with respect to certain requirements, many issues remain uncertain. It is difficult to predict the impact of Health Care Reform on our business due to the law's complexity, the political environment, the continuing development of implementing regulations and interpretive guidance, legal challenges and possible future legislative changes. We are unable to predict how these events will develop and what impact they will have on Health Care Reform, and in turn, on our business including, but not limited to, our relationships with current and future customers, producers and health care providers, products, services, processes and technology. Further, if we fail 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 Health Care Reform and any other future legislative or regulatory changes, this failure may have a material adverse effect on our results of operations, financial condition and cash flows, including, but not limited to, our ability to maintain the value of our goodwill and other intangible assets.

Our insurance and HMO subsidiaries must be licensed by and are subject to the regulations of the jurisdictions in which they conduct business. For example, health maintenance organizations and insurance companies are regulated under state insurance holding company regulations and other health care-related regulations. State regulations mandate minimum capital or restricted cash reserve requirements and subject us to assessments under guaranty fund laws and related regulations for certain obligations to claimants of insolvent insurance companies, which would expose our business to the risk of insolvency of a competitor in these states. We also participate in the emerging private exchange marketplace and the extent to which states may issue regulations that apply to private exchanges remains uncertain.

In addition to the regulations discussed above, we are required to obtain and maintain insurance and other regulatory approvals to market many of our products, 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.

The health care industry also is regularly subject to negative media attention, including as a result of the political environment and the ongoing debate concerning Health Care Reform. Such publicity may adversely affect our stock price and reputation in certain markets.

For more information on regulation, see "Business – Regulation" in Part I, Item 1 of this Form 10-K. See also the description of Health Care Reform's minimum medical loss ratio and customer rebate requirements in the "Business – Global Health Care" section beginning on page 2 of this Form 10-K.

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 in the ordinary course of business, including that of administering and insuring employee benefit programs. These could include benefit claims, breach of contract actions, tort claims, claims disputes under federal or state laws and disputes regarding reinsurance arrangements, employment and employment discrimination-related suits, anti-trust claims, employee benefit claims, wage and hour claims, tax, privacy, intellectual property and real estate disputes. 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, and claims related to self-funded business. There are currently, and may be in the future, attempts to bring class action lawsuits against the industry or, absent a class action, individual plaintiffs 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 non-economic or punitive damages may be sought. We seek to procure insurance coverage to cover some of these potential liabilities. However, certain potential liabilities may not be covered by insurance, insurers may dispute coverage or the amount of insurance may be insufficient to cover the entire damages awarded. In addition, certain types of damages, such as punitive damages, may not be covered by insurance, and insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. It is possible that the resolution of current or future legal matters and claims could result in losses material to our results of operations, financial condition and liquidity.

We are frequently the subject of regulatory market conduct and other reviews, audits and investigations by state insurance and health and welfare departments, attorneys general, CMS and the OIG and comparable authorities in foreign jurisdictions. With respect to our Medicare Advantage business, 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. There also continues to be heightened review by federal and state regulators of business and reporting practices within the health care and disability insurance industry and increased scrutiny by other state and federal governmental agencies (such as state attorney general offices) empowered to bring criminal actions in circumstances that could have previously given rise only to civil or administrative proceedings. These regulatory audits or reviews or actions by other governmental agencies could result in changes to or clarifications of our business practices, retroactive adjustments to certain premiums, significant fines, penalties, civil liabilities, criminal liabilities or other sanctions, including restrictions on our ability to operate, that could have a material adverse effect on our business, results of operation, financial condition and liquidity.

A description of material pending legal actions and other legal matters is included in Note 23 to our Consolidated Financial Statements included in this Form 10-K. The outcome of litigation and other legal matters is always uncertain, and outcomes that are not justified by the evidence or existing law can occur.

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 including: (1) driving growth in targeted geographies, product lines, customer buying segments and distribution channels; (2) improving our strategic and financial flexibility; and (3) pursuing additional opportunities in high-growth markets with particular focus on individuals. Successfully executing these initiatives depends on a number of factors, including our ability to:

- differentiate our products and services from those of our competitors;
- develop and introduce new products or programs, particularly in response to government regulation and the increased focus on consumer-directed products;
- grow our commercial product portfolio, including expanded participation in the public health insurance exchanges;
- identify and introduce the proper mix or integration of products that will be accepted by the marketplace;
- attract and retain sufficient numbers of qualified employees;
- attract, develop and maintain collaborative relationships with a sufficient number of qualified partners, including physicians and other health care providers in an environment of growing shortages of primary care professionals and consolidation within the provider industry;
- transition health care providers from volume-based fee for service arrangements to a value-based system;
- improve medical cost competitiveness in targeted markets;
- manage our medical and administrative costs effectively;
- manage our balance sheet exposures effectively, including our pension funding obligations; and

- reduce our Global Health Care operating expenses to achieve sustainable benefits.

If these initiatives fail or are not executed effectively, it could harm our consolidated financial position and results of operations. For example, efforts to reduce operating expenses while maintaining the necessary resources and talent pool are important and, if not managed effectively, could have long-term effects on our business by negatively impacting our ability to drive improvements in the quality of our products. For our strategic initiatives to succeed, we must effectively integrate our operations, including our acquired businesses, actively work to ensure consistency throughout the organization, and promote a global mind-set and a focus on individual customers. If we fail to do so, our business may be unable to grow as planned, or the result of expansion may be unsatisfactory. In addition, the current competitive, economic and regulatory environment requires our organization to adapt rapidly and nimbly to new opportunities and challenges. We will be unable to do so if we do not make important decisions quickly, define our appetite for risk specifically, implement new governance, managerial and organizational processes smoothly and communicate roles and responsibilities clearly.

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

As a global company, our business is increasingly exposed to risks inherent in foreign operations. These risks, which can vary substantially by market, 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:

- varying regional and geopolitical business conditions and demands;
- regulation that may discriminate against U.S. companies, favor nationalization or expropriate assets;
- price controls or other pricing issues and exchange controls or other restrictions that prevent us from transferring funds from these operations out of the countries in which we operate or converting local currencies that our foreign operations hold into U.S. dollars or other currencies;
- foreign currency exchange rates and fluctuations that may have an impact on the future costs or on future sales and cash flows from our international operations, and any measures that we may implement to reduce the effect of volatile currencies and other risks of our international operations may not be effective;
- our reliance on local sales forces for some operations in countries that may have labor problems and/or less flexible employee relationships that can be difficult and expensive to terminate, or where changes in local regulation or law may disrupt business operations;
- effectively managing our partner relationships in countries outside of the United States;
- managing more geographically diverse operations and projects;
- operating in new foreign markets that may require considerable management time before operations generate any significant revenues and earnings;
- the need to provide data protection on a global basis and sufficient levels of technical support in different locations;
- political instability or acts of war, terrorism, natural disasters or pandemics in locations where we operate; and
- general economic and political conditions.

These factors may increase in significance as we continue to expand globally, and any one of these challenges could negatively affect our operations or long-term growth. For example, due to the concentration of business in South Korea, the Global Supplemental Benefits segment is exposed to potential losses resulting from economic, regulatory and geopolitical developments in that country, 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, 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 and data protection. 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. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our business and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties. 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.

There are various risks associated with participating in government-sponsored programs, such as Medicare, including dependence upon government funding, changes occurring as a result of Health Care Reform, compliance with government contracts and increased regulatory oversight.

Through our Cigna-HealthSpring business, we contract with CMS and various state governmental agencies to provide managed health care services, including Medicare Advantage plans and Medicare-approved prescription drug plans. Revenues from Medicare programs are dependent, in whole or in part, upon annual funding from the federal government through CMS and/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, could substantially reduce our revenues and profitability.

The Medicare program has been the subject of recent regulatory reform initiatives, including Health Care Reform. The premium rates paid to Medicare Advantage plans are established by contract, although the rates differ depending on a combination of factors, many of which are outside our control. Effective in 2012, Health Care Reform ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star rating" by CMS, with those plans receiving a rating of three or more stars eligible for quality-based bonus payments. The star rating system considers various measures adopted by CMS, including, among other things, quality of care, preventative services, chronic illness management and customer satisfaction. Beginning in 2015, plans must have a star rating of four or higher to qualify for bonus payments. Our Medicare Advantage plans' operating results, premium revenue and benefit offerings are likely to continue to be significantly determined by their star ratings. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for full-level quality bonuses, which could adversely affect the benefits that our plans can offer, reduce our customer base and/or reduce margins.

Contracts with CMS and the various state governmental agencies contain certain provisions regarding data submission, provider network maintenance, quality measures, claims payment, continuity of care, call center performance and other requirements. If we fail to comply with these requirements, we may be subject to fines or penalties that could impact our profitability.

In addition, 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 fines, limits on expansion, restrictions or exclusions from programs or other agreements with federal or state governmental agencies that could adversely impact our business, cash flows, financial condition and results of operations.

In addition, our Medicare Advantage and Medicare prescription drug businesses face a number of other risks including potential uncollectible receivables resulting from processing and/or verifying enrollment, inadequate underwriting assumptions, inability to receive and process correct information or increased medical or pharmaceutical costs. Actual results may be materially different than our assumptions and estimates regarding these complex and wide-ranging programs, which could have a material adverse effect on our business, financial condition and results of operations.

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

We contract with physicians, hospitals and other health care providers for services rendered 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 care providers could refuse to contract, demand higher payments or take other actions that could result in higher medical costs or less desirable products for our customers. In some markets, certain providers, particularly hospitals, physician/hospital organizations and multi-specialty 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 favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our ability to develop and maintain satisfactory relationships with health care providers also may be negatively impacted by other factors not associated with us, such as changes in Medicare and/or Medicaid reimbursement levels, increasing revenue and other pressures on health care providers and consolidation activity among hospitals, physician groups and health care providers. For example, ongoing reductions by CMS and state governments in amounts payable to providers, particularly hospitals, for services provided to Medicare and Medicaid enrollees may pressure the financial condition of certain providers and, in turn, adversely impact our ability to maintain or develop new cost-effective health care provider contracts or result in a loss of revenues or customers.

Recent and continuing consolidation among physicians, hospitals and other health care providers, development of accountable care organizations and other changes in the organizational structures that physicians, hospitals and health care providers choose may change the way these 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 that we price our products or causing us to incur increased costs if we change our operations to be more competitive. Our focus on developing collaborative accountable care organizations and independent practice associations or similar business arrangements with physicians and other health care providers may not achieve intended benefits, which could adversely affect our strategy or prospects.

Out-of-network providers do not have an understanding with us about the amount of compensation due for their services. Some states define by law or regulation the amounts due, but in most instances it is not defined or is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe that they were underpaid and may litigate or arbitrate their dispute with us or try to recover from our customers the difference between what we have paid them and the amount they charged us. 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.

We are dependent on the success of our relationships with third parties for various services and functions, including, but not limited to, pharmacy benefit management services.

To improve operating costs, productivity and efficiencies, we outsource to, or enter into partnership arrangements with, third parties for selected services and functions, such as pharmacy benefit management, information technology, independent practice associations, medical management, call centers and claim services. Our operations may be vulnerable if these third parties fail to satisfy their obligations to us or if the arrangement is terminated in whole or in part for any reason or if there is a contractual dispute between us and these third parties. 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 or 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. In addition, with respect to outsourced services or functions to third parties in foreign jurisdictions, we also are exposed to risks inherent in conducting business outside of the United States.

Outsourcing also may require us to change our existing operations, adopt new processes for managing these providers and/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 realize on a timely basis, the anticipated economic and other benefits of these relationships. This could result in substantial costs or regulatory compliance issues, divert management's attention from other strategic activities, negatively affect employee morale 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 termination or transition, we may not be able to meet the demands of our customers and, in turn, our business and results of operations could be unfavorably impacted.

Acquisitions, joint ventures and other 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 growth strategy, we regularly consider and enter into strategic transactions, including mergers, acquisitions, joint ventures, licenses and other relationships (collectively referred to as "transactions"), with the expectation that these transactions will result in various benefits. Our ability to achieve the anticipated benefits of these transactions is subject to numerous uncertainties and risks, including our ability to integrate operations, resources and systems in an efficient and effective manner. We could also face challenges in implementing business plans; changes in laws and regulations or conditions imposed by regulators applicable to the business; retaining key employees; and general competitive factors in the marketplace. These events could result in increased costs, decreases in expected revenues, earnings or cash flow, and goodwill or other intangible asset impairment charges. Further, we may finance transactions by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders, or by incurring additional debt that could 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 result in our systems and internal controls becoming increasingly complex and more difficult to manage. Any difficulties in assimilating businesses into our control system could cause us to fail to meet our financial reporting obligations. Ineffective internal controls also could cause investors to lose confidence in our reported financial information, which could negatively impact the trading price of our stock and our access to capital.

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 both effective information systems and the integrity and timeliness of the data we use to serve our customers and health care professionals 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 the third-party service providers were to fail to maintain information systems and data integrity effectively, we could experience operational disruptions that may impact our customers and health care professionals and hinder our ability to establish appropriate pricing for products and services, retain and attract 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. Increasing regulatory and legislative mandated changes will place additional demands on our information technology infrastructure that could have a direct impact on available resources for projects more directly tied to strategic initiatives. 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. We also must 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 impede our ability to deliver

services at a competitive cost. 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.

In addition, 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, and processing new and renewal business. Unavailability, cyber-attack or other failure of one or more of our information technology or other systems could cause slower response times, resulting in claims not being processed as quickly as clients or customers desire, decreased levels of client or customer service and satisfaction, and harm to our reputation. Because our information technology and other systems interface with and depend on third-party systems, we could experience service denials if demand for such service exceeds capacity or a third-party system fails or experiences an interruption. If sustained or repeated, such business interruptions, systems failures or service denials could have material adverse effects on our business, results of operations, financial condition and liquidity.

We may be subject to cyber-attacks. 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, programming errors, attacks by third parties or similar disruptive problems. As we increase the amount of personal information that we store and share digitally, our exposure to these data security and related cybersecurity risks increases, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access, and the cost of attempting to protect against these risks also increases. We have implemented security technologies, processes and procedures to protect consumer identity; however, there are no assurances that such measures will be effective against all types of breaches.

Events that negatively affect that trust, including failing to keep our information technology systems and our clients' and customers' sensitive information secure from attack, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates or vendors, could adversely affect our reputation, membership and revenues and also expose us to mandatory disclosure to the media, litigation and other enforcement proceedings, material fines, penalties and/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.

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

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 customers. In some cases, such laws, rules and regulations also apply to our vendors and require us to obtain written assurances of their compliance with such requirements or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction.

These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA may further restrict our ability to collect, disclose and use sensitive personal information and may impose additional compliance requirements on our business. While we have prepared for the transition to ICD-10, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after the final implementation date, we will have to reject such claims, leading to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, potentially resulting in lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. If we do not adequately implement the new ICD-10 coding set, or if providers in our network do not adequately transition to the new ICD-10 coding set, our results of operations, financial position and cash flows may be materially adversely affected.

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 members, 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 legislation and related regulations being adopted to enhance regulators' enforcement powers and whistleblower incentives and protections mean that 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 customers. 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.

Our pharmacy benefit management business and related operations are subject to a number of risks and uncertainties that are in addition to those we face in our health care business.

Notwithstanding our pharmacy benefits management services arrangement with a third-party vendor, we remain responsible to regulators and members for the delivery of pharmacy benefits. This business is subject to federal and state regulation, including federal and state anti-remuneration laws, ERISA, HIPAA and laws related to the operation of Internet and mail-service pharmacies. In addition, certain of our subsidiaries are pharmacies subject to state licensing and U.S. Drug Enforcement Agency registration requirements and laws concerning labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. Noncompliance with such regulations by us or our third-party vendor could have material adverse effects on our business, results of operations, financial condition, liquidity and reputation.

Our pharmacy benefit management business also would be adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and we could suffer claims and reputational harm in connection with purported errors by mail order or retail pharmacy businesses.

In operating 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 and other health care professionals at onsite low acuity and primary care clinics that we operate for our customers, as well as certain clinics for our employees. In addition, our Cigna-HealthSpring business operates LivingWell health centers and we own and operate multispecialty health care centers, low acuity clinics and other types of centers in the Phoenix, Arizona metropolitan area that employ physicians and other health care professionals. As a direct employer of health care professionals and as an owner or operator of medical facilities, we are subject to liability for negligent acts, omissions, or injuries occurring at one of these clinics or caused by one of our employees. Even if any claims brought against us are unsuccessful or without merit, we still have to defend against such claims. The defense of any actions may result in significant expenses that could have a material adverse effect on our business, results of operations, financial condition and liquidity.

We face price competition and other pressures that could result in premiums that are insufficient to cover the cost of the health care services delivered to our members and inadequate medical claims reserves.

While health plans 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 and customer contracts are subject to negotiation as clients and customers seek to contain their costs, including by reducing benefits offered or elected. Alternatively, our clients and customers may purchase different types of products that are less profitable, or move to a competitor to obtain more favorable premiums. Each of these events would likely negatively impact our financial results.

Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. For example, Health Care Reform includes an annual rate review requirement to prohibit unreasonable rate increases in the individual and small group health insurance markets. Fiscal concerns regarding the continued viability of programs such as Medicare may cause decreasing reimbursement rates, delays in premium payments or insufficient increases in reimbursement rates for government-sponsored programs in which we participate. Any limitation on our ability to maintain or increase our premium or reimbursement levels, or a significant loss of membership 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.

In addition, factors such as business consolidations, strategic alliances, legislation and marketing practices will likely continue to create pressure to contain or otherwise restrict premium price increases, despite increasing medical costs. For example, the Gramm-Leach-Bliley Act gives banks and other financial institutions the ability to be affiliated with insurance companies. This may lead to new competitors with significant financial resources. Our product margins and growth depend, in part, on our ability to compete effectively in our markets, set rates appropriately in highly competitive markets to keep or increase our market share, increase membership as planned, and avoid losing accounts with favorable medical cost experience while retaining or increasing membership in accounts with unfavorable medical cost experience.

Premiums in the health care business are generally set for one-year periods, based on our estimate of future health care costs over such period. Actual costs may exceed what we estimate and charge in premiums due to factors such as medical cost inflation, higher than expected utilization of medical services, new or costly treatments and technology, and membership mix. 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, such as influenza-related health care costs, epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, as well as changes in members' health care utilization patterns and provider billing practices. Our profitability depends, in part, on our ability to accurately predict and control future health care costs through

underwriting criteria, provider contracting, utilization management and product design.

We record medical claims reserves on our balance sheet for estimated future payments. While we continually review estimates of future payments relating to medical claims costs for services incurred in the current and prior periods and make adjustments to our reserves, the actual health care costs may exceed the reserves we have recorded.

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 also are exposed to interest rate and equity risk associated with our pension and other post-retirement 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 9 to our Consolidated Financial Statements for more information on our obligations under the pension plan.

Significant changes in market interest rates affect the value of our financial instruments that promise a fixed return or benefit and the value of particular assets and liabilities.

As an insurer, we have substantial investment assets that support insurance and contractholder deposit liabilities. Generally low levels of interest rates on investments, such as those experienced in U.S. and foreign financial markets during recent years, have negatively impacted our level of investment income earned in recent periods.

Substantially all of our investment assets are in fixed interest-yielding debt securities of varying maturities, fixed redeemable preferred securities 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 and increase interest expense if we were to access our available lines of credit.

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 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 these ratings in the future could make it more difficult to either market our products successfully or raise capital to support business growth within our insurance subsidiaries.

Global market, economic and geopolitical conditions may cause fluctuations in equity market prices, interest rates and credit spreads that could impact our ability to raise or deploy capital and affect our overall liquidity.

If the equity and credit markets experience extreme volatility and disruption, there could be downward pressure on stock prices and credit capacity for certain issuers without regard to those issuers' underlying financial strength. Extreme disruption in the credit markets could adversely impact our availability and cost of credit in the future. In addition, unpredictable or unstable market conditions or continued pressure in the global or U.S. economy could result in reduced opportunities to find suitable opportunities to raise capital.

As of December 31, 2014, our outstanding long-term debt totaled $5.0 billion. In the event of adverse economic and industry conditions, we may be required to dedicate a greater percentage of our cash flow from operations to the payment of principal and interest on our debt, thereby reducing the funds we have available for other purposes, such as investments in ongoing businesses, acquisitions, dividends and stock repurchases. In these circumstances, our ability to execute our strategy may be limited, our flexibility in planning for or reacting to changes in business and market conditions may be reduced, or our access to capital markets may be limited such that additional capital may not be available or may be available only on unfavorable terms.

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

Global economic conditions continue to be challenging. Many factors, including geopolitical issues, confidence in any economic recoveries and any future economic downturns, availability and cost of credit and other capital and consumer spending, can negatively impact expectations for the U.S. and global economies. Our results of operations could be materially and adversely affected by the impact of unfavorable economic conditions on our customers (both employers and individuals), health care 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 Health Care Reform, 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.
- Our historical disability claim experience and industry data indicate that submitted disability claims rise under adverse economic conditions.
- If customers are not successful in generating sufficient profits 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 customers or potential customers may force us to compete more vigorously on factors such as price and service to retain or obtain their business.
- A prolonged unfavorable economic environment could adversely impact the financial position of hospitals and other health care providers, potentially increasing our medical costs as these providers attempt to maintain revenue levels in their efforts to adjust to their own economic challenges.
- 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.

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

In addition, during a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in state and federal government programs, such as Medicare and Social Security. These state and federal 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 to limit losses from large exposures or to permit recovery of a portion of direct losses. We also may enter into reinsurance arrangements 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 by 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

Our global real estate portfolio consists of approximately 8.3 million square feet of owned and leased properties. Our domestic portfolio has approximately 6.2 million square feet in 37 states, the District of Columbia, Puerto Rico and the Virgin Islands. Our International properties contain approximately 2.1 million square feet located throughout the following countries: Belgium, Canada, China, France, Hong Kong, India, Indonesia, Kenya, Malaysia, Netherlands, New Zealand, Singapore, South Korea, Spain, Sweden, Switzerland, Taiwan, Thailand, Turkey, United Arab Emirates, and the United Kingdom.

Our principal, domestic office locations, including various support operations, along with Group Disability and Life Insurance, Health Services, Core Medical and Service Operations and the domestic office of our Global Supplemental Benefits business are the Wilde Building located at 900 Cottage Grove Road in Bloomfield, Connecticut (our corporate headquarters) and Two Liberty Place located at 1601 Chestnut Street in Philadelphia, Pennsylvania. The Wilde Building measures approximately 833,000 square feet and is owned, while Two Liberty Place measures approximately 462,000 square feet and is leased office space.

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" in Note 23 to our Financial Statements beginning on page 114 of this Form 10-K, is incorporated herein by reference.

ITEM 4. Mine Safety Disclosures

Not applicable.

EXECUTIVE OFFICERS OF THE REGISTRANT

All officers are elected to serve for a one-year term or until their successors are elected. Principal occupations and employment during the past five years are listed below.

LISA R. BACUS, 50, Executive Vice President and Global Chief Marketing Officer of Cigna beginning May 2013; Executive Vice President and Chief Marketer at American Family Insurance from February 2008 until May 2013.

MARK L. BOXER, 55, Executive Vice President and Global Chief Information Officer of Cigna beginning April 2011; Deputy Chief Information Officer, Xerox Corporation; and Group President, Government Health Care, for Xerox Corporation/Affiliated Computer Services from March 2009 until April 2011.

DAVID M. CORDANI, 49, 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.

HERBERT A. FRITCH, 64, President, Cigna HealthSpring beginning January 2012; and Chairman of the Board and Chief Executive Officer of HealthSpring and its predecessor, NewQuest, LLC, from commencement of operations in September 2000 until HealthSpring was acquired by Cigna in January 2012.

NICOLE S. JONES, 44, 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.

THOMAS A. McCARTHY, 58, Executive Vice President and Chief Financial Officer of Cigna beginning July 2013; Vice President of Finance with responsibility for treasury, tax, strategy and corporate development, and management of run-off reinsurance from February 2003 until July 2013; Acting Chief Financial Officer from September 2010 until June 2011, and Treasurer from July 2008 until June 2011.

MATTHEW G. MANDERS, 53, President, U.S. Commercial Markets and Global Health Care Operations beginning June 2014; 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 of Cigna HealthCare, Total Health, Productivity, Network & Middle Market from June 2009 until January 2010.

JOHN M. MURABITO, 56, Executive Vice President, Human Resources and Services of Cigna beginning August 2003.

JASON D. SADLER, 46, 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.

PART II

ITEM 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

The information under the caption "Quarterly Financial Data – Stock and Dividend Data" appears on page 115 and the number of shareholders of record as of December 31, 2014 appears under the caption "Highlights" on page 31 of this Form 10-K. Cigna's common stock is listed with, and trades on, the New York Stock Exchange under the symbol "CI".

Issuer Purchases of Equity Securities

The following table provides information about Cigna's share repurchase activity for the quarter ended December 31, 2014:

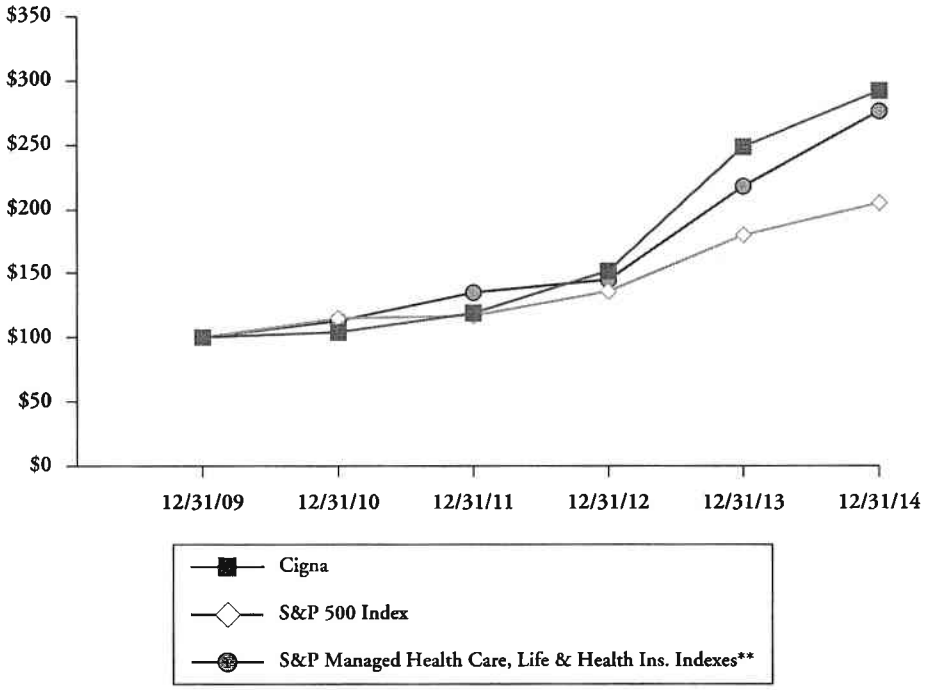
Period	Total # of shares purchased [1]	Average price paid per share	Total # of shares purchased as part of publicly announced program [2]	Approximate dollar value of shares that may yet be purchased as part of publicly announced program [3]
October 1-31, 2014	1,619,626	$ 89.54	1,619,398	$ 411,255,576
November 1-30, 2014	1,014,804	$ 102.39	1,012,115	$ 307,618,626
December 1-31, 2014	1,208,630	$ 103.46	1,207,945	$ 682,648,486
Total	**3,843,060**	**$ 97.31**	**3,839,458**	**N/A**

(1) Includes shares tendered by employees as payment of taxes withheld on the exercise of stock options and the vesting of restricted stock granted under the Company's equity compensation plans. Employees tendered 228 shares in October, 2,689 in November and 685 shares in December 2014.

(2) Cigna has had a repurchase program for many years, and has had varying levels of repurchase authority and activity under this program. The program has no expiration date. Cigna suspends activity under this program from time to time and also removes such suspensions, generally without public announcement. In 2014, the Company repurchased 18.5 million shares for approximately $1.6 billion. Remaining authorization under the program was approximately $683 million as of December 31, 2014. From January 1, 2015 through February 25, 2015, the Company repurchased 1.9 million shares for approximately $217 million. The Company's Board of Directors increased share repurchase authority by $500 million on February 25, 2015. Remaining authorization under the program was $966 million as of February 25, 2015.

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

Five Year Cumulative Total Shareholder Return*
December 31, 2009 – December 31, 2014



	12/31/09	12/31/10	12/31/11	12/31/12	12/31/13	12/31/14
Cigna	$ 100	$ 104	$ 119	$ 152	$ 249	$ 293
S&P 500 Index	$ 100	$ 115	$ 117	$ 136	$ 180	$ 205
S&P Managed Health Care, Life & Health Ins. Indexes**	$ 100	$ 113	$ 135	$ 145	$ 218	$ 277

* *Assumes that the value of the investment in Cigna common stock and each index was $100 on December 31, 2009 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 should be read in conjunction with Management's Discussion and Analysis of Financial Condition and Results of Operations and the Consolidated Financial Statements and accompanying notes included elsewhere herein.

Highlights

(Dollars in millions, except per share amounts)	2014	2013	2012	2011	2010
Revenues					
Premiums and fees and other revenues	$ 31,355	$ 29,176	$ 26,308	$ 19,210	$ 18,528
Net investment income	1,166	1,164	1,144	1,146	1,105
Mail order pharmacy revenues	2,239	1,827	1,623	1,447	1,420
Realized investment gains	154	213	44	62	75
TOTAL REVENUES	**$ 34,914**	**$ 32,380**	**$ 29,119**	**$ 21,865**	**$ 21,128**
Results of Operations:					
Global Health Care	$ 1,646	$ 1,517	$ 1,418	$ 1,105	$ 940
Global Supplemental Benefits	230	175	142	97	84
Group Disability and Life	317	259	279	295	305
Other Operations[1]	68	(394)	82	(94)	111
Corporate	(265)	(222)	(329)	(184)	(211)
Realized investment gains, net of taxes	106	141	31	41	50
Shareholders' net income	2,102	1,476	1,623	1,260	1,279
Income (loss) attributable to noncontrolling interests	(8)	2	1	1	4
NET INCOME	**$ 2,094**	**$ 1,478**	**$ 1,624**	**$ 1,261**	**$ 1,283**
Shareholders' net income per share:					
Basic	$ 7.97	$ 5.28	$ 5.70	$ 4.65	$ 4.69
Diluted	$ 7.83	$ 5.18	$ 5.61	$ 4.59	$ 4.65
Common dividends declared per share	$ 0.04	$ 0.04	$ 0.04	$ 0.04	$ 0.04
Total assets	$ 55,896	$ 54,336	$ 53,734	$ 50,697	$ 45,393
Long-term debt	$ 5,005	$ 5,014	$ 4,986	$ 4,990	$ 2,288
Shareholders' equity	$ 10,774	$ 10,567	$ 9,769	$ 7,994	$ 6,356
Per share	$ 41.55	$ 38.35	$ 34.18	$ 28.00	$ 23.38
Common shares outstanding (in thousands)	259,276	275,526	285,829	285,533	271,880
Shareholders of record	7,129	7,535	7,885	8,178	8,568
Employees	37,200	36,500	35,800	31,400	30,600

(1) Beginning in 2014, we combined the results of our run-off reinsurance segment with Other Operations. Prior year segment information has been conformed to the current year presentation.

ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

Index

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 and results of operations. 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 and the "Risk Factors" contained in Part I Item 1A of this Annual Report on Form 10-K ("Form 10-K").

Unless otherwise indicated, financial information in the MD&A is presented in accordance with accounting principles generally accepted in the United States of America ("GAAP"). See Note 2 to the Consolidated Financial Statements for additional information regarding the Company's significant accounting policies. We measure the financial results of our segments using "segment earnings (loss)", defined as shareholders' net income (loss) before after-tax realized investment results. In this MD&A, we also present information using adjusted income from operations on both a consolidated and segment basis. Adjusted income (loss) from operations is another measure of profitability used by our management because it presents the underlying results of operations of our businesses and permits analysis of trends in underlying revenue, expenses and shareholders' net income. Adjusted income (loss) from operations is defined as segment earnings (loss) excluding special items (described in the table on page 36 of this Form 10-K) and results of the GMIB business. This measure is not determined in accordance with GAAP and should not be viewed as a substitute for the most directly comparable GAAP measures, which are shareholders' net income on a consolidated basis and segment earnings (loss) on a segment basis. We exclude special items because management does not believe they are representative of our underlying results of operations. We also exclude the results of the GMIB business because, prior to February 4, 2013, the changes in the fair value of GMIB assets and liabilities were volatile and unpredictable. 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, and changes in percentages are expressed in basis points ("bps").

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 dedicated to a **mission** of helping individuals **improve their health, well-being and sense of security**. To execute on our mission, Cigna's **strategy** is to "Go Deep", "Go Global" and "Go Individual" with a differentiated set of medical, dental, disability, life and accident insurance and related products and services offered by our subsidiaries.

For further information on our business and strategy, please see Item 1, "Business" in this Form 10-K.

Our Segments

As explained in Note 22 to the Consolidated Financial Statements, effective with the first quarter of 2014, we began combining the results of our run-off reinsurance business with other immaterial operating segments in Other Operations for segment reporting purposes. Prior year segment information has been conformed to the current year presentation.

We present the financial results of our businesses in the following three reportable segments:

Segment	% of Revenues	Description
Global Health Care	78%	Aggregates the Commercial and Government operating segments: *Commercial* • Encompasses both our U.S. commercial and certain international health care businesses. • Serves employers and their employees, including globally mobile individuals, and other groups (e.g., governmental and non-governmental organizations, unions and associations). In addition, our U.S. commercial health care business also serves individuals. • Offers insured and self-insured medical, dental, behavioral health, vision, and prescription drug benefit plans, health advocacy programs and other products and services that may be integrated as part of a comprehensive global health care benefit program. *Government* • Offers Medicare Advantage, Medicare Part D and Medicaid plans.
Global Supplemental Benefits	9%	Offers supplemental health, life and accident insurance products in selected international markets and the U.S.
Group Disability and Life	11%	Offers group long-term and short-term disability, group life, accident and specialty insurance products and related services.

We present the remainder of our segment results in ***Other Operations,*** consisting of the corporate-owned life insurance business ("COLI"), run-off reinsurance and settlement annuity businesses and deferred gains associated with the sales of the individual life insurance and annuity and retirement benefits businesses.

Key Transactions and Other Significant Items

The following is a summary of key transactions and other significant items since January 1, 2012 affecting period-to-period comparisons of our results.

Run-off Reinsurance Transaction. Prior to February 4, 2013, our run-off reinsurance business had significant exposures, primarily from our guaranteed minimum death benefits ("GMDB" also known as "VADBe") and guaranteed minimum income benefits ("GMIB") businesses. Effective February 4, 2013, we entered into an agreement with Berkshire to reinsure future exposures for this business, net of existing retrocessional arrangements, up to a specified limit, for a payment of $2.2 billion. The reinsurance transaction aligned with our strategy of increasing financial flexibility by accomplishing an effective exit from the GMDB and GMIB businesses. As a result of this transaction, we recorded an after-tax charge of $507 million in the first quarter of 2013 that was reported as a special item. See Note 7 to the Consolidated Financial Statements and the Other Operations section of this MD&A for additional information.

Pharmacy Benefit Management ("PBM") Services Agreement. In June 2013, we entered into a 10-year pharmacy benefit management services agreement with Catamaran Corporation. Under this agreement, we utilize their technology and service platforms, retail network contracting and claims processing services. In the second quarter of 2013, we recorded one-time transaction costs of $37 million pre-tax ($24 million after-tax) that were reported as a special item. This arrangement has produced a positive contribution to earnings in 2014 through improved clinical management, purchasing and administrative efficiencies.

Organizational Efficiency Plans. We regularly evaluate ways to deliver our products and services more efficiently and at a lower cost. During 2013 and 2012, we adopted specific plans to increase our organizational efficiency, resulting in a charge of $60 million pre-tax ($40 million after-tax) in 2013 and $77 million pre-tax ($50 million after-tax in 2012. See Note 6 to the Consolidated Financial Statements for additional information.

Disability Claims Regulatory Matter

During the second quarter of 2013, we finalized an agreement with the Departments of Insurance for Maine, Massachusetts, Pennsylvania, Connecticut and California (together, the "monitoring states") related to our long-term disability claims handling practices. In connection with the terms of the agreement, the Company recorded a charge of $77 million before-tax ($51 million after-tax) in the first quarter of 2013. The charge was comprised of two elements: (1) $48 million of benefit costs and reserves from reassessed claims expected to be reopened, and (2) $29 million of additional costs for open claims as a result of the claims handling changes being implemented. This charge was reported in the Group Disability and Life segment. We are actively implementing the terms of the agreement and continue to communicate with the monitoring states on progress. If the monitoring states find material non-compliance

with the terms of the agreement upon re-examination, we may be subject to additional fines or penalties. In addition to the monitoring states, most other jurisdictions have joined the agreement as participating, non-monitoring states.

Health Care Industry Developments

Health Care Reform and the implementing regulations have resulted in broad changes that are meaningfully impacting the industry, including relationships with customers and health care providers, the design of products and services, and pricing and delivery systems. In 2013, the industry saw government-prescribed reductions to Medicare reimbursement rates (i.e., sequestration), ongoing payment reductions for Medicare Advantage plans by the Centers for Medicare and Medicaid Services ("CMS") and changes in requirements associated with operational and performance metrics used to determine Medicare Advantage payments and benefits. For 2014, there have been further changes resulting from Health Care Reform and the implementing regulations including public exchanges, a non-deductible industry tax in addition to fees and assessments, and minimum medical loss ratio requirements for Medicare Advantage and Medicare Part D plans. Collectively, these changes have had a significant impact on our business and customers, requiring adjustments to our business model to mitigate their effects on our results of operations and cash flows.

The "Regulation" section of this Form 10-K provides a detailed and up-to-date description of Health Care Reform provisions and other legislative initiatives that impact our domestic health care business, including regulations issued by CMS and the Departments of the Treasury and Health and Human Services ("HHS"). The table presented below provides a summary of the financial impacts of key provisions of Health Care Reform in 2014 and beyond.

Item	Description
Medicare Advantage ("MA") and Part D Program Impacts – **Sequestration** – **MA Rates** – **Medical Loss Ratio (MA and Part D)**	***Sequestration***: As a result of sequestration, federal government reimbursement rates for MA and Part D were lowered by 2% beginning April 1, 2013. This program is expected to run through 2023. While these rate reductions significantly impact our Government operating segment, their overall effect on consolidated net income and cash flows was immaterial in 2013 and 2014 and is expected to continue to be immaterial. ***MA Rates***: In April 2014, CMS published its notice of final federal government reimbursement rates for calendar year 2015. Based on industry data, overall MA rates for 2015 are expected to be 2% lower than 2014 for MA carriers. Assuming a similar book of business to 2014, we would expect a 2% rate decrease to lower full-year 2015 MA premiums by approximately $100 million. We do not expect these lower rates to have a significant impact on our 2015 net income or cash flows based on our 2015 bid submissions that included adjustments to our programs and services to reflect the 2015 rates. The 2014 federal government reimbursement rates established by CMS included a variety of payment reductions to Medicare plans. Overall, these rates were reduced by approximately 6% compared with 2013. Assuming a similar book of business to 2013, we estimated this rate decrease would lower full-year 2014 MA premiums by approximately $300 million. In 2014, premium decreases related to the CMS rate reductions have been partially mitigated through changes in member risk scores and customer enrollment mix (in total, and by county). These rate reductions, together with the impact of the health insurance industry tax, have negatively impacted margins for the Government operating segment. ***Medical Loss Ratio ("MLR")***: Beginning in 2014, if our MLR for MA or Part D business is less than the required 85% minimum, we will be required to pay a rebate to CMS. The effect of these MLR rebates was not material to our results of operations or cash flows in 2014.

Item	Description
Health Care Reform Taxes and Fees – Industry Tax	***Health Insurance Industry Tax***: See Note 2 to the Consolidated Financial Statements for additional information. In 2014, we recognized $238 million in operating expenses for the industry tax. Because this tax is not deductible for federal income tax purposes, our effective tax rate increased in 2014, both on a consolidated basis and for the Global Health Care segment. Of the full-year tax, $134 million relates to our commercial business and the remaining $104 million relates to our Medicare business. For our commercial business, we incorporated the 2014 fees into our targeted pricing actions. For our Medicare business, although we have partially mitigated the effect of the tax through benefit changes and customer premium increases, the combination of the tax and lower MA rates in 2014 have contributed to lower margins in the Government operating segment in 2014. See the Consolidated Results of Operations and Global Health Care segment sections of this MD&A for further discussion.
– Reinsurance Fee	***Reinsurance Fee***: This fee is a fixed dollar per customer levy that applies to insurers and self-insured major medical plans excluding Medicare Advantage and Medicare Part D products. Proceeds from the fee will be used to fund the reinsurance program for non-grandfathered individual business sold either on or off the public exchanges beginning in 2014. For our insured business, the amount of the fee is approximately $110 million in 2014 and is tax deductible. We incorporated the 2014 fees into our targeted pricing actions. See the Global Health Care section of this MD&A for further discussion.
Public Health Exchanges	***Public Health Exchanges***: For 2014, we offered individual coverage on five public health insurance exchanges (Arizona, Colorado, Florida, Tennessee and Texas). Beginning in 2015, in addition to those five states, we began offering coverage on exchanges in Maryland, Georgia and Missouri. See the Global Health Care segment section of this MD&A for further discussion around the results from our individual business.
Risk Mitigation Programs	***Risk Mitigation Programs***: See Note 2 to the Consolidated Financial Statements for a description of these programs that commenced on January 1, 2014 along with our accounting policy. We recorded receivables of approximately $200 million after-tax in 2014 related to these programs.
Commercial MLR	***Commercial MLR***: The effect of the commercial MLR rebate accrual was not material to our results of operations or cash flows in 2014.

Consolidated Results of Operations

Summarized below are our results of operations on a GAAP basis.

Financial Summary *(In millions)*	For the Years Ended December 31, 2014	2013	2012	Increase/(Decrease) 2014 vs. 2013		Increase/(Decrease) 2013 vs. 2012	
Premiums	$ 27,214	$ 25,575	$ 23,017	$ 1,639	6%	$ 2,558	11%
Fees and other revenues	4,141	3,601	3,291	540	15	310	9
Net investment income	1,166	1,164	1,144	2	–	20	2
Mail order pharmacy revenues	2,239	1,827	1,623	412	23	204	13
Realized investment gains	154	213	44	(59)	(28)	169	N/M
Total revenues	34,914	32,380	29,119	2,534	8	3,261	11
Global Health Care medical claims expense	16,694	15,867	14,228	827	5	1,639	12
Other benefit expenses	4,640	4,998	3,672	(358)	(7)	1,326	36
Mail order pharmacy costs	1,907	1,509	1,328	398	26	181	14
Other operating expenses	8,369	7,830	7,414	539	7	416	6
Benefits and expenses	31,610	30,204	26,642	1,406	5	3,562	13
Income before income taxes	3,304	2,176	2,477	1,128	52	(301)	(12)
Income taxes	1,210	698	853	512	73	(155)	(18)
Net income	2,094	1,478	1,624	616	42	(146)	(9)
Less: net income (loss) attributable to noncontrolling interests	(8)	2	1	(10)	N/M	1	100
Shareholders' net income	$ 2,102	$ 1,476	$ 1,623	$ 626	42%	$ (147)	(9)%

A reconciliation of shareholders' net income to adjusted income from operations follows:

Financial Summary *(In millions)*	For the Years Ended December 31, 2014	2013	2012	Increase/(Decrease) 2014 vs. 2013		Increase/(Decrease) 2013 vs. 2012	
Shareholders' net income	$ 2,102	$ 1,476	$ 1,623	$ 626	42%	$ (147)	(9)%
Less: realized investment gains, net of taxes	106	141	31	(35)	(25)	110	N/M
Segment earnings	1,996	1,335	1,592	661	50	(257)	(16)
Less: GMIB and special items (after-tax):							
Results of GMIB business	–	25	29	(25)		(4)	
Costs associated with PBM services agreement	–	(24)	–	24		(24)	
Charge related to reinsurance transaction (See Note 7 to the Consolidated Financial Statements)	–	(507)	–	507		(507)	
Charge for disability claims regulatory matter (See Note 23 to the Consolidated Financial Statements)	–	(51)	–	51		(51)	
Charges for organizational efficiency plans (See Note 6 to the Consolidated Financial Statements)	–	(40)	(50)	40		10	
Charges associated with litigation matters discussed in Note 23 to the Consolidated Financial Statements	–	–	(81)	–		81	
Costs associated with acquisitions (See Note 3 to the Consolidated Financial Statements)	–	–	(40)	–		40	
ADJUSTED INCOME FROM OPERATIONS	**$ 1,996**	**$ 1,932**	**$ 1,734**	**$ 64**	**3%**	**$ 198**	**11%**
Other Key Consolidated Financial Data							
Global medical customers, excluding limited benefits *(in thousands)*	14,456	14,078	13,856	378	3%	222	2%
Effective tax rate	36.6%	32.1%	34.4%	450bps		(230)bps	

Consolidated Results of Operations: 2014 Compared to 2013 and 2013 Compared to 2012

- ***Revenues:*** The components of revenue changes are discussed further below:
  - *Premiums.* The increase in 2014 compared with 2013 reflects premium growth in each of our ongoing reporting segments: Global Health Care, Global Supplemental Benefits and Group Disability and Life. These results are primarily attributable to rate increases to recover both medical cost trend and new taxes and fees assessed under Health Care Reform. Business growth in certain of our market segments and products, including U.S. commercial individual, stop loss and Medicaid also contributed to the increase. The increase in 2013 compared with 2012 was driven primarily by continued customer growth in targeted markets of all of the ongoing segments, and, to a lesser extent, acquisitions in late 2012 in the Global Supplemental Benefits segment.
  - *Fees and other revenues.* The increase in 2014 compared with 2013 largely resulted from growth in specialty contributions, including pharmacy and cost containment. For 2013, the growth in fees and other revenues over 2012 was due to customer growth as well as increased specialty contributions. Fees and other revenues also included pre-tax losses of $39 million in 2013 and $119 million in 2012 attributable to the hedge program associated with the GMDB and GMIB businesses prior to the reinsurance transaction with Berkshire in 2013.
  - *Net investment income.* In 2014, net investment income was flat compared with 2013, reflecting higher average investment assets offset by lower yields. The slight increase in 2013, compared with 2012, was primarily due to higher yields driven in part by higher partnership income, partially offset by lower average investment assets primarily due to sales of assets to fund the reinsurance transaction with Berkshire.
  - *Mail order pharmacy revenues.* Increases in each of 2014 and 2013 compared with the prior year, primarily reflected higher prescription volume for specialty medications (injectibles) and price increases to recover pharmacy cost trend.
  - *Realized investment results.* In 2014, realized investment results decreased compared with 2013, primarily due to significantly lower gains on sales of fixed maturities that were partially offset by a gain on the sale of an equity interest in 2014. The significant increase in 2013, compared with 2012, primarily resulted from gains on the sales of real estate joint ventures and higher gains on sales of fixed maturities. In the first quarter of 2013, we realized large gains on sales of fixed maturities primarily to fund the reinsurance transaction with Berkshire. See Note 14 to the Consolidated Financial Statements for additional information.
- ***Global Health Care medical claims expense.*** See the Global Health Care section of this MD&A for further discussion.
- ***Other benefit expenses.*** The decrease in other benefit expenses in 2014 compared with 2013 resulted from the absence of the charges recorded in the first quarter of 2013 associated with the reinsurance agreement with Berkshire ($727 million pre-tax), partially offset by continued business growth in the Global Supplemental and Group Disability and Life segments. In 2013, the increase compared with 2012 reflected the charges recorded in the first quarter of 2013 associated with the reinsurance agreement with Berkshire and, to a lesser extent, continued business growth in the Global Supplemental and Group Disability and Life segments.
- ***Mail order pharmacy costs.*** The increases in both 2014 and 2013 are due to volume increases for specialty medications (injectibles) and higher unit costs.
- ***Other operating expenses.*** In 2014, the increase in other operating expenses over 2013 was largely driven by new taxes and fees assessed under Health Care Reform and business growth in all of our ongoing segments. The increase in 2013 compared with 2012 was due primarily to business growth in all of our ongoing segments. See the segment reporting section of this MD&A for additional discussion of operating expenses.
- ***Shareholders' net income.*** For 2014, the significant increase in shareholders' net income compared with 2013 is largely due to the absence of the $507 million after-tax charge associated with the reinsurance agreement with Berkshire recorded in the first quarter of 2013. The decrease in shareholders' net income in 2013, compared with 2012 was also driven by this after-tax charge, partially offset by an increase in adjusted income from operations.
- ***Adjusted income from operations.*** In 2014, the increase in adjusted income from operations compared with 2013 was largely driven by higher earnings in our ongoing business segments (Global Health Care, Global Supplemental Benefits, and Group Disability and Life), partially offset by higher taxes in Corporate related to Health Care Reform and the absence of favorable tax benefits recorded in the third quarter of 2013. The increase in adjusted income from operations in 2013 compared with 2012 was largely attributable to earnings growth in all of our ongoing business segments (Global Health Care, Global Supplemental Benefits, and Group Disability and Life). See the segment discussions later in this MD&A for further information.
- ***Consolidated effective tax rate.*** The increase in the consolidated effective tax rate in 2014, compared with 2013, was primarily driven by the non-deductible health insurance industry tax first assessed under Health Care Reform in 2014. The consolidated effective tax rate decreased in 2013, compared with 2012, primarily driven by favorable tax benefits reported in the third quarter of 2013. See Note 19 to the Consolidated Financial Statements for additional information.
- ***Global medical customers (excluding limited benefits).*** We exited the limited benefits business in 2014 as required by Health Care Reform. Excluding limited benefits customers, our medical customer base increased in both 2014 and 2013 compared with comparable prior years, primarily driven by continued growth in our targeted market segments.

Liquidity and Capital Resources

Financial Summary *(In millions)*	2014	2013	2012
Short-term investments	$ 163	$ 631	$ 154
Cash and cash equivalents	$ 1,420	$ 2,795	$ 2,978
Short-term debt	$ 147	$ 233	$ 201
Long-term debt	$ 5,005	$ 5,014	$ 4,986
Shareholders' equity	$ 10,774	$ 10,567	$ 9,769

Consolidated short-term investments decreased in 2014 compared with 2013 as a result of the Company reinvesting proceeds from maturities of short-term investments in longer-term holdings. The increase in short-term investments in 2013 compared with 2012 was driven by purchases of liquid commercial paper and United States Government obligations.

Liquidity

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

Liquidity requirements at the subsidiary level generally consist of:

- claim and benefit payments to policyholders; and
- operating expense requirements, primarily for employee compensation and benefits, information technology and real estate.

Our subsidiaries normally meet their operating requirements by:

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

Liquidity requirements at the parent company level generally consist of:

- debt service and dividend payments to shareholders; and
- pension plan funding.

The parent company normally meets its liquidity requirements by:

- maintaining appropriate levels of cash, cash equivalents and short-term investments;
- collecting dividends from its subsidiaries;
- using proceeds from issuance of debt (including commercial paper) and equity securities; and
- borrowing from its subsidiaries.

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

(In millions)	2014	2013	2012
Net cash provided by operating activities	$ 1,994	$ 719	$ 2,350
Net cash provided by (used in) investing activities	$ (1,755)	$ 15	$ (3,857)
Net cash used in financing activities	$ (1,582)	$ (930)	$ (228)

Cash flows from operating activities consist of cash receipts and disbursements for premiums and fees, mail order pharmacy, other revenues, investment income, taxes, benefits and expenses, and, prior to February 4, 2013, gains and losses recognized in connection with our GMDB and GMIB equity hedge programs. Because certain income and expense transactions do not generate cash, and because cash transactions related to revenues and expenses may occur in periods different from when those revenues and expenses are recognized in shareholders' net income, cash flows from operating activities can be significantly different from shareholders' net income.

Cash flows from investing activities generally consist of net investment purchases or sales and net purchases of property and equipment including capitalized software, as well as cash used to acquire businesses.

Cash flows from financing activities are generally comprised of issuances and re-payment of debt at the parent company level, proceeds on the issuance of common stock resulting from stock option exercises, and stock repurchases. In addition, the subsidiaries report deposits to and withdrawals from investment contract liabilities (including universal life insurance liabilities) because such liabilities are considered financing activities with policyholders.

Operating activities

Cash flows from operating activities increased substantially in 2014 compared with 2013, primarily due to the absence of the 2013 reinsurance payments totaling $2.2 billion to Berkshire. Excluding those payments and tax benefits realized in connection with the Berkshire transaction, cash flows from operating activities in 2014 decreased by $0.6 billion, compared with 2013. This decrease was primarily related to the volume and timing of reimbursements prescribed by government programs.

Cash provided by operating activities declined by $1.6 billion in 2013 compared with 2012 primarily due to reinsurance payments totaling $2.2 billion made in 2013 to Berkshire.

Investing activities

Cash flows from investing activities decreased by $1.8 billion in 2014 compared with 2013, primarily due to higher net purchases of fixed maturities. In 2013, net purchases of fixed maturities were lower than 2014 primarily due to funding the Berkshire transaction. Cash flows from investing activities increased by $3.9 billion in 2013 compared with 2012 primarily driven by the absence of 2012 payments to acquire HealthSpring.

Financing activities

Cash used in financing activities increased in 2014 compared with the same period in 2013, primarily reflecting $0.6 billion in higher repurchases of common stock. Cash used in financing activities in 2013 increased by $0.7 billion compared with 2012 primarily due to higher repurchases of common stock.

Share repurchase

We maintain a share repurchase program that was authorized by our Board of Directors. The decision to repurchase shares depends on market conditions and alternate uses of capital. We have repurchased, and may continue to repurchase, shares on the open market through a Rule 10b5-1 plan that permits a company to repurchase its shares at times when it otherwise might be precluded from doing so under insider trading laws or because of self-imposed trading blackout periods. We suspend activity under this program from time to time and also remove such suspensions, generally without public announcement.

In 2014, we repurchased 18.5 million shares for $1.6 billion. From January 1, 2015 through February 25, 2015 we repurchased 1.9 million shares for $217 million. On February 25, 2015, the Company's Board of Directors increased share repurchase authority by $500 million. Accordingly, the total remaining share repurchase authorization as of February 25, 2015 was $966 million. In 2013, the Company repurchased 13.6 million shares for $1.0 billion and, in 2012, we repurchased 4.4 million shares for $208 million.

Interest Expense

Interest expense on long-term debt, short-term debt and capital leases was as follows:

(In millions)	2014	2013	2012
Interest expense	$ 265	$ 270	$ 268

The weighted average interest rate for outstanding short-term debt (primarily commercial paper) was 0.27% at December 31, 2014 and 0.41% at December 31, 2013.

Capital Resources

Our capital resources (primarily retained earnings and proceeds from the issuance of debt and equity securities) provide protection for policyholders, furnish the financial strength to underwrite insurance risks and facilitate continued business growth.

Management, guided by regulatory requirements and rating agency capital guidelines, determines the amount of capital resources that we maintain. Management allocates resources to new long-term business commitments when returns, considering the risks, look promising and when the resources available to support existing business are adequate.

We prioritize our use of capital resources to:

- provide the capital necessary to support growth and maintain or improve the financial strength ratings of subsidiaries;
- consider acquisitions that are strategically and economically advantageous; and
- return capital to investors through share repurchase.

The availability of capital resources will be impacted by equity and credit market conditions. Extreme volatility in credit or equity market conditions may reduce our ability to issue debt or equity securities.

Liquidity and Capital Resources Outlook

At December 31, 2014, there was approximately $400 million in cash and short-term investments available at the parent company level. In 2015, the parent company's combined cash obligations are expected to be approximately $380 million to pay for commercial paper maturities, interest, dividends and required pension contributions.

We expect, based on the parent company's current cash position, current projections for subsidiary dividends, and the ability to refinance its commercial paper borrowing, to have sufficient liquidity to meet the obligations discussed above.

Our cash projections 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. In those cases, we expect to have the flexibility to satisfy liquidity needs through a variety of measures, including intercompany borrowings and sales of liquid investments. The parent company may borrow up to $1.3 billion from its insurance subsidiaries without additional state approval. As of December 31, 2014, the parent company had approximately $165 million of net intercompany loans receivable from its insurance subsidiaries. Alternatively, to satisfy parent company liquidity requirements we may use short-term borrowings, such as the commercial paper program, the committed revolving credit and letter of credit agreement of up to $1.5 billion subject to the maximum debt leverage covenant in its line of credit agreement. As of December 31, 2014, $1.5 billion of short-term borrowing capacity under the credit

agreement was available to us. Within the maximum debt leverage covenant in the line of credit agreement, we have $6.5 billion of borrowing capacity in addition to the $5.2 billion of debt outstanding.

Though we believe we have adequate sources of liquidity, continued significant disruption or volatility in the capital and credit markets could affect our ability to access those markets for additional borrowings or increase costs associated with borrowing funds.

We maintain a capital management strategy to retain overseas a significant portion of the earnings from our foreign operations. These undistributed earnings are deployed outside of the U.S. in support of the liquidity and capital needs of our foreign operations. As of December 31, 2014 undistributed earnings were approximately $1.8 billion. Approximately $15 million of cash and cash equivalents held overseas would, if repatriated, be subject to a charge representing the difference between the U.S. and foreign tax rates. This strategy does not materially limit our ability to meet our liquidity and capital needs in the United States. Cash and cash equivalents in foreign operations are held primarily to meet local liquidity and surplus needs with excess funds generally invested in longer duration, high quality securities.

Unfunded Pension Plan Liability. As of December 31, 2014, our unfunded pension liability was $1.1 billion, reflecting an increase of approximately $0.5 billion from December 31, 2013. The year over year increase in the unfunded liability reflected $0.6 billion in higher projected benefit obligations primarily as a result of a decrease of 75 basis points in the assumed discount rate, and changes to our mortality assumptions based on an updated pension mortality table. These impacts were partially offset by $0.1 billion in asset growth driven by pension contributions and strong asset returns. In 2015, we do not expect to make pension contributions in excess of the $5 million minimum required under the Pension Protection Act of 2006. See Note 9 for additional information regarding our pension plans.

Solvency II. Our businesses in the European Union will be subject to the directive on insurance regulation, solvency and governance requirements known as Solvency II. This directive will impose economic risk-based solvency and governance requirements and supervisory rules and becomes effective in 2016, although certain EU country regulators are requiring companies to demonstrate technical capability and comply with increased capital levels in advance of this effective date. Our European insurance companies are capitalized at levels consistent with projected Solvency II requirements and in compliance with anticipated governance and technical capability requirements.

Guarantees and Contractual Obligations

We are contingently liable for various contractual obligations entered into in the ordinary course of business. The maturities of our primary contractual cash obligations, as of December 31, 2014, are estimated to be as follows:

(In millions, on an undiscounted basis)	Total	Less than 1 year	1-3 years	4-5 years	After 5 years
On-Balance Sheet:					
Insurance liabilities:					
Contractholder deposit funds	$ 6,693	$ 744	$ 966	$ 777	$ 4,206
Future policy benefits	11,665	459	1,114	1,091	9,001
Global Health Care medical claims payable	2,193	2,125	24	11	33
Unpaid claims and claims expenses	4,776	1,463	927	624	1,762
Short-term debt	147	147	–	–	–
Long-term debt	8,435	263	1,383	828	5,961
Other long-term liabilities	695	154	121	87	333
Off-Balance Sheet:					
Purchase obligations	945	462	284	139	60
Operating leases	604	139	207	130	128
TOTAL	**$ 36,153**	**$ 5,956**	**$ 5,026**	**$ 3,687**	**$ 21,484**

The expected future cash flows for GMDB and GMIB contracts included in the table above (within future policy benefits and other long-term liabilities) do not consider any of the related reinsurance arrangements.

On-Balance Sheet:

- ***Insurance liabilities.*** Contractual cash obligations for insurance liabilities, excluding unearned premiums, represent estimated net benefit payments for health, life and disability insurance policies and annuity contracts. Recorded contractholder deposit funds reflect current fund balances primarily from universal life customers. Contractual cash obligations for these universal life contracts are estimated by projecting future payments using assumptions for lapse, withdrawal and mortality. These projected future payments 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. Actual obligations in any single year will vary based on actual morbidity, mortality, lapse, withdrawal, investment and premium experience. The sum of the obligations presented above exceeds the corresponding insurance and contractholder liabilities of $20 billion recorded on the balance sheet because the recorded insurance liabilities reflect discounting for interest and the recorded

contractholder liabilities exclude future interest crediting, charges and fees. We manage our investment portfolios to generate cash flows needed to satisfy contractual obligations. Any shortfall from expected investment yields could result in increases to recorded reserves and adversely impact results of operations. The amounts associated with the sold retirement benefits and individual life insurance and annuity businesses, as well as the reinsured workers' compensation, personal accident and supplemental benefits businesses, are excluded from the table above as net cash flows associated with them are not expected to impact us. The total amount of these reinsured reserves excluded is approximately $5 billion.

- ***Short-term debt*** represents commercial paper, current maturities of long-term debt, and current obligations under capital leases.
- ***Long-term debt*** includes scheduled interest payments. Capital leases are included in long-term debt and represent obligations for IT network storage, servers and equipment.
- ***Other long-term liabilities.*** This table includes estimated payments for GMIB contracts, pension and other postretirement and postemployment benefit obligations, supplemental and deferred compensation plans, interest rate and foreign currency swap contracts, and certain tax and reinsurance liabilities. These items are presented in accounts payable, accrued expenses and other liabilities in our Consolidated Balance Sheets.

Estimated payments of $76 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. Our best estimate is that contributions to the qualified domestic pension plans during 2015 will be approximately $5 million. We expect to make payments subsequent to 2015 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 9 to the Consolidated Financial Statements for further information on pension and other postretirement benefit obligations.

The above table also does not contain $26 million of liabilities for uncertain tax positions because we cannot reasonably estimate the timing of their resolution with the respective taxing authorities. See Note 19 to the Consolidated Financial Statements for the year ended December 31, 2014 for further information.

Off-Balance Sheet:

Purchase obligations. As of December 31, 2014, purchase obligations consisted of estimated payments required under contractual arrangements for future services and investment commitments as follows:

(In millions)		
Fixed maturities	$	74
Commercial mortgage loans		65
Real estate		–
Limited liability entities (other long-term investments)		682
Total investment commitments		821
Future service commitments		124
TOTAL PURCHASE OBLIGATIONS	**$**	**945**

We had commitments to invest in limited liability entities that hold real estate, loans to real estate entities or securities. See Note 11(C) to the Consolidated Financial Statements for additional information.

Our estimated future service commitments primarily represent contracts for certain outsourced business processes and IT 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 cancelable without penalty and those that do not specify minimum levels of goods or services to be purchased.

Operating leases. For additional information, see Note 21 to the Consolidated Financial Statements.

Guarantees

We are contingently liable for various financial and other guarantees provided in the ordinary course of business. See Note 23 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 the development and selection of its critical accounting estimates with the Audit Committee of our Board of Directors and the Audit Committee has reviewed the disclosures presented below.

In addition to the estimates presented in the following table, there are other accounting estimates used in the preparation of our Consolidated Financial Statements, including estimates of liabilities for future policy benefits, as well as estimates with respect to unpaid claims and claim expenses, postemployment and postretirement benefits other than pensions, certain compensation accruals, and income taxes.

Management believes the current assumptions used to estimate amounts reflected in our Consolidated Financial Statements are appropriate. However, if actual experience 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 our liquidity and financial condition.

See Note 2 to the Consolidated Financial Statements for further information on significant accounting policies.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Goodwill At the acquisition date, goodwill represents the excess of the cost of businesses acquired over the fair value of their net assets. We completed our annual evaluations of goodwill for impairment during the third quarter of 2014. These evaluations were performed at the reporting unit level, based on discounted cash flow analyses. The evaluations indicated that no impairment was required. Fair value of a reporting unit was 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 range of discount rates was used, corresponding with the 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 the reporting units. Projections of future cash flows were consistent with our annual planning process for revenues, claims, operating expenses, taxes, capital levels and long-term growth rates. Our Cigna-HealthSpring business (reported in the Government operating segment that is also the reporting unit) contracts with CMS and various state governmental agencies to provide managed health care services, including Medicare Advantage plans and Medicare-approved prescription drug plans. Estimated future cash flows for this business incorporated the potential effects of sequestration and Medicare Advantage reimbursement rates for 2015 and beyond as discussed in the "Overview" section of this MD&A. Revenues from the Medicare programs are dependent, in whole or in part, upon annual funding from the federal government through CMS. Funding for these programs is dependent on many factors including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal level and general political issues and priorities. Goodwill as of December 31 was as follows (in millions): • **2014 – $5,989** • 2013 – $6,029 See Notes 2(H) and 8 to the Consolidated Financial Statements for additional discussion of our goodwill.	If we do not achieve our earnings objectives or the cost of capital rises significantly, the assumptions and estimates underlying these impairment evaluations could be adversely affected and result in future impairment charges that would negatively impact our operating results. Future reductions in the funding for our Medicare programs by the federal government would reduce Cigna-HealthSpring's revenues and profitability and adversely impact the fair value of the Government operating segment. The estimated fair value of each reporting unit exceeded its carrying value by a substantial margin based on our annual evaluations of goodwill for impairment during the third quarter of 2014.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Accounts payable, accrued expenses and other liabilities – pension liabilities These liabilities are estimates of the present value of the qualified and nonqualified pension benefits to be paid (attributed to employee service to date) net of the fair value of plan assets. The accrued pension benefit liability as of December 31 was as follows (in millions): • **2014 – $1,099** • 2013 – $611 See Note 9 to the Consolidated Financial Statements for assumptions and methods used to estimate pension liabilities.	The discount rate is typically the most significant assumption in measuring the pension liability. We develop the discount rate by applying actual annualized yields at various durations from a discount rate curve constructed from high quality corporate bonds. If discount rates for the qualified and nonqualified pension plans decreased by 50 basis points, the accrued pension benefit liability would increase by approximately $240 million as of December 31, 2014 resulting in an after-tax decrease to shareholders' equity of approximately $155 million. If the December 31, 2014 fair values of domestic qualified plan assets decreased by 10%, the accrued pension benefit liability would increase by approximately $415 million as of December 31, 2014 resulting in an after-tax decrease to shareholders' equity of approximately $270 million. The impacts of these hypothetical changes on pension expense or minimum funding requirements would not be material to our results of operations, financial condition or liquidity in 2015. An increase in these key assumptions would result in impacts to, the accrued pension liability and shareholders' equity in an opposite direction, but similar amounts.
Global Health Care medical claims payable Medical claims payable for the Global Health Care segment include both reported claims and estimates for losses incurred but not yet reported. Liabilities for medical claims payable as of December 31 were as follows (in millions): • **2014 – gross $2,180; net $1,928** • 2013 – gross $2,050; net $1,856 These liabilities are presented above both gross and net of reinsurance and other recoverables and generally exclude amounts for administrative services only business. See Notes 2 and 5 to the Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.	In 2014, actual experience differed from our key assumptions as of December 31, 2013, resulting in $159 million of favorable incurred claims related to prior years' medical claims payable or 1.0% of the current year incurred claims as reported in 2013. In 2013, actual experience differed from our key assumptions as of December 31, 2012, resulting in $182 million of favorable incurred claims related to prior years' medical claims, or 1.3% of the current year incurred claims reported in 2012. Specifically, the favorable impact is due to faster than expected completion factors and lower than expected medical cost trends, both of which included an assumption for moderately adverse experience. The impact of this favorable prior year development was an increase to shareholders' net income of $53 million in 2014. The change in the amount of the incurred claims related to prior years in the medical claims payable liability does not directly correspond to an increase or decrease in shareholders' net income as explained in Note 5 to the Consolidated Financial Statements.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Valuation of fixed maturity investments Most fixed maturities 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 fixed maturities are public securities, and one-third are private placement securities. See Note 10 to the Consolidated Financial Statements for a discussion of our fair value measurements and the procedures performed by management to determine that the amounts represent appropriate estimates.	Typically, the most significant input in the measurement of fair value is the market interest rate used to discount the estimated future cash flows from 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. If the interest rates used to calculate fair value increased by 100 basis points, the fair value of the total fixed maturity portfolio of $19.0 billion would decrease by approximately $1.2 billion.
Assessment of "other-than-temporary" impairments of fixed maturities To determine whether a fixed maturity's decline in fair value below its amortized cost is other than temporary, we must evaluate the expected recovery in value and our intent to sell or the likelihood of a required sale of the fixed maturity prior to an expected recovery. To make this determination, we consider a number of general and specific factors including the regulatory, economic and market environments, length of time and severity of the decline, and the financial health and specific near term prospects of the issuer. See Notes 2 (C) and 11 to the Consolidated Financial Statements for additional discussion of our review of declines in fair value, including information regarding our accounting policies for fixed maturities.	For all fixed maturities with cost in excess of their fair value, if this excess was determined to be other-than-temporary, shareholders' net income for the year ended December 31, 2014 would have decreased by approximately $28 million after-tax.

Segment Reporting

The following section of this MD&A discusses the results of each of our reporting segments. We measure the financial results of our segments using "segment earnings (loss)", defined as shareholders' net income (loss) before after-tax realized investment results. In the following segment discussions, we also present information using "adjusted income (loss) from operations", defined as segment earnings (loss) excluding special items and results of the GMIB business. Adjusted income (loss) from operations is another measure of profitability used by our management because it presents the underlying results of operations of our businesses and permits analysis of trends in underlying revenue, expenses and shareholders' net income. This measure is not determined in accordance with GAAP and should not be viewed as a substitute for the most directly comparable GAAP measure that is shareholders' net income. We exclude special items because management does not believe they are representative of our underlying results of operations. We also exclude

the results of the GMIB business because, prior to the reinsurance transaction with Berkshire on February 4, 2013, the changes in the fair value of GMIB assets and liabilities were volatile and unpredictable.

The tables presented below summarize results from operations by segment.

Shareholders' Net Income *(In millions)*	**For the Years Ended December 31,**			**Increase/(Decrease)**		**Increase/(Decrease)**	
	2014	**2013**	**2012**	**2014 vs. 2013**		**2013 vs. 2012**	
Segment earnings (loss)							
Global Health Care	$ 1,646	$ 1,517	$ 1,418	$ 129	9%	$ 99	7%
Global Supplemental Benefits	230	175	142	55	31	33	23
Group Disability and Life	317	259	279	58	22	(20)	(7)
Other Operations	68	(394)	82	462	117	(476)	N/M
Corporate	(265)	(222)	(329)	(43)	(19)	107	33
Total	1,996	1,335	1,592	661	50	(257)	(16)
Net realized investment gains, net of taxes	106	141	31	(35)	(25)	110	N/M
Shareholders' net income	$ 2,102	$ 1,476	$ 1,623	$ 626	42%	$ (147)	(9)%

Adjusted Income (Loss) From Operations *(In millions)*	**For the Years Ended December 31,**			**Increase/(Decrease)**		**Increase/(Decrease)**	
	2014	**2013**	**2012**	**2014 vs. 2013**		**2013 vs. 2012**	
Global Health Care	$ 1,646	$ 1,572	$ 1,480	$ 74	5%	$ 92	6%
Global Supplemental Benefits	230	183	148	47	26	35	24
Group Disability and Life	317	311	281	6	2	30	11
Other Operations	68	88	53	(20)	(23)	35	66
Corporate	(265)	(222)	(228)	(43)	(19)	6	3
Total	$ 1,996	$ 1,932	$ 1,734	$ 64	3%	$ 198	11%

Global Health Care Segment

We measure the operating effectiveness of the Global Health Care segment using the following key factors:

- segment earnings and adjusted income from operations;
- customer growth;
- sales of specialty products;
- operating expense as a percentage of segment revenues (operating expense ratio); and
- medical expense as a percentage of premiums (medical care ratio or "MCR").

Results of Operations

Financial Summary *(In millions)*	For the Years Ended December 31, 2014	2013	2012	Increase/(Decrease) 2014 vs. 2013		Increase/(Decrease) 2013 vs. 2012	
Premiums	$ 20,709	$ 19,626	$ 17,877	$ 1,083	6%	$ 1,749	10%
Fees and other revenues	4,005	3,518	3,321	487	14	197	6
Net investment income	337	325	259	12	4	66	25
Mail order pharmacy revenues	2,239	1,827	1,623	412	23	204	13
Segment revenues	27,290	25,296	23,080	1,994	8	2,216	10
Medical claims expense	16,694	15,867	14,228	827	5	1,639	12
Mail order pharmacy costs	1,907	1,509	1,328	398	26	181	14
Operating expenses	6,009	5,581	5,313	428	8	268	5
Benefits and expenses	24,610	22,957	20,869	1,653	7	2,088	10
Income before taxes	2,680	2,339	2,211	341	15	128	6
Income taxes	1,035	822	793	213	26	29	4
Loss attributable to noncontrolling interest	(1)	–	–	(1)	(100)	–	–
SEGMENT EARNINGS	**1,646**	**1,517**	**1,418**	**129**	**9**	**99**	**7**
Less: special items (after-tax) included in segment earnings:							
Charge for organizational efficiency plan (See Note 6 to the Consolidated Financial Statements)	–	(31)	(42)	31		11	
Costs associated with PBM services agreement	–	(24)	–	24		(24)	
Costs associated with acquisitions	–	–	(7)	–		7	
Charge related to litigation matter	–	–	(13)	–		13	
ADJUSTED INCOME FROM OPERATIONS	**$ 1,646**	**$ 1,572**	**$ 1,480**	**$ 74**	**5%**	**$ 92**	**6%**
Realized investment gains, net of taxes	$ 54	$ 73	$ 9	$ (19)	(26)%	$ 64	N/M
Effective tax rate	38.6%	35.1%	35.9%	350bps		(80)bps	

Earnings Discussion: 2014 compared to 2013

Excluding the special items reported in 2013, segment earnings and adjusted income from operations increased in 2014, compared with 2013. This growth was primarily driven by increased specialty contributions, including strong pharmacy results, partially offset by lower earnings in our government segment primarily due to taxes and fees mandated by Health Care Reform and a higher medical care ratio in our Medicare Part D business. In addition, results include the impact of higher operating expenses reflecting investment spending to enhance our capabilities, and lower margins in our U.S. Commercial group risk business, including our exit from the limited benefits business. Results in the U.S. commercial individual business (after considering receivables from the government risk mitigation programs) were flat.

Earnings Discussion: 2013 compared to 2012

The increase in Global Health Care's segment earnings and adjusted income from operations in 2013, compared with 2012, reflected revenue growth from a higher customer base and rate increases consistent with underlying medical cost trends. Results in 2013 also benefited from increased specialty contributions and higher net investment income.

These favorable effects were partially offset by a higher MCR in Medicare Advantage in 2013 driven by lower per member government reimbursements and higher inpatient and outpatient medical costs. In 2013, results also included higher operating expenses associated with customer growth and enhancements to our capabilities, partially offset by operating cost efficiencies.

Revenues

The table below shows premiums by product line for the Global Health Care segment:

	For the years ended December 31,		
(In millions)	2014	2013	2012
Guaranteed cost	$ 4,600	$ 4,463	$ 4,256
Experience-rated	2,322	2,292	2,022
Stop loss	2,318	1,907	1,672
International health care	1,827	1,752	1,648
Dental	1,257	1,139	1,005
Medicare	5,660	5,639	4,969
Medicaid	515	317	207
Medicare Part D	1,405	1,387	1,421
Other	805	730	677
TOTAL PREMIUMS	**$ 20,709**	**$ 19,626**	**$ 17,877**

Premiums. The increase in 2014 compared with 2013 was primarily driven by rate increases on most products in the Commercial segment to recover underlying medical cost trends and taxes and fees mandated by Health Care Reform. In addition, premiums reflect customer growth in our U.S. commercial individual business, as well as in targeted markets for stop loss and Medicaid products. These increases were partially offset by a decline in group commercial risk customers including a shift from our insured to self-insured products and our exit from the limited benefits business.

Premiums increased in 2013, compared with 2012, in the U.S. Commercial segment due to customer growth and rate increases consistent with underlying medical cost trends. In addition, Medicare Advantage premiums were higher due to timing of the HealthSpring acquisition and customer growth.

Fees and other revenues. The increase in 2014, compared with 2013, largely resulted from growth in specialty contributions, including pharmacy and cost containment. In 2013, the growth in fees and other revenues compared to 2012 was due to customer growth as well as increased cost containment revenues.

Net investment income. The increases in both 2014 and 2013, compared with each prior year, were due to higher assets and higher income from partnership investments, with the 2014 increase partially offset by lower yields.

Benefits and Expenses

Global Health Care segment benefits and expenses consist of the following:

(In millions)	2014	2013	2012
Mail order pharmacy costs	$ 1,907	$ 1,509	$ 1,328
Medical claims expense	16,694	15,867	14,228
Operating expenses, excluding special items	6,009	5,497	5,217
Special items	–	84	96
TOTAL BENEFITS AND EXPENSES	**$ 24,610**	**$ 22,957**	**$ 20,869**
Selected ratios			
Guaranteed cost medical care ratio	81.8%	81.5%	80.2%
Medicare Advantage medical care ratio	83.5%	84.8%	80.9%
Medicare Part D medical care ratio	86.3%	82.3%	81.2%
Operating expense ratio – including special items	22.0%	22.1%	23.0%
Operating expense ratio – excluding special items	22.0%	21.7%	22.6%

Medical claims expense. The 5% increase in 2014 compared with 2013 primarily reflects medical cost inflation and customer growth, partially offset by our exit from the limited benefits business.

Medical claims expense increased 12% in 2013 compared with 2012, primarily due to medical cost inflation, the timing of the HealthSpring acquisition, and customer growth. Higher Medicare Advantage inpatient and outpatient medical costs also contributed to the increase.

The guaranteed cost medical care ratio increased slightly in 2014, compared with 2013, due to a higher medical care ratio in the U.S. individual business and the exit from the limited benefits business, offset by rate increases to cover new taxes and fees mandated by Health Care Reform.

The Medicare Advantage medical care ratio decreased in 2014, compared to 2013, reflecting improved per-customer revenues. The ratio increased in 2013, compared with 2012, driven by lower government reimbursement rates as well as higher medical costs.

The Medicare Part D medical care ratio increased in 2014, compared with 2013, primarily due to higher pharmacy costs including some impact from the mix and channel of customer drug purchases as well as increased specialty medication costs.

Operating expenses. Operating expenses increased 8% in 2014 compared with 2013. Excluding the 2013 special items and the Health Care Reform taxes and fees that became effective in 2014, operating expenses increased 3% in 2014 compared with 2013. The increase primarily reflects higher volume-related expenses and greater spending to enhance our capabilities, partially offset by cost efficiencies.

Operating expenses increased 5% in 2013 compared with 2012, primarily reflecting customer growth, increased spending to enhance our capabilities, including costs associated with our new PBM arrangement, and the timing of the HealthSpring acquisition, partially offset by cost efficiencies.

The operating expense ratios, both including and excluding special items, are essentially flat in 2014, compared with 2013. Excluding the Health Care Reform taxes and fees that became effective in 2014, the operating expense ratios decreased in 2014 compared with 2013, reflecting cost efficiencies and higher revenue, partially offset by higher spending to enhance our capabilities.

The operating expense ratios including and excluding special items decreased in 2013, compared with 2012, primarily driven by revenue growth and cost efficiencies partially offset by higher spending to enhance our capabilities, including 2013 costs associated with our new PBM arrangement.

Effective Tax Rates. The increase in the segment's effective tax rate in 2014 compared with 2013 was attributable to the 2014 health insurance industry tax that is not tax deductible. The slight decline in the effective tax rate in 2013 compared with 2012 primarily reflected the recognition of tax benefits in certain of the segment's foreign operations.

Other Items Affecting Health Care Results

Global Health Care Medical Claims Payable

Medical claims payable increased 6% in 2014 compared with 2013, primarily driven by growth in the individual and stop loss books of business. Medical claims payable increased 10% in 2013 compared with 2012, primarily reflecting growth in the stop loss and HealthSpring books of business.

Medical Customers

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

- is covered under an insurance policy or service agreement issued by the Company;
- has access to the Company's provider network for covered services under their medical plan; or
- has medical claims that are administered by the Company.

As of December 31, estimated medical customers were as follows:

(In thousands)	2014	2013	2012
Commercial Risk:			
U.S. Guaranteed cost[1]	930	960	946
U.S. Experience-rated	840	794	786
International health care – Risk	764	742	744
Total commercial risk[1]	2,534	2,496	2,476
Medicare	459	467	426
Medicaid	59	25	23
Total government	518	492	449
Total risk[1]	3,052	2,988	2,925
Service, including international health care	11,404	11,090	10,931
TOTAL MEDICAL CUSTOMERS (excluding limited benefits)	**14,456**	**14,078**	**13,856**
Limited benefits	–	139	189
TOTAL MEDICAL CUSTOMERS	14,456	14,217	14,045

(1) 2013 and 2012 exclude limited benefits customers.

As required by Health Care Reform, we exited the limited benefits business effective December 31, 2013. Excluding this impact, our medical customer base increased 3% in 2014, primarily driven by continued growth in the middle market, select, individual, and government market segments, partially offset by a decline in the national market segment.

Excluding limited benefits customers, medical customers increased 2% in 2013 compared to 2012, primarily reflecting continued ASO customer growth due to strong retention and sales in targeted market segments.

Global Supplemental Benefits Segment

Segment Description

The key factors affecting segment earnings and adjusted income from operations for this segment are:

- premium growth, including new business and customer retention;
- benefits expense as a percentage of earned premium (loss ratio);
- operating expense and acquisition expense as a percentage of segment revenues (expense ratio and acquisition cost ratio);
- the impact of movements in foreign currency; and
- the effective tax rate.

Throughout this discussion, prior period currency adjusted income from operations, revenues, and benefits and expenses are being calculated by applying the current period's exchange rates to reported results in the prior period. A strengthening U.S. Dollar against foreign currencies will decrease segment earnings, while a weakening U.S. Dollar produces the opposite effect.

As described in Note 3 to the Consolidated Financial Statements, the Global Supplemental Benefits segment acquired two businesses during the second half of 2012: Great American Supplemental Benefits and Finans Emeklilik (also referred to as the "Turkey JV"). Collectively, throughout this discussion these two transactions are referred to as "the acquisitions."

Results of Operations

Financial Summary *(In millions)*	For the Years Ended December 31, 2014	2013	2012	Increase/(Decrease) 2014 vs. 2013		Increase/(Decrease) 2013 vs. 2012	
Premiums	$ 2,844	$ 2,496	$ 1,975	$ 348	14%	$ 521	26%
Fees and other revenues	52	43	30	9	21	13	43
Net investment income	109	100	90	9	9	10	11
Segment revenues	3,005	2,639	2,095	366	14	544	26
Benefit expenses	1,544	1,310	1,005	234	18	305	30
Operating expenses	1,190	1,102	911	88	8	191	21
Total benefits and expenses	2,734	2,412	1,916	322	13	496	26
Income before taxes	271	227	179	44	19	48	27
Income taxes	48	50	36	(2)	(4)	14	39
Income (loss) attributable to redeemable noncontrolling interest	(7)	2	–	(9)	N/M	2	N/M
Income attributable to other noncontrolling interest	–	–	1	–	–	(1)	(100)
SEGMENT EARNINGS	**230**	**175**	**142**	**55**	**31**	**33**	**23**
Less: special items (after-tax) included in segment earnings:							
Charges for organizational efficiency plans (See Note 6 to the Consolidated Financial Statements)	–	(8)	(6)	8		(2)	
ADJUSTED INCOME FROM OPERATIONS	**$ 230**	**$ 183**	**$ 148**	**$ 47**	**26%**	**$ 35**	**24%**
Adjusted income from operations, using actual 2014 currency exchange rates	$ 230	$ 190	$ 152	$ 40	21%	$ 38	25%
Realized investment gains, net of taxes	$ 3	$ 5	$ 1	$ (2)	(40)%	$ 4	N/M
Effective tax rate	17.7%	22.0%	20.1%	(430) bps		190 bps	
Loss ratio	54.3%	52.5%	50.9%	180 bps		160 bps	
Acquisition cost ratio	21.4%	23.6%	25.1%	(220) bps		(150) bps	
Expense ratio (excluding acquisition costs)	18.2%	18.2%	18.4%	– bps		(20) bps	

Earnings Discussion: 2014 compared to 2013

The increase in segment earnings and adjusted income from operations was driven in part by a lower acquisition cost ratio and continuing business growth, primarily in South Korea, partially offset by a higher loss ratio driven by a business mix shift and higher incurred claims. 2014 results also included favorable tax-related items of $21 million recorded in the third quarter of 2014 (see effective tax rate discussion below).

Earnings Discussion: 2013 compared to 2012

The increase in segment earnings and adjusted income from operations was primarily driven by business growth, primarily in South Korea, lower acquisition costs in Europe reflecting a decision to cease selling activities in certain markets, and earnings of the acquisitions during the second half of 2013, partially offset by higher acquisition and benefits expenses.

Revenues

Premiums increased in both 2014 and 2013 compared with each prior year. When applying 2014 exchange rates to 2013 and 2012 results, premiums increased by 13% in 2014 and 25% in 2013. These increases were primarily attributable to new sales, particularly in South Korea and the U.S. reflecting both customer growth and sales of higher premium products. In 2013, the increase was also due to the impact of the acquisitions in the second half of 2012.

Net investment income. In 2014, net investment income increased compared with 2013, primarily due to asset growth in South Korea. Net investment income increased in 2013 compared with 2012, primarily due to the impact of the acquisitions in the second half of 2012.

Benefits and Expenses

Benefit expenses increased in both 2014 and 2013, compared with each prior year. Applying actual 2014 currency exchange rates to 2013 results, benefit expenses increased by 16%. These increases were primarily due to business growth and higher claims primarily in South Korea and the U.S. Applying actual 2014 currency exchange rates to prior year results, benefit expenses increased 28% in 2013, compared with 2012, primarily due to the acquisitions in the second half of 2012 and business growth.

Loss ratios increased in 2014 and 2013 compared with each prior year. In 2014, the increase is due primarily to a business mix shift toward products with higher loss ratios and higher incurred claims. For 2013, the increase primarily results from the inherently higher loss ratios of the acquisitions in the second half of 2012.

Operating expenses. Included in operating expenses for the Global Supplemental Benefits segment are both policy acquisition costs and other operating expenses. Overall operating expenses were higher in 2014 and 2013 compared with each prior year, reflecting increases in both policy acquisition costs and other operating expenses. For 2014, the increase in policy acquisition costs reflects higher commissions in Hong Kong, the U.K. and the U.S., primarily driven by higher sales. For 2013, the increase in policy acquisition costs was largely attributable to the acquisitions and business growth, partially offset by lower acquisition costs in Europe reflecting a decision to cease selling activities in certain markets during 2012. The increases in other operating expenses in both 2014 and 2013 compared with each prior year were largely driven by strategic business investments.

Acquisition cost ratios decreased in both 2014 and 2013 compared with each prior year. For 2014, the decline in the ratio largely represents a shift toward higher premium products and more disciplined acquisition cost spending. The decrease in the ratio in 2013 was primarily driven by lower acquisition costs in Europe reflecting a decision to cease selling activities in certain markets during 2012 and, to a lesser extent, the impact of the lower acquisition cost ratios associated with our supplemental benefits business in the U.S.

The expense ratio (excluding acquisition costs) was flat in 2014 compared with 2013 reflecting strategic business investments largely offset by operating efficiencies. In 2013, the expense ratio decreased compared with 2012 primarily due to the lower expense ratios associated with our supplemental benefits business in the U.S., partially offset by strategic business investments.

Effective tax rates. The effective tax rate for the Global Supplemental Benefits segment decreased in 2014 compared with 2013, due to favorable tax related items reported in the third quarter of 2014, primarily the favorable effect of expanding our capital management strategy to retain a significant portion of our foreign operations' earnings overseas. Effective tax rates in 2013 and 2012 largely reflect the continuing favorable impact of this capital management strategy.

Other Items Affecting Global Supplemental Benefits Results

For our Global Supplemental Benefits segment, South Korea is the single largest geographic market. South Korea generated 52% of the segment's revenues and 76% of the segment's earnings in 2014. Due to the concentration of business in South Korea, the Global Supplemental Benefits segment is exposed to potential losses resulting from economic, regulatory and geopolitical developments in that country, as well as foreign currency movements affecting the South Korean won, that could have a significant impact on the segment's results and our consolidated financial results. In South Korea and certain other geographic markets, we continue to innovate and broaden our product and channel distribution capabilities to support business growth and mitigate potential adverse effects of increased data privacy regulatory requirements and other risks to telemarketing distribution. In 2014, our Global Supplemental Benefits segment operations in South Korea represented 4% of our total consolidated revenues and 8% of shareholders' net income.

Group Disability and Life Segment

Key factors for this segment are:

- premium growth, including new business and customer retention;
- net investment income;
- benefit expenses as a percentage of earned premium (loss ratio); and
- other operating expense as a percentage of earned premiums and fees (expense ratio).

Results of Operations

Financial Summary *(In millions)*	For the Years Ended December 31, 2014	2013	2012	Increase/(Decrease) 2014 vs. 2013		Increase/(Decrease) 2013 vs. 2012	
Premiums	$ 3,549	$ 3,348	$ 3,044	$ 201	6%	$ 304	10%
Fees and other revenues	86	78	65	8	10	13	20
Net investment income	335	321	300	14	4	21	7
Segment revenues	3,970	3,747	3,409	223	6	338	10
Benefit expenses	2,716	2,621	2,290	95	4	331	14
Operating expenses	797	766	724	31	4	42	6
Total benefits and expenses	3,513	3,387	3,014	126	4	373	12
Income before taxes	457	360	395	97	27	(35)	(9)
Income taxes	140	101	116	39	39	(15)	(13)
SEGMENT EARNINGS	**317**	**259**	**279**	**58**	**22**	**(20)**	**(7)**
Less: special items (after-tax) included in segment earnings:							
Charge for disability claims regulatory matter (See Note 23 to the Consolidated Financial Statements)	–	(51)	–	51		(51)	
Charge for organizational efficiency plans (See Note 6 to the Consolidated Financial Statements)	–	(1)	(2)	1		1	
ADJUSTED INCOME FROM OPERATIONS	**$ 317**	**$ 311**	**$ 281**	**$ 6**	**2%**	**$ 30**	**11%**
Realized investment gains, net of taxes	$ 14	$ 40	$ 18	$ (26)	(65)%	$ 22	122%
Effective tax rate	30.6%	28.1%	29.4%	250bps		(130)bps	
Loss ratio	76.5%	78.3%	75.2%	(180)bps		310bps	
Loss ratio, excluding special items	76.5%	76.0%	75.2%	50bps		80bps	
Operating expense ratio	21.9%	22.4%	23.3%	(50)bps		(90)bps	

Earnings Discussion: 2014 compared to 2013

Segment earnings increased in 2014 compared with 2013 due primarily to the absence of the $51 million after-tax charge related to a disability claims regulatory matter. See the Overview section of this MD&A for further information. The increase in adjusted income from operations reflected favorable life results, higher net investment income and a lower expense ratio partially offset by higher disability claim costs largely due to a lower discount rate. Disability claim costs were lower in 2013 in part due to the $29 million favorable after-tax effect of a higher discount rate on claims incurred in 2013, resulting from the reallocation of higher yielding assets to the disability and life portfolio that had previously supported liabilities in the run-off reinsurance business. The favorable after-tax effects of reserve reviews were $52 million in 2014 and $60 million in 2013.

Earnings Discussion: 2013 compared to 2012

Segment earnings decreased in 2013 compared with 2012 primarily due to the charge associated with the disability claims regulatory matter. Adjusted income from operations increased reflecting lower disability claim costs, a lower expense ratio and higher net investment income partially offset by unfavorable life claims experience. Lower disability claim costs included the $29 million favorable after-tax effect of a higher discount rate on claims incurred during 2013 as discussed above. Results included the favorable after-tax effect of reserve reviews of $60 million in 2013 and $43 million in 2012.

Revenues

Premiums. The increases in both 2014 and in 2013 reflected new business growth due to disability and life sales and continued strong customer retention.

Net investment income. The increases in both 2014 and in 2013 were primarily due to higher assets partially offset by lower yields.

Benefits and Expenses

Benefit expenses. The increase in 2014 compared with 2013 was due primarily to premium growth and higher disability claims costs including the effect of a lower discount rate, partially offset by the absence of the $77 million before-tax charge for the disability claims regulatory matter and favorable life results. Disability claim costs in 2013 benefited from the $40 million before-tax impact of higher discount rates driven by the reallocation of higher yielding assets to the disability and life portfolio as noted above. The favorable life results reflected lower new claim incidence. Benefit expenses included the before-tax favorable impact of reserve reviews of $75 million in 2014 compared with $84 million in 2013.

The increase in benefit expenses in 2013 compared with 2012 was primarily due to the $77 million before-tax impact of the disability claims regulatory matter, premium growth and unfavorable life claims experience partially offset by lower disability claim costs. The unfavorable life claims experience was driven by higher new claim sizes and the lower disability claim costs were driven by discount rate changes in 2013 as discussed above and the favorable impact of reserve reviews. Benefit expenses in 2013 included the before-tax favorable impact of reserve reviews of $84 million compared with $60 million in 2012.

Operating expense ratio. The decrease in the operating expense ratio in both 2014 and 2013 reflected continued expense discipline.

Effective tax rate. The segment's effective tax rate is generally lower than the federal tax rate of 35%, primarily due to tax-exempt interest income on bonds. The increase in the effective tax rate in 2014 compared with 2013 resulted from a decline in the proportion of the segment's income that was attributable to tax-exempt interest and, to a lesser extent, the absence of the tax benefit reported in 2013 related to the completion of IRS tax audits. The decline in the effective tax rate in 2013 compared with 2012 was due to the tax benefit reported in 2013 related to the completion of IRS tax audits.

Other Operations

Description

Cigna's COLI business contributes the majority of earnings in Other Operations. In the first quarter of 2014, we combined the results of the Run-off Reinsurance segment with other immaterial segments in Other Operations, because the results are expected to be immaterial subsequent to the reinsurance transaction with Berkshire in 2013. Cigna's Other Operations segment also includes the results from the run-off settlement annuity business, as well as the remaining deferred gains recognized from the sale of the individual life insurance and annuity and retirement benefits businesses. Prior year information has been conformed to the current year presentation.

Results of Operations

Financial Summary *(In millions)*	For the Years Ended December 31, 2014	2013	2012	Increase/(Decrease) 2014 vs. 2013		Increase/(Decrease) 2013 vs. 2012	
Premiums	$ 112	$ 105	$ 121	$ 7	7%	$ (16)	(13)%
Fees and other revenues	14	(24)	(101)	38	158	77	76
Net investment income	384	408	490	(24)	(6)	(82)	(17)
Segment revenues	510	489	510	21	4	(21)	(4)
Benefit expenses	380	1,067	377	(687)	(64)	690	183
Operating expenses	33	53	8	(20)	(38)	45	N/M
Benefits and expenses	413	1,120	385	(707)	(63)	735	191
Income (loss) before taxes	97	(631)	125	728	115	(756)	N/M
Income taxes (benefits)	29	(237)	43	266	112	(280)	N/M
SEGMENT EARNINGS (LOSS)	68	(394)	82	462	117	(476)	N/M
Less: results of GMIB business	–	25	29	(25)		(4)	
Less: special items (after-tax) included in segment earnings:							
Charge related to reinsurance transaction	–	(507)	–	507		(507)	
ADJUSTED INCOME FROM OPERATIONS	$ 68	$ 88	$ 53	$ (20)	(23)%	$ 35	66%
Realized investment gains, net of taxes	$ 11	$ 23	$ 3	$ (12)	(52)%	$ 20	N/M
Effective tax rate	29.9%	37.6%	34.4%	(770)bps		320bps	

Earnings Discussion: 2014 compared to 2013

Segment earnings increased significantly in 2014 compared with 2013, due primarily to the absence of the 2013 charge related to the reinsurance transaction with Berkshire. Adjusted income from operations decreased in 2014 compared with 2013, primarily reflecting the absence of the $14 million favorable impact of the 2009-2010 IRS examinations completed during the third quarter of 2013 and higher COLI claims experience in 2014.

Earnings Discussion: 2013 compared to 2012

The decrease in segment results in 2013 compared with 2012 was driven largely by the 2013 charge related to the reinsurance transaction with Berkshire. The increase in adjusted income from operations in 2013, compared with 2012, primarily resulted from the absence of the 2012 reserve strengthening in the GMDB business of $27 million and the $14 million favorable impact of completing the 2009-2010 IRS examinations during the third quarter of 2013. See Note 19 to the Consolidated Financial Statements for additional information on the IRS examinations.

Revenues

Premiums reflect revenue primarily on universal and whole life insurance policies in the COLI business. Premiums increased in 2014 compared with 2013 driven primarily by strong persistency as well as the impact of higher mortality in 2014 on experience-rated business. In 2013, premiums decreased compared with 2012, due to the absence of VADBe premium in 2013 because of the reinsurance transaction, partially offset by higher COLI premium.

Fees and other revenues included losses of $39 million in 2013 and $119 million in 2012 associated with a dynamic hedge program for the run-off reinsurance business that was discontinued in 2013 with

the effective exit from the GMDB and GMIB businesses. Excluding this hedge activity, other revenues were slightly lower in both 2014 and 2013 compared with each prior year, primarily due to the continued decline in deferred gain amortization related to the sold retirement benefits and individual life insurance and annuity businesses.

Net investment income decreased in 2014 and, to a much more significant degree, in 2013 compared with each prior year. These decreases were primarily due to lower average yields and the selling or reallocating of investment assets in 2013 as a result of the reinsurance transaction with Berkshire.

Benefits and expenses

Benefit expenses decreased in 2014 compared with 2013 primarily due to the absence of the $727 million charge resulting from the Berkshire transaction as well as GMDB activity prior to the transaction, partially offset by higher claims experience in the COLI business. Excluding the $727 million charge resulting from the Berkshire transaction, benefit expenses decreased in 2013 compared with 2012 largely due to the GMDB activity prior to the Berkshire transaction, that was favorable in early 2013 and unfavorable in 2012.

Operating expenses decreased in 2014 compared with 2013 primarily due to the absence of expenses associated with the Berkshire transaction and lower ongoing expenses subsequent to the transaction. Operating expenses in 2012 included GMIB fair value gains of $(41) million. Excluding this GMIB activity, operating expenses increased in 2013 compared with 2012 primarily due to expenses associated with the Berkshire transaction.

Corporate

Description

Corporate reflects amounts not allocated to operating segments, such as net interest expense (defined as interest on corporate debt less net investment income on investments not supporting segment operations), interest on uncertain tax positions, certain litigation matters, intersegment eliminations, compensation cost for stock options, expense associated with our frozen pension plans and certain overhead and project costs.

Financial Summary *(In millions)*	**For the Years Ended December 31,**			**Increase/(Decrease)**		**Increase/(Decrease)**	
	2014	**2013**	**2012**	**2014 vs. 2013**		**2013 vs. 2012**	
Segment loss	$ (265)	$ (222)	$ (329)	$ (43)	(19)%	$ 107	33%
Less: special items (after-tax) included in segment loss: Cost associated with HealthSpring acquisition (See Note 3 to the Consolidated Financial Statements)	–	–	(33)	–		33	
Charge related to a litigation matter discussed in Note 23 to the Consolidated Financial Statements	–	–	(68)	–		68	
ADJUSTED LOSS FROM OPERATIONS	**$ (265)**	**$ (222)**	**$ (228)**	**$ (43)**	**(19)%**	**$ 6**	**3%**
Realized investment gains, net of taxes	$ 24	$ –	$ –	$ 24	N/M	$ –	–%

Corporate's segment loss and adjusted loss from operations increased in 2014 compared with 2013, primarily due to an increase in taxes related to certain employee stock compensation costs that are not deductible for income tax purposes under Health Care Reform.

The decrease in Corporate's segment loss in 2013 compared with 2012 is primarily attributable to the absence of special item costs associated with both litigation matters and the HealthSpring acquisition in 2012.

Investment Assets

The following table presents our invested asset portfolio, excluding separate account assets, as of December 31, 2014 and 2013. Additional information regarding our investment assets and related accounting policies is included in Notes 2, 10, 11, 12, 13, 14 and 17 to the Consolidated Financial Statements.

(In millions)	**2014**	**2013**
Fixed maturities	$ 18,983	$ 16,486
Equity securities	189	141
Commercial mortgage loans	2,081	2,252
Policy loans	1,438	1,485
Other long-term investments	1,488	1,370
Short-term investments	163	631
TOTAL	**$ 24,342**	**$ 22,365**

Fixed Maturities

Investments in fixed maturities include publicly traded and privately placed debt securities, 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 10 of the Consolidated Financial Statements.

The following table reflects our fixed maturity portfolio by type of issuer as of December 31, 2014 and 2013.

(In millions)	2014	2013
Federal government and agency	$ 954	$ 880
State and local government	1,856	2,144
Foreign government	1,940	1,444
Corporate	13,498	10,981
Mortgage-backed	85	153
Other asset-backed	650	884
TOTAL	**$ 18,983**	**$ 16,486**

The fixed maturity portfolio increased approximately $2.5 billion during 2014, reflecting increased investment in fixed maturities and the impact of decreased market yields on asset valuations. Although overall asset values are well in excess of amortized cost, there are specific securities with amortized cost in excess of fair value by $42 million in aggregate as of December 31, 2014. See Note 11 to the Consolidated Financial Statements for further information.

As of December 31, 2014, $17.1 billion, or 90%, of the fixed maturities in our investment portfolio were investment grade (Baa and above, or equivalent), and the remaining $1.9 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. These quality characteristics have not materially changed during the year.

Our investment in state and local government securities, with an average quality rating of Aa2 is diversified by issuer and geography with no single exposure greater than $28 million. We assess each issuer's credit quality based on a fundamental analysis of underlying financial information and do not rely solely on statistical rating organizations or monoline insurer guarantees.

We invest in high quality foreign government obligations, with an average quality rating of Aa3 as of December 31, 2014. These investments are primarily concentrated in Asia consistent with the geographic distribution of our international business operations. Foreign government obligations also include $218 million of investments in European sovereign debt, none of which are in countries with significant political or economic concerns (Portugal, Italy, Ireland, Greece, and Spain).

Corporate fixed maturities include private placement investments of $5.2 billion that 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, diversify investments by industry and issuer and require financial and other covenants that allow us to monitor issuers for deteriorating financial strength and pursue remedial actions, if warranted. Corporate fixed maturities include $343 million of investments in companies that are domiciled or have significant business interests in Italy, Ireland, and Spain. These investments have an average quality rating of Baa2 and are diversified by industry sector, including approximately 2% invested in financial institutions. Corporate fixed maturities also include investments in the energy and natural gas sector of $1.4 billion that have an average quality rating of Baa and are diversified by issuer with no single exposure greater than $45 million.

Commercial Mortgage Loans

Our commercial mortgage loans are fixed rate loans, diversified by property type, location and borrower. Loans are secured by high quality commercial properties and are generally made at less than 75% 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 securitize or service mortgage loans.

We completed an annual in-depth review of our commercial mortgage loan portfolio during the second quarter of 2014. This review included an analysis of each property's year-end 2013 financial statements, rent rolls, operating plans and budgets for 2014, a physical inspection of the property and other pertinent factors. Based on property values and cash flows estimated as part of this review and subsequent fundings and repayments, the portfolio's average loan-to-value ratio improved to 63% at December 31, 2014, from 64% as of December 31, 2013, reflecting a modest increase in values for high quality commercial real estate. The portfolio's average debt service coverage ratio also improved, increasing to 1.66 at December 31, 2014 from 1.62 as of December 31, 2013. See Note 11 to the Consolidated Financial Statements for further information.

Commercial real estate capital markets remain most active for well leased, quality commercial real estate located in strong institutional investment markets. The vast majority of properties securing the mortgages in our mortgage portfolio possess these characteristics. While commercial real estate fundamentals continued to improve, the improvement has varied across geographies and property types.

The commercial mortgage loan portfolio contains approximately 80 loans, including five impaired loans with a carrying value totaling $166 million that are classified as problem or potential problem loans. Two of these loans totaling $86 million, net of $4 million in reserves, are current based on restructured terms and three loans totaling

$80 million, net of $8 million in reserves, are current. All of the remaining loans continue to perform under their contractual terms. We have $247 million of loans maturing in the next twelve months. Given the quality and diversity of the underlying real estate, positive debt service coverage and significant borrower cash investment averaging 30%, we remain confident that the vast majority of borrowers will continue to perform as expected under the contract terms.

Other Long-term Investments

Other long-term investments of $1.5 billion primarily include investments in security partnership and real estate funds as well as direct investments in real estate joint ventures. The funds typically invest in mezzanine debt or equity of privately held companies (securities partnerships) 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, investments are diversified across approximately 110 separate partnerships, and approximately 65 general partners who manage one or more of these partnerships. Also, the funds' underlying investments are diversified by industry sector or property type, and geographic region. No single partnership investment exceeds 6% of our securities and real estate partnership portfolio.

Although the total fair values of investments exceeded their carrying values as of December 31, 2014, the fair value of our ownership interest in certain funds that are carried at cost was less than carrying value by $17 million. We expect to recover our carrying value over the average remaining life of these investments of approximately 5 years. Given the current economic environment, future impairments are possible; however, management does not expect those losses to have a material effect on our results of operations, financial condition or liquidity. See Note 11 to the Consolidated Financial Statements for further information regarding Other Long-term Investments.

Problem and Potential Problem Investments

"Problem" bonds and commercial mortgage loans are either delinquent by 60 days or more or have been restructured as to terms, including concessions by us for modification of interest rate, principal payment or maturity date. "Potential problem" bonds and commercial mortgage loans are considered current (no payment more than 59 days past due), but management believes they have certain characteristics that increase the likelihood that they may become problems. The characteristics management considers include, but are not limited to, the following:

- request from the borrower for restructuring;
- principal or interest payments past due by more than 30 but fewer than 60 days;
- downgrade in credit rating;
- collateral losses on asset-backed securities; and
- for commercial mortgages, deterioration of debt service coverage below 1.0 or value declines resulting in estimated loan-to-value ratios increasing to 100% or more.

We recognize interest income on problem bonds and commercial mortgage loans only when payment is actually received because of the risk profile of the underlying investment. The amount that would have been reflected in net income if interest on non-accrual investments had been recognized in accordance with the original terms was not significant for 2014 or 2013.

The following table shows problem and potential problem investments at amortized cost, net of valuation reserves and write-downs:

	December 31, 2014			December 31, 2013		
(In millions)	Gross	Reserve	Net	Gross	Reserve	Net
Problem bonds	$ –	$ –	$ –	$ 2	$ (2)	$ –
Problem commercial mortgage loans[1]	90	(4)	86	41	(3)	38
Foreclosed real estate	24	–	24	29	–	29
TOTAL PROBLEM INVESTMENTS	**$ 114**	**$ (4)**	**$ 110**	**$ 72**	**$ (5)**	**$ 67**
Potential problem bonds	$ 22	$ (9)	$ 13	$ 30	$ (9)	$ 21
Potential problem commercial mortgage loans	130	(8)	122	135	(8)	127
TOTAL POTENTIAL PROBLEM INVESTMENTS	**$ 152**	**$ (17)**	**$ 135**	**$ 165**	**$ (17)**	**$ 148**

(1) Other long-term investments included $7 million at December 31, 2013 of restructured loans that were previously reported in commercial mortgage loans.

Net problem and potential problem investments representing approximately 1% of total investments, excluding policy loans at December 31, 2014, increased by approximately $30 million from December 31, 2013, primarily due to the addition of one commercial mortgage loan to problem investments.

Included in realized investment gains (losses) were increases in valuation reserves related to commercial mortgage loans and other-than-temporary impairments on fixed maturities and partnership investments of $52 million. See Note 11 to the Consolidated Financial Statements for further information.

Investment Outlook

Although financial markets in the United States continued to stabilize during 2014, they have more recently been impacted by continuing global uncertainty. Fixed income asset values have appreciated broadly since the beginning of the year, however the changes in valuation have varied amongst investment sectors depending on perceived risk in the global markets. 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. We believe that the vast majority of our fixed maturity investments will continue to perform under their contractual terms and that the commercial mortgage loan portfolio is positioned to perform well due to its solid aggregate loan-to-value ratio and strong debt service coverage. 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 credit deterioration and interest rate movements 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. Our primary market risk exposures 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 and our employee pension liabilities.
- ***Foreign currency exchange rate risk*** of the U.S. dollar primarily to the South Korean won, Euro, British pound, Chinese yuan renminbi and Taiwan 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 support generally 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 pay out periods such as annuities and long-term disability liabilities.
- ***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. While this technique does not reduce foreign currency exposure on our net assets, it substantially limits exchange rate risk to those net assets.
- ***Use of derivatives.*** We generally use derivative financial instruments to minimize certain market risks. In 2014, we entered into interest rate swap contracts to convert a portion of our interest rate exposure on long-term debt from fixed rates to variable rates to more closely align interest expense with interest income received on our cash equivalent and short-term investment balances.

See Notes 2(C) and 12 to the Consolidated Financial Statements for additional information about financial instruments, including derivative financial instruments.

Effect of Market Fluctuations

The examples that follow illustrate the adverse effect of hypothetical changes in market rates or prices on the fair value of certain financial instruments including:

- a hypothetical increase in market interest rates, primarily for fixed maturities and commercial mortgage loans, partially offset by liabilities for long-term, fixed-rate debt; and
- a hypothetical strengthening of the U.S. dollar to foreign currencies, primarily for the net assets of foreign subsidiaries denominated in a foreign currency.

Management believes that actual results could differ materially from these examples because:

- these examples were developed using estimates and assumptions;
- changes in the fair values of all insurance-related assets and liabilities have been excluded 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) have been excluded, consistent with the disclosure guidance; and
- changes in the fair values of other significant assets and liabilities such as goodwill, deferred policy acquisition costs, taxes, and various accrued liabilities have been excluded; because they are not financial instruments, their primary risks are other than market risk.

The effects of hypothetical changes in market rates or prices on the fair values of certain of our financial instruments, subject to the exclusions noted above (particularly insurance liabilities), would have been as follows as of December 31:

	Loss in fair value	
Market scenario for certain non-insurance financial instruments *(in millions)*	**2014**	**2013**
100 basis point increase in interest rates	$ 850	$ 585
10% strengthening in U.S. dollar to foreign currencies	$ 320	$ 285

The effect of a hypothetical increase in interest rates was determined by estimating the present value of future cash flows using various models, primarily duration modeling. The impact of a hypothetical increase to interest rates at December 31, 2014 was greater than that at December 31, 2013 reflecting increased asset purchases as well as valuation increases resulting from lower market yields of fixed maturities during 2014.

The effect of a hypothetical strengthening of the U.S. dollar relative to the foreign currencies held by us was estimated to be 10% of the U.S. dollar equivalent fair value. Our foreign operations hold investment assets, such as fixed maturities, cash, and cash equivalents, that are generally invested in the currency of the related liabilities. Due to the increase in 2014 of the amount of these investments that are primarily denominated in the South Korean won, the effect of a hypothetical 10% strengthening in the U.S. dollar to foreign currencies at December 31, 2014 was greater than that effect at December 31, 2013.

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

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of income, comprehensive income, changes in total equity and cash flows present fairly, in all material respects, the financial position of Cigna Corporation and its subsidiaries at December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014 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, 2014, based on criteria established in *Internal Control – Integrated Framework 2013* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these 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 these financial statements and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. 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.

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.

/s/ PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania
February 26, 2015

Cigna Corporation
Consolidated Statements of Income

(In millions, except per share amounts)

For the years ended December 31,	2014	2013	2012
Revenues			
Premiums	$ 27,214	$ 25,575	$ 23,017
Fees and other revenues	4,141	3,601	3,291
Net investment income	1,166	1,164	1,144
Mail order pharmacy revenues	2,239	1,827	1,623
Realized investment gains (losses):			
Other-than-temporary impairments on fixed maturities	(36)	(11)	(11)
Other realized investment gains	190	224	55
Total realized investment gains	154	213	44
TOTAL REVENUES	**34,914**	**32,380**	**29,119**
Benefits and Expenses			
Global Health Care medical claims expense	16,694	15,867	14,228
Other benefit expenses	4,640	4,998	3,672
Mail order pharmacy costs	1,907	1,509	1,328
Other operating expenses	8,369	7,830	7,414
TOTAL BENEFITS AND EXPENSES	**31,610**	**30,204**	**26,642**
Income before Income Taxes	3,304	2,176	2,477
Income taxes:			
Current	1,232	501	719
Deferred	(22)	197	134
TOTAL TAXES	**1,210**	**698**	**853**
Net Income	2,094	1,478	1,624
Less: Net Income (Loss) Attributable to Noncontrolling Interests	(8)	2	1
SHAREHOLDERS' NET INCOME	**$ 2,102**	**$ 1,476**	**$ 1,623**
Shareholders' Net Income Per Share:			
Basic	$ 7.97	$ 5.28	$ 5.70
Diluted	$ 7.83	$ 5.18	$ 5.61
Dividends Declared Per Share	$ 0.04	$ 0.04	$ 0.04

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,	2014	2013	2012
Shareholders' net income	$ 2,102	$ 1,476	$ 1,623
Shareholders' other comprehensive income (loss):			
Net unrealized appreciation (depreciation) on securities	143	(410)	147
Net unrealized appreciation (depreciation), derivatives	11	9	(5)
Net translation of foreign currencies	(144)	13	66
Postretirement benefits liability adjustment	(426)	539	(92)
Shareholders' other comprehensive income (loss)	(416)	151	116
Shareholders' comprehensive income	1,686	1,627	1,739
Comprehensive income attributable to noncontrolling interests:			
Net income attributable to redeemable noncontrolling interests	1	2	1
Net loss attributable to other noncontrolling interest	(9)	–	–
Other comprehensive income (loss) attributable to redeemable noncontrolling interests	(7)	(19)	2
Other comprehensive income attributable to other noncontrolling interest	1	–	–
TOTAL COMPREHENSIVE INCOME	$ 1,672	$ 1,610	$ 1,742

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

Cigna Corporation
Consolidated Balance Sheets

(In millions, except per share amounts)

As of December 31,	2014	2013
ASSETS		
Investments:		
Fixed maturities, at fair value (amortized cost, $17,278; $15,273)	$ 18,983	$ 16,486
Equity securities, at fair value (cost, $199; $146)	189	141
Commercial mortgage loans	2,081	2,252
Policy loans	1,438	1,485
Other long-term investments	1,488	1,370
Short-term investments	163	631
Total investments	24,342	22,365
Cash and cash equivalents	1,420	2,795
Premiums, accounts and notes receivable, net	2,757	1,991
Reinsurance recoverables	7,080	7,299
Deferred policy acquisition costs	1,502	1,395
Property and equipment	1,502	1,464
Deferred income taxes, net	293	92
Goodwill	5,989	6,029
Other assets, including other intangibles	2,683	2,654
Separate account assets	8,328	8,252
TOTAL ASSETS	**$ 55,896**	**$ 54,336**
LIABILITIES		
Contractholder deposit funds	$ 8,430	$ 8,470
Future policy benefits	9,642	9,306
Unpaid claims and claim expenses	4,400	4,298
Global Health Care medical claims payable	2,180	2,050
Unearned premiums	621	580
Total insurance and contractholder liabilities	25,273	24,704
Accounts payable, accrued expenses and other liabilities	6,264	5,456
Short-term debt	147	233
Long-term debt	5,005	5,014
Separate account liabilities	8,328	8,252
TOTAL LIABILITIES	**45,017**	**43,659**
Contingencies – Note 23		
Redeemable noncontrolling interests	90	96
SHAREHOLDERS' EQUITY		
Common stock (par value per share, $0.25; shares issued, 296, 366; authorized, 600)	74	92
Additional paid-in capital	2,769	3,356
Accumulated other comprehensive loss	(936)	(520)
Retained earnings	10,289	13,676
Less: treasury stock, at cost	(1,422)	(6,037)
TOTAL SHAREHOLDERS' EQUITY	**10,774**	**10,567**
Noncontrolling interest	15	14
Total equity	10,789	10,581
Total liabilities and equity	$ 55,896	$ 54,336
SHAREHOLDERS' EQUITY PER SHARE	**$ 41.55**	**$ 38.35**

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, except per share amounts)	Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Shareholders' Equity	Noncontrolling Interest	Total Equity	Redeemable Noncontrolling Interest
Balance at January 1, 2012	$ 92	$ 3,188	$ (787)	$ 10,787	$(5,286)	$ 7,994	$ –	$ 7,994	$ –
2012 Activity:									
Effect of issuing stock for employee benefit plans		107		(69)	217	255		255	
Effects of acquisition of joint venture									111
Other comprehensive income			116			116		116	2
Net income				1,623		1,623		1,623	1
Common dividends declared (per share: $0.04)				(11)		(11)		(11)	
Repurchase of common stock					(208)	(208)		(208)	
BALANCE AT DECEMBER 31, 2012	**92**	**3,295**	**(671)**	**12,330**	**(5,277)**	**9,769**	**–**	**9,769**	**114**
2013 Activity:									
Effect of issuing stock for employee benefit plans		61		(119)	243	185		185	
Effects of acquisition of joint venture							14	14	6
Other comprehensive income (loss)			151			151		151	(19)
Net income				1,476		1,476		1,476	2
Common dividends declared (per share: $0.04)				(11)		(11)		(11)	
Repurchase of common stock					(1,003)	(1,003)		(1,003)	
Distribution to noncontrolling interest									(7)
BALANCE AT DECEMBER 31, 2013	**92**	**3,356**	**(520)**	**13,676**	**(6,037)**	**10,567**	**14**	**10,581**	**96**
2014 Activity:									
Effect of issuing stock for employee benefit plans		69		(124)	220	165		165	
Other comprehensive income (loss)			(416)			(416)	1	(415)	(7)
Net income (loss)				2,102		2,102	(9)	2,093	1
Common dividends declared (per share: $0.04)				(11)		(11)		(11)	
Repurchase of common stock					(1,629)	(1,629)		(1,629)	
Retirement of treasury stock	(18)	(652)		(5,354)	6,024	–		–	
Capital contribution by noncontrolling interest		(4)				(4)	9	5	4
Distribution to noncontrolling interest									(4)
BALANCE AT DECEMBER 31, 2014	**$ 74**	**$ 2,769**	**$ (936)**	**$ 10,289**	**$(1,422)**	**$ 10,774**	**$ 15**	**$ 10,789**	**$ 90**

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,	2014	2013	2012
Cash Flows from Operating Activities			
Net income	$ 2,094	$ 1,478	$ 1,624
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	588	597	560
Realized investment gains	(154)	(213)	(44)
Deferred income taxes	(22)	197	134
Net changes in assets and liabilities, net of non-operating effects:			
Premiums, accounts and notes receivable	(780)	(110)	(71)
Reinsurance recoverables	22	369	62
Deferred policy acquisition costs	(176)	(227)	(159)
Other assets	(265)	405	31
Insurance liabilities	457	1,040	245
Accounts payable, accrued expenses and other liabilities	202	(483)	(132)
Current income taxes	111	(56)	29
Cash used to exit the Run-off Reinsurance Business	–	(2,196)	–
Proceeds from sales of mortgage loans held for sale	–	–	61
Other, net	(83)	(82)	10
NET CASH PROVIDED BY OPERATING ACTIVITIES	**1,994**	**719**	**2,350**
Cash Flows from Investing Activities			
Proceeds from investments sold:			
Fixed maturities and equity securities	1,769	1,775	591
Investment maturities and repayments:			
Fixed maturities and equity securities	1,640	1,621	1,507
Commercial mortgage loans	453	653	722
Other sales, maturities and repayments (primarily short-term and other long-term investments)	2,706	1,661	831
Investments purchased or originated:			
Fixed maturities and equity securities	(5,424)	(3,062)	(2,334)
Commercial mortgage loans	(287)	(58)	(364)
Other (primarily short-term and other long-term investments)	(2,115)	(1,930)	(821)
Property and equipment purchases	(473)	(527)	(408)
Acquisitions, net of cash acquired	–	(76)	(3,581)
Other, net	(24)	(42)	–
NET CASH PROVIDED BY / (USED IN) INVESTING ACTIVITIES	**(1,755)**	**15**	**(3,857)**
Cash Flows from Financing Activities			
Deposits and interest credited to contractholder deposit funds	1,482	1,399	1,337
Withdrawals and benefit payments from contractholder deposit funds	(1,456)	(1,358)	(1,264)
Net change in short-term debt	(112)	(101)	98
Repayment of long-term debt	–	(15)	(326)
Repurchase of common stock	(1,612)	(1,003)	(208)
Issuance of common stock	110	150	121
Common dividends paid	(11)	(11)	(11)
Other, net	17	9	25
NET CASH USED IN FINANCING ACTIVITIES	**(1,582)**	**(930)**	**(228)**
Effect of foreign currency rate changes on cash and cash equivalents	(32)	13	23
Net decrease in cash and cash equivalents	(1,375)	(183)	(1,712)
Cash and cash equivalents, January 1,	2,795	2,978	4,690
Cash and cash equivalents, December 31,	$ 1,420	$ 2,795	$ 2,978
Supplemental Disclosure of Cash Information:			
Income taxes paid, net of refunds	$ 1,085	$ 519	$ 655
Interest paid	$ 259	$ 265	$ 248

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

Notes to the Consolidated Financial Statements

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 dedicated to a **mission** of helping individuals **improve their health, well-being and sense of security**. To execute on our mission, Cigna's **strategy** is to "Go Deep", "Go Global" and "Go Individual" with a differentiated set of medical, dental, disability, life and accident insurance and related products and services offered by our subsidiaries. The majority of these products are offered through employers and other groups (e.g. 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 U.S. and selected international markets. In addition to its ongoing operations described above, Cigna also has certain run-off operations.

NOTE 2 Summary of Significant Accounting Policies

A. Basis of Presentation

The Consolidated Financial Statements include the accounts of Cigna Corporation and its 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 valuation, 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. Certain reclassifications have been made to prior year amounts to conform to the current presentation. Beginning in the first quarter of 2014, the Company combined the results of its run-off reinsurance business with Other Operations for segment reporting purposes. See Note 22 for additional information.

Variable interest entities. As of December 31, 2014 and 2013, the Company determined it was not a primary beneficiary in any material variable interest entities.

B. Recent Accounting Changes

Accounting for Health Care Reform's Risk Mitigation Programs. Beginning in 2014, as prescribed by the Patient Protection and Affordable Care Act (referred to as "Health Care Reform"), programs went into effect to reduce the risk for participating health insurance companies selling coverage on the public exchanges.

- *A three-year (2014-2016) reinsurance program* is designed to provide reimbursement to insurers for high cost individual business sold on or off the public exchanges. The reinsurance entity established by the U.S. Department of Health and Human Services ("HHS") is funded by a per-customer reinsurance fee assessed on all insurers, HMOs and self-insured group health plans, excluding certain products such as Medicare Advantage and Medicare Part D. Only non-grandfathered individual plans are eligible for recoveries if claims exceed a specified threshold, up to a reinsurance cap. Reinsurance contributions associated with non-grandfathered individual plans are reported as a reduction in premium revenue, and estimated reinsurance recoveries are established with an offsetting reduction in Global Health Care medical claims expense. Reinsurance fee contributions for other insured business are reported in other operating expenses. Final recoverable amounts are determined and settled with HHS in the year following the policy year.
- *A premium stabilization program* is comprised of two components: 1) a *permanent component* that 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 members compared to the risk of other members in the same state and market, considering data obtained from industry studies; and 2) a *temporary (2014-2016) component* designed to limit insurer gains and losses by comparing allowable medical costs to a target amount as defined by HHS. This program applies to individual and small group qualified health plans, operating on and off the exchanges. Variances from the target amount exceeding certain thresholds may result in amounts due to or due from HHS.

  For the premium stabilization program, the Company records receivables or payables 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.

Revenue from Contracts with Customers (Accounting Standards Update ("ASU") 2014-09). In May 2014, the Financial Accounting Standards Board ("FASB") issued new revenue recognition guidance that will apply to various contracts with customers to provide goods or services, including the Company's non-insurance, administrative services contracts. It will not apply to certain contracts within the

scope of other GAAP, such as insurance contracts. This new guidance introduces a model that requires companies to estimate and allocate the expected contract revenue among distinct goods or services in the contract based on relative standalone selling prices. Revenue is recognized as goods or services are delivered. This new method replaces the current GAAP approach of recognizing revenue that is fixed and determinable primarily based on contract terms. In addition, extensive new disclosures will be required including the presentation of additional categories of revenues and information about related contract assets and liabilities. This new guidance must be implemented on January 1, 2017; early adoption is not permitted. The Company may choose to adopt these changes through retrospective restatement with or without using certain practical expedients or with a cumulative effect adjustment on adoption. The Company continues to monitor developing implementation guidance and evaluate these new requirements for its non-insurance customer contracts to determine the method of implementation and any resulting estimated effects on the financial statements.

Amendments to the Consolidation Analysis (ASU 2015-2). In February 2015, the FASB issued guidance to improve targeted areas of consolidation guidance for legal entities such as limited partnerships, limited liability companies and securitization structures. In addition to reducing the number of consolidation models, the new standard aims to simplify and improve U.S. GAAP by placing more emphasis on risk of loss when determining a controlling financial interest. This new standard is effective beginning on January 1, 2016, with early adoption permitted. The Company is evaluating this guidance for applicable legal entities to determine any resulting estimated effects on the financial statements.

Fees Paid to the Federal Government by Health Insurers (ASU 2011-06). Effective January 1, 2014, the Company adopted the FASB's accounting guidance for the health insurance industry assessment (the "tax") mandated by Health Care Reform. This non-deductible tax is being levied based on a ratio of an insurer's net health insurance premiums written for the previous calendar year compared to the U.S. health insurance industry total. As required by the guidance, the Company reports a liability at the beginning of each year in accounts payable, accrued expenses and other liabilities and a corresponding deferred cost in other assets, including other intangibles based on a preliminary assessment of the full year. The Company recognizes the tax in operating expenses on a straight line basis and reduces the deferred cost correspondingly. For full-year 2014, the Company recognized $238 million in operating expenses for the tax. As of December 31, 2014, there were no such remaining balances in deferred costs or accounts payable, accrued expenses and other liabilities. This accounting will be reflected for the 2015 tax beginning in the first quarter of 2015.

Investment Company Accounting (ASU 2013-08). Effective January 1, 2014, the Company adopted the FASB's amended accounting guidance to change the criteria for reporting as an investment company, clarify the fair value measurement used by an investment company and require additional disclosures. This guidance also confirms that parent company accounting for an investment company should reflect fair value accounting. While this guidance applies to certain of the Company's security and real estate partnership investments, its adoption did not have a material impact on the Company's financial statements.

Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income ("AOCI") (ASU 2013-02). Effective January 1, 2013, the Company adopted new requirements to disclose the effect of items reclassified out of AOCI into net income for each individual line item impacted in the statement of income. See Note 17 for the Company's disclosures.

Disclosures about Offsetting Assets and Liabilities (ASU 2011-11). The FASB's new requirements to disclose information related to certain investments on both a gross and net basis became effective January 1, 2013. The Company had no transactions or arrangements subject to these new disclosure requirements.

C. Investments

Fixed maturities and equity securities. Fixed maturities (including bonds, mortgage and other asset-backed securities and preferred stocks redeemable by the investor) and most equity 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. The Company records impairment losses in net income for fixed maturities with fair value below amortized cost that meet either of the following conditions:

- If the Company intends to sell or determines that it is more likely than not to be required to sell these fixed maturities before their fair values recover, an impairment loss is recognized for the excess of the amortized cost over fair value.
- If the net present value of projected future cash flows of a fixed maturity (based on qualitative and quantitative factors, including the probability of default, and the estimated timing and amount of recovery) is below the amortized cost basis, that difference is recognized as an impairment loss. For mortgage and asset-backed securities, estimated future cash flows are also based on assumptions about the collateral attributes including prepayment speeds, default rates and changes in value.

Commercial mortgage loans. These loans are made exclusively to commercial borrowers at a fixed rate of interest. Commercial mortgage loans are carried at unpaid principal balances or, if impaired, the lower of unpaid principal or fair value of the underlying real estate. If the fair value of the underlying real estate is less than unpaid principal of an impaired loan, a valuation reserve is recorded. Commercial mortgage loans are considered impaired when it is probable that the Company will not collect amounts due according to the terms of the original loan agreement. The Company monitors credit risk and assesses the impairment of loans individually and on a consistent basis for all loans in the portfolio. The Company estimates the fair value of the underlying real estate using internal valuations generally based on discounted cash flow analyses. Certain commercial mortgage loans without valuation reserves are considered impaired because the Company will not collect all interest due according to the terms of the original agreements; however, the Company expects to recover the unpaid principal because it is less than the fair value of the underlying real estate.

Policy loans. Policy loans are carried at unpaid principal balances plus accumulated interest, the total of which approximates fair value. The loans are collateralized by life insurance policy cash values and therefore have no exposure to credit loss. Interest rates are reset annually based on an index.

Other long-term investments. Other long-term investments include investments in unconsolidated entities. These entities include 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 reported income or loss in cases where the Company has significant influence, otherwise the investment is carried at cost. Income from certain entities is reported on a one quarter lag depending on when their financial information is received. Other long-term investments are considered impaired, and written down to their fair value, when cash flows indicate that the carrying value may not be recoverable. Fair value is generally determined based on a discounted cash flow analysis.

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, 2014 and 2013 is expected to be held longer than one year and includes real estate acquired through the foreclosure of commercial mortgage loans.

Additionally, other long-term investments include interest rate and foreign currency swaps carried at fair value. See Note 12 for information on the Company's accounting policies for these derivative financial instruments.

Short-term investments. Security investments with maturities of greater than 90 days but less than one year from time of purchase are classified as short-term, available for sale and carried at fair value, which approximates cost.

Derivative financial instruments. The Company applies hedge accounting when derivatives are designated, qualified and highly effective as hedges. Effectiveness is formally assessed and documented at inception and each period throughout the life of a hedge using various quantitative methods appropriate for each hedge, including regression analysis and dollar offset. 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.

The Company accounts for derivative instruments as follows:

- Derivatives are reported on the balance sheet at fair value with changes in fair values reported in shareholders' net income or accumulated other comprehensive income.
- Changes in the fair value of derivatives that hedge market risk related to future cash flows and that qualify for hedge accounting are reported in accumulated other comprehensive income ("cash flow hedges").
- Changes in the fair value of a derivative instrument may not always equal changes in the fair value of the hedged item (referred to as "hedge ineffectiveness"). The Company generally reports hedge ineffectiveness in realized investment gains and losses.
- On early termination, the changes in fair value of derivatives that qualified for hedge accounting are reported in shareholders' net income (generally as part of realized investment gains and losses).

Net investment income. 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.

Investment gains and losses. Realized investment gains and losses are based on specifically identified assets and result from sales, investment asset write-downs, changes in the fair values of certain derivatives and changes in valuation reserves on commercial mortgage loans.

Unrealized gains and losses on fixed maturities and equity securities carried at fair value and certain derivatives are included in accumulated other comprehensive income (loss), net of deferred income taxes and amounts required to adjust future policy benefits for the run-off settlement annuity business.

D. Cash and Cash Equivalents

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 accounts payable, accrued expenses and other liabilities when the legal right of offset does not exist.

E. Premiums, Accounts and Notes Receivable and Reinsurance Recoverables

Premiums, accounts and notes receivable and reinsurance recoverables are reported net of allowances for doubtful accounts and unrecoverable reinsurance of $105 million as of December 31, 2014 and $47 million as of December 31, 2013. The Company estimates these allowances for doubtful accounts and unrecoverable reinsurance using management's best estimates of collectability, taking into consideration the age of the outstanding amounts, historical collection patterns and other economic factors.

F. 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 and premium

taxes. The Company records acquisition costs differently depending on the product line. Acquisition costs for:

- ***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.
- ***Supplemental health, life and accident insurance (primarily individual products) 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.
- ***Other products*** are expensed as incurred.

Deferred policy acquisition costs also include the value of business acquired with the supplemental benefits business in 2012.

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 expense. The Company recorded amortization for policy acquisition costs of $289 million in 2014, $255 million in 2013 and $218 million in 2012 in other operating expenses.

G. Property and Equipment

Property and equipment is carried at cost less accumulated depreciation. When applicable, cost includes interest, real estate taxes and other costs incurred during construction. Also included in this category is internal-use software that is acquired, developed or modified solely to meet the Company's internal needs, with no plan to market externally. 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, one 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. If the Company determines the carrying value of any of these assets is not recoverable, an impairment charge is recorded. See Note 8 for additional information.

H. Goodwill

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, allocated to reporting units based on relative fair values and reported in the Global Health Care segment ($5.7 billion) and the Global Supplemental Benefits segment ($331 million). The Company evaluates goodwill for impairment at least annually during the third quarter at the reporting unit level and writes it down through results of operations if impaired. Fair value of a reporting unit is generally estimated based on 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 range of discount rates is used that corresponds with the 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 the reporting units. Projections of future cash flows for the reporting units were consistent with our annual planning process for revenues, claims, operating expenses, taxes, capital levels and long-term growth rates. Cash flows for the Cigna-HealthSpring business incorporate the effects of sequestration and 2015 government reimbursement rates. In 2014, the resulting discounted cash flow analyses indicated that estimated fair values for the reporting units significantly exceeded their carrying values, including goodwill and other intangibles. See Note 8 for additional information.

I. Other Assets, including Other Intangibles

Other assets primarily consist of guaranteed minimum income benefits ("GMIB") assets and various insurance-related assets. The Company's other intangible assets include purchased customer and producer relationships, provider networks and trademarks. The fair value of purchased customer relationships and the amortization method were determined using an income approach that relies on projected future net cash flows including key assumptions for the customer attrition rate and discount rate. The Company amortizes other intangibles on an accelerated or straight-line basis over periods from 3 to 30 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. See Notes 8 and 10 for additional information.

J. Separate Account Assets and Liabilities

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 for related separate account liabilities. The investment income, gains and losses of these accounts generally accrue 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 and are reported in either premiums or fees and other revenues.

K. 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 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.

L. 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 primarily consist of reserves for annuity contracts, life insurance benefits, guaranteed minimum death benefit ("GMDB") contracts (see Note 7 for additional information) and certain health, life and accident insurance products of our Global Supplemental Benefits 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 to be paid to policyholders, net of future premiums 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/or published actuarial tables. Interest rate assumptions are based on management's judgment considering the Company's experience and future expectations, and range from 0.1% to 10.0%. Obligations for the run-off settlement annuity business include adjustments for realized and unrealized investment returns consistent with requirements of GAAP when a premium deficiency exists.

M. Unpaid Claims and Claims Expenses

Liabilities for unpaid claims and claim expenses are estimates of future payments under insurance coverages (primarily long-term disability, life and health) for reported claims and for losses incurred but not yet reported. When estimates of these liabilities change, the Company immediately records the adjustment in benefits and expenses.

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's liability for disability claims reported but not yet paid is the present value of estimated future benefit payments over the expected disability period. The Company projects 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. Using the Company's experience, expected claim resolution rates may vary based upon the anticipated disability period, the covered benefit period, cause of disability, benefit design and the policyholder's age, gender and income level. The gross monthly benefit is reduced (offset) by disability income received under other benefit programs, such as Social Security Disability Income, workers' compensation, statutory disability or other group benefit plans. For offsets not yet finalized, the Company estimates the probability and amount of the offset based on the Company's experience over the past three to five years.

The Company discounts certain unpaid claim liabilities because benefit payments are made over extended periods. Substantially all of these liabilities are associated with the group long-term disability business. Discount rate assumptions for that business are based on projected investment returns for the asset portfolios that support these liabilities and range from 4.1% to 5.5%. Discounted liabilities were $3.9 billion at December 31, 2014 and $3.5 billion at December 31, 2013.

N. Global Health Care Medical Claims Payable

Medical claims payable for the Global Health Care segment include reported claims, estimates for losses incurred but not yet reported and liabilities for services rendered by providers as well as liabilities under risk-sharing and quality management arrangements with providers. The Company uses actuarial principles and assumptions consistently applied each reporting period and recognizes the actuarial best estimate of the ultimate liability within a level of confidence. This approach is consistent with actuarial standards of practice that the liabilities be adequate under moderately adverse conditions.

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) provider claims submission rates, 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.

For the more recent months, the Company relies on medical cost trend analysis that reflects expected claim payment patterns and other relevant operational considerations. Medical cost trend is primarily impacted by medical service utilization and unit costs that are affected by changes in the level and mix of medical 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.

For each reporting period, the Company compares key assumptions used to establish the medical claims payable to actual experience. When actual experience differs from these assumptions, medical claims payable are adjusted through current period shareholders' net income. Additionally, the Company evaluates expected future developments and emerging trends that may impact key assumptions. The estimation process involves 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 trends.

O. Redeemable Noncontrolling Interest

The Company offers products and services in Turkey and India through joint venture entities. The redeemable noncontrolling interest on our consolidated balance sheet represents our joint venture partners' preferred and common stock interests in these entities. Our joint venture partners may, at their election, require the Company to purchase their redeemable noncontrolling interests. We also have the right to require our joint venture partners to sell their redeemable noncontrolling interests to us. The redeemable noncontrolling interests were recorded at fair value on the dates 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 and its effect is included in shareholders' net income per share.

P. Accounts Payable, Accrued Expenses and Other Liabilities

Accounts payable, accrued expenses and other liabilities consist principally of liabilities for pension, other postretirement and postemployment benefits (see Note 9), GMIB contracts (see Note 10), self-insured exposures, management compensation, cash overdraft positions and various insurance-related liabilities, including experience-rated refunds, the minimum medical loss ratio rebate accrual under Health Care Reform and reinsurance contracts. Legal costs to defend the Company's litigation and arbitration matters are expensed when incurred in cases where the Company cannot reasonably estimate the ultimate cost to defend. In cases where the Company can reasonably estimate the cost to defend, a liability for these costs is accrued when the claim is reported.

Q. 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 generally 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.

R. 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 Global Health Care business, medical claims expense is presented net of pharmaceutical manufacturer rebates. For experience-rated contracts, premium revenue includes an adjustment for experience-rated refunds which is calculated according to contract terms and 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 Health Care Reform. These rebates are settled in the year following the policy year.

Premiums received for the Company's Medicare Advantage Plans and Medicare Part D products from customers and the Centers for Medicare and Medicaid Services ("CMS") 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 the demographics and health severity of enrollees. 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 includes payments from CMS for risk sharing adjustments. The risk sharing adjustments that are estimated quarterly based on claim experience, compare actual incurred drug benefit costs to estimated costs submitted in original contracts and 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 also includes 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 Health Care Reform.

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:

- Net investment income on assets supporting universal life products is recognized 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. Expenses are recognized when claims are submitted, and income is credited to policyholders in accordance with contract provisions.

The unrecognized portion of premiums received is recorded as unearned premiums.

S. Fees, Related Expenses and Mail Order Pharmacy Revenues and Costs

Contract fees for administrative services only ("ASO") programs and pharmacy programs and services are recognized in fees and other revenues as services are provided, net of pharmaceutical manufacturer rebates payable to clients and estimated refunds under performance guarantees. In some cases, the Company provides performance guarantees associated with meeting certain service standards, clinical outcomes or financial metrics. If these service standards, clinical outcomes or financial 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 establishes deferred revenues for estimated payouts associated with these performance guarantees. Approximately 12% of ASO fees reported for the year ended December 31, 2014 were at risk, with reimbursements estimated to be approximately 1%. Expenses associated with these programs and services are recognized in other operating expenses as incurred, net of pharmaceutical rebates from manufacturers.

Revenue for investment-related products is recognized as follows:

- Net investment income on assets supporting investment-related products is recognized as earned.
- Contract fees based upon related administrative expenses are recognized in fees and other revenues as they are earned ratably over the contract period.

Benefits and expenses for investment-related products consist primarily of income credited to policyholders in accordance with contract provisions.

Mail order pharmacy revenues and the cost of prescriptions are recognized as each prescription is shipped.

T. Stock Compensation

The Company records compensation expense for stock awards and options over their vesting periods primarily based on the estimated fair value at the grant date. For stock options, fair value is estimated using an option-pricing model, whereas for restricted stock grants and units, fair value is equal to the market price of the Company's common stock on the date of grant. Compensation expense for strategic performance shares is recorded over the performance period. For strategic performance shares with payment dependent on a market condition, fair value is determined at the grant date using a Monte Carlo simulation model and not subsequently adjusted regardless of the final outcome. For strategic performance shares with payment dependent on performance conditions, expense is initially accrued based on the most likely outcome, but evaluated for adjustment each period for updates in the expected outcome. At the end of the performance period, expense is adjusted to the actual outcome (number of shares awarded times the share price at the grant date).

U. Participating Business

The Company's participating life insurance policies entitle policyholders to earn dividends that represent a portion of the earnings of the Company's life insurance subsidiaries. Participating insurance accounted for approximately 1% of the Company's total life insurance in force at the end of 2014, 2013 and 2012.

V. Income Taxes

Deferred income tax assets and liabilities are recognized for differences between the financial and income tax reporting bases of the 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. The deferred income tax provision generally represents the net change in deferred income tax assets and liabilities during the year, exclusive of amounts reported as adjustments to accumulated other comprehensive income or amounts initially recorded due to business combinations. The current income tax provision generally represents the estimated amounts due on the various income tax returns for the year reported plus the effect of any uncertain tax positions. Uncertain tax positions are evaluated in accordance with the model set forth in FASB guidance.

Income tax provisions related to the Company's foreign operations are generally determined based upon the local country income tax rate.

Note 19 contains detailed information about the Company's income taxes.

W. Earnings Per Share

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 unvested restricted stock granted after 2009 using the treasury stock method and the effect of strategic performance shares.

NOTE 3 Acquisitions and Dispositions

The Company may from time to time acquire or dispose of assets, subsidiaries or lines of business. The three significant transactions described below were completed in 2012. The combined pro forma effect of these transactions was not material to the Company's 2012 consolidated revenue and net income.

A. Joint Venture Agreement with Finansbank

On November 9, 2012, the Company acquired 51% of the total shares of Finans Emeklilik ve Hayat A.S. ("Finans Emeklilik"), a Turkish insurance company for a cash purchase price of approximately $116 million. Finans Emeklilik operates in life insurance, accident insurance and pension product markets. Results of this business and the related goodwill and intangible assets (see Note 8 for additional information) are reported in the Global Supplemental Benefits segment. The redeemable noncontrolling interest is classified as temporary equity in the Company's Consolidated Balance Sheet because Finansbank has the right to require the Company to purchase its 49% interest for the value of its net assets and the inforce business in 15 years.

B. Acquisition of Great American Supplemental Benefits Group

On August 31, 2012, the Company acquired Great American Supplemental Benefits Group, one of the largest providers of supplemental health insurance products in the U.S. for a cash purchase price of $326 million. Results of this business and the related goodwill and intangible assets (see Note 8 for additional information) are reported in the Global Supplemental Benefits segment.

C. Acquisition of HealthSpring, Inc.

On January 31, 2012 the Company acquired the outstanding shares of HealthSpring, Inc. ("HealthSpring") for $55 per share in cash and Cigna stock awards, representing a cost of approximately $3.8 billion. At the time of the acquisition, HealthSpring provided Medicare Advantage coverage in 15 states and the District of Columbia, as well as a large, national stand-alone Medicare prescription drug business. Results of this business and the related goodwill and intangible assets (see Note 8 for additional information) are reported in the Global Health Care segment. During 2012, the Company recorded $53 million pre-tax ($40 million after-tax: $7 million in Global Health Care and $33 million in Corporate) of acquisition-related costs in other operating expenses.

During the three years ended December 31, 2014, the Company entered into other acquisition and divestiture transactions, the results of which were not material to the Company's results of operations, liquidity or financial condition.

NOTE 4 Earnings Per Share

Basic and diluted earnings per share were computed as follows:

(Shares in thousands, dollars in millions, except per share amounts)	Basic	Effect of Dilution	Diluted
2014			
Shareholders' net income	$ 2,102	$ –	$ 2,102
Shares			
Weighted average	263,889	–	263,889
Common stock equivalents		4,714	4,714
Total shares	263,889	4,714	268,603
EPS	$ 7.97	$ (0.14)	$ 7.83
2013			
Shareholders' net income	$ 1,476	$ –	$ 1,476
Shares			
Weighted average	279,296	–	279,296
Common stock equivalents		5,389	5,389
Total shares	279,296	5,389	284,685
EPS	$ 5.28	$ (0.10)	$ 5.18
2012			
Shareholders' net income	$ 1,623	$ –	$ 1,623
Shares			
Weighted average	284,819	–	284,819
Common stock equivalents		4,711	4,711
Total shares	284,819	4,711	289,530
EPS	$ 5.70	$ (0.09)	$ 5.61

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)	2014	2013	2012
Anti-dilutive options	1.0	0.9	2.5

NOTE 5 Global Health Care Medical Claims Payable

Medical claims payable for the Global Health Care segment reflects estimates of the ultimate cost of claims that have been incurred but not yet reported, those that have been reported but not yet paid (reported claims in process), and other medical expenses payable that is primarily comprised of accruals for incentives and other amounts payable to health care professionals and facilities, as follows:

(In millions)	2014	2013
Incurred but not yet reported	$ 1,777	$ 1,615
Reported claims in process	288	355
Physician incentives and other medical expense payable	115	80
MEDICAL CLAIMS PAYABLE	**$ 2,180**	**$ 2,050**

Activity in medical claims payable was as follows:

(In millions)	2014	2013	2012
Balance at January 1,	$ 2,050	$ 1,856	$ 1,305
Less: Reinsurance and other amounts recoverable	194	242	249
Balance at January 1, net	1,856	1,614	1,056
Acquired net:	–	–	504
Incurred claims related to:			
Current year	16,853	16,049	14,428
Prior years	(159)	(182)	(200)
Total incurred	16,694	15,867	14,228
Paid claims related to:			
Current year	14,966	14,267	12,854
Prior years	1,656	1,358	1,320
Total paid	16,622	15,625	14,174
Balance at December 31, net	1,928	1,856	1,614
Add: Reinsurance and other amounts recoverable	252	194	242
Balance at December 31,	$ 2,180	$ 2,050	$ 1,856

Reinsurance and other amounts recoverable reflect amounts due from reinsurers and policyholders to cover incurred but not reported and pending claims for minimum premium products and certain ASO business where the right of offset does not exist. See Note 7 for additional information on reinsurance. For the year ended December 31, 2014, actual experience differed from the Company's key assumptions resulting in favorable incurred claims related to prior years' medical claims payable of $159 million, or 1.0% of the current year incurred claims as reported for the year ended December 31, 2013. Actual completion factors accounted for $61 million, or 0.4%, while actual medical cost trend resulted in the remaining $98 million, or 0.6%.

For the year ended December 31, 2013, actual experience differed from the Company's key assumptions, resulting in favorable incurred claims related to prior years' medical claims payable of $182 million, or 1.3% of the current year incurred claims as reported for the year ended December 31, 2012. Actual completion factors accounted for $74 million of favorability, or 0.5%, while actual medical cost trend resulted in the remaining $108 million, or 0.8%.

The impact of prior year development on shareholders' net income was $53 million for the year ended December 31, 2014 compared with $77 million for the year ended December 31, 2013. The favorable effect of prior year development for both years primarily reflects low utilization of medical services. The change in the amount of the incurred claims related to prior years in the medical claims payable liability does not directly correspond to an increase or decrease in the Company's shareholders' net income recognized for the following reasons:

First, the Company consistently recognizes the actuarial best estimate of the ultimate liability within a level of confidence, as required by actuarial standards of practice that require the liabilities be adequate under moderately adverse conditions. As the Company establishes the liability for each incurral year, the Company ensures that its assumptions appropriately consider moderately adverse conditions. When a portion of the development relates to a release of the prior year's provision for moderately adverse conditions, the Company does not consider that amount as impacting shareholders' net income to the extent that it is offset by an increase determined appropriate to address moderately adverse conditions for the current year incurred claims.

Second, as a result of the medical loss ratio ("MLR") provisions of Health Care Reform, changes in medical claim estimates due to prior year development may be offset by a change in the MLR rebate accrual.

Third, changes in reserves for the Company's retrospectively experience-rated business for accounts in surplus do not usually impact shareholders' net income because such amounts are generally offset by a change in the liability to the policyholder. An account is in surplus when the accumulated premium received exceeds the accumulated medical costs and administrative charges, including profit charges.

The determination of liabilities for Global Health Care medical claims payable requires the Company to make critical accounting estimates. See Note 2(N) for further information about the assumptions and estimates used to establish this liability.

NOTE 6 Organizational Efficiency Plans

The Company is regularly evaluating ways to deliver its products and services more efficiently and at a lower cost. During 2013 and 2012, the Company adopted specific plans to increase its organizational efficiency as follows:

2013 Plan. During the fourth quarter of 2013, the Company committed to a plan to increase its organizational efficiency and reduce costs through a series of actions that includes employee headcount reductions. As a result, the Company recognized charges in other operating expenses of $60 million pre-tax ($40 million after-tax) in the fourth quarter of 2013, primarily for severance costs. The Company expects most of the severance to be paid by the end of 2015.

2012 Plan. During the third quarter of 2012, in connection with the execution of its strategy, the Company committed to a series of actions to further improve its organizational alignment, operational effectiveness, and efficiency. As a result, the Company recognized charges in other operating expenses of $77 million pre-tax ($50 million after-tax) in the third quarter of 2012 consisting primarily of severance costs. The costs associated with this plan were substantially paid as of March 31, 2014.

Summarized below is the activity for the 2013 plan described above.

(In millions)	Severance	Real estate	Total
Fourth quarter 2013 charge	$ 47	$ 13	$ 60
Less: 2013 payments	1	1	2
Balance, December 31, 2013	46	12	58
Less: 2014 payments	26	2	28
Balance, December 31, 2014	$ 20	$ 10	$ 30

NOTE 7 Reinsurance

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

Effective Exit of GMDB and GMIB Business

On February 4, 2013, the Company entered into an agreement with Berkshire Hathaway Life Insurance Company of Nebraska ("Berkshire") to effectively exit the GMDB and GMIB businesses via a reinsurance transaction. Berkshire reinsured 100% of the Company's future claim payments in these businesses, net of retrocessional arrangements existing at that time. The reinsurance agreement is subject to an overall limit with approximately $3.7 billion remaining.

This transaction resulted in an after-tax charge to shareholders' net income in the first quarter of 2013 of $507 million ($781 million pre-tax reported as follows: $727 million in other benefit expenses; $45 million in GMIB fair value loss; and $9 million in other operating expenses). The payment to Berkshire under the agreement was $2.2 billion and was funded from the sale of investment assets, tax benefits related to the transaction and available parent cash.

Because this effective exit was accomplished via a reinsurance contract, the amounts related to the reinsured GMDB and GMIB contracts cannot be netted, so the gross assets and liabilities must continue to be measured and reported. The following disclosures provide further context to the methods and assumptions used to determine these assets and liabilities.

GMDB

The Company estimates this liability 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. Because the product is premium deficient, the Company records increases to the reserve if it is inadequate based on the model. Prior to the reinsurance transaction with Berkshire, any such reserve increases were recorded as a charge to shareholders' net income. Reserve increases after the reinsurance transaction are expected to have a corresponding

increase in the recorded reinsurance recoverable, provided the increased recoverable is not capped due to the overall Berkshire limit (including the GMIB assets).

The Company's dynamic hedge programs were discontinued at the time of the Berkshire reinsurance transaction in 2013. These hedge programs generated losses (included in Other Revenues) of $32 million in 2013, and $105 million in 2012.

Activity in future policy benefit reserves for the GMDB business was as follows:

(In millions)	2014	2013	2012
Balance at January 1,	$ 1,396	$ 1,090	$ 1,170
Add: Unpaid claims	18	24	40
Less: Reinsurance and other amounts recoverable	1,317	42	53
Balance at January 1, net	97	1,072	1,157
Add: Incurred benefits	3	699	17
Less: Paid benefits (including the $1,647 payment for Berkshire reinsurance transaction)	–	1,674	102
Ending balance, net	100	97	1,072
Less: Unpaid claims	16	18	24
Add: Reinsurance and other amounts recoverable	1,186	1,317	42
Balance at December 31,	$ 1,270	$ 1,396	$ 1,090

Benefits paid and incurred are net of ceded amounts, including the impact of the 2013 reinsurance transaction with Berkshire. The ending net retained reserve as of December 31, 2014 and December 31, 2013 covers ongoing administrative expenses, as well as the few claims retained by the Company. Prior to 2013, incurred benefits reflected the favorable or unfavorable impact of a rising or falling equity market on the liability, and included reserve strengthening of $43 million in 2012.

The majority of the exposure arises under annuities that guarantee that the benefit received at death will be no less than the highest historical account value of the related mutual fund investments on a contractholder's anniversary date. Under this type of death benefit, the Company is liable to the extent the highest historical anniversary account value exceeds the fair value of the related mutual fund investments at the time of a contractholder's death.

The table below presents the account value, net amount at risk and average attained age of underlying 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. Unless the Berkshire reinsurance limit is exceeded, the Company should be reimbursed in full for these payments.

(Dollars in millions, excludes impact of reinsurance ceded)	2014	2013
Account value	$ 13,078	$ 14,062
Net amount at risk	$ 2,763	$ 3,023
Average attained age of contractholders (weighted by exposure)	73	73
Number of contractholders	354,000	390,000

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 direct benefits and expenses in the Company's Consolidated Statements of Income.

(In millions)	2014	2013	2012
Premiums			
Short-duration contracts:			
Direct	$ 24,294	$ 23,056	$ 20,792
Assumed	429	394	385
Ceded	(226)	(252)	(216)
	24,497	23,198	20,961
Long-duration contracts:			
Direct	2,921	2,485	2,222
Assumed	173	183	86
Ceded:			
Individual life insurance and annuity business sold	(254)	(176)	(186)
Other	(123)	(115)	(66)
	2,717	2,377	2,056
TOTAL	**$ 27,214**	**$ 25,575**	**$ 23,017**
Reinsurance recoveries			
Individual life insurance and annuity business sold	$ 366	$ 335	$ 316
Other	292	(18)	201
TOTAL	**$ 658**	**$ 317**	**$ 517**

Recoveries were higher in 2014 primarily due to the absence of the 2013 activity related to the Berkshire transaction, including the initial payment. The increase in long-duration assumed premiums in 2013 largely results from the acquisition of Great American Supplemental Benefits in 2012.

The effects of reinsurance on written premiums for short-duration contracts were not materially different from the recognized premium amounts shown in the table above.

Reinsurance Recoverables

The majority of the Company's reinsurance recoverables resulted from acquisition and disposition transactions in which the underwriting company was not acquired. Components of the Company's reinsurance recoverables are presented below:

(In millions)

Line of Business	Reinsurer(s)	December 31, 2014	December 31, 2013	Collateral and Other Terms at December 31, 2014
GMDB	Berkshire	$ 1,147	$ 1,276	100% were secured by assets in a trust.
	Other	39	41	96% were secured by assets in a trust or letter of credit.
Individual Life and Annuity (sold in 1998)	Lincoln National Life and Lincoln Life & Annuity of New York	3,817	3,905	Both companies' ratings were sufficient to avoid triggering a contractual obligation to fully secure the outstanding balance.
Retirement Benefits Business (sold in 2004)	Prudential Retirement Insurance and Annuity	1,092	1,200	100% were secured by assets in a trust.
Supplemental Benefits Business (2012 acquisition)	Great American Life	336	363	99% were secured by assets in a trust.
Global Health Care, Global Supplemental Benefits, Group Disability and Life	Various	561	407	Recoverables were from more than 80 reinsurers used in the ordinary course of business. Balances ranged from less than $1 million up to $167 million, with 9% secured by assets in trusts or letters of credit.
Other run-off reinsurance	Various	88	107	100% of this balance was secured by assets in a trust, and other deposits.
Total reinsurance recoverables		**$ 7,080**	**$ 7,299**	

Over 90% of the Company's reinsurance recoverables were from companies that are rated A or higher by Standard & Poor's at December 31, 2014. The Company reviews its reinsurance arrangements and establishes reserves against the recoverables in the event that recovery is not considered probable. As of December 31, 2014, the Company's recoverables were net of a reserve of $4 million.

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.

NOTE 8 Goodwill, Other Intangibles, and Property and Equipment

Goodwill is primarily reported in the Global Health Care segment ($5.7 billion) and, to a lesser extent, the Global Supplemental Benefits segment ($331 million).

Activity in Goodwill during 2014 and 2013 was as follows:

(In millions)	2014	2013
Balance at January 1,	$ 6,029	$ 6,001
Goodwill acquired:		
Finans Emeklilik	–	3
Other	3	33
Impact of foreign currency translation	(43)	(8)
Balance at December 31,	$ 5,989	$ 6,029

Other intangible assets were comprised of the following at December 31:

(Dollars in millions)	Cost	Accumulated Amortization	Net Carrying Value
2014			
Customer relationships	$ 1,266	$ 779	$ 487
Other	313	91	222
Total reported in other assets, including other intangibles	1,579	870	709
Value of business acquired (reported in deferred policy acquisition costs)	165	30	135
Internal-use software (reported in property and equipment)	2,191	1,467	724
TOTAL OTHER INTANGIBLE ASSETS	**$ 3,935**	**$ 2,367**	**$ 1,568**
2013			
Customer relationships	$ 1,289	$ 635	$ 654
Other	324	76	248
Total reported in other assets, including other intangibles	1,613	711	902
Value of business acquired (reported in deferred policy acquisition costs)	168	20	148
Internal-use software (reported in property and equipment)	1,942	1,307	635
TOTAL OTHER INTANGIBLE ASSETS	**$ 3,723**	**$ 2,038**	**$ 1,685**

Property and equipment was comprised of the following as of December 31:

(Dollars in millions)	Cost	Accumulated Amortization	Net Carrying Value
2014			
Internal-use software	$ 2,191	$ 1,467	$ 724
Other property and equipment	1,740	962	778
TOTAL PROPERTY AND EQUIPMENT	**$ 3,931**	**$ 2,429**	**$ 1,502**
2013			
Internal-use software	$ 1,942	$ 1,307	$ 635
Other property and equipment	1,747	918	829
TOTAL PROPERTY AND EQUIPMENT	**$ 3,689**	**$ 2,225**	**$ 1,464**

Other property and equipment includes assets recorded under capital leases with a cost of $84 million, accumulated amortization of $36 million, and a net carrying value of $48 million as of December 31, 2014. Other property and equipment includes assets recorded under capital leases with a cost of $306 million, accumulated amortization of $16 million, and a net carrying value of $290 million as of December 31, 2013. The reduction in assets recorded under capital leases in 2014, compared with the prior year, was primarily related to the Company's purchase of a building in South Korea that it had previously leased. Current capital lease agreements are for equipment and generally have a term of 48 months with the equipment returned to the lessor at the end of the term.

Depreciation and amortization was comprised of the following for the years ended December 31:

(Dollars in millions)	2014	2013	2012
Internal-use software	$ 260	$ 225	$ 209
Other property and equipment	153	160	144
Value of business acquired (reported in deferred policy acquisition costs)	12	19	2
Other intangibles	163	193	205
TOTAL DEPRECIATION AND AMORTIZATION	**$ 588**	**$ 597**	**$ 560**

Other property and equipment includes amortization on assets recorded under capital leases of $20 million in 2014 and $16 million in 2013.

The Company estimates annual pre-tax amortization for intangible assets, including internal-use software, over the next five calendar years to be as follows: $425 million in 2015, $348 million in 2016, $237 million in 2017, $154 million in 2018, and $129 million in 2019.

NOTE 9 Pension and Other Postretirement Benefit Plans

A. Pension and Other Postretirement Benefit Plans

The Company and certain of its subsidiaries provide pension, health care and life insurance defined benefits to eligible retired employees, spouses and other eligible dependents through various domestic and foreign plans. The effect of its foreign pension and other postretirement benefit plans is immaterial to the Company's results of operations, liquidity and financial position. The Company froze its defined benefit postretirement medical plan in the first quarter of 2013 and its primary domestic pension plans in 2009.

As further discussed in Note 23, the Company and the Cigna Pension Plan are defendants in a class action lawsuit that has yet to be resolved. When the parties agree on a final plan amendment, the pension benefit obligation will be updated to reflect additional benefits resulting from this litigation.

In the first quarter of 2013, the Company also announced a change in the cost sharing arrangement with retirees for pharmacy subsidy payments received from the U.S. Government effective January 1, 2014, resulting in a reduced other postretirement benefit obligation of $57 million. This reduction was recorded in accumulated other comprehensive income, net of deferred taxes, resulting in an after-tax increase to shareholders' equity of $37 million.

The Company measures the assets and liabilities of its domestic pension and other postretirement benefit plans as of December 31. The following table summarizes the projected benefit obligations and assets related to the Company's domestic and international pension and other postretirement benefit plans as of, and for the year ended, December 31:

	Pension Benefits		Other Postretirement Benefits	
(In millions)	2014	2013	2014	2013
Change in benefit obligation				
Benefit obligation, January 1	$ 4,700	$ 5,267	$ 323	$ 442
Service cost	2	3	–	1
Interest cost	206	181	12	12
(Gain) loss from past experience	679	(464)	31	(37)
Effect of plan amendment	2	–	–	(57)
Benefits paid from plan assets	(291)	(262)	(5)	(3)
Benefits paid – other	(29)	(25)	(26)	(28)
Curtailment	–	–	–	(7)
Benefit obligation, December 31	5,269	4,700	335	323
Change in plan assets				
Fair value of plan assets, January 1	4,089	3,665	16	20
Actual return on plan assets	257	488	1	(1)
Benefits paid	(291)	(262)	(5)	(3)
Contributions	115	198	–	–
Fair value of plan assets, December 31	4,170	4,089	12	16
Funded Status	$ (1,099)	$ (611)	$ (323)	$ (307)

The postretirement benefits liability adjustment included in accumulated other comprehensive loss consisted of the following as of December 31:

	Pension Benefits		Other Postretirement Benefits	
(In millions)	2014	2013	2014	2013
Unrecognized net gain (loss)	$ (2,317)	$ (1,696)	$ (16)	$ 14
Unrecognized prior service cost	(7)	(5)	54	57
POSTRETIREMENT BENEFITS LIABILITY ADJUSTMENT	**$ (2,324)**	**$ (1,701)**	**$ 38**	**$ 71**

During 2014, the Company's postretirement benefits liability adjustment increased by $656 million pre-tax ($426 million after-tax) resulting in a decrease to shareholders' equity. The increase in the liability was primarily due to a change in the mortality assumption (as discussed further in the assumptions section of this note) and a decrease in the discount rate.

Pension benefits. The Company's pension plans were underfunded by $1.1 billion in 2014 and $0.6 billion in 2013 and had related accumulated benefit obligations of $5.3 billion as of December 31, 2014 and $4.7 billion as of December 31, 2013.

The Company funds its 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. For 2015, the Company expects to make minimum required contributions totaling approximately $5 million. 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.

Components of net pension cost for the years ended December 31 were as follows:

(In millions)	2014	2013	2012
Service cost	$ 2	$ 3	$ 3
Interest cost	206	181	198
Expected long-term return on plan assets	(264)	(272)	(270)
Amortization of:			
Net loss from past experience	57	74	58
Settlement loss	6	–	6
NET PENSION COST	**$ 7**	**$ (14)**	**$ (5)**

The Company expects to recognize pre-tax losses of $70 million in 2015 from amortization of past experience. This estimate is based on a weighted average amortization period for the frozen and inactive plans that is based on the average expected remaining life of plan participants of approximately 29 years.

Other postretirement benefits. Unfunded retiree health benefit plans had accumulated benefit obligations of $206 million at December 31, 2014 and $190 million at December 31, 2013. Retiree life insurance plans had accumulated benefit obligations of $129 million as of December 31, 2014 and $133 million as of December 31, 2013.

Components of net other postretirement benefit cost for the years ended December 31 were as follows:

(In millions)	2014	2013	2012
Service cost	$ –	$ 1	$ 2
Interest cost	12	12	16
Expected long-term return on plan assets	–	(1)	(1)
Amortization of:			
Prior service cost	(3)	(4)	(12)
Curtailment gain	–	(19)	–
NET OTHER POSTRETIREMENT BENEFIT COST	**$ 9**	**$ (11)**	**$ 5**

The Company expects to recognize $3 million pre-tax gains related to amortization of prior service cost and no pre-tax gains from amortization of past experience in 2015. The amortization period is based on an average expected remaining life of plan participants of 29 years.

The estimated rate of future increases in the per capita cost of health care benefits is 6.75% in 2015, decreasing by 0.25% per year to 4.75% in 2023 and beyond. This estimate reflects the Company's current claim experience and management's estimate that rates of growth will decline in the future. A 1% increase or decrease in the estimated rate in 2014 would have no impact on postretirement benefit costs, and $1 million on the postretirement benefit obligation.

Plan assets. The Company's current target investment allocation percentages (50% fixed income, 25% public equity securities, and 25% in other investments, including securities partnerships, hedge funds 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 would expect to further reduce the allocation to equity securities and move further into fixed income investments as funding levels improve.

As of December 31, 2014, pension plan assets included $3.8 billion invested in the separate accounts of Connecticut General Life Insurance Company ("CGLIC") and Life Insurance Company of North America, that are subsidiaries of the Company, as well as an additional $361 million invested directly in funds offered by the buyer of the retirement benefits business.

The fair values of plan assets by category and by the fair value hierarchy as defined by GAAP are as follows. See Note 10 for further details regarding how the Company determines fair value, including the level within the fair value hierarchy and the procedures the Company uses to validate fair value measurements.

December 31, 2014 *(In millions)*	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Plan assets at fair value:				
Fixed maturities:				
Federal government and agency	$ 1	$ 1	$ –	$ 2
Corporate	–	1,025	35	1,060
Mortgage and other asset-backed	–	21	3	24
Fund investments and pooled separate accounts[1]	–	744	3	747
TOTAL FIXED MATURITIES	**1**	**1,791**	**41**	**1,833**
Equity securities:				
Domestic	640	5	73	718
International, including funds and pooled separate accounts[1]	131	241	7	379
TOTAL EQUITY SECURITIES	**771**	**246**	**80**	**1,097**
Real estate, including pooled separate accounts[1]	–	–	331	331
Commercial mortgage loans	–	–	110	110
Securities partnerships	–	–	357	357
Hedge funds	–	–	283	283
Guaranteed deposit account contract	–	–	44	44
Cash equivalents	–	115	–	115
TOTAL PLAN ASSETS AT FAIR VALUE	**$ 772**	**$ 2,152**	**$ 1,246**	**$ 4,170**

(1) A pooled separate account has several participating benefit plans and each owns a share of the total pool of investments.

December 31, 2013 *(In millions)*	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Plan assets at fair value:				
Fixed maturities:				
Federal government and agency	$ –	$ 2	$ –	$ 2
Corporate	–	725	24	749
Mortgage and other asset-backed	–	18	5	23
Fund investments and pooled separate accounts[1]	–	1,019	3	1,022
TOTAL FIXED MATURITIES	**–**	**1,764**	**32**	**1,796**
Equity securities:				
Domestic	824	–	35	859
International, including funds and pooled separate accounts[1]	187	124	7	318
TOTAL EQUITY SECURITIES	**1,011**	**124**	**42**	**1,177**
Real estate, including pooled separate accounts[1]	–	–	251	251
Commercial mortgage loans	–	–	88	88
Securities partnerships	–	–	304	304
Hedge funds	–	–	360	360
Guaranteed deposit account contract	–	–	44	44
Cash equivalents	–	69	–	69
TOTAL PLAN ASSETS AT FAIR VALUE	**$ 1,011**	**$ 1,957**	**$ 1,121**	**$ 4,089**

(1) A pooled separate account has several participating benefit plans and each owns a share of the total pool of investments.

Plan assets in Level 1 include exchange-listed equity securities. Level 2 assets primarily include:

- fixed income and international equity funds priced using their daily net asset value that is the exit price; and
- fixed maturities valued using recent trades of similar securities or pricing models as described below.

Plan assets classified in Level 3 include investments primarily in securities partnerships, equity real estate and hedge funds generally valued based on the pension plan's ownership share of the equity of the investee including changes in the fair values of its underlying investments.

The following table summarizes the changes in pension plan assets classified in Level 3 for the years ended December 31, 2014 and December 31, 2013. Actual return on plan assets in this table may include changes in fair value that are attributable to both observable and unobservable inputs.

(In millions)	Fixed Maturities & Equity Securities	Real Estate & Mortgage Loans	Securities Partnerships	Hedge Funds	Guaranteed Deposit Account Contract	Total
Balance at January 1, 2014	$ 74	$ 339	$ 304	$ 360	$ 44	$ 1,121
Actual return on plan assets:						
Assets still held at the reporting date	1	41	40	17	2	101
Assets sold during the period	–	–	–	–	–	–
TOTAL ACTUAL RETURN ON PLAN ASSETS	**1**	**41**	**40**	**17**	**2**	**101**
Purchases, sales, settlements, net	44	61	13	(94)	(2)	22
Transfers into/out of Level 3	2	–	–	–	–	2
Balance at December 31, 2014	$ 121	$ 441	$ 357	$ 283	$ 44	$ 1,246

(In millions)	Fixed Maturities & Equity Securities	Real Estate & Mortgage Loans	Securities Partnerships	Hedge Funds	Guaranteed Deposit Account Contract	Total
Balance at January 1, 2013	$ 44	$ 352	$ 328	$ 327	$ 47	$ 1,098
Actual return on plan assets:						
Assets still held at the reporting date	–	29	16	38	1	84
Assets sold during the period	7	–	–	–	–	7
TOTAL ACTUAL RETURN ON PLAN ASSETS	**7**	**29**	**16**	**38**	**1**	**91**
Purchases, sales, settlements, net	25	(42)	(40)	(5)	(4)	(66)
Transfers into/out of Level 3	(2)	–	–	–	–	(2)
Balance at December 31, 2013	$ 74	$ 339	$ 304	$ 360	$ 44	$ 1,121

Assumptions for pension and other postretirement benefit plans. Management determined the present value of the projected benefit obligation and the accumulated other postretirement benefit obligation and related benefit costs based on the following weighted average assumptions as of and for the years ended December 31:

	2014	2013
Discount rate:		
Pension benefit obligation	3.75%	4.50%
Other postretirement benefit obligation	3.50%	4.00%
Pension benefit cost	4.50%	3.50%
Other postretirement benefit cost	4.00%	3.25%
Expected long-term return on plan assets:		
Pension benefit cost	7.25%	8.00%
Other postretirement benefit cost	5.00%	5.00%

Based on a 2014 study of the Company's mortality experience over the past several years, it was determined that the new Society of Actuaries mortality table and projection scale published in the fourth quarter of 2014 should be adopted for the Company's defined benefit pension and other postretirement plans as of December 31, 2014.

In measuring the benefit obligation, the Company sets discount rates by applying actual annualized yields at various durations from a discount rate curve to the expected cash flows of the pension and other postretirement benefits liabilities. The discount rate curve is constructed using an array of bonds in various industries throughout the domestic market for high quality bonds, but only selects those for the curve that have an above average return at each duration. The bond portfolio used to construct the curve is monitored to ensure that only high quality issues are included. The Company believes that this curve is representative of the yields that the Company is able to achieve in its plan asset investment strategy. As part of its discount rate setting process, the Company reviewed alternative indices and determined that they were not materially different than the result produced by the curve used.

Expected long-term rates of return on plan assets were developed considering actual long-term historical returns, expected long-term market conditions, plan asset mix and management's investment strategy, that continues a significant allocation to domestic and foreign equity securities as well as real estate, securities partnerships and hedge funds. Expected long-term market conditions take into consideration certain key macroeconomic trends including expected domestic and foreign GDP growth, employment levels and inflation. The expected return assumption was considered reasonable for 2014. The Company will reconsider its expected return assumption for 2015 given some changes in asset mix and re-evaluation of future return expectations among various asset classes.

To measure pension costs, the Company uses a market-related asset valuation for domestic pension plan assets invested in non-fixed income investments. The market-related value of these pension assets recognizes the difference between actual and expected long-term returns in the portfolio over 5 years, a method that reduces the short-term impact of market fluctuations on pension cost. At December 31, 2014, the market-related asset value was approximately $3.9 billion compared with a market value of approximately $4.2 billion.

Benefit payments. The following benefit payments, including expected future services, are expected to be paid in:

(In millions)	Pension Benefits	Other Postretirement Benefits
2015	$ 399	$ 31
2016	$ 334	$ 30
2017	$ 336	$ 29
2018	$ 337	$ 28
2019	$ 338	$ 27
2020-2024	$ 1,631	$ 115

B. 401(k) Plans

The Company sponsors a 401(k) plan in which the Company matches a portion of employees' pre-tax contributions. Another 401(k) plan with an employer match was frozen in 1999. Participants in the active 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. In conjunction with the action to freeze the domestic defined benefit pension plans, effective January 1, 2010, the Company increased its matching contributions to 401(k) plan participants.

The Company may elect to increase its matching contributions if the Company's annual performance meets certain targets. The Company's expense for these plans was $98 million for 2014, $91 million for 2013 and $78 million for 2012.

NOTE 10 Fair Value Measurements

The Company carries certain financial instruments at fair value in the financial statements including fixed maturities, equity securities, short-term investments and derivatives. Other financial instruments are measured at fair value under certain conditions, such as when impaired.

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 may 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, as well as 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 completed by the Company and third-party pricing services include reviewing to ensure that prices do not become stale and whether changes from prior valuations are reasonable or require additional review. The Company also performs sample testing of sales values to confirm the accuracy of prior fair value estimates. Exceptions identified during these processes indicate that adjustments to prices are infrequent and do not significantly impact valuations.

Financial Assets and Financial Liabilities Carried at Fair Value

The following tables provide information as of December 31, 2014 and 2013 about the Company's financial assets and liabilities carried at fair value. Separate account assets that are also recorded at fair value on the Company's Consolidated Balance Sheets are reported separately under the heading "Separate account assets" as gains and losses related to these assets generally accrue directly to policyholders.

December 31, 2014 *(In millions)*	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Financial assets at fair value:				
Fixed maturities:				
Federal government and agency	$ 290	$ 664	$ –	$ 954
State and local government	–	1,856	–	1,856
Foreign government	–	1,936	4	1,940
Corporate	–	13,105	393	13,498
Mortgage-backed	–	84	1	85
Other asset-backed	–	234	416	650
Total fixed maturities[1]	290	17,879	814	18,983
Equity securities	61	85	43	189
Subtotal	351	17,964	857	19,172
Short-term investments	–	163	–	163
GMIB assets[2]	–	–	953	953
Other derivative assets[3]	–	6	–	6
TOTAL FINANCIAL ASSETS AT FAIR VALUE, EXCLUDING SEPARATE ACCOUNTS	**$ 351**	**$ 18,133**	**$ 1,810**	**$ 20,294**
Financial liabilities at fair value:				
GMIB liabilities	$ –	$ –	$ 929	$ 929
Other derivative liabilities[3]	–	1	–	1
TOTAL FINANCIAL LIABILITIES AT FAIR VALUE	**$ –**	**$ 1**	**$ 929**	**$ 930**

(1) Fixed maturities included $756 million of net appreciation required to adjust future policy benefits for the run-off settlement annuity business including $65 million of appreciation for securities classified in Level 3.

(2) The GMIB assets represented retrocessional contracts in place from three external reinsurers that cover the exposures on these contracts.

(3) Other derivative assets included $5 million of interest rate and foreign currency swaps qualifying as cash flow hedges and $1 million of interest rate swaps qualifying as fair value hedges. Other derivative liabilities reflected interest rate and foreign currency swaps qualifying as cash flow hedges. See Note 12 for additional information.

December 31, 2013 *(In millions)*	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Financial assets at fair value:				
Fixed maturities:				
Federal government and agency	$ 297	$ 583	$ –	$ 880
State and local government	–	2,144	–	2,144
Foreign government	–	1,421	23	1,444
Corporate	–	10,476	505	10,981
Mortgage-backed	–	152	1	153
Other asset-backed	–	282	602	884
Total fixed maturities[1]	297	15,058	1,131	16,486
Equity securities	8	74	59	141
Subtotal	305	15,132	1,190	16,627
Short-term investments	–	631	–	631
GMIB assets[2]	–	–	751	751
Other derivative assets[3]	–	3	–	3
TOTAL FINANCIAL ASSETS AT FAIR VALUE, EXCLUDING SEPARATE ACCOUNTS	**$ 305**	**$ 15,766**	**$ 1,941**	**$ 18,012**
Financial liabilities at fair value:				
GMIB liabilities	$ –	$ –	$ 741	$ 741
Other derivative liabilities[3]	–	16	–	16
TOTAL FINANCIAL LIABILITIES AT FAIR VALUE	**$ –**	**$ 16**	**$ 741**	**$ 757**

(1) Fixed maturities included $458 million of net appreciation required to adjust future policy benefits for the run-off settlement annuity business including $60 million of appreciation for securities classified in Level 3.

(2) The GMIB assets represented retrocessional contracts in place from three external reinsurers that cover the exposures on these contracts.

(3) Other derivative assets reflected interest rate and foreign currency swaps qualifying as cash flow hedges. Other derivative liabilities included $15 million of interest rate and foreign currency swaps qualifying as cash flow hedges and $1 million of interest rate and foreign currency swaps not designated as accounting hedges. See Note 12 for additional information.

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. Given the narrow definition of Level 1 and the Company's investment asset strategy to maximize investment returns, a relatively small portion of the Company's investment assets are classified in this category.

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.

Fixed maturities and equity securities. Approximately 94% of the Company's investments in fixed maturities and equity securities are classified in Level 2 including most public and private corporate debt and equity securities, federal agency and municipal bonds, non-government mortgage-backed securities and preferred stocks. Because many fixed maturities do not trade daily, third-party pricing services and internal methods often use recent trades of securities with similar features and characteristics. When recent trades are not available, pricing models are used to determine these prices. 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 which approximates cost. On a regular basis the Company compares market prices for

these securities to recorded amounts 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.

Other derivatives classified in Level 2 represent over-the-counter instruments such as interest rate and foreign currency 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 adjustment for credit risk was required as of December 31, 2014 or December 31, 2013. Level 2 also includes exchange-traded interest rate swap contracts. Credit risk related to the clearinghouse counterparty and the Company is considered minimal when estimating the fair values of these derivatives because of upfront margin deposits and daily settlement requirements. The nature and use of these other derivatives are described in Note 12.

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, as well as assets and liabilities relating to GMIB, in Level 3. Approximately 5% of fixed maturities and equity securities are priced using significant unobservable inputs and classified in this category.

Fair values of other asset and mortgage-backed securities, corporate and government fixed maturities 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. For other asset and mortgage-backed securities, inputs and assumptions for pricing may also include collateral attributes and prepayment speeds. Recent trades in the subject security or similar securities are assessed when available, and the Company may also review published research, as well as the issuer's financial statements, in its evaluation.

Quantitative Information about Unobservable Inputs

The following tables summarize the fair value and significant unobservable inputs used in pricing Level 3 securities that were developed directly by the Company as of December 31, 2014 and 2013. The range and weighted average basis point amounts for fixed maturity spreads (adjustment to discount rates) and price to earnings multiples for equity investments reflect the Company's best estimates of the unobservable adjustments a market participant would make to calculate the fair values.

Other asset and mortgage-backed securities. The significant unobservable inputs used to value the following other asset and mortgage-backed securities are liquidity and weighting of credit spreads. When there is limited trading activity for the security, an adjustment for liquidity is made as of the measurement date that considers current market conditions, issuer circumstances and complexity of the security structure. 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. The resulting wide range of unobservable adjustments in the table below is due to the varying liquidity and quality of the underlying collateral, ranging from high credit quality to below investment grade.

Corporate and government fixed maturities. The significant unobservable input used to value the following corporate and government fixed maturities is an adjustment for liquidity. When there is limited trading activity for the security, an adjustment is needed to reflect current market conditions and issuer circumstances.

Equity securities. The significant unobservable input used to value the following equity securities is a multiple of earnings before interest, taxes, depreciation and amortization (EBITDA). These securities are comprised of private equity investments with limited trading activity and therefore a ratio of EBITDA is used to estimate value based on company circumstances and relative risk characteristics.

As of December 31, 2014 *(Fair value in millions)*	**Fair Value**	**Unobservable Input**	**Unobservable Adjustment to Discount Rates Range (Weighted Average)**
Fixed maturities:			
Other asset and mortgage-backed securities	$ 417	Liquidity	60 - 370 (140)
		Weighting of credit spreads	160 - 2,560 (290)
Corporate and government fixed maturities	344	Liquidity	80 - 930 (262)
Total fixed maturities	761		
Equity securities	43	Price-to-earnings multiples	4.2 - 9.8 (8.1)
Subtotal	804		
Pricing exemption securities[1]	53		
Total Level 3 securities	$ 857		

(1) The fair values for these securities use single, unadjusted non-binding broker quotes not developed directly by the Company.

As of December 31, 2013 *(Fair value in millions)*	Fair Value	Unobservable Input	Unobservable Adjustment to Discount Rates Range (Weighted Average)
Fixed maturities:			
Other asset and mortgage-backed securities	$ 593	Liquidity	60 - 620 (170)
		Weighting of credit spreads	120 - 2,090 (290)
Corporate and government fixed maturities	416	Liquidity	80 - 930 (310)
Total fixed maturities	1,009		
Equity securities	59	Price-to-earnings multiples	4.2 - 9.8 (8.1)
Subtotal	1,068		
Pricing exemption securities[1]	122		
Total Level 3 securities	$ 1,190		

(1) The fair values for these securities use single, unadjusted non-binding broker quotes not developed directly by the Company.

Significant increases in fixed maturity spreads would result in a lower fair value measurement while decreases in these inputs would result in a higher fair value measurement. Significant decreases in equity price to earnings multiples would result in a lower fair value measurement while increases in these inputs would result in a higher fair value measurement. Generally, the unobservable inputs are not interrelated and a change in the assumption used for one unobservable input is not accompanied by a change in the other unobservable input. See the preceding discussion regarding the Company's valuation processes and controls.

Guaranteed minimum income benefit contracts. As discussed in Note 7, the Company effectively exited the GMIB business in 2013. Although these GMIB assets and liabilities must continue to be reported as derivatives at fair value, the only assumption that is expected to impact future shareholders' net income is the risk of non-performance. This assumption reflects a market participant's view of (a) the risk of the Company not fulfilling its GMIB obligations (GMIB liabilities) and (b) the credit risk that the reinsurers do not pay their obligations (GMIB assets). As of December 31, 2014, there were three reinsurers for GMIB, with collateral securing 70% of the balance.

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. Under the terms of these written and purchased contracts, the Company periodically receives and pays fees 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. The Company estimates the fair value of the assets and liabilities for GMIB contracts by calculating the results for many scenarios run through a model utilizing various assumptions that include non-performance risk, among other things.

The non-performance risk adjustment is incorporated by adding an additional spread to the discount rate in the calculation of both (a) the GMIB liabilities to reflect a market participant's view of the risk of the Company not fulfilling its GMIB obligations, and (b) the GMIB assets to reflect a market participant's view of the credit risk of the reinsurers, after considering collateral.

Other assumptions that affect GMIB assets and liabilities include capital market assumptions (including market returns, interest rates and market volatilities of the underlying equity and bond mutual fund investments) and future annuitant behavior (including mortality, lapse, and annuity election rates). As certain assumptions used to estimate fair values for these contracts are largely unobservable (primarily related to future annuitant behavior), the Company classifies GMIB assets and liabilities in Level 3.

The Company regularly evaluates each of the assumptions used in establishing these assets and liabilities. Significant decreases in assumed lapse rates or spreads used to calculate non-performance risk, or increases in assumed annuity election rates, would result in higher fair value measurements. A change in one of these assumptions is not necessarily accompanied by a change in another assumption.

GMIB liabilities are reported in the Company's Consolidated Balance Sheets in accounts payable, accrued expenses and other liabilities. GMIB assets associated with these contracts represent net receivables in connection with reinsurance that the Company has purchased from three external reinsurers and are reported in the Company's Consolidated Balance Sheets in other assets, including other intangibles.

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, 2014 and 2013. Separate account asset changes are reported separately under the heading "Separate account assets" as the changes in fair values of these

assets accrue directly to the policyholders. 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)	Fixed Maturities & Equity Securities	GMIB Assets	GMIB Liabilities	GMIB Net
Balance at January 1, 2014	$ 1,190	$ 751	$ (741)	$ 10
Gains (losses) included in shareholders' net income:				
GMIB fair value gain/(loss)	–	251	(251)	–
Other	15	(1)	15	14
Total gains (losses) included in shareholders' net income	15	250	(236)	14
Gains included in other comprehensive income	14	–	–	–
Gains required to adjust future policy benefits for settlement annuities[1]	55	–	–	–
Purchases, sales, settlements:				
Purchases	101	–	–	–
Sales	(202)	–	–	–
Settlements	(156)	(48)	48	–
Total purchases, sales and settlements	(257)	(48)	48	–
Transfers into/(out of) Level 3:				
Transfers into Level 3	165	–	–	–
Transfers out of Level 3	(325)	–	–	–
Total transfers into/(out of) Level 3	(160)	–	–	–
Balance at December 31, 2014	$ 857	$ 953	$ (929)	$ 24
Total gains (losses) included in shareholders' net income attributable to instruments held at the reporting date	$ 2	$ 250	$ (236)	$ 14

(1) Amounts do not accrue to shareholders.

(In millions)	Fixed Maturities & Equity Securities	GMIB Assets	GMIB Liabilities	GMIB Net
Balance at January 1, 2013	$ 1,351	$ 622	$ (1,170)	$ (548)
Gains (losses) included in shareholders' net income:				
GMIB fair value gain/(loss)	–	(380)	380	–
Other	16	17	(23)	(6)
Total gains (losses) included in shareholders' net income	16	(363)	357	(6)
Losses included in other comprehensive income	(19)	–	–	–
Losses required to adjust future policy benefits for settlement annuities[1]	(50)	–	–	–
Purchases, sales, settlements:				
Purchases	110	–	–	–
Sales	(64)	–	–	–
Settlements	(121)	492	72	564
Total purchases, sales, and settlements	(75)	492	72	564
Transfers into/(out of) Level 3:				
Transfers into Level 3	115	–	–	–
Transfers out of Level 3	(148)	–	–	–
Total transfers into/(out of) Level 3	(33)	–	–	–
Balance at December 31, 2013	$ 1,190	$ 751	$ (741)	$ 10
Total gains (losses) included in shareholders' net income attributable to instruments held at the reporting date	$ 7	$ (363)	$ 357	$ (6)

(1) Amounts do not accrue to shareholders.

As noted in the tables above, total gains and losses included in shareholders' net income are reflected in the following captions in the Consolidated Statements of Income:

- Realized investment gains (losses) and net investment income for amounts related to fixed maturities and equity securities and realized investment gains (losses) for the impact of changes in non-performance risk related to GMIB assets and liabilities beginning February 4, 2013, similar to hedge ineffectiveness; and
- Other operating expenses for amounts related to GMIB assets and liabilities (GMIB fair value gain/loss), except for the impact of changes in non-performance risk subsequent to February 4, 2013.

In the tables above, gains and losses included in other comprehensive income are reflected in net unrealized appreciation (depreciation) on securities in the Consolidated Statements of Comprehensive Income.

Reclassifications impacting Level 3 financial instruments are reported as transfers into or out of the Level 3 category as of the beginning of the quarter in which the transfer occurs. Therefore gains and losses in income only reflect activity for the period the instrument was classified in Level 3.

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. For the years ended December 31, 2014 and 2013, transfers between Level 2 and Level 3 primarily reflect the change in significance of the unobservable inputs used to value certain public and private corporate bonds, principally related to liquidity of the securities and credit risk of the issuers.

Because GMIB reinsurance arrangements remain in effect at the reporting date, the Company has reflected the total gain or loss for the period as the total gain or loss included in income attributable to instruments still held at the reporting date. However, the Company reduces the GMIB assets and liabilities resulting from these reinsurance arrangements when annuitants lapse, die, elect their benefit, or reach the age after which the right to elect their benefit expires.

Separate account assets

Fair values and changes in the fair values of separate account assets generally accrue directly to the policyholders and are excluded from the Company's revenues and expenses. At December 31, separate account assets were as follows:

2014 *(In millions)*	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Guaranteed separate accounts (See Note 23)	$ 242	$ 288	$ –	$ 530
Non-guaranteed separate accounts[1]	1,609	5,031	1,158	7,798
TOTAL SEPARATE ACCOUNT ASSETS	**$ 1,851**	**$ 5,319**	**$ 1,158**	**$8,328**

(1) As of December 31, 2014, non-guaranteed separate accounts included $3.8 billion in assets supporting the Company's pension plans, including $1.1 billion classified in Level 3.

2013 *(In millions)*	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Guaranteed separate accounts (See Note 23)	$ 264	$ 284	$ –	$ 548
Non-guaranteed separate accounts [1]	1,844	4,825	1,035	7,704
TOTAL SEPARATE ACCOUNT ASSETS	**$ 2,108**	**$ 5,109**	**$ 1,035**	**$8,252**

(1) As of December 31, 2013, non-guaranteed separate accounts included $3.8 billion in assets supporting the Company's pension plans, including $983 million classified in Level 3.

Separate account assets in 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 and separate accounts priced using the daily net asset value which is the exit price.

Separate account assets classified in Level 3 include investments primarily in securities partnerships, real estate and hedge funds generally valued based on the separate account's ownership share of the equity of the investee including changes in the fair values of its underlying investments.

The following table summarizes the change in separate account assets reported in Level 3 for the years ended December 31, 2014 and 2013.

(In millions)	2014	2013
Balance at January 1	$ 1,035	$ 1,005
Policyholder gains [1]	85	82
Purchases, issuances, settlements:		
Purchases	266	173
Sales	(2)	(14)
Settlements	(226)	(209)
Total purchases, sales and settlements	38	(50)
Transfers into/(out of) Level 3:		
Transfers into Level 3	20	5
Transfers out of Level 3	(20)	(7)
Total transfers into/(out of) Level 3:	–	(2)
Balance at December 31	$ 1,158	$ 1,035

(1) Included in this amount were gains of $85 million attributable to instruments still held at December 31, 2014 and gains of $76 million attributable to instruments still held at December 31, 2013.

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 investments in real estate entities and commercial mortgage loans when they become impaired. Impaired real estate entities and commercial mortgage loans representing less than 1% of total investments were written down to their fair values, resulting in realized investment losses of $10 million, after-tax in 2014 and $12 million, after-tax in 2013.

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, 2014 and 2013. Financial instruments that are carried in the Company's Consolidated Financial Statements at amounts that approximate fair value are excluded from the following table.

(In millions)	Classification in Fair Value Hierarchy	December 31, 2014 Fair Value	December 31, 2014 Carrying Value	December 31, 2013 Fair Value	December 31, 2013 Carrying Value
Commercial mortgage loans	Level 3	$ 2,168	$ 2,081	$ 2,338	$ 2,252
Contractholder deposit funds, excluding universal life products	Level 3	$ 1,136	$ 1,124	$ 1,081	$ 1,072
Long-term debt, including current maturities, excluding capital leases	Level 2	$ 5,740	$ 4,993	$ 5,550	$ 4,997

The fair values presented in the table above have been estimated using market information when available. The following valuation methodologies and inputs are used by the Company to determine fair value.

Commercial mortgage loans. The Company estimates the fair value of commercial mortgage loans generally by discounting the contractual cash flows at estimated market interest rates that reflect the Company's assessment of the credit quality of the loans. Market interest rates are derived by calculating the appropriate spread over comparable U.S. Treasury rates, based on the property type, quality rating and average life of the loan. The quality ratings reflect the relative risk of the loan, considering debt service coverage, the loan-to-value ratio and other factors. Fair values of impaired mortgage loans are based on the estimated fair value of the underlying collateral generally determined using an internal discounted cash flow model. The fair value measurements were classified in Level 3 because the cash flow models incorporate significant unobservable inputs.

Contractholder deposit funds, excluding universal life products. Generally, these funds do not have stated maturities. Approximately 60% of these balances can be withdrawn by the customer at any time without prior notice or penalty. The fair value for these contracts is the amount estimated to be payable to the customer as of the reporting date, which is generally the carrying value. Most of the remaining contractholder deposit funds are reinsured by the buyers of the individual life and annuity and retirement benefits businesses. The fair value for these contracts is determined using the fair value of these buyers' assets supporting these reinsured contracts. The Company had reinsurance recoverables equal to the carrying value of these reinsured contracts. These instruments were classified in Level 3 because certain inputs are unobservable (supported by little or no market activity) and significant to their resulting fair value measurement.

Long-term debt, including current maturities, excluding capital leases. The fair value of long-term debt is based on quoted market prices for recent trades. When quoted market prices are not available, fair value is estimated using a discounted cash flow analysis and the Company's estimated current borrowing rate for debt of similar terms

and remaining maturities. These measurements were classified in Level 2 because the fair values are based on quoted market prices or other inputs that are market observable or can be corroborated by market data.

Fair values of off-balance-sheet financial instruments were not material as of December 31, 2014 and 2013.

NOTE 11 Investments

A. Fixed Maturities and Equity Securities

The amortized cost and fair value by contractual maturity periods for fixed maturities were as follows at December 31, 2014:

(In millions)	Amortized Cost	Fair Value
Due in one year or less	$ 1,152	$ 1,166
Due after one year through five years	5,681	6,051
Due after five years through ten years	6,531	6,891
Due after ten years	3,267	4,140
Mortgage and other asset-backed securities	647	735
TOTAL	**$ 17,278**	**$ 18,983**

Actual maturities of these securities could differ from their contractual maturities used in the table above. This could occur because issuers may have the right to call or prepay obligations, with or without penalties, or because in certain cases the Company may have the option to unilaterally extend the contractual maturity date.

Gross unrealized appreciation (depreciation) on fixed maturities by type of issuer is shown below.

	December 31, 2014			
(In millions)	Amortized Cost	Unrealized Appreciation	Unrealized Depreciation	Fair Value
Federal government and agency	$ 608	$ 346	$ –	$ 954
State and local government	1,682	176	(2)	1,856
Foreign government	1,824	121	(5)	1,940
Corporate	12,517	1,014	(33)	13,498
Mortgage-backed	83	3	(1)	85
Other asset-backed	564	87	(1)	650
TOTAL	**$ 17,278**	**$ 1,747**	**$ (42)**	**$ 18,983**
(In millions)	**December 31, 2013**			
Federal government and agency	$ 640	$ 242	$ (2)	$ 880
State and local government	1,983	167	(6)	2,144
Foreign government	1,392	64	(12)	1,444
Corporate	10,306	749	(74)	10,981
Mortgage-backed	153	3	(3)	153
Other asset-backed	799	87	(2)	884
TOTAL	**$ 15,273**	**$ 1,312**	**$ (99)**	**$ 16,486**

The above table includes investments with a fair value of $3.1 billion supporting liabilities of the Company's run-off settlement annuity business, with gross unrealized appreciation of $758 million and gross unrealized depreciation of $2 million at December 31, 2014. Such unrealized amounts are reported in future policy benefit liabilities rather than accumulated other comprehensive income. At December 31, 2013, investments supporting this business had a fair value of $2.6 billion, gross unrealized appreciation of $478 million and gross unrealized depreciation of $20 million.

As of December 31, 2014, the Company had commitments to purchase $74 million of fixed maturities, all of which bear interest at a fixed market rate.

Review of declines in fair value. Management reviews fixed maturities with a decline in fair value from cost for impairment based on criteria that include:

- length of time and severity of decline;
- financial health and specific near term prospects of the issuer;

- changes in the regulatory, economic or general market environment of the issuer's industry or geographic region; and
- the Company's intent to sell or the likelihood of a required sale prior to recovery.

The table below summarizes fixed maturities with a decline in fair value from amortized cost as of December 31, 2014. These fixed maturities are primarily corporate securities with a decline in fair value that reflects an increase in market yields since purchase.

	December 31, 2014			
(Dollars in millions)	Fair Value	Amortized Cost	Unrealized Depreciation	Number of Issues
Fixed maturities:				
One year or less:				
Investment grade	$ 999	$ 1,010	$ (11)	251
Below investment grade	$ 293	$ 307	$ (14)	236
More than one year:				
Investment grade	$ 256	$ 264	$ (8)	93
Below investment grade	$ 78	$ 87	$ (9)	22

There were no available for sale equity securities with a significant unrealized loss reflected in accumulated other comprehensive income at December 31, 2014. 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 other realized investment gains (losses) and dividends reported in net investment income. As of December 31, 2014, fair values of these securities were $57 million and amortized cost was $69 million. As of December 31, 2013, fair values of these securities were $56 million and amortized cost was $68 million.

B. Commercial Mortgage Loans

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 a fixed rate of interest and are secured by high quality, primarily completed and substantially leased operating properties.

At December 31, commercial mortgage loans were distributed among the following property types and geographic regions:

(In millions)	2014	2013
Property type		
Office buildings	$ 700	$ 761
Apartment buildings	264	321
Industrial	466	450
Hotels	351	407
Retail facilities	272	285
Other	28	28
TOTAL	**$ 2,081**	**$ 2,252**
Geographic region		
Pacific	$ 637	$ 805
South Atlantic	572	564
New England	277	379
Central	214	260
Middle Atlantic	287	201
Mountain	94	43
TOTAL	**$ 2,081**	**$ 2,252**

At December 31, 2014, scheduled commercial mortgage loan maturities were as follows (in millions): $247 in 2015, $533 in 2016, $229 in 2017, $179 in 2018 and $893 thereafter. Actual maturities could differ from contractual maturities for several reasons: borrowers may have the right to prepay obligations with or without prepayment penalties; the maturity date may be extended; and loans may be refinanced.

As of December 31, 2014, the Company had commitments to extend credit under commercial mortgage loan agreements of $65 million.

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 an ongoing basis, classifying each loan as a loan in good standing, potential problem loan or problem loan.

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 tables summarize 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, 2014 and 2013:

	December 31, 2014					
(In millions)	Debt Service Coverage Ratio					
Loan-to-Value Ratios	**1.30x or Greater**	**1.20x to 1.29x**	**1.10x to 1.19x**	**1.00x to 1.09x**	**Less than 1.00x**	**Total**
Below 50%	$ 340	$ 17	$ –	$ 6	$ –	$ 363
50% to 59%	681	38	–	–	–	719
60% to 69%	394	–	15	–	60	469
70% to 79%	68	36	33	–	80	217
80% to 89%	6	41	–	–	58	105
90% to 100%	–	–	55	–	153	208
TOTAL	**$ 1,489**	**$ 132**	**$ 103**	**$ 6**	**$ 351**	**$ 2,081**

	December 31, 2013					
(In millions)	Debt Service Coverage Ratio					
Loan-to-Value Ratios	**1.30x or Greater**	**1.20x to 1.29x**	**1.10x to 1.19x**	**1.00x to 1.09x**	**Less than 1.00x**	**Total**
Below 50%	$ 314	$ –	$ –	$ 6	$ –	$ 320
50% to 59%	581	131	–	18	–	730
60% to 69%	438	16	29	–	24	507
70% to 79%	79	113	–	–	–	192
80% to 89%	65	42	34	28	143	312
90% to 100%	–	–	58	50	83	191
TOTAL	**$ 1,477**	**$ 302**	**$ 121**	**$ 102**	**$ 250**	**$ 2,252**

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 most recent review was completed by the Company's investment professionals in the second quarter of 2014 and 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 estimates the current year and future stabilized property income and fair value, and categorizes the investments as loans in good standing, potential problem loans or problem loans. Based on property valuations and cash flows estimated as part of this review, and considering updates for loans where material changes were subsequently identified, the portfolio's average loan-to-value ratio improved slightly to 63% at December 31, 2014 from 64% at December 31, 2013. The portfolio's average debt service coverage ratio was estimated to be 1.66 at December 31, 2014, a modest improvement from 1.62 at December 31, 2013.

The Company will reevaluate 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.

During 2013, the Company restructured its subordinate interest in two cross-collateralized pools of industrial loans totaling $31 million by extending the maturity dates and reducing the interest rates. This modification was considered a troubled debt restructuring and the loans were classified as problem mortgage loans because the borrower was experiencing financial difficulties and an interest rate concession was granted. No valuation reserves were required because the fair values of the underlying properties exceeded the carrying values of the outstanding loans.

Certain other loans were modified during 2014 and 2013. However, these were not considered troubled debt restructures and the impact of such modifications was not material to the Company's results of operations, financial condition or liquidity.

Potential problem mortgage loans are considered current (no payment more than 59 days past due), but exhibit certain characteristics that increase the likelihood of future default such as the deterioration of debt service coverage below 1.0, estimated loan-to-value ratios increasing to 100% or more, downgrade in quality rating and requests from the borrower for restructuring. In addition, loans are considered potential problems if principal or interest payments are past due by more than 30 but less than 60 days. Problem mortgage loans are either in default by 60 days or more or have been restructured as to terms, which could include concessions on interest rate, principal payment or maturity date. The Company monitors each problem and potential problem mortgage loan on an ongoing basis, and updates the loan categorization and quality rating when warranted.

Problem and potential problem mortgage loans, net of valuation reserves, totaled $208 million at December 31, 2014 and $158 million at December 31, 2013. At December 31, 2014 and December 31, 2013, industrial loans located in the South Atlantic region represented the most significant component of problem and potential problem mortgage loans.

Impaired commercial mortgage loans. The carrying value of the Company's impaired commercial mortgage loans and related valuation reserves were as follows:

	2014			2013		
(In millions)	Gross	Reserves	Net	Gross	Reserves	Net
Impaired commercial mortgage loans with valuation reserves	$ 147	$ (12)	$ 135	$ 89	$ (8)	$ 81
Impaired commercial mortgage loans with no valuation reserves	31	–	31	31	–	31
TOTAL	**$ 178**	**$ (12)**	**$ 166**	**$ 120**	**$ (8)**	**$ 112**

The average recorded investment in impaired loans was $155 million during 2014 and $127 million during 2013. Because of the risk profile of the underlying investment, the Company recognizes interest income on problem mortgage loans only when payment is actually received. Interest income that would have been reflected in net income if interest on non-accrual commercial mortgage loans had been received in accordance with the original terms was not significant for 2014 or 2013. Interest income on impaired commercial mortgage loans was not significant for 2014 or 2013. See Note 2 for further information on impaired commercial mortgage loans.

The following table summarizes the changes in valuation reserves for commercial mortgage loans:

(In millions)	2014	2013
Reserve balance, January 1,	$ 8	$ 7
Increase in valuation reserves	4	4
Charge-offs upon sales and repayments, net of recoveries	–	(3)
RESERVE BALANCE, DECEMBER 31,	**$ 12**	**$ 8**

C. Other Long-Term Investments

As of December 31, other long-term investments consisted of the following:

(In millions)	2014	2013
Real estate investments	$ 916	$ 909
Securities partnerships	456	357
Other	116	104
TOTAL	**$ 1,488**	**$ 1,370**

Real estate investments and securities partnerships with a carrying value of $264 million at December 31, 2014 and $217 million at December 31, 2013 were non-income producing during the preceding twelve months.

As of December 31, 2014, the Company had commitments to contribute:

- $207 million to limited liability entities that hold either real estate or loans to real estate entities that are diversified by property type and geographic region; and
- $476 million to entities that hold securities diversified by issuer and maturity date.

The Company expects to disburse approximately 40% of the committed amounts in 2015.

D. Short-Term Investments and Cash Equivalents

Short-term investments and cash equivalents included corporate securities of $509 million, federal government securities of $274 million and money market funds of $33 million as of

December 31, 2014. The Company's short-term investments and cash equivalents as of December 31, 2013 included corporate securities of $2.2 billion, federal government securities of $323 million and money market funds of $35 million.

E. Concentration of Risk

As of December 31, 2014 and 2013, the Company did not have a concentration of investments in a single issuer or borrower exceeding 10% of shareholders' equity.

NOTE 12 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 contractholder liabilities (such as paying claims, investment returns and withdrawals) and to hedge interest rate risk of its long-term debt. The Company has written and purchased Guaranteed Minimum Income Benefit (GMIB) reinsurance contracts in its run-off reinsurance business that are accounted for as freestanding derivatives. The Company also used derivative financial instruments to manage the equity, foreign currency, and certain interest rate risk exposures of its run-off reinsurance business until the time of the Berkshire reinsurance transaction in 2013. For information on the Company's accounting policy for derivative financial instruments, see Note 2. 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.

Collateral and termination features. The Company routinely monitors exposure to credit risk associated with derivatives and diversifies the portfolio among approved dealers of high credit quality to minimize this risk. As of December 31, 2014, the Company had $21 million in cash on deposit representing the upfront margin required for the Company's centrally-cleared derivative instruments. Certain of the Company's over-the-counter derivative instruments contain provisions requiring either the Company or the counterparty to post collateral or demand immediate payment depending on the amount of the net liability position and predefined financial strength or credit rating thresholds. Collateral posting requirements vary by counterparty. The net liability positions of these derivatives were not material as of December 31, 2014 or 2013.

Investment Cash Flow Hedges.

Purpose. The Company uses interest rate, foreign currency, and combination (interest rate and foreign currency) swap contracts to hedge the interest and foreign currency cash flows of its fixed maturity bonds to match associated insurance liabilities.

Accounting policy. Using cash flow hedge accounting, fair values are reported in other long-term investments or other liabilities. Changes in fair value are reported in accumulated other comprehensive income and amortized into net investment income or reported in other realized investment gains and losses as interest or principal payments are received.

Cash flows. Under the terms of these various contracts, the Company periodically exchanges cash flows between variable and fixed interest rates and/or between two currencies for both principal and interest. Foreign currency and combination swaps are primarily Euros, Australian dollars, Canadian dollars, Japanese yen and British pounds and have terms for periods of up to seven years. Net interest cash flows are reported in operating activities.

Volume of activity. The following table provides the notional values of these derivative instruments as of December 31:

	Notional Amount *(In millions)*	
Instrument	**2014**	**2013**
Interest rate swaps	$ 14	$ 45
Foreign currency swaps	91	118
Combination interest rate and foreign currency swaps	40	40
TOTAL	**$ 145**	**$ 203**

The following table provides the effect of these derivative instruments on the financial statements for the indicated periods:

Fair Value Effect on the Financial Statements *(In millions)*

	Other Long-Term Investments [2]		Accounts Payable, Accrued Expenses and Other Liabilities [2]		Gain (Loss) Recognized in Other Comprehensive Income [1]	
	As of December 31,		As of December 31,		For the years ended December 31,	
Instrument	**2014**	**2013**	**2014**	**2013**	**2014**	**2013**
Interest rate swaps	$ –	$ 2	$ –	$ –	$ (2)	$ (2)
Foreign currency swaps	5	1	1	13	13	1
Combination interest rate and foreign currency swaps	–	–	–	2	3	10
TOTAL	**$ 5**	**$ 3**	**$ 1**	**$ 15**	**$ 14**	**$ 9**

(1) Other comprehensive income for foreign currency swaps excludes amounts required to adjust future policy benefits for the run-off settlement annuity business.

(2) There were no amounts offset in the Consolidated Balance Sheets at December 31, 2014 or 2013.

For the years ended December 31, 2014 and 2013, the amounts of gains (losses) reclassified from accumulated other comprehensive income into shareholders' net income were not material. No amounts were excluded from the assessment of hedge effectiveness and no gains (losses) were recognized due to hedge ineffectiveness.

Interest Rate Fair Value Hedges.

Purpose. Beginning in 2014, the Company entered into centrally-cleared interest rate swap contracts to convert a portion of the interest rate exposure on its long-term debt from fixed to variable rates to more closely align interest expense with interest income received on its cash equivalent and short-term investment balances. The variable rates are benchmarked to LIBOR.

Accounting Policy. Using fair value hedge accounting, the fair values of the swap contracts are reported in other assets or other liabilities. As the critical terms of these swaps match those of the long-term debt being hedged, the carrying value of the hedged debt is adjusted to reflect changes in its fair value driven by LIBOR. The effects of those adjustments on other operating expenses are offset by the effects of corresponding changes in the swaps' fair value, including interest expense for the difference between the variable and fixed interest rates.

Cash flows. Under the terms of these contracts, the Company provides upfront margin and settles fair value changes and net interest between variable and fixed interest rates daily with the clearinghouse. Net interest cash flows are reported in operating activities.

Volume of activity. As of December 31, 2014, the notional value of these derivative instruments was $750 million. As of December 31, 2014, the effects of these derivative instruments on the Consolidated Financial Statements were not material.

Guaranteed Minimum Income Benefits (GMIB).

Purpose. The Company's run-off reinsurance business has written reinsurance contracts with issuers of variable annuity contracts that provide annuitants with certain guarantees of minimum income benefits resulting from the level of variable annuity account values compared with a contractually guaranteed amount ("GMIB liabilities"). According to the contractual terms of the written reinsurance contracts, payment by the Company depends on the actual account value in the underlying mutual funds and the level of interest rates when the contractholders elect to receive minimum income payments.

The fair value effects of GMIB contracts on the financial statements are included in Note 10 and their volume of activity is included in Note 23. Further information on these contracts is also presented in Note 7. Cash flows on these contracts are reported in operating activities.

NOTE 13 Variable Interest Entities

When the Company becomes involved with a variable interest entity and when the nature of the Company's involvement with the entity changes, to determine if the Company is the primary beneficiary and must consolidate the entity, it evaluates:

- the structure and purpose of the entity;
- the risks and rewards created by and shared through the entity; and
- the entity's participants' ability to direct its activities, receive its benefits and absorb its losses. Participants include the entity's sponsors, equity holders, guarantors, creditors and servicers.

In the normal course of its investing activities, the Company makes passive investments in securities that are issued by variable interest entities for which the Company is not the sponsor or manager. These investments are predominantly asset-backed securities primarily collateralized by foreign bank obligations or mortgage-backed securities. The asset-backed securities are largely fixed-rate debt securities issued by trusts that hold perpetual floating-rate subordinated notes issued by foreign banks. The mortgage-backed securities are senior interests in pools of commercial or residential mortgages created and held by special-purpose entities to provide investors with diversified exposure to these assets. The Company owns senior securities issued by several entities and receives fixed-rate cash flows from the underlying assets in the pools.

To provide certain services to its Medicare Advantage customers, the Company contracts with independent physician associations ("IPAs") that are variable interest entities. Physicians provide health care services to the Medicare Advantage customers and the Company provides medical management and administrative services to the IPAs.

The Company is not the primary beneficiary and does not consolidate these entities because either:

- it has no power to direct the activities that most significantly impact the entities' economic performance; or
- it has neither the right to receive benefits nor the obligation to absorb losses that could be significant to these variable interest entities.

The Company has not provided, and does not intend to provide, financial support to these entities that is not contractually required. The Company performs ongoing qualitative analyses of its involvement with these variable interest entities to determine if consolidation is required. The Company's maximum potential exposure to loss related to the investment entities is limited to the aggregate carrying amount of its investments of $762 million as of December 31, 2014 reported in fixed maturities and equity securities; the Company's combined ownership interests are insignificant relative to the total principal amounts issued by these entities. The Company's maximum exposure to loss related to the IPA arrangements is limited to the liability for incurred but not reported claims for the Company's Medicare Advantage customers. These liabilities are not material and are generally secured by deposits maintained by the IPAs.

NOTE 14 Investment Income and Gains and Losses

A. Net Investment Income

The components of pre-tax net investment income for the years ended December 31 were as follows:

(In millions)	2014	2013	2012
Fixed maturities	$ 876	$ 823	$ 843
Equity securities	3	6	4
Commercial mortgage loans	133	174	192
Policy loans	72	74	74
Other long-term investments	105	101	57
Short-term investments and cash	17	22	14
Total investment income	1,206	1,200	1,184
Less investment expenses	40	36	40
NET INVESTMENT INCOME	**$ 1,166**	**$ 1,164**	**$ 1,144**

Net investment income for separate accounts that is excluded from the Company's revenues was $225 million for 2014, $232 million for 2013, and $181 million for 2012.

B. Realized Investment Gains and Losses

The following realized gains and losses on investments for the years ended December 31 exclude amounts required to adjust future policy benefits for the run-off settlement annuity business.

(In millions)	2014	2013	2012
Fixed maturities	$ 14	$ 113	$ 48
Equity securities	13	8	4
Commercial mortgage loans	(6)	(3)	(9)
Other investments, including derivatives	133	95	1
Realized investment gains, before income taxes	154	213	44
Less income taxes	48	72	13
NET REALIZED INVESTMENT GAINS	**$ 106**	**$ 141**	**$ 31**

Included in these realized investment gains (losses) were pre-tax asset write-downs as follows:

(In millions)	2014	2013	2012
Credit related [1]	$ (16)	$ (8)	$ (20)
Other	(36)	(21)	(2)
TOTAL	**$ (52)**	**$ (29)**	**$ (22)**

(1) Credit-related losses include other-than-temporary declines in fair value of equity securities, increases in valuation reserves on commercial mortgage loans and asset write-downs related to investments in real estate entities.

In 2014 and 2013, realized investment gains in other investments, including derivatives, primarily represented gains on sale of real estate properties held in joint ventures.

Realized investment gains that are excluded from the Company's revenues for the years ended December 31 were as follows:

(In millions)	2014	2013	2012
Separate accounts	$ 376	$ 417	$ 206
Investment gains required to adjust future policy benefits for the run-off settlement annuity business	$ 86	$ 9	$ 21

Sales information for available-for-sale fixed maturities and equity securities for the years ended December 31 were as follows:

(In millions)	2014	2013	2012
Proceeds from sales	$ 1,769	$ 1,775	$ 591
Gross gains on sales	$ 62	$ 102	$ 37
Gross losses on sales	$ 6	$ 4	$ 2

NOTE 15 Debt

(In millions)	2014	2013
Short-term:		
Commercial paper	$ 100	$ 100
Other, including capital leases	47	133
TOTAL SHORT-TERM DEBT	**$ 147**	**$ 233**
Long-term:		
Uncollateralized debt:		
$600 million, 2.75% Notes due 2016	$ 600	$ 600
$250 million, 5.375% Notes due 2017	250	250
$131 million, 6.35% Notes due 2018	131	131
$251 million, 8.5% Notes due 2019	251	251
$250 million, 4.375% Notes due 2020[1]	254	249
$300 million, 5.125% Notes due 2020[1]	303	299
$78 million, 6.37% Notes due 2021	78	78
$300 million, 4.5% Notes due 2021[1]	303	299
$750 million, 4% Notes due 2022	745	744
$100 million, 7.65% Notes due 2023	100	100
$17 million, 8.3% Notes due 2023	17	17
$300 million, 7.875% Debentures due 2027	300	300
$83 million, 8.3% Step Down Notes due 2033	83	83
$500 million, 6.15% Notes due 2036	500	500
$300 million, 5.875% Notes due 2041	298	298
$750 million, 5.375% Notes due 2042	750	750
Other, including capital leases	42	65
TOTAL LONG-TERM DEBT	**$ 5,005**	**$ 5,014**

(1) In 2014, the Company entered into interest rate swap contracts hedging a portion of these fixed-rate debt instruments. See Note 12 for further information about the Company's interest rate risk management and these derivative instruments.

In December 2014, the Company entered into an updated revolving credit and letter of credit agreement for $1.5 billion, that permits up to $500 million to be used for letters of credit. This agreement extends through December 2019 and is diversified among 16 banks, with three banks each having 12% of the commitment and the remainder spread among 13 banks. The credit agreement includes options, subject to consent by the administrative agent and the committing banks, to increase the commitment amount to $2 billion and to extend the term past December 2019. The credit agreement is available for general corporate purposes, including for the issuance of letters of credit. This agreement has certain covenants, including a financial covenant requiring the Company to maintain a leverage ratio of total consolidated debt-to-consolidated capitalization (each as defined in the credit agreement) at or below 0.50. As of December 31, 2014, the Company had $6.5 billion of borrowing capacity within the maximum debt coverage covenant in the agreement, in addition to the $5.2 billion of debt outstanding. Letters of credit outstanding as of December 31, 2014 totaled $23 million. The Company was in compliance with its debt covenants as of December 31, 2014.

Maturities of long-term debt, excluding capital leases, are as follows (in millions): $25 in 2015, $600 in 2016, $250 in 2017, $131 in 2018, $251 in 2019 and the remainder in years after 2019. Maturities of debt under capital lease arrangements are as follows (in millions): $22 in 2015, $22 in 2016, $11 in 2017, $4 in 2018, none in 2019 and the remainder in years after 2019. Interest expense on long-term and short-term debt was $265 million in 2014, $270 million in 2013, and $268 million in 2012.

NOTE 16 Common and Preferred Stock

As of December 31, the Company had issued the following shares:

(Shares in thousands)	2014	2013	2012
Common: Par value $0.25 600,000 shares authorized			
Outstanding – January 1,	275,526	285,829	285,533
Issued for stock option and other benefit plans	2,284	3,319	4,695
Repurchase of common stock	(18,534)	(13,622)	(4,399)
Outstanding – December 31,	259,276	275,526	285,829
Treasury stock	36,869	90,619	80,316
ISSUED – DECEMBER 31,	296,145	366,145	366,145

The Company maintains a share repurchase program, authorized by its Board of Directors. Under this program, we may repurchase shares from time to time, depending on market conditions and alternate uses of capital. We may suspend activity under our share repurchase program from time to time and may also remove such suspensions, generally without public announcement. We may also repurchase shares at times when we otherwise might be precluded from doing so under insider trading laws or because of self-imposed trading black-out periods by using a Rule 10b5-1 trading plan.

In 2014, the Company repurchased 18.5 million shares for $1.6 billion. The Company repurchased 13.6 million shares for $1.0 billion during 2013 and 4.4 million shares for $208 million during 2012.

In 2014, the Company retired 70 million shares of treasury stock. This transaction had no effect on total shareholders' equity.

The Company has authorized a total of 25 million shares of $1 par value preferred stock. No shares of preferred stock were outstanding at December 31, 2014, 2013 or 2012.

NOTE 17 Accumulated Other Comprehensive Income (Loss)

Accumulated other comprehensive loss excludes amounts required to adjust future policy benefits for the run-off settlement annuity business and a portion of deferred acquisition costs associated with the corporate owned life insurance business. As required by GAAP, the Company parenthetically identifies the income statement line item affected by reclassification adjustments in the table below. Changes in the components of accumulated other comprehensive loss were as follows:

(In millions) 2014	Pre-Tax	Tax (Expense) Benefit	After-Tax
Net unrealized appreciation securities, January 1,	$ 733	$ (256)	$ 477
Net unrealized appreciation on securities arising during the year	249	(89)	160
Reclassification adjustment for (gains) included in shareholders' net income (realized investment gains)	(27)	10	(17)
Net unrealized appreciation, securities arising during the year	222	(79)	143
Net unrealized appreciation, securities, December 31,	$ 955	$ (335)	$ 620
Net unrealized depreciation, derivatives, January 1,	$ (29)	$ 10	$ (19)
Net unrealized appreciation, derivatives arising during the year	17	(6)	11
Net unrealized depreciation, derivatives, December 31,	$ (12)	$ 4	$ (8)
Net translation of foreign currencies, January 1,	$ 91	$ (9)	$ 82
Net translation of foreign currencies arising during the year	(162)	18	(144)
Net translation of foreign currencies, December 31,	$ (71)	$ 9	$ (62)
Postretirement benefits liability adjustment, January 1,	$ (1,630)	$ 570	$ (1,060)
Reclassification adjustment for amortization of net losses from past experience and prior service costs (other operating expenses)	54	(18)	36
Reclassification adjustment for settlement (other operating expenses)	6	(2)	4
Total reclassification adjustment to shareholders' net income (other operating expenses)	60	(20)	40
Net change due to valuation update	(716)	250	(466)
Net postretirement benefits liability adjustment arising during the year	(656)	230	(426)
Postretirement benefits liability adjustment, December 31,	$ (2,286)	$ 800	$ (1,486)

(In millions) 2013	Pre-Tax	Tax (Expense) Benefit	After-Tax
Net unrealized appreciation, securities, January 1,	$ 1,352	$ (465)	$ 887
Net unrealized depreciation on securities arising during the year	(498)	166	(332)
Reclassification adjustment for (gains) included in shareholders' net income (realized investment gains)	(121)	43	(78)
Net unrealized depreciation, securities arising during the year	(619)	209	(410)
Net unrealized appreciation, securities, December 31,	$ 733	$ (256)	$ 477
Net unrealized depreciation, derivatives, January 1,	$ (43)	$ 15	$ (28)
Net unrealized appreciation, derivatives, arising during the year	14	(5)	9
Net unrealized depreciation, derivatives, December 31,	$ (29)	$ 10	$ (19)
Net translation of foreign currencies, January 1,	$ 91	$ (22)	$ 69
Net translation of foreign currencies, arising during the year	–	13	13
Net translation of foreign currencies, December 31,	$ 91	$ (9)	$ 82
Postretirement benefits liability adjustment, January 1,	$ (2,460)	$ 861	$ (1,599)
Reclassification adjustment for amortization of net losses from past experience and prior service costs (other operating expenses)	70	(25)	45
Reclassification adjustment for curtailment gain (other operating expenses)	(19)	7	(12)
Total reclassification adjustment to shareholders' net income (other operating expenses)	51	(18)	33
Net change due to valuation update and plan amendments	779	(273)	506
Net postretirement benefits liability adjustment arising during the year	830	(291)	539
Postretirement benefits liability adjustment, December 31,	$ (1,630)	$ 570	$ (1,060)

(In millions) 2012	Pre-Tax	Tax (Expense) Benefit	After-Tax
Net unrealized appreciation, securities, January 1,	$ 1,133	$ (393)	$ 740
Net unrealized appreciation on securities arising during the year	271	(90)	181
Reclassification adjustment for (gains) included in net income (realized investment gains)	(52)	18	(34)
Net unrealized appreciation, securities arising during the year	219	(72)	147
Net unrealized appreciation, securities, December 31,	$ 1,352	$ (465)	$ 887
Net unrealized depreciation, derivatives, January 1,	$ (36)	$ 13	$ (23)
Net unrealized depreciation, derivatives arising during the year	(7)	2	(5)
Net unrealized depreciation, derivatives, December 31,	$ (43)	$ 15	$ (28)
Net translation of foreign currencies, January 1,	$ 13	$ (10)	$ 3
Net translation of foreign currencies arising during the year	78	(12)	66
Net translation of foreign currencies, December 31,	$ 91	$ (22)	$ 69
Postretirement benefits liability adjustment, January 1,	$ (2,331)	$ 824	$ (1,507)
Reclassification adjustment for amortization of net losses from past experience and prior service costs and settlement charges (other operating expenses)	52	(18)	34
Net change due to valuation update and plan amendments	(181)	55	(126)
Net postretirement benefits liability adjustment arising during the year	(129)	37	(92)
Postretirement benefits liability adjustment, December 31,	$ (2,460)	$ 861	$ (1,599)

NOTE 18 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 insurance and HMO company subsidiaries are

regulated by such statutory requirements. The statutory net income of the Company's life insurance and HMO subsidiaries for the years ended, and their statutory surplus as of December 31, were as follows:

(In millions)	2014	2013	2012
Net income	$ 2,002	$ 1,631	$ 1,520
Surplus	$ 7,487	$ 6,316	$ 6,109

The minimum statutory surplus required by regulators for the Company's life insurance and HMO company subsidiaries was approximately $2.5 billion as of December 31, 2014. As of December 31, 2014, statutory surplus for each of the Company's life insurance and HMO subsidiaries is sufficient to meet the minimum required by regulators. For one of the Company's foreign insurance subsidiaries, the regulatory authority has permitted deferral of certain policy acquisition costs that increased statutory capital and surplus by approximately $0.2 billion as of December 31, 2014. There were no other permitted practices for the Company's insurance subsidiaries that significantly differed from prescribed regulatory accounting practices. As of December 31, 2014, the Company's life insurance and HMO subsidiaries had investments on deposit with state departments of insurance and other regulatory bodies with statutory carrying values of approximately $0.4 billion. The Company's life insurance and HMO subsidiaries are also subject to regulatory restrictions that limit the amount of annual dividends or other distributions (such as loans or cash advances) insurance companies may extend to the parent company without prior approval of regulatory authorities. The maximum dividend distribution that the Company's life insurance and HMO subsidiaries may make during 2015 without prior approval is approximately $1.0 billion. Restricted net assets of the Company as of December 31, 2014, were approximately $8.8 billion. Certain life insurance subsidiaries of the Company are permitted to loan up to approximately $1.0 billion to the parent company without prior approval.

NOTE 19 Income Taxes

A. Income Tax Expense

The components of income taxes for the years ended December 31 were as follows:

(In millions)	2014	2013	2012
Current taxes			
U.S. income taxes	$ 1,068	$ 382	$ 604
Foreign income taxes	115	77	72
State income taxes	49	42	43
	1,232	501	719
Deferred taxes (benefits)			
U.S. income taxes	10	152	131
Foreign income taxes	(22)	46	4
State income taxes	(10)	(1)	(1)
	(22)	197	134
TOTAL INCOME TAXES	**$ 1,210**	**$ 698**	**$ 853**

Total income taxes for the years ended December 31 were different from the amount computed using the nominal federal income tax rate of 35% for the following reasons:

(In millions)	2014	2013	2012
Tax expense at nominal rate	$ 1,156	$ 761	$ 867
Effect of undistributed foreign earnings	(74)	(42)	(37)
Health insurance industry tax	83	–	–
State income tax (net of federal income tax benefit)	25	27	28
Other	20	(48)	(5)
TOTAL INCOME TAXES	**$ 1,210**	**$ 698**	**$ 853**

Consolidated pre-tax income from the Company's foreign operations was approximately 10% in 2014, 12% in 2013 and 8% in 2012.

Effective Tax Rates

The consolidated effective tax rate of 36.6% in 2014 has increased from historical levels due to the health insurance industry tax that took effect in 2014 and that is not deductible for federal income tax

purposes. Other matters having a significant impact on the effective tax rate included:

- ***Undistributed foreign earnings.*** As part of its global capital management strategy, the Company's foreign operations retain a significant portion of their earnings overseas. These undistributed earnings are deployed outside of the U.S. in support of the liquidity and capital needs of our foreign operations. The Company does not intend to repatriate these earnings to the U.S. and as a result, income taxes are provided using the respective foreign jurisdictions' tax rate. The Company has accumulated undistributed foreign earnings of $1.8 billion as of December 31, 2014. If the Company intended to repatriate these foreign earnings to the U.S., the Company's consolidated balance sheet would have included an additional $218 million of deferred tax liabilities as of December 31, 2014.
- ***Completion of IRS examinations/other 2013 impacts.*** In 2013, the Internal Revenue Service ("IRS") completed its examination of the Company's 2009 and 2010 tax years, resulting in an increase to shareholders' net income of $18 million. In addition, income tax expense was reduced in 2013 due to certain other tax benefits related to the Company's foreign operations.

B. Deferred Income Taxes

Deferred income tax assets and liabilities as of December 31 are as follows:

(In millions)	2014	2013
Deferred tax assets		
Employee and retiree benefit plans	$ 594	$ 422
Other insurance and contractholder liabilities	415	407
Policy acquisition expenses	141	142
Other accrued liabilities	204	157
Other	98	128
Deferred tax assets before valuation allowance	1,452	1,256
Valuation allowance for deferred tax assets	(49)	(49)
Deferred tax assets, net of valuation allowance	1,403	1,207
Deferred tax liabilities		
Depreciation and amortization	688	700
Foreign operations, net	120	162
Unrealized appreciation on investments and foreign currency translation	302	253
Total deferred tax liabilities	1,110	1,115
NET DEFERRED INCOME TAX ASSETS	**$ 293**	**$ 92**

Management believes that future results will be sufficient to realize the Company's deferred tax assets. Substantially all of the Company's deferred tax benefits may be carried forward indefinitely. As of December 31, 2014, net operating loss related benefits were $71 million, the majority of which relate to foreign jurisdictions and do not expire. The Company establishes a valuation allowance when it determines that realization of a deferred tax asset does not meet the more likely than not standard. Valuation allowances have been established against certain federal, foreign and state deferred tax assets, generally due to the requirement to assess them on a separate entity basis.

C. Uncertain Tax Positions

A reconciliation of unrecognized tax benefits for the years ended December 31 is as follows:

(In millions)	2014	2013	2012
Balance at January 1,	$ 17	$ 51	$ 52
Decrease due to prior year positions	–	(35)	(5)
Increase due to current year positions	12	6	7
Reduction related to lapse of applicable statute of limitations	(3)	(5)	(3)
BALANCE AT DECEMBER 31,	**$ 26**	**$ 17**	**$ 51**

Unrecognized tax benefits increased $9 million in 2014 of which $6 million impacted shareholders' net income. The prior year decrease was primarily attributable to completion of an IRS examination.

The Company classifies net interest expense on uncertain tax positions as a component of income tax expense, but excludes this amount from the liability for uncertain tax positions. The Company's liability for net interest was immaterial at December 31, 2014, 2013 and 2012.

D. Other Tax Matters

In 2013, the IRS completed its examination of the Company's 2009 and 2010 tax years, resulting in two issues that could not be resolved at the examination level. The Company subsequently filed a formal protest challenging the IRS positions on the two disputed matters. The IRS previously withdrew its challenge relating to the first of these matters, and the parties have since agreed on a resolution of the second matter. The resolution of these matters did not materially impact shareholders' net income.

The IRS began its examination of the Company's 2011 and 2012 tax years in the third quarter of 2014 that is expected to continue through 2015.

The Company conducts business in numerous state and foreign jurisdictions, and may be engaged in multiple audit proceedings at any given time. Generally, no further state audit activity is expected for tax years prior to 2010, and prior to 2008 for foreign audit activity.

NOTE 20 Employee Incentive Plans

The People Resources Committee ("the Committee") of the Board of Directors awards stock options, restricted stock, deferred stock and strategic performance shares to certain employees. The Committee has issued common stock instead of cash compensation and dividend equivalent rights to a very limited extent, as part of restricted and deferred stock units. The Company issues shares from Treasury stock for option exercises, awards of restricted stock grants and payment of strategic performance shares, deferred stock units and restricted stock units.

In connection with the HealthSpring acquisition on January 31, 2012, HealthSpring employees' awards of options and restricted shares of HealthSpring stock were rolled over to Cigna stock options and restricted stock. Unless otherwise indicated, information in this footnote includes the effect of the HealthSpring rollover awards.

Compensation cost and related tax benefits for these awards were as follows:

(In millions)	2014	2013	2012
Compensation cost	$ 101	$ 88	$ 98
Tax benefits	$ 12	$ 25	$ 26

The Company had the following number of common stock shares available for award at December 31: 10.3 million in 2014, 13.2 million in 2013 and 8.4 million in 2012.

Stock options. The Company awards options to purchase the Company's common stock at the market price of the stock on the grant date. Options vest over periods ranging from one to five years and expire no later than 10 years from grant date.

The table below shows the status of, and changes in, common stock options during the last three years:

	2014		2013		2012	
(Options in thousands)	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price
Outstanding – January 1	7,350	$ 42.24	8,951	$ 36.29	9,581	$ 33.92
Granted	2,012	$ 78.11	1,890	$ 58.84	3,446	$ 28.29
Exercised	(1,869)	$ 41.29	(3,107)	$ 34.99	(3,740)	$ 22.72
Expired or canceled	(162)	$ 64.27	(384)	$ 43.86	(336)	$ 37.85
OUTSTANDING – DECEMBER 31	**7,331**	**$ 51.84**	**7,350**	**$ 42.24**	**8,951**	**$ 36.29**
Options exercisable at year-end	3,919	$ 38.11	4,217	$ 35.84	5,731	$ 34.93

Compensation expense of $32 million related to unvested stock options at December 31, 2014 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)	2014	2013	2012
Intrinsic value of options exercised	$ 84	$ 105	$ 95
Cash received for options exercised	$ 76	$ 109	$ 85
Excess tax benefits realized from options exercised	$ 19	$ 23	$ 15

The following table summarizes information for outstanding common stock options at December 31, 2014:

	Options Outstanding	Options Exercisable
Number (in thousands)	7,331	3,919
Total intrinsic value (in millions)	$ 374	$ 254
Weighted average exercise price	$ 51.84	$ 38.11
Weighted average remaining contractual life	6.8	5.2

The weighted average fair value of options granted under employee incentive plans was $23.56 for 2014, $19.84 for 2013 and $14.99 for 2012 (excluding the HealthSpring rollover options issued in 2012) using the Black-Scholes option-pricing model and the assumptions presented in the following table.

	2014	2013	2012
Dividend yield	0.1%	0.1%	0.1%
Expected volatility	35.0%	40.0%	40.0%
Risk-free interest rate	1.3%	0.7%	0.8%
Expected option life	4.3 years	4.5 years	4.5 years

The expected volatility reflects the Company's past daily stock price volatility. The Company does not consider volatility implied in the market prices of traded options to be a good indicator of future volatility because remaining maturities of traded options are less than 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 grant. Expected option life reflects the Company's historical experience.

Restricted stock. The Company awards restricted stock to its employees or directors with vesting periods ranging from two to five years. These awards are generally in one of two forms: restricted stock grants or restricted stock units. Restricted stock grants are the most widely used form of restricted stock award and are used for substantially all U.S.-based employees receiving such awards. Recipients of restricted stock grants accumulate dividends and can vote during the vesting period, but forfeit their awards and accumulated dividends if their employment terminates before the vesting date. Awards of restricted stock units are generally limited to overseas employees. A restricted stock unit represents a right to receive a common share of stock when the unit vests. Recipients of restricted stock units are entitled to accumulate hypothetical dividends, but cannot vote during the vesting period. They forfeit their units and accumulated dividends if their employment terminates before the vesting date.

The table below shows the status of, and changes in, restricted stock grants and units during the last three years:

	2014		2013		2012	
(Awards in thousands)	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	2,844	$ 41.56	4,064	$ 35.00	4,246	$ 28.88
Awarded	454	$ 78.99	525	$ 59.36	1,563	$ 44.37
Vested	(1,065)	$ 32.34	(1,480)	$ 30.24	(1,485)	$ 27.60
Forfeited	(112)	$ 52.95	(265)	$ 39.46	(260)	$ 33.61
OUTSTANDING – DECEMBER 31	**2,121**	**$ 53.59**	**2,844**	**$ 41.56**	**4,064**	**$ 35.00**

The fair value of vested restricted stock was: $85 million in 2014, $94 million in 2013 and $66 million in 2012.

At the end of 2014, approximately 3,400 employees held 2.1 million restricted stock grants and units with $54 million of related compensation expense to be recognized over the next three years (weighted average period).

Strategic Performance Shares. The Company awards strategic performance shares to executives and certain other key employees generally with a performance period of three years. Strategic performance shares are divided into two broad groups: 50% are subject to a market condition (total shareholder return relative to industry peer companies) and 50% are subject to performance conditions (revenue growth and cumulative adjusted net income). These targets are set by the Committee. At the end of the performance period, holders of strategic performance shares will be awarded anywhere from 0 to 200% of the original grant of strategic performance shares in Cigna common stock.

The table below shows the status of, and changes in, strategic performance shares during the last three years:

	2014		2013		2012	
(Awards in thousands)	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	1,572	$ 49.67	1,600	$ 41.92	834	$ 39.45
Awarded	450	$ 78.50	616	$ 59.84	842	$ 44.49
Vested	(397)	$ 43.53	(448)	$ 36.88	–	$ –
Forfeited	(78)	$ 58.41	(196)	$ 47.52	(76)	$ 43.39
OUTSTANDING – DECEMBER 31	**1,547**	**$ 59.20**	**1,572**	**$ 49.67**	**1,600**	**$ 41.92**

The fair value of vested strategic performance shares was $57 million in 2014 and $42 million in 2013. No strategic performance shares vested in 2012.

At the end of 2014, approximately 1,200 employees held 1.5 million strategic performance shares and $32 million of related compensation expense is expected to be recognized over the next two years. For strategic performance shares subject to a performance condition, the amount of expense may vary based on actual performance in 2015 and 2016.

NOTE 21 Leases and Rentals

The Company's operating leases are primarily for office space. Some of these leases include renewal options and other incentives that are amortized over the life of the lease. Office space leases active in 2014 had terms ranging from 1 month to 18 years. Rental expenses for operating leases amounted to $150 million in 2014, $137 million in 2013 and $144 million in 2012. As of December 31, 2014, future net minimum rental payments under non-cancelable operating leases were approximately $605 million, payable as follows (in millions): $140 in 2015, $120 in 2016, $87 in 2017, $71 in 2018, $59 in 2019 and $128 thereafter.

The Company also has capital lease arrangements. See Note 8 and Note 15 for further information on assets recorded under capital leases and the related obligations.

NOTE 22 Segment Information

Beginning in the first quarter of 2014, the Company combined the results of its run-off reinsurance business with other immaterial operating segments in Other Operations. Prior year segment information has been conformed to the current presentation.

The financial results of the Company's businesses are reported in the following segments:

Global Health Care aggregates the Commercial and Government operating segments due to their similar economic characteristics, products and services and regulatory environment:

- The ***Commercial*** operating segment encompasses both the U.S. commercial and certain international health care businesses serving employers and their employees, other groups, and individuals. Products and services include medical, dental, behavioral health, vision, and prescription drug benefit plans, health advocacy programs and other products and services to insured and self-insured customers.
- The ***Government*** operating segment offers Medicare Advantage and Medicare Part D plans to seniors and Medicaid plans.

Global Supplemental Benefits includes supplemental health, life and accident insurance products offered in selected international markets and in the U.S.

Group Disability and Life provides group long-term and short-term disability, group life, accident and specialty insurance products and related services.

Other Operations consist of:

- corporate-owned life insurance ("COLI");
- run-off reinsurance business that is predominantly comprised of GMDB and GMIB business that was effectively exited through reinsurance with Berkshire in 2013;
- deferred gains recognized from the 1998 sale of the individual life insurance and annuity business and the 2004 sale of the retirement benefits business; and
- run-off settlement annuity business.

Corporate reflects amounts not allocated to other segments, such as net interest expense (defined as interest on corporate debt less net investment income on investments not supporting segment operations), interest on uncertain tax positions, certain litigation matters, intersegment eliminations, compensation cost for stock options, expense associated with its frozen pension plans, and certain corporate project and overhead costs.

The Company measures the financial results of its segments using "segment earnings (loss)", defined as shareholders' net income (loss) before after-tax realized investment results. The Company determines segment earnings (loss) consistent with accounting policies used in preparing the consolidated financial statements, except that amounts included in Corporate are not allocated to segments. The Company allocates certain other operating expenses, such as systems and other key corporate overhead expenses, on systematic bases. Income taxes are generally computed as if each segment were filing a separate income tax return. The Company does not report total assets by segment because this is not a metric used to allocate resources or evaluate segment performance.

Summarized segment financial information for the years ended December 31, was as follows:

(In millions)	2014	2013	2012
Global Health Care			
Premiums:			
Guaranteed cost	$ 4,600	$ 4,463	$ 4,256
Experience-rated	2,322	2,292	2,022
Stop loss	2,318	1,907	1,672
International health care	1,827	1,752	1,648
Dental	1,257	1,139	1,005
Medicare	5,660	5,639	4,969
Medicaid	515	317	207
Medicare Part D	1,405	1,387	1,421
Other	805	730	677
Total premiums	20,709	19,626	17,877
Fees and other revenues	4,005	3,518	3,321
Mail order pharmacy revenues	2,239	1,827	1,623
Net investment income	337	325	259
Segment revenues	$ 27,290	$ 25,296	$ 23,080
Depreciation and amortization	$ 513	$ 529	$ 516
Income taxes	$ 1,035	$ 822	$ 793
Segment earnings	$ 1,646	$ 1,517	$ 1,418
Global Supplemental Benefits			
Premiums	$ 2,844	$ 2,496	$ 1,975
Fees and other revenues	52	43	30
Net investment income	109	100	90
Segment revenues	$ 3,005	$ 2,639	$ 2,095
Depreciation and amortization	$ 50	$ 50	$ 29
Income taxes	$ 48	$ 50	$ 36
Equity in income of investees	$ 18	$ 17	$ 10
Segment earnings	$ 230	$ 175	$ 142
Group Disability and Life			
Premiums:			
Life	$ 1,629	$ 1,552	$ 1,426
Disability	1,681	1,539	1,348
Other	239	257	270
Total	3,549	3,348	3,044
Fees and other revenues	86	78	65
Net investment income	335	321	300
Segment revenues	$ 3,970	$ 3,747	$ 3,409
Depreciation and amortization	$ 22	$ 14	$ 11
Income taxes	$ 140	$ 101	$ 116
Segment earnings	$ 317	$ 259	$ 279
Other Operations			
Premiums	$ 112	$ 105	$ 121
Fees and other revenues	14	(24)	(101)
Net investment income	384	408	490
Segment revenues	$ 510	$ 489	$ 510
Depreciation and amortization	$ 2	$ 1	$ 2
Income taxes (benefits)	$ 29	$ (237)	$ 43
Segment earnings (loss)	$ 68	$ (394)	$ 82

(In millions)	2014	2013	2012
Corporate			
Other revenues and eliminations	$ (16)	$ (14)	$ (24)
Net investment income	1	10	5
Segment revenues	$ (15)	$ (4)	$ (19)
Depreciation and amortization	$ 1	$ 3	$ 3
Income tax benefits	$ (90)	$ (110)	$ (148)
Segment loss	$ (265)	$ (222)	$ (329)
Realized investment gains			
Realized investment gains	$ 154	$ 213	$ 44
Income taxes	48	72	13
Realized investment gains, net of taxes	$ 106	$ 141	$ 31
Total			
Premiums	$ 27,214	$ 25,575	$ 23,017
Fees and other revenues	4,141	3,601	3,291
Mail order pharmacy revenues	2,239	1,827	1,623
Net investment income	1,166	1,164	1,144
Realized investment gains	154	213	44
Total revenues	$ 34,914	$ 32,380	$ 29,119
Depreciation and amortization	$ 588	$ 597	$ 560
Income taxes	$ 1,210	$ 698	$ 853
Segment earnings	$ 1,996	$ 1,335	$ 1,592
Realized investment gains, net of taxes	$ 106	$ 141	$ 31
Shareholders' net income	$ 2,102	$ 1,476	$ 1,623

Revenue from external customers includes premiums, fees and other revenues, and mail order pharmacy revenues. The following table presents these revenues by product type for the years ended December 31:

(In millions)	2014	2013	2012
Medical	$ 24,476	$ 22,933	$ 20,973
Disability	1,767	1,616	1,413
Supplemental Health, Life, and Accident	4,739	4,322	3,680
Mail order pharmacy	2,239	1,827	1,623
Other	373	305	242
TOTAL	**$ 33,594**	**$ 31,003**	**$ 27,931**

Foreign and U.S. revenues from external customers for the 3 years ended December 31 are shown below. In the periods shown, no foreign country contributed more than 5% of consolidated revenues from external customers.

(In millions)	2014	2013	2012
U.S.	$ 30,070	$ 27,868	$ 25,217
Foreign	3,524	3,135	2,714
TOTAL	**$ 33,594**	**$ 31,003**	**$ 27,931**

As a percentage of consolidated revenues, premiums from CMS were 21% in 2014 and 22% in both 2013 and 2012. These amounts were reported in the Global Health Care segment.

NOTE 23 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

Separate account assets are contractholder funds maintained in accounts with specific investment objectives. The Company records separate account liabilities equal to separate account assets. In certain cases, the Company guarantees a minimum level of benefits for retirement and insurance contracts written in separate accounts. The Company establishes an additional liability if management believes that the Company will be required to make a payment under these guarantees.

The Company guarantees that separate account assets will be sufficient to pay certain life insurance or retiree 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. This percentage varies depending on the asset class within a sponsoring employer's portfolio (for example, a bond fund would require a lower percentage than a riskier equity fund) and thus will vary as the composition of the portfolio changes. If employers do not maintain the required levels of separate account assets, the Company or an affiliate of the buyer of the retirement benefits business (see Note 7 for additional information) has the right to redirect the management of the related assets to provide for benefit payments. As of December 31, 2014, employers maintained assets that exceeded the benefit obligations. Benefit obligations under these arrangements were $496 million as of December 31, 2014 and approximately 13% of these are reinsured by an affiliate of the buyer of the retirement benefits business. The remaining guarantees are provided by the Company with minimal reinsurance from third parties. There were no additional liabilities required for these guarantees as of December 31, 2014. Separate account assets supporting these guarantees are classified in Levels 1 and 2 of the GAAP fair value hierarchy. See Note 10 for further information on the 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. Guaranteed Minimum Income Benefit Contracts

Under these guarantees, the future payment amounts are dependent on underlying mutual fund investment values and interest rate levels prior to and at the date of annuitization election that must occur within 30 days of a policy anniversary after the appropriate waiting period. Therefore, the future payments are not fixed and determinable under the terms of these contracts. Accordingly, the Company calculated exposure, without considering retrocessional coverage, using the following hypothetical assumptions as a proxy for maximum potential undiscounted future payments.

- no annuitants surrendered their accounts;
- all annuitants lived to elect their benefit;
- all annuitants elected to receive their benefit on the next available date (2015 through 2020); and
- all underlying mutual fund investment values remained at the December 31, 2014 value of $1.1 billion with no future returns.

Using these hypothetical assumptions, GMIB exposure is $754 million. The recorded liability for GMIB is calculated using fair value assumptions. The Company has retrocessional coverage in place that covers the exposures on these contracts. See Notes 7, 10 and 12 for further information on GMIB contracts.

C. Certain Other Guarantees

The Company had indemnification obligations to lenders of up to $208 million as of December 31, 2014, related to borrowings by certain real estate joint ventures that the Company either records as an investment or consolidates. These borrowings, that are nonrecourse to the Company, are secured by the joint ventures' real estate properties with fair values in excess of the loan amounts and mature at various dates beginning in 2015 through 2021. The Company's indemnification obligations would require payment to lenders for any actual damages resulting from certain acts such as unauthorized ownership transfers, misappropriation of rental payments by others or environmental damages. Based on initial and ongoing reviews of property management and operations, the Company does not expect that payments will be required under these indemnification obligations. Any payments that might be required could be recovered through a refinancing or sale of the assets. In some cases, the Company also has recourse to partners for their proportionate share of amounts paid. There were no liabilities required for these indemnification obligations as of December 31, 2014.

As of December 31, 2014, the Company guaranteed that it would compensate the lessors for a shortfall of up to $41 million in the market value of certain leased equipment at the end of the lease. Guarantees of $16 million expire in 2016 and $25 million expire in 2025. The Company had liabilities for these guarantees of $7 million as of December 31, 2014.

The Company had indemnification obligations as of December 31, 2014 in connection with acquisition, disposition and reinsurance 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, actuarial models, the filing of tax returns, compliance with law or the 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, 2014.

The Company does not expect that these guarantees will have a material adverse effect on the Company's consolidated results of operations, financial condition or liquidity.

D. Guaranty Fund Assessments

The Company operates in a regulatory environment that may require the Company to participate 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. For the year ended December 31, 2014 and 2013, charges related to guaranty fund assessments were immaterial to the Company's results of operations.

The Company is aware of an insurer that is in rehabilitation. In 2012, the state court denied the regulator's amended petitions for liquidation and set forth specific requirements and a deadline for the regulator to develop a plan of rehabilitation without liquidating the insurer. The regulator has appealed the court's decision. If the actions taken in the rehabilitation plan fail to improve this insurer's financial condition, or if the state court's ruling is overturned on appeal, this insurer may be forced into insolvency. In that event, the Company would be required to pay guaranty fund assessments related to this insurer. Due to the uncertainties surrounding this matter, the Company is unable to estimate the amount of any potential guaranty fund assessments and is monitoring the situation.

E. Legal and Regulatory Matters

The Company is routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal matters arising, for the most part, in the ordinary course of managing a health services business. These actions may include benefit disputes, breach of contract claims, tort claims, provider disputes, disputes regarding reinsurance arrangements, employment and employment discrimination-related suits, employee benefit claims, wage and hour claims, privacy, intellectual property claims and real estate related disputes. There are currently, and may be in the future, attempts to bring class action lawsuits against the industry. The Company also is regularly engaged in IRS audits and may be subject to examinations by various state and foreign taxing authorities. Disputed income tax matters arising from these examinations, including those resulting in litigation, are accounted for under the FASB's guidance for uncertain tax positions. Further information on income tax matters can be found in Note 19.

The business of administering and insuring health services programs, particularly health care and group insurance programs, is heavily regulated by federal and state laws and administrative agencies, such as state departments of insurance and the U.S. Departments of Health and Human Services, Treasury, Labor and Justice, as well as the courts. Health care regulation and legislation in its various forms, including the implementation of Health Care Reform, other regulatory reform initiatives, such as those relating to Medicare programs, or additional changes in existing laws or regulations or their interpretations, could have a material adverse effect on the Company's business, results of operations and financial condition.

In addition, there is heightened review by federal and state regulators of the health care, disability and life insurance industry business and related reporting practices. Cigna is frequently the subject of regulatory market conduct reviews and other examinations of its business and reporting practices, audits and investigations by state insurance and health and welfare departments, state attorneys general, the CMS and the Office of Inspector General ("OIG"). With respect to Cigna's Medicare Advantage business, the CMS and OIG perform audits to determine a health plan's compliance with federal regulations and contractual obligations, including compliance with proper coding practices (sometimes referred to as Risk Adjustment Data Validation audits or RADV audits), that may result in retrospective adjustments to payments made to health plans. Regulatory actions can result in assessments, civil or criminal fines or penalties or other sanctions, including loss of licensing or exclusion from participating in government programs.

As a global company, Cigna is also subject to the laws, regulations and rules of the foreign jurisdictions in which it conducts business. Foreign laws and rules, and regulatory audit and investigation practices, may differ from or be more stringent than, similar requirements in the United States.

Regulation, legislation and judicial decisions have resulted in changes to industry and the Company's business practices, financial liability or other sanctions and will continue to do so in the future.

When the Company (in the course of its regular review of pending litigation and legal or regulatory matters) has determined that a material loss is reasonably possible, the matter is disclosed. In accordance with GAAP, when litigation and regulatory matters present loss contingencies that are both probable and estimable, the Company accrues the estimated loss by a charge to income. The amount accrued represents the Company's best estimate of the probable loss at the time. If only a range of estimated losses can be determined, the Company accrues an amount within the range that, in the Company's judgment, reflects the most likely outcome; if none of the estimates within that range is a better estimate than any other amount, the Company accrues the minimum amount of the range. In cases when the Company has accrued an estimated loss, the accrued amount may differ materially from the ultimate amount of the loss. In many proceedings, it is inherently difficult to determine whether any loss is probable or even possible or to estimate the amount or range of any loss. The Company provides disclosure in the aggregate for material pending litigation and legal or regulatory matters, including accruals, range of loss, or a statement that such information cannot be estimated. As a litigation or regulatory matter develops, the Company monitors the matter for further developments that could affect the amount previously accrued, if any, and updates such amount accrued or disclosures previously provided as appropriate.

The outcome of litigation and other legal or regulatory matters is always uncertain, and unfavorable outcomes that are not justified by the evidence or existing law can occur. The Company believes that it has valid defenses to the matters pending against it and is defending itself vigorously. Except as otherwise noted, the Company believes

that the legal actions, regulatory matters, proceedings and investigations currently pending against it should not have a material adverse effect on the Company's results of operation, financial condition or liquidity based upon current knowledge and taking into consideration current accruals. The Company had pre-tax reserves as of December 31, 2014 of $189 million ($123 million after-tax) for the matters discussed below. 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.

Litigation Matters

Amara cash balance pension plan litigation. In December 2001, Janice Amara filed a class action lawsuit in the U.S. District Court for the District of Connecticut against Cigna Corporation and the Cigna Pension Plan (the "Plan") on behalf of herself and other similarly situated participants in the Plan affected by the 1998 conversion to a cash balance formula. The plaintiffs allege various ERISA violations, including, that the Plan's cash balance formula discriminates against older employees; that the conversion resulted in a wear-away period (when the pre-conversion accrued benefit exceeded the post-conversion benefit); and that the Plan communications contained inaccurate or inadequate disclosures about these conditions.

In 2008, the District Court (1) found for plaintiffs on the disclosure claim only; (2) affirmed the Company's right to convert to a cash balance plan prospectively beginning in 1998; and (3) required the Company to pay pre-1998 benefits under the pre-conversion traditional annuity formula and post-1997 benefits under the post-conversion cash balance formula. The Second Circuit upheld this decision. In 2011, the Supreme Court reversed the lower court decisions in this matter and returned the case to the District Court, which ordered the Company to pay substantially the same benefits as had been ordered in 2008 and denied the Company's motion to decertify the class. The parties again appealed, with the plaintiffs challenging the District Court's denial of their request to return to the prior annuity benefit plan formula, and Cigna and the Plan appealing the District Court's order and the denial of a motion to decertify the class. In December 2014, the Second Circuit upheld the District Court ruling. In January 2015, the plaintiffs filed a petition for re-hearing with the Second Circuit. The Company will continue to vigorously defend its position.

Ingenix. In April 2004, the Company was sued in a number of putative nationwide class actions alleging that the Company improperly underpaid claims for out-of-network providers through the use of data provided by Ingenix, Inc., a subsidiary of one of the Company's competitors. These actions were consolidated into *Franco v. Connecticut General Life Insurance Company, et al.*, pending in the U.S. District Court for the District of New Jersey. The consolidated amended complaint, filed in 2009 on behalf of subscribers, health care providers and various medical associations, asserted claims related to benefits and disclosure under ERISA, the Racketeer Influenced and Corrupt Organizations ("RICO") Act, the Sherman Antitrust Act and New Jersey state law and seeks recovery for alleged underpayments from 1998 through the present. Other major health insurers have been the subject of, or have settled, similar litigation.

In September 2011, the District Court (1) dismissed all claims by the health care provider and medical association plaintiffs for lack of standing; and (2) dismissed the antitrust claims, the New Jersey state law claims and the ERISA disclosure claim. In January 2013 and again in April 2014, the District Court denied separate motions by the plaintiffs to certify a nationwide class of subscriber plaintiffs. The Third Circuit denied plaintiff's request for an immediate appeal of the January 2013 ruling. As a result, the case is proceeding on behalf of the named plaintiffs only. In June 2014, the District Court granted the Company's motion for summary judgment to terminate all claims, and denied the plaintiffs' partial motion for summary judgment. In July 2014, the plaintiffs appealed all of the District Court's decisions in favor of the Company, including the class certification decision, to the Third Circuit. The Company will continue to vigorously defend its position.

Regulatory Matters

Disability claims regulatory matter. During the second quarter of 2013, the Company finalized an agreement with the Departments of Insurance for Maine, Massachusetts, Pennsylvania, Connecticut and California (together, the "monitoring states") related to an examination of the Company's long-term disability claims handling practices. The agreement requires, among other things: (1) enhanced claims handling procedures related to documentation and disposition; (2) monitoring the Company's implementation of these procedures during a two-year period following the execution date of the agreement; and (3) a reassessment of claims denied or closed during a two-year prior period, except California for which the reassessment period is three years.

In connection with the terms of the agreement, the Company recorded a charge of $77 million before-tax ($51 million after-tax) in the first quarter of 2013. The charge is comprised of two elements: (1) $48 million of benefit costs and reserves from reassessed claims expected to be reopened, and (2) $29 million in additional costs for open claims as a result of the claims handling changes being implemented. The Company is actively implementing the terms of the agreement and continues to communicate with the monitoring states on progress. If the monitoring states find material non-compliance with the agreement upon re-examination, the Company may be subject to additional costs and penalties. Most other jurisdictions have joined the agreement as participating, non-monitoring states.

Quarterly Financial Data *(unaudited)*

The following unaudited quarterly financial data is presented on a consolidated basis for each of the years ended December 31, 2014 and December 31, 2013. Quarterly financial results necessarily rely heavily on estimates. This and certain other factors, such as the seasonal nature of portions of the insurance business, suggest the need to exercise caution in drawing specific conclusions from quarterly consolidated results.

	Three Months Ended			
(In millions, except per share amounts)	**March 31**	**June 30**	**Sept. 30**	**Dec. 31**
Consolidated Results				
2014				
Total revenues	$ 8,496	$ 8,733	$ 8,757	$ 8,928
Income before income taxes	853	901	818	732
Shareholders' net income	528	573	534	467
Shareholders' net income per share:				
Basic	1.96	2.16	2.04	1.80
Diluted	1.92	2.12	2.01	1.77
2013				
Total revenues	$ 8,183	$ 7,980	$ 8,066	$ 8,151
Income before income taxes	74	767	799	536
Shareholders' net income	57[1]	505[2]	553	361[3]
Shareholders' net income per share:				
Basic	0.20	1.79	1.99	1.32
Diluted	0.20	1.76	1.95	1.29
Stock and Dividend Data				
2014				
Price range of common stock – high	$ 90.63	$ 93.20	$ 97.28	$ 105.73
– low	$ 75.37	$ 73.47	$ 87.33	$ 85.75
Dividends declared per common share	$ 0.04	$ –	$ –	$ –
2013				
Price range of common stock – high	$ 63.19	$ 73.13	$ 84.68	$ 88.57
– low	$ 53.91	$ 61.88	$ 71.12	$ 72.64
Dividends declared per common share	$ 0.04	$ –	$ –	$ –

(1) The first quarter of 2013 includes an after-tax gain of $25 million for the GMIB business, an after-tax charge of $507 million for the reinsurance transaction with Berkshire to effectively exit the Run-off Reinsurance business, and an after-tax charge of $51 million related to the disability claims regulatory matter in the Group Disability and Life segment.

(2) The second quarter of 2013 includes an after-tax charge of $24 million for the Pharmacy Benefits Manager ("PBM") partnering agreement with Catamaran.

(3) The fourth quarter of 2013 includes an after-tax charge of $40 million for an organizational efficiency plan.

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, 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 SEC's rules and forms.

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 to the Company's management and Board of Directors 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 and liabilities 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, 2014. 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, 2014.

The Company's independent registered public accounting firm, PricewaterhouseCoopers, has audited the effectiveness of the Company's internal control over financial reporting, as stated in their report located on page 60 in this Form 10-K.

ITEM 9B. Other Information

None.

PART III

ITEM 10. Directors and Executive Officers of the Registrant

A. Directors of the Registrant

The information under the captions "Corporate Governance Matters – Process for Director Elections," "– Board of Directors' Nominees," "– Directors Who Will Continue in Office" and "– Board Meetings and Committees" (as it relates to Audit Committee disclosure) in Cigna's definitive proxy statement related to the 2015 annual meeting of shareholders is incorporated by reference.

B. Executive Officers of the Registrant

See PART I – "Executive Officers of the Registrant" on page 28 in this Form 10-K.

C. Code of Ethics and Other Corporate Governance Disclosures

Cigna's Code of Ethics is the Company's code of business conduct and ethics, and applies to Cigna's directors, officers (including the Chief Executive Officer, Chief Financial Officer and Chief Accounting Officer) and employees. The Code of Ethics is posted on the Corporate Governance section found on the "About Cigna" page of the Company's website, www.cigna.com. In the event the Company substantively amends its Code of Ethics or waives a provision of the Code, Cigna intends to disclose the amendment or waiver on the Corporate Governance section of the Company's website.

In addition, the Company's corporate governance guidelines (Board Practices) and the charters of its board committees (Audit, Corporate Governance, Executive, Finance and People Resources) are available on the Corporate Governance section of the Company's website. These corporate governance documents, as well as the Code of Ethics, are available in print to any shareholder who requests them.

D. Section 16(a) Beneficial Ownership Reporting Compliance

The information under the caption "Ownership of Cigna Common Stock – Section 16(a) Beneficial Ownership Reporting Compliance" in Cigna's definitive proxy statement related to the 2015 annual meeting of shareholders is incorporated by reference.

ITEM 11. Executive Compensation

The information under the captions "Corporate Governance Matters – Non-Employee Director Compensation," "Compensation Matters – Report of the People Resources Committee," "– Compensation Discussion and Analysis" and "– Executive Compensation Tables" in Cigna's definitive proxy statement related to the 2015 annual meeting of shareholders is incorporated 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, 2014:

Plan Category	(a) [1] Securities To Be Issued Upon Exercise Of Outstanding Options, Warrants And Rights	(b) [2] Weighted Average Exercise Price Per Share 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	10,692,086	$ 51.84	10,616,584
Equity Compensation Plans Not Approved by Security Holders	–	–	–
Total	10,692,086	$ 51.84	10,616,584

(1) Includes, in addition to outstanding stock options, 169,963 restricted stock units, 97,745 deferred shares and 3,093,054 strategic performance shares, which are reported at the maximum 200% payout rate. Also includes 724,329 shares of common stock underlying stock option awards granted under the HealthSpring, Inc. Amended and Restated 2006 Equity Incentive Plan and 18,776 shares of common stock underlying stock option awards granted under the NewQuest Holdings, Inc. 2005 Stock Option Plan, each of which was approved by the applicable company's shareholders before Cigna's acquisition of HealthSpring in January 2012.

(2) The weighted-average exercise price is based only on outstanding stock options. The outstanding stock options assumed due to Cigna's acquisition of HealthSpring, Inc. have a weighted-average exercise price of $17.74. Excluding these assumed options results in a weighted-average exercise price of $55.69.

(3) Includes 285,176 shares of common stock available as of the close of business December 31, 2014 for future issuance under the Cigna Directors Equity Plan and 10,331,408 shares of common stock available as of the close of business on December 31, 2014 for future issuance under the Cigna Long-Term Incentive Plan.

The information under the captions "Ownership of Cigna Common Stock – Stock held by Directors, Nominees and Executive Officers" and "Ownership of Cigna Common Stock – Largest Security Holders" in Cigna's definitive proxy statement related to the 2015 annual meeting of shareholders is incorporated by reference.

ITEM 13. Certain Relationships and Related Transactions

The information under the captions "Corporate Governance Matters – Director Independence" and "– Certain Transactions" in Cigna's definitive proxy statement related to the 2015 annual meeting of shareholders is incorporated by reference.

ITEM 14. Principal Accounting 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 2015 annual meeting of shareholders is incorporated by reference.

PART IV

ITEM 15. Exhibits and Financial Statement Schedules

(a) (1) The following Financial Statements appear on pages 60 through 114:

Report of Independent Registered Public Accounting Firm.

Consolidated Statements of Income for the years ended December 31, 2014, 2013 and 2012.

Consolidated Statements of Comprehensive Income for the years ended December 31, 2014, 2013 and 2012.

Consolidated Balance Sheets as of December 31, 2014 and 2013.

Consolidated Statements of Changes in Total Equity for the years ended December 31, 2014, 2013 and 2012.

Consolidated Statements of Cash Flows for the years ended December 31, 2014, 2013 and 2012.

Notes to the Consolidated Financial Statements.

(2) The financial statement schedules are listed in the Index to Financial Statement Schedules on page FS-1.

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.

CIGNA CORPORATION

Date:	February 26, 2015
By:	/s/ Thomas A. McCarthy
	Thomas A. McCarthy
	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 26, 2015.

Signature	Title
/s/ David M. Cordani	Chief Executive Officer and Director (Principal Executive Officer)
David M. Cordani	
/s/ Thomas A. McCarthy	Executive Vice President and Chief Financial Officer (Principal Financial Officer)
Thomas A. McCarthy	
/s/ Mary T. Hoeltzel	Vice President and Chief Accounting Officer (Principal Accounting Officer)
Mary T. Hoeltzel	
/s/ Eric J. Foss	Director
Eric J. Foss	
/s/ Michelle D. Gass	Director
Michelle D. Gass	
/s/ Isaiah Harris, Jr.	Chairman of the Board
Isaiah Harris, Jr.	
/s/ Jane E. Henney, M.D.	Director
Jane E. Henney, M.D.	
/s/ Roman Martinez IV	Director
Roman Martinez IV	
/s/ John M. Partridge	Director
John M. Partridge	
/s/ James E. Rogers	Director
James E. Rogers	
/s/ Eric C. Wiseman	Director
Eric C. Wiseman	
/s/ Donna F. Zarcone	Director
Donna F. Zarcone	
/s/ William D. Zollars	Director
William D. Zollars	

Cigna Corporation and Subsidiaries

INDEX TO FINANCIAL STATEMENT SCHEDULES

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 and of the effectiveness of internal control over financial reporting referred to in our report dated February 26, 2015 (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 in Item 15(a)(2) 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

Philadelphia, Pennsylvania
February 26, 2015

Cigna Corporation and Subsidiaries
Schedule I – Summary of Investments – Other Than Investments in Related Parties
December 31, 2014

Type of Investment *(In millions)*	Cost	Fair Value	Amount at which shown in the Consolidated Balance Sheet
Fixed maturities:			
Bonds:			
United States government and government agencies and authorities	$ 608	$ 954	$ 954
States, municipalities and political subdivisions	1,682	1,856	1,856
Foreign governments	1,824	1,940	1,940
Public utilities	437	447	447
All other corporate bonds	12,042	13,012	13,012
Asset backed securities:			
Mortgage-backed	83	85	85
Other asset-backed	564	650	650
Redeemable preferred stocks	38	39	39
TOTAL FIXED MATURITIES	**17,278**	**18,983**	**18,983**
Equity securities:			
Common stocks:			
Industrial, miscellaneous and all other	111	113	113
Non-redeemable preferred stocks	88	76	76
TOTAL EQUITY SECURITIES	**199**	**189**	**189**
Commercial mortgage loans on real estate	2,081		2,081
Policy loans	1,438		1,438
Other long-term investments	1,494		1,488
Short-term investments	163		163
TOTAL INVESTMENTS	**$ 22,653**		**$ 24,342**

Cigna Corporation and Subsidiaries
Schedule II – Condensed Financial Information of Cigna Corporation – (Registrant)

Statements of Income

	For the years ended December 31,		
(In millions)	2014	2013	2012
Operating expenses:			
Interest	$ 258	$ 264	$ 262
Intercompany interest	5	2	–
Other	82	69	190
TOTAL OPERATING EXPENSES	**345**	**335**	**452**
Loss before income taxes	(345)	(335)	(452)
Income tax benefit	(89)	(109)	(143)
Loss of parent company	(256)	(226)	(309)
Equity in income of subsidiaries	2,358	1,702	1,932
SHAREHOLDERS' NET INCOME	**2,102**	**1,476**	**1,623**
Shareholders' other comprehensive income (loss):			
Net unrealized appreciation (depreciation) on securities	143	(410)	147
Net unrealized appreciation (depreciation), derivatives	11	9	(5)
Net translation of foreign currencies	(144)	13	66
Postretirement benefits liability adjustment	(426)	539	(92)
Shareholders' other comprehensive income (loss)	(416)	151	116
SHAREHOLDERS' COMPREHENSIVE INCOME	**$ 1,686**	**$ 1,627**	**$ 1,739**

See Notes to Financial Statements on the following pages.

Cigna Corporation and Subsidiaries
Schedule II – Condensed Financial Information of Cigna Corporation (Registrant)

Balance Sheets

(In millions)	As of December 31, 2014	2013
ASSETS:		
Cash and cash equivalents	$ 51	$ –
Investments in subsidiaries	17,645	16,932
Intercompany	74	40
Other assets	553	435
TOTAL ASSETS	**$ 18,323**	**$ 17,407**
LIABILITIES:		
Intercompany	$ 1,138	$ 1,043
Short-term debt	100	100
Long-term debt	4,885	4,871
Other liabilities	1,426	826
TOTAL LIABILITIES	**7,549**	**6,840**
SHAREHOLDERS' EQUITY:		
Common stock (shares issued, 296; authorized, 600)	74	92
Additional paid-in capital	2,769	3,356
Accumulated other comprehensive loss	(936)	(520)
Retained earnings	10,289	13,676
Less treasury stock, at cost	(1,422)	(6,037)
TOTAL SHAREHOLDERS' EQUITY	**10,774**	**10,567**
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	**$ 18,323**	**$ 17,407**

See Notes to Financial Statements on the following pages.

Cigna Corporation and Subsidiaries
Schedule II – Condensed Financial Information of Cigna Corporation (Registrant)

Statements of Cash Flows

(In millions)	For the years ended December 31, 2014	2013	2012
Cash Flows from Operating Activities:			
Shareholders' Net Income	$ 2,102	$ 1,476	$ 1,623
Adjustments to reconcile shareholders' net income to net cash provided by operating activities:			
Equity in income of subsidiaries	(2,358)	(1,702)	(1,932)
Dividends received from subsidiaries	1,648	506	671
Other liabilities	(73)	(245)	(213)
Other, net	173	63	191
Net cash provided by operating activities	1,492	98	340
Cash Flows from Investing Activities:			
Other, net	11	–	(19)
Net cash provided by / (used in) investing activities	11	–	(19)
Cash Flows from Financing Activities:			
Net change in amounts due to / from affiliates	61	751	(208)
Net change in short-term debt	–	(100)	100
Issuance of common stock	110	150	121
Common dividends paid	(11)	(11)	(11)
Repurchase of common stock	(1,612)	(1,003)	(208)
Net cash used in financing activities	(1,452)	(213)	(206)
Net increase (decrease) in cash and cash equivalents	51	(115)	115
Cash and cash equivalents, beginning of year	–	115	–
Cash and cash equivalents, end of year	$ 51	$ –	$ 115

See Notes to Financial Statements on the following pages.

Cigna Corporation and Subsidiaries
Schedule II – 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 Form 10-K.

Note 1 – For purposes of these condensed financial statements, Cigna Corporation's (the "Company") wholly-owned and majority-owned subsidiaries are recorded using the equity basis of accounting.

Note 2 – Short-term and long-term debt consisted of the following at December 31:

(In millions)	December 31, 2014	December 31, 2013
Short-term:		
Commercial Paper	$ 100	$ 100
TOTAL SHORT-TERM DEBT	**$ 100**	**$ 100**
Long-term:		
Uncollateralized debt:		
$600 million, 2.75% Notes due 2016	$ 600	$ 600
$250 million, 5.375% Notes due 2017	250	250
$131 million, 6.35% Notes due 2018	131	131
$251 million, 8.5% Notes due 2019	251	251
$250 million, 4.375% Notes due 2020[1]	254	249
$300 million, 5.125% Notes due 2020[1]	303	299
$300 million, 4.5% Notes due 2021[1]	303	299
$750 million, 4% Notes due 2022	745	744
$100 million, 7.65% Notes due 2023	100	100
$17 million, 8.3% Notes due 2023	17	17
$300 million, 7.875% Debentures due 2027	300	300
$83 million, 8.3% Step Down Notes due 2033	83	83
$500 million, 6.15% Notes due 2036	500	500
$300 million, 5.875% Notes due 2041	298	298
$750 million, 5.375% Notes due 2042	750	750
TOTAL LONG-TERM DEBT	**$ 4,885**	**$ 4,871**

(1) In 2014, the Company entered into interest rate swap contracts hedging a portion of these fixed-rate debt instruments.

In December, 2014, the Company entered into an updated revolving credit and letter of credit agreement for $1.5 billion, that permits up to $500 million to be used for letters of credit. This agreement extends through December 2019 and is diversified among 16 banks, with three banks each having 12% of the commitment and the remainder spread among 13 banks. The credit agreement includes options, subject to consent by the administrative agent and the committing banks, to increase the commitment amount to $2 billion and to extend the term past December 2019. The credit agreement is available for general corporate purposes, including for the issuance of letters of credit. This agreement has certain covenants, including a financial covenant requiring the Company to maintain a leverage ratio of total consolidated debt-to-consolidated capitalization (each as defined in the credit agreement) at or below 0.50. As of December 31, 2014, the Company had $6.5 billion of borrowing capacity within the maximum debt coverage covenant in the agreement, in addition to the $5.2 billion of debt outstanding. Letters of credit outstanding as of December 31, 2014 totaled $23 million. The Company was in compliance with its debt covenants as of December 31, 2014.

Maturities of debt are as follows (in millions): none in 2015, $600 in 2016, $250 in 2017, $131 in 2018, $251 in 2019 and the remainder in years after 2019. Interest expense on long-term and short-term debt was $258 million in 2014, $264 million in 2013, and $262 million in 2012. Interest paid on long-term and short-term debt was $252 million in 2014, $259 million in 2013, and $242 million in 2012.

Note 3 – Intercompany liabilities consist primarily of loans payable to Cigna Holdings, Inc. of $877 million as of December 31, 2014 and $1,043 million as of December 31, 2013. Interest was accrued at an average monthly rate of 0.52% for 2014 and 0.59% for 2013.

Note 4 – As of December 31, 2014, the Company had guarantees and similar agreements in place to secure payment obligations or solvency requirements of certain wholly-owned subsidiaries as follows:

- The Company has arranged for bank letters of credit in the amount of $4 million to provide collateral in support of its indirect wholly-owned subsidiaries.
- Various indirect, wholly-owned subsidiaries have obtained surety bonds in the normal course of business. If there is a claim on a surety bond and the subsidiary is unable to pay, the Company guarantees payment to the company issuing the surety bond. The aggregate amount of such surety bonds as of December 31, 2014 was $79 million.
- The Company is obligated under a $6 million letter of credit required by the insurer of its high-deductible self-insurance programs to indemnify the insurer for claim liabilities that fall within deductible amounts for policy years dating back to 1994.
- The Company also provides solvency guarantees aggregating $34 million under state and federal regulations in support of its indirect wholly-owned medical HMOs in several states.
- The Company has arranged a $13 million letter of credit in support of Cigna Europe Insurance Company, an indirect wholly-owned subsidiary. The Company has agreed to indemnify the banks providing the letters of credit in the event of any draw. Cigna Europe Insurance Company is the holder of the letters of credit.
- The Company has agreed to indemnify payment of losses included in Cigna Europe Insurance Company's reserves on the assumed reinsurance business transferred from ACE. As of December 31, 2014, the reserve was $22 million.

In 2014, no payments have been made on these guarantees and none are pending. The Company provided other guarantees to subsidiaries that, in the aggregate, do not represent a material risk to the Company's results of operations, liquidity or financial condition.

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Cigna Corporation and Subsidiaries
Schedule III – Supplementary Insurance Information

(In millions) Segment	Deferred policy acquisition costs	Future policy benefits and contractholder deposit funds	Medical claims payable and unpaid claims	Unearned premiums
Year Ended December 31, 2014:				
Global Health Care	$ 17	$ 182	$ 2,180	$ 155
Global Supplemental Benefits	1,437	2,785	339	431
Group Disability and Life	1	1,662	3,844	15
Other Operations	47	13,443	222	20
Corporate	–	–	(5)	–
TOTAL	**$ 1,502**	**$ 18,072**	**$ 6,580**	**$ 621**
Year Ended December 31, 2013:				
Global Health Care	$ 20	$ 197	$ 2,050	$ 116
Global Supplemental Benefits	1,323	2,525	305	419
Group Disability and Life	1	1,615	3,739	23
Other Operations	51	13,439	260	22
Corporate	–	–	(6)	–
TOTAL	**$ 1,395**	**$ 17,776**	**$ 6,348**	**$ 580**
Year Ended December 31, 2012:				
Global Health Care	$ 19	$ 175	$ 1,856	$ 111
Global Supplemental Benefits	1,113	2,227	306	388
Group Disability and Life	1	1,599	3,482	26
Other Operations	65	13,772	295	24
Corporate	–	–	(21)	–
TOTAL	**$ 1,198**	**$ 17,773**	**$ 5,918**	**$ 549**

	Premiums [1]	Net investment income [2]	Benefit expenses [1][3]	Amortization of deferred policy acquisition expenses	Other operating expenses [4]
Year Ended December 31, 2014					
Global Health Care	$ 20,709	$ 337	$ 16,694	$ 73	$ 7,843
Global Supplemental Benefits	2,844	109	1,544	209	981
Group Disability and Life	3,549	335	2,716	1	796
Other Operations	112	384	380	6	27
Corporate	–	1	–	–	340
TOTAL	**$ 27,214**	**$ 1,166**	**$ 21,334**	**$ 289**	**$ 9,987**
Year Ended December 31, 2013:					
Global Health Care	$ 19,626	$ 325	$ 15,867	$ 69	$ 7,021
Global Supplemental Benefits	2,496	100	1,310	178	924
Group Disability and Life	3,348	321	2,621	1	765
Other Operations	105	408	1,067	7	46
Corporate	–	10	–	–	328
TOTAL	**$ 25,575**	**$ 1,164**	**$ 20,865**	**$ 255**	**$ 9,084**
Year Ended December 31, 2012:					
Global Health Care	$ 17,877	$ 259	$ 14,228	$ 68	$ 6,573
Global Supplemental Benefits	1,975	90	1,005	141	770
Group Disability and Life	3,044	300	2,290	3	721
Other Operations	121	490	377	6	2
Corporate	–	5	–	–	458
TOTAL	**$ 23,017**	**$ 1,144**	**$ 17,900**	**$ 218**	**$ 8,524**

(1) Amounts presented are shown net of the effects of reinsurance. See Note 7 to the Consolidated Financial Statements included in this Form 10-K.

(2) The allocation of net investment income is based upon the investment year method, the identification of certain portfolios with specific segments, or a combination of both.

(3) Benefit expenses include Global Health Care medical claims expense and other benefit expenses.

(4) Other operating expenses include mail order pharmacy costs and other operating expenses, and excludes amortization of deferred policy acquisition expenses.

Cigna Corporation and Subsidiaries
Schedule IV – Reinsurance

(In millions)	Gross amount	Ceded to other companies	Assumed from other companies	Net amount	Percentage of amount assumed to net
Year Ended December 31, 2014:					
Life insurance in force	$ 879,508	$ 58,133	$ 3,180	$ 824,555	0.4%
Premiums:					
Life insurance and annuities	$ 2,302	$ 320	$ 32	$ 2,014	1.6%
Accident and health insurance	24,913	283	570	25,200	2.3%
TOTAL	**$ 27,215**	**$ 603**	**$ 602**	**$ 27,214**	**2.2%**
Year Ended December 31, 2013:					
Life insurance in force	$ 781,053	$ 59,003	$ 3,459	$ 725,509	0.5%
Premiums:					
Life insurance and annuities	$ 2,140	$ 279	$ 28	$ 1,889	1.5%
Accident and health insurance	23,401	264	549	23,686	2.3%
TOTAL	**$ 25,541**	**$ 543**	**$ 577**	**$ 25,575**	**2.3%**
Year Ended December 31, 2012:					
Life insurance in force	$ 710,140	$ 48,702	$ 4,435	$ 665,873	0.7%
Premiums:					
Life insurance and annuities	$ 2,013	$ 268	$ 29	$ 1,774	1.6%
Accident and health insurance	21,001	200	442	21,243	2.1%
TOTAL	**$ 23,014**	**$ 468**	**$ 471**	**$ 23,017**	**2.1%**

Cigna Corporation and Subsidiaries
Schedule V – 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[1]	Balance at end of year
2014:					
Investment asset valuation reserves: Commercial mortgage loans	$ 8	$ 4	$ –	$ –	$ 12
Allowance for doubtful accounts: Premiums, accounts and notes receivable	$ 43	$ 53	$ 5	$ –	$ 101
Deferred tax asset valuation allowance	$ 49	$ 21	$ (21)	$ –	$ 49
Reinsurance recoverables	$ 4	$ –	$ –	$ –	$ 4
2013:					
Investment asset valuation reserves: Commercial mortgage loans	$ 7	$ 4	$ –	$ (3)	$ 8
Allowance for doubtful accounts: Premiums, accounts and notes receivable	$ 51	$ –	$ (2)	$ (6)	$ 43
Deferred tax asset valuation allowance	$ 42	$ 7	$ –	$ –	$ 49
Reinsurance recoverables	$ 4	$ –	$ –	$ –	$ 4
2012:					
Investment asset valuation reserves: Commercial mortgage loans	$ 19	$ 10	$ –	$ (22)	$ 7
Allowance for doubtful accounts: Premiums, accounts and notes receivable	$ 45	$ 4	$ 1	$ 1	$ 51
Deferred tax asset valuation allowance	$ 45	$ 4	$ (7)	$ –	$ 42
Reinsurance recoverables	$ 5	$ (1)	$ –	$ –	$ 4

(1) Amounts for commercial mortgage loans primarily reflect charge-offs upon sales and repayments, as well as transfers to foreclosed real estate. 2012 amount also includes restructures reclassified to Other Long-term Investments.

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Index to Exhibits

Number		Description	Method of Filing
3.1		Restated Certificate of Incorporation of the registrant as last amended October 28, 2011	Filed as Exhibit 3.1 to the registrant's Form 10-Q for the quarterly period ended September 30, 2011 and incorporated herein by reference.
3.2		By-Laws of the registrant as last amended and restated December 6, 2012	Filed as Exhibit 3.2 to the registrant's Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
4.1	(a)	Indenture dated August 16, 2006 between Cigna Corporation and U.S. Bank National Association	Filed as Exhibit 4.1(a) to the registrant's Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
	(b)	Supplemental Indenture No. 1 dated November 11, 2006 between Cigna Corporation and U.S. Bank National Association	Filed as Exhibit 4.1(b) to the registrant's Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
	(c)	Supplemental Indenture No. 2 dated March 15, 2008 between Cigna Corporation and U.S. Bank National Association	Filed as Exhibit 4.1(c) to the registrant's Form 10-Q for the quarterly period ended March 31, 2011 and incorporated herein by reference
	(d)	Supplemental Indenture No. 3 dated March 7, 2008 between Cigna Corporation and U.S. Bank National Association	Filed as Exhibit 4.1 to the registrant's Form 8-K on March 10, 2008 and incorporated herein by reference.
	(e)	Supplemental Indenture No. 4 dated May 7, 2009 between Cigna Corporation and U.S. Bank National Association	Filed as Exhibit 99.2 to the registrant's Form 8-K on May 12, 2009 and incorporated herein by reference.
	(f)	Supplemental Indenture No. 5 dated May 17, 2010 between Cigna Corporation and U.S. Bank National Association	Filed as Exhibit 99.2 to the registrant's Form 8-K on May 28, 2010 and incorporated herein by reference.
	(g)	Supplemental Indenture No. 6 dated December 8, 2010 between Cigna Corporation and U.S. Bank National Association	Filed as Exhibit 99.2 to the registrant's Form 8-K on December 9, 2010 and incorporated herein by reference.
	(h)	Supplemental Indenture No. 7 dated March 7, 2011 between Cigna Corporation and U.S. Bank National Association	Filed as Exhibit 99.2 to the registrant's Form 8-K on March 8, 2011 and incorporated herein by reference.
	(i)	Supplemental Indenture No. 8 dated November 10, 2011 between Cigna Corporation and U.S. Bank National Associated	Filed as Exhibit 4.1 to the registrant's Form 8-K on November 14, 2011 and incorporated herein by reference.
4.2		Indenture dated January 1, 1994 between Cigna Corporation and Marine Midland Bank	Filed as Exhibit 4.2 to the registrant's Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
4.3		Indenture dated June 30, 1988 between Cigna Corporation and Bankers Trust	Filed as Exhibit 4.3 to the registrant's Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
Exhibits 10.1 through 10.31 are identified as compensatory plans, management contracts or arrangements pursuant to Item 15 of Form 10-K.			
10.1		Deferred Compensation Plan for Directors of Cigna Corporation, as amended and restated January 1, 1997	Filed as Exhibit 10.1 to the registrant's Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.2		Deferred Compensation Plan of 2005 for Directors of Cigna Corporation, amended and restated effective April 28, 2010	Filed as Exhibit 10.2 to the registrant's Form 10-K for the year ended December 31, 2010 and incorporated herein by reference.
10.3		Cigna Corporation Non-Employee Director Compensation Program amended and restated effective February 26, 2014	Filed as Exhibit 10.1 to the registrant's Form 10-Q for the quarterly period ended March 31, 2014 and incorporated herein by reference.
10.4		Cigna Restricted Share Equivalent Plan for Non-Employee Directors as amended and restated effective January 1, 2008	Filed as Exhibit 10.4 to the registrant's Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
10.5		Cigna Corporation Director Equity Plan	Filed as Exhibit 10.3 to the registrant's Form 10-Q for the quarterly period ended March 31, 2010 and incorporated herein by reference.
10.6		Cigna Corporation Stock Plan, as amended and restated through July 2000	Filed as Exhibit 10.7 to the registrant's Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.7	(a)	Cigna Stock Unit Plan, as amended and restated effective July 22, 2008	Filed as Exhibit 10.1 to the registrant's Form 10-Q for the quarterly period ended September 30, 2008 and incorporated herein by reference.
	(b)	Amendment No. 1 to the Cigna Stock Unit Plan, as amended and restated effective July 22, 2008	Filed as Exhibit 10.3 to the registrant's Form 10-Q for the quarterly period ended June 30, 2010 and incorporated herein by reference.
10.8		Cigna Executive Severance Benefits Plan as amended and restated effective April 27, 2010	Filed as Exhibit 10.2 to the registrant's Form 10-Q for the quarterly period ended June 30, 2010 and incorporated herein by reference.
10.9		Description of Severance Benefits for Executives in Non-Change of Control Circumstances	Filed as Exhibit 10.10 to the registrant's Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.10		Cigna Executive Incentive Plan amended and restated as of January 12, 2012	Filed as Exhibit 10.1 to the registrant's Form 10-Q for the quarterly period ended March 31, 2012 and incorporated herein by reference.
10.11	(a)	Cigna Long-Term Incentive Plan as amended and restated effective as of April 28, 2010	Filed as Exhibit 10.2 to the registrant's Form 10-Q for the quarterly period ended March 31, 2010 and incorporated herein by reference.
	(b)	Amendment No. 1 to the Cigna Long-Term Incentive Plan as amended and restated effective as of April 28, 2010	Filed as Exhibit 10.1 to the registrant's Form 10-Q for the quarterly period ended June 30, 2010 and incorporated herein by reference.
	(c)	Amendment No. 2 to the Cigna Long-Term Incentive Plan as amended and restated effective as of April 28, 2010	Filed as Exhibit 10.1 to the registrant's Form 10-Q for the quarterly period ended March 31, 2011 and incorporated herein by reference.
10.12		Cigna Deferred Compensation Plan, as amended and restated October 24, 2001	Filed as Exhibit 10.14 to the registrant's Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.13		Cigna Deferred Compensation Plan of 2005 effective as of January 1, 2005	Filed as Exhibit 10.15 to the registrant's Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.

PART IV
ITEM 15. Exhibits and Financial Statement Schedules

Number		Description	Method of Filing
10.14	(a)	Cigna Supplemental Pension Plan as amended and restated effective August 1, 1998	Filed as Exhibit 10.15(a) to the registrant's Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
	(b)	Amendment No. 1 to the Cigna Supplemental Pension Plan, amended and restated effective as of September 1, 1999	Filed as Exhibit 10.15(b) to the registrant's Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
	(c)	Amendment No. 2 dated December 6, 2000 to the Cigna Supplemental Pension	Filed as Exhibit 10.16(c) to the registrant's Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.15	(a)	Cigna Supplemental Pension Plan of 2005 effective as of January 1, 2005	Filed as Exhibit 10.15 to the registrant's Form 10-K for the year ended December 31, 2007 and incorporated herein by reference.
	(b)	Amendment No. 1 to the Cigna Supplemental Pension Plan of 2005	Filed as Exhibit 10.1 to the registrant's Form 10-Q for the quarterly period ended June 30, 2009 and incorporated herein by reference.
10.16		Cigna Supplemental 401(k) Plan effective January 1, 2010	Filed as Exhibit 10.17 to the registrant's Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.17		Description of Cigna Corporation Financial Services Program	Filed as Exhibit 10.18 to the registrant's Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.18		Form of Cigna Long-Term Incentive Plan: Nonqualified Stock Option Grant Agreement	Filed as Exhibit 10.2 to the registrant's Form 10-Q for the period ended March 31, 2014 and incorporated herein by reference.
10.19		Form of Cigna Long-Term Incentive Plan: Restricted Stock Grant Agreement	Filed as Exhibit 10.3 to the registrant's Form 10-Q for the period ended March 31, 2014 and incorporated herein by reference.
10.20		Form of Cigna Long-Term Incentive Plan: Restricted Stock Unit Grant Agreement	Filed as Exhibit 10.4 to the registrant's Form 10-Q for the period ended March 31, 2014 and incorporated herein by reference.
10.21		Form of Cigna Long-Term Incentive Plan: Strategic Performance Share Grant Agreement	Filed as Exhibit 10.5 to the registrant's Form 10-Q for the period ended March 31, 2014 and incorporated herein by reference.
10.22		Schedule regarding Amended Deferred Stock Unit Agreements effective December 31, 2008 with John M. Murabito and Form of Amended Deferred Stock Unit Agreement	Filed as Exhibit 10.20 to the registrant's Form 10-K for the year ended December 31, 2008 and incorporated herein by reference.
10.23		Nicole Jones' Offer of Employment dated April 27, 2011	Filed as Exhibit 10.2 to the registrant's Form 10-Q for the period ended March 31, 2012 and incorporated herein by reference.
10.24		Matthew Manders' Promotion Letter dated June 2, 2014	Filed as Exhibit 10.1 to the registrant's Form 8-K filed on June 4, 2014 and incorporated herein by reference.
10.25		Thomas A. McCarthy's Offer Letter dated May 9, 2013	Filed as Exhibit 10.1 to the registrant's Form 8-K filed on May 13, 2013 and incorporated herein by reference.
10.26	(a)	Retention Agreement with Herbert Fritch dated October 24, 2011	Filed as Exhibit 10.1 to the registrant's Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
	(b)	Agreement dated December 7, 2011 with Herbert Fritch	Filed as Exhibit 10.2 to the registrant's Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
	(c)	Retention Agreement with Herbert Fritch dated September 15, 2014.	Filed as Exhibit 10.1 to the registrant's Form 8-K filed on September 19, 2014 and incorporated herein by reference.
10.27		HealthSpring, Inc. Amended and Restated 2006 Equity Incentive Plan (the "HealthSpring Equity Incentive Plan")	Filed as Exhibit 10.3 to the registrant's Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
10.28		HealthSpring Equity Incentive Plan: Form of Restricted Share Award	Filed as Exhibit 10.4 to the registrant's Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
10.29		HealthSpring Equity Incentive Plan: Form of Non-Qualified Stock Option Agreement	Filed as Exhibit 10.5 to the registrant's Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
10.30		Ralph Nicoletti's Offer of Employment dated April 27, 2011	Filed as Exhibit 10.1 to the registrant's Form 8-K filed on May 31, 2011 and incorporated herein by reference.
10.31		Agreement and Release with Ralph J. Nicoletti dated July 10, 2013	Filed as Exhibit 10.1 to the registrant's Form 8-K filed on July 17, 2013 and incorporated herein by reference.
10.32		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, 6.4, 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 as Exhibit 10.29 to the registrant's Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
12		Computation of Ratios of Earnings to Fixed Charges	Filed herewith.
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.

Number	Description	Method of Filing
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, 2014, formatted in 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, II, III, IV and V.	Filed herewith.

The registrant will furnish to the Commission upon request of any other instruments defining the rights of holders of long-term debt.

Shareholders may obtain copies of exhibits by writing to Cigna Corporation, Shareholder Services Department, 1601 Chestnut Street, Philadelphia, PA 19192.

EXHIBIT 12 Cigna Corporation – Computation of Ratio of Earnings to Fixed Charges

(Dollars in millions)

Year Ended December 31,	2014	2013	2012	2011	2010
Income before income taxes	$ 3,304	$ 2,176	$ 2,477	$ 1,876	$ 1,802
Adjustments:					
Income from equity investee	(18)	(17)	(10)	(15)	(18)
(Income) loss attributable to noncontrolling interests	5	(3)	(1)	(1)	(4)
Income before income taxes, as adjusted	$ 3,291	$ 2,156	$ 2,466	$ 1,860	$ 1,780
Fixed charges included in income:					
Interest expense	$ 265	$ 270	$ 268	$ 202	$ 182
Interest portion of rental expense	50	38	43	38	42
Interest credited to contractholders	3	5	4	5	5
	$ 318	$ 313	$ 315	$ 245	$ 229
Income available for fixed charges	$ 3,609	$ 2,469	$ 2,781	$ 2,105	$ 2,009
RATIO OF EARNINGS TO FIXED CHARGES:	11.3	7.9	8.8	8.6	8.8

Exhibit 21 Subsidiaries of the Registrant

Listed below are subsidiaries of Cigna Corporation as of December 31, 2014 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
Allegiance Life & Health Insurance Company, Inc.	Montana
Allegiance Re, Inc.	Montana
American Retirement Life Insurance Company	Ohio
Benefits Management Corp.	Montana
Bravo Health Mid-Atlantic, Inc.	Maryland
Bravo Health of Pennsylvania, Inc.	Pennsylvania
Bravo Health, LLC	Delaware
Central Reserve Life Insurance Company	Ohio
Ceres Sales of Ohio, LLC	Ohio
Cigna & CMB Life Insurance Company Limited	China
Cigna Alder Holdings, LLC	Delaware
Cigna Apac Holdings Limited	Bermuda
Cigna Arbor Life Insurance Company	Connecticut
Cigna Beechwood Holdings, MTS	Belgium
Cigna Behavioral Health of California, Inc.	California
Cigna Behavioral Health of Texas, Inc.	Texas
Cigna Behavioral Health, Inc.	Minnesota
Cigna Bellevue Alpha, LLC	Delaware
Cigna Benefits Financing, Inc.	Delaware
Cigna Brokerage & Marketing (Thailand) Limited	Thailand
Cigna Chestnut Holdings, Ltd.	United Kingdom
Cigna Corporate Services, LLC	Delaware
Cigna Data Services (Shanghai) Company Limited	China
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 Dental Health, Inc.	Florida
Cigna Elmwood Holdings, SPRL	Belgium
Cigna Europe Insurance Company S.A.-N.V.	Belgium
Cigna European Services (UK) Limited	United Kingdom
Cigna Finans Emeklilik ve Hayat A.S.	Turkey
Cigna Global Holdings, Inc.	Delaware
Cigna Global Insurance Company Limited	Guernsey, C.I
Cigna Global Reinsurance Company, Ltd.	Bermuda
Cigna Health and Life Insurance Company	Connecticut
Cigna Health Corporation	Delaware
Cigna Health Management, Inc.	Delaware
Cigna Health Solutions India Pvt. Ltd.	India
Cigna Healthcare Holdings, Inc.	Colorado
Cigna Healthcare Mid-Atlantic, Inc.	Maryland
Cigna Healthcare of Arizona, Inc.	Arizona
Cigna Healthcare of California, Inc.	California
Cigna Healthcare of Colorado, Inc.	Colorado

Entity Name	Jurisdiction
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 New York, Inc.	New York
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 HLA Technology Services Company Limited	Hong Kong
Cigna Holdings Overseas, Inc.	Delaware
Cigna Holdings, Inc.	Delaware
Cigna Hong Kong Holdings Company Limited	Hong Kong
Cigna Insurance Public Company Limited	Thailand
Cigna Insurance Services (Europe) Limited	United Kingdom
Cigna Intellectual Property, Inc.	Delaware
Cigna International Corporation	Delaware
Cigna International Health Services BVBA	Belgium
Cigna International Services Australia Pty. Ltd.	Australia
Cigna Investment Group, Inc.	Delaware
Cigna Investments, Inc.	Delaware
Cigna Life Insurance Company of Canada	Canada
Cigna Life Insurance Company of Europe S.A.- N.V.	Belgium
Cigna Life Insurance Company of New York	New York
Cigna Life Insurance New Zealand Limited	New Zealand
Cigna Linden Holdings, Inc.	Delaware
Cigna Myrtle Holdings, Ltd.	Malta
Cigna Nederland Alpha Cooperatief U.A.	Netherlands
Cigna Nederland Beta N.V.	Netherlands
Cigna Nederland Gamma N.V.	Netherlands
Cigna Palmetto Holdings, Ltd.	Bermuda
Cigna Poplar Holdings, Inc.	Delaware
Cigna Saico Benefits Services WLL	Bahrain
Cigna Sequoia Holdings, SPRL	Belgium
Cigna Taiwan Life Assurance Company Limited	Taiwan
CignaTTK Health Insurance Company Limited	India
Cigna Walnut Holdings, Ltd.	United Kingdom
Cigna Worldwide General Insurance Company Limited	Hong Kong
Cigna Worldwide Insurance Company	Delaware
Cigna Worldwide Life Insurance Company Limited	Hong Kong
Connecticut General Corporation	Connecticut
Connecticut General Life Insurance Company	Connecticut
FirstAssist Administration Limited	United Kingdom
FirstAssist Group Holdings Limited	United Kingdom
FirstAssist Group Limited	United Kingdom
FirstAssist Legal Protection Limited	United Kingdom
Great-West Healthcare of Illinois, Inc.	Illinois
Healthsource, Inc.	New Hampshire
HealthSpring, Inc.	Delaware
HealthSpring of Alabama, Inc	Alabama
HealthSpring of Florida, Inc.	Florida
HealthSpring Life & Health Insurance Company, Inc.	Texas
HealthSpring Management, Inc.	Tennessee

Entity Name	Jurisdiction
HealthSpring of Tennessee, Inc.	Tennessee
KDM Thailand Limited	Thailand
Life Insurance Company of North America	Pennsylvania
LINA Financial Service	Korea
LINA Life Insurance Company of Korea	Korea
Loyal American Life Insurance Company	Ohio
MCC Independent Practice Association of New York, Inc.	New York
NewQuest, LLC	Texas
Provident American Life and Health Insurance Company	Ohio
PT Asuransi Cigna	Indonesia
RHP (Thailand) Limited	Thailand
Tel Drug, Inc.	South Dakota
Tel Drug of Pennsylvania, LLC	Pennsylvania
Temple Insurance Company Limited	Bermuda
United Benefit Life Insurance Company	Ohio
Vanbreda International LLC	Florida
Vanbreda International SDN. BHD.	Malaysia
Vielife Holdings Limited	United Kingdom
Vielife Limited	United Kingdom

EXHIBIT 23 Consent of Independent Registered Public Accounting Firm

We hereby consent to the incorporation by reference in the Registration Statement on Form S-3 (No. 333-183238) and Form S-8 (No. 333-179307, No. 333-166583, No. 333-163899, No. 333-147994, No. 333-64207, No. 333-129395, No. 333-107839, No. 333-90785, No. 333-22391, No. 033-60053 and No. 033-51791) of Cigna Corporation of our reports dated February 26, 2015 relating to the financial statements, the financial statement schedules and the effectiveness of internal control over financial reporting, which appear in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania
February 26, 2015

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.

/s/ David M. Cordani

Chief Executive Officer

Date: February 26, 2015

EXHIBIT 31.2 Certification

I, THOMAS A. MCCARTHY, 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.

/s/ Thomas A. McCarthy

Chief Financial Officer

Date: February 26, 2015

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, 2014 (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 26, 2015

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, 2014 (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/ Thomas A. McCarthy

Thomas A. McCarthy
Chief Financial Officer
February 26, 2015

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Together, all the way.™

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STAY CONNECTED

Cigna

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CIGNA.COM