CIGNA CORP
Form 10-K
February 23, 2017

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

þ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2016
OR
o 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.	**þ**	**o**
if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.	**o**	**þ**
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.	**þ**	**o**
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).	**þ**	**o**
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.	**þ**	**o**

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 **þ**	Accelerated filer **o**	Non-accelerated filer **o**	Smaller Reporting Company **o**

whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). **o** **þ**

The aggregate market value of the voting stock held by non-affiliates of the registrant as of June 30, 2016 was approximately $32.7 billion.

As of January 31, 2017, 257,052,404 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 2017 annual meeting of shareholders.

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FREQUENTLY REQUESTED 10-K INFORMATION

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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 and strategic or operational initiatives including our ability to deliver personalized and innovative solutions for customers and clients; future growth and expansion; future financial or operating performance; economic, regulatory or competitive environments; our projected cash position, future pension funding and financing or capital deployment plans; the proposed merger between Cigna and Anthem, Inc. ("Anthem") and litigation related thereto; statements regarding the timing of resolution of the issues raised by the Centers for Medicare and Medicaid Services ("CMS"); and other statements regarding Cigna's future beliefs, expectations, plans, intentions, financial condition or performance. You may identify forward-looking statements by the use of words such as "believe," "expect," "plan," "intend," "anticipate," "estimate," "predict," "potential," "may," "should," "will" or other words or expressions of similar meaning, although not all forward-looking statements contain such terms.

Forward-looking statements are subject to risks and uncertainties, both known and unknown, that could cause actual results to differ materially from those expressed or implied in forward-looking statements. Such risks and uncertainties include, but are not limited to: our ability to achieve our 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 and 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 including the CMS review and sanctions, investigations, actions and guaranty fund assessments; uncertainties surrounding participation in government-sponsored programs such as Medicare; the effectiveness and security of our information technology and other business systems; unfavorable industry, economic or political conditions including foreign currency movements; ongoing litigation with respect to the ruling of the District Court enjoining the merger, including the appeal of that ruling; potential adverse reactions or changes to business or employee relationships, including those resulting from the announcement of the ruling enjoining the merger; uncertainty as to litigation with respect to the termination of the merger agreement, the reverse termination fee, declaratory judgments with respect to the foregoing and/or contract and non-contract damages for claims filed against Anthem; the risk that a government entity or court of competent jurisdiction, in any litigation, arbitration or other forum, finds in any binding or non-binding decision that Cigna has not complied, in full or in part, with its obligations under the merger agreement or that Cigna is liable for any breach, willful or otherwise, of the merger agreement; uncertainty as to whether and, if so, when Anthem will pay the reverse termination fee; uncertainty as to litigation with respect to the suit initiated by Anthem against Cigna, including for contract and non-contract damages with respect to the transactions contemplated in the merger agreement; competitive responses to the ruling; the inability to retain key personnel; the timing and likelihood of completion of the proposed merger, including the timing, receipt and terms and conditions of any required governmental and regulatory approvals for the proposed merger that could reduce anticipated benefits or cause the parties to abandon the transaction; if the merger is consummated, the possibility that the expected synergies and value creation from the proposed merger will not be realized or will not be realized within the expected time period; if the merger is consummated, the risk that the businesses of Cigna and Anthem will not be integrated successfully; disruption from the proposed merger making it more difficult to maintain business and operational relationships; the risk that unexpected costs will be incurred; the possibility that the proposed merger does not close, including a failure to satisfy the closing conditions; the risk that financing for the proposed merger may not be available on favorable terms, as well as more specific risks and uncertainties discussed in Part I, Item 1A Risk Factors and Part II, Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations of this Form 10-K and as described from time to time in our future reports filed with the Securities and Exchange Commission (the "SEC") as well as the risks and uncertainties described in Anthem's most recent report on Form 10-K and subsequent reports filed with the SEC.

You should not place undue reliance on forward-looking statements that 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.

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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.

In an increasingly retail-oriented marketplace, we focus on delivering **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 continue the 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.

In particular, over the past several years, to achieve the goals of better health, affordability, localization and an improved experience for the customer, we have continued expanding our participation in collaborative care and other delivery arrangements with health care professionals across the care delivery spectrum, including large and small physician groups, specialist groups and hospitals. More recently, we have developed innovative tools and flexible provider arrangements that provide a truly personalized customer experience. These arrangements and tools are discussed in more detail in the "Global Health Care" section of this Annual Report on Form 10-K ("Form 10-K") beginning on page 3.

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

Global Health Care aggregates the Commercial and Government operating segments.

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. In this segment, we refer to employer or other groups as the "client" and the individual as the "customer." 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.

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The ***Government*** operating segment offers Medicare Advantage and Medicare Part D plans to seniors and Medicaid plans.

Global Supplemental Benefits offers supplemental health, life and accident insurance products 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.

Financial Results for the year ended and as of December 31, 2016 (in billions)

Consolidated basis:		**Consolidated basis:**	
Total revenues	$ 39.7	Shareholders' net income	$ 1.9
Operating revenues (1)	$ 39.5	Adjusted income from operations (1)	$ 2.1
Total assets	$ 59.4	Total shareholders' equity	$ 13.7
Reportable segments results (2):		**Reportable segments results (2):**	
Operating revenues (1)	$ 39.0	Adjusted income from operations (1)	$ 2.3

(1)

See page 36 for the definition of these metrics.

(2)

Global Health Care, Global Supplemental Benefits and Group Disability and Life segments

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.

Our revenues are derived principally from premiums on insured products, fees from self-insured products and services, mail-order pharmacy sales and investment income.

Proposed Merger with Anthem, Inc. ("Anthem")

On July 23, 2015, we entered into a definitive agreement to engage in a series of transactions to merge Cigna with Anthem, subject to certain terms, conditions and customary operating covenants, with Anthem continuing as the surviving company. At special shareholders' meetings in December 2015, Cigna shareholders approved the merger with Anthem and Anthem shareholders voted to approve the issuance of shares of Anthem common stock according to the merger agreement. Upon closing, our shareholders would receive $103.40 in cash and 0.5152 of a share of Anthem common stock for each common share of the Company.

Consummation of the merger is subject to certain customary conditions, including the receipt of certain necessary governmental and regulatory approvals, and the absence of a legal restraint prohibiting the consummation of the merger. On July 21, 2016, the U.S. Department of Justice ("DOJ") and certain state attorneys general filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia (the "District Court") seeking to block the merger and, on January 4, 2017, the parties concluded the District Court trial. On February 8, 2017, the District Court issued an order enjoining the proposed merger. Anthem appealed this ruling to the U.S. Court of Appeals for the District of Columbia Circuit (the "Appeals Court"). Cigna appealed following the Chancery Court decision described below, and oral arguments for the appeal are scheduled for March 24, 2017.

On February 14, 2017, Cigna delivered a notice to Anthem terminating the merger agreement and filed suit in the Delaware Court of Chancery (the "Chancery Court") seeking, among other things, declaratory judgment that Cigna's termination of the merger agreement is lawful and that Anthem does not have the right to extend the merger agreement termination date. Later that day, Anthem filed a lawsuit in the Chancery Court against us seeking, among other things, a temporary restraining order to enjoin Cigna from terminating the merger agreement, specific performance and damages, and, on February 15, 2017, the Chancery Court issued an order temporarily enjoining the Company from terminating the merger agreement. This order will be subject to further review at a preliminary injunction hearing.

See Notes 3 and 21 to the Consolidated Financial Statements in this Form 10-K for additional information about the proposed merger. See Item 1A. - Risk Factors in this Form 10-K for risks to our business due to the proposed merger.

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The Health Care Reform Act

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively referred to throughout this Form 10-K as the "Health Care Reform Act," "ACA" or "PPACA") continues to have a significant impact on our business operations. With the outcome of the U.S. elections in 2016, and the advent of the Trump Administration in January 2017, the future of the Health Care Reform Act is uncertain. The effects of the Health Care Reform Act 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 ("MD&A"), and the Notes to the Consolidated Financial Statements.

Other Information

The financial information included in this Form 10-K for the fiscal year ended December 31, 2016 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, 2016 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 115 of this Form 10-K for additional available information.

Global Health Care

Broad and deep portfolio of solutions across Commercial and Government operating segments

Committed to highest quality health outcomes and customer experiences

Differentiated physician engagement models emphasizing value over volume of services

Innovative solutions that deliver value for our customers, clients and partners

Technology powering actionable insights and affordable, personalized solutions

Talented and caring people embracing change and putting customers at the center of all we do

Medical	Pharmacy	Medicare Advantage	Administrative Services Only (ASO)

Stop Loss	Behavioral	Medicare Part D	Guaranteed Cost
Dental	Health Advocacy and Coaching	Medicaid	Experience Rated
Vision			

Collaborative Accountable Care Organizations	National	Insurance brokers and consultants
Independent Practice Associations	Middle Market	Sales representatives
CareAllies	Select	Cigna private exchange
Delivery System Alliances	Individual	3rd party private exchanges
Customer Engagement	Government	Public exchanges
	International	

We seek to differentiate ourselves in this business by providing innovative personalized and affordable health care solutions to our clients and customers. As a leader in the drive to transition the health care delivery system from volume-based reimbursements to a value orientation, our strategy is to accelerate our engagement with employers and individuals in order to: 1) increase our customers' involvement in their health care and 2) develop deep insights into customer needs. Our differentiated approach also targets selected geographies and market segments and, within those local markets, stronger relationships with health care providers that promote quality and affordability of care for our customers and clients.

Innovation is core to the way we do business. We seek new and innovative solutions through technology and physician engagement to drive efficiencies, as well as bring differentiated value to our customers. Product development in the following areas reflects our innovative approach: our industry-leading CDHP (consumer-directed health plan) offerings; the recently introduced Cigna One Guide® program that combines a state-of-the-art digital experience with a human concierge service; and the Cigna SureFit® network that allows individual family members to choose their personal care networks, consistent with their health needs and provider preferences.

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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.

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, Asia, Africa and Australia. We offer a variety of medical plans including:

Managed Care Plans including HMO, Network, Network Open Access and Open Access Plus. We offer health care services through insured and self-insured indemnity managed care benefit plans and Health Maintenance Organizations ("HMOs") 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. If a particular plan covers non-emergency services received from a non-participating health care provider, the customer's cost-sharing obligation is usually greater for the 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 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: Health Reimbursement Accounts ("HRA"), Health Savings Accounts ("HSA") and Flexible Spending Accounts ("FSA"). These Choice Fund products are designed to encourage customers to play an active role in understanding and managing their health and associated expenses. Customers can use these tax-advantaged accounts to finance eligible health care expenses and other approved services. In most cases, these products are combined with a high deductible medical plan. Over three million customers have chosen Choice Fund product solutions.

Cigna Connect is an individual plan offered in markets within eight states. The product is comprised of a network of health care providers in local areas who have been selected with cost and quality in mind. Customers who participate in the Connect network will receive care at Cigna's lower negotiated rates to help keep out-of-pocket costs down. Out-of-network coverage is not available except for urgent and emergent care.

Cigna Focus is an individual plan offered in one market. The product is comprised of a network of health care providers in the local area where members have direct access to providers, where no referrals or PCP selection is required. Out-of-network coverage is not available except for urgent and emergent care.

Approximately 90% of our commercial medical customers are enrolled in medical plans with either Administrative Services Only or Experience-Rated funding arrangements that allow the corporate client to directly benefit from lower medical costs.

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The funding arrangements available for our commercial medical and dental health plans are as follows:

Funding Arrangements and Descriptions: Commercial

		Administrative Services Only
		Plan sponsors self-fund all claims, but may purchase stop loss insurance to limit exposure.
		We collect fees from plan sponsors for providing access to our participating provider network and for other services and programs including: claims administration; behavioral health; disease management; utilization management; cost containment; dental; and pharmacy benefit management.
		In some cases, we provide performance guarantees that provide potential fee refunds if certain service standards, clinical outcomes or financial metrics are not met.
Insured	*Experience Rated ("Shared Returns")*	

Premium charged during a 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 credited for a portion of this premium.

However, if claims and expenses exceed the initial premium (an "experience deficit"), we bear these costs. In certain cases, experience deficits may be recovered through experience surpluses in a future year if the policyholder renews.

Insured Guaranteed Cost

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 similar policyholders.

HMO and individual plans (medical and dental) are offered on a guaranteed cost basis only. Individual and "small employer" (employers with 50 or fewer employees) plans are required to be community-rated under federal law.

In most states, individual and group insurance premium rates must be approved by the applicable state regulatory agency (typically department of insurance) and state or federal laws may restrict or limit the use of rating methods. Premium rates for groups and individuals are subject to state review for reasonableness. In addition, the Health Care Reform Act 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 the Health Care Reform Act.

Government Health Plans

Medicare Advantage

We offer Medicare Advantage plans in 17 states and the District of Columbia through our Cigna-HealthSpring brand. Under such a 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 "Star Ratings"). The Medicare Stars payment equals 5% per member risk-adjusted revenue added to the CMS payment for each contract that achieves four stars or higher. See the "Executive Overview" section of our MD&A beginning on page 36 of this Form 10-K for additional discussion of our Star ratings. 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. The Health Care Reform Act requires Medicare Advantage and Medicare Part D plans to meet a minimum MLR of 85%. If the MLR for a CMS contract

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is less than 85%, we are required to pay a rebate to CMS and could be required to make additional payments if the MLR continues to be less than 85% for successive years.

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. Eligible beneficiaries 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 receive revenue from the states of Texas and Illinois for our Medicaid only customers. For customers eligible for both Medicare and Medicaid ("dual eligibles") we receive revenue from both the state and CMS. All revenue is based on customer demographic data and actual customer health risk factors. Similar to Medicare Advantage, there are minimum MLR requirements in Illinois (85% for the dual product and 88% for the Medicaid only product). However, Texas utilizes an experience rebate in an effort to provide better value to consumers and increase transparency. The Texas experience rebate takes into account operating expenses and requires a rebate of dollars to the state as different profitability thresholds are met.

Specialty Products and Services

Our specialty products and services described below are designed to improve the quality of care, lower the cost and help customers achieve better health outcomes. Many 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

Stop Loss. We offer stop loss insurance coverage for self-insured plans that provides reimbursement for claims in excess of a predetermined amount for individuals ("specific"), the entire group ("aggregate"), or both.

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 and costs, including educating customers regarding the availability of lower cost, in-network services, negotiating discounts, reviewing provider bills, and recovering overpayments from other payers or health care providers. We charge fees for providing or arranging for these services.

Consumer Health Engagement. We offer a wide array of medical management, disease management, and wellness 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 *Medical Management* programs include case management, specialty case management and utilization management including a 24-hour nurse information line. Our *Health Advocacy* programs and services include early intervention in the treatment of chronic conditions (such as Asthma, Diabetes, etc.). We also offer a combination of online tools and education programs to help customers manage their health and an array of health and wellness coaching to address lifestyle management issues (such as stress, weight, and tobacco cessation) and other conditions (such as Hypertension, Hyperlipidemia, Pre-Diabetes, etc.). We also administer incentives to motivate customers to engage in and improve their health.

Pharmacy Management

We offer prescription drug plans to our commercial and government customers both in conjunction with our medical products and on a stand-alone basis. With a network of over 68,000 pharmacies, Cigna Pharmacy Management is a comprehensive pharmacy benefits manager ("PBM") offering clinical 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 may benefit from continuity of care, integrated reporting, and meaningful unit cost discounts on specialty drugs.

Behavioral Health

We arrange for behavioral health care services for customers through our network of approximately 108,700 participating behavioral health care professionals and 13,900 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.

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Dental

We offer a variety of insured and self-insured dental care products including dental health maintenance organization plans ("Dental HMO") in 36 states, dental preferred provider organization ("Dental PPO") plans in 49 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.

Cigna has partnered with a healthcare technology company, to launch an online consumer engagement tool for Dental PPO customers in 2016. This enhancement allows Cigna Dental PPO customers to schedule appointments online, compare out-of-pocket costs across multiple dentists, and access information that evaluates the dentist's professional history, affordability, and service quality.

As of December 31, 2016, our dental customers totaled 15 million worldwide and approximately 65% are enrolled in plans with funding arrangements that allow the corporate client to directly benefit from lower dental costs. Our U.S. customers access care from one of the largest Dental PPO networks and Dental HMO networks, with approximately 142,700 Dental PPO and 19,800 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 84,000 health care providers in over 26,200 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 17 service centers that together in 2016 processed approximately 163 million medical claims and handled 32.5 million calls providing our customers service 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 1.5 million customers around the world. We service them from nine globally deployed service centers that are also available 24 hours a day, 365 days a year.

Technology

Cigna Technology supports the Go Deep, Go Global, Go Individual strategy by focusing on strong foundational services, executing on an aligned business portfolio and targeting innovation and digital enhancements in key differentiating areas. Paramount to our global information technology strategy is supporting the imperatives of affordability, personalization and localization. Our goal is a continued focus on targeted technology investments to enable our strategic business objectives. This is accomplished by delivering innovative technology that enables more efficient operations, improves process integrity, builds stronger relationships with our key stakeholders; optimizes our economies of scale; and maximizes delivery of flexible payment arrangements, innovative products and services and intelligent analytics to support evidence-based medicine. Through continued execution of these capabilities, we are able to better and more rapidly deliver market-differentiating and innovative solutions.

Our approach to innovation is based on three major pillars: 1) **organic development** that creates new capabilities through internal research and development; 2) **venture partnerships/early-stage investments** where we are working with other external stakeholders; and 3) **client-centric prototyping** that develops solutions directly with clients to address specific needs. This approach to innovation has fueled our ability to rapidly innovate and bring to market solutions that differentiate us from competitors. This has resulted in an increased number of solutions that improve affordability, increase patient access and optimize the consumer experience. Examples include capabilities such as Cigna Virtual Health, first launched in the United Kingdom as the first totally digital virtual care team to Cigna One Guide® that simplifies and streamlines the entire customer experience in a highly personalized manner. Cigna has launched a growing portfolio that leverages emerging technologies such as artificial intelligence based predictive analytics, augmented reality and virtual reality, social experiences and gamification. Innovation is core to the way we do business and we continuously seek opportunities to drive efficiencies and create a superior customer experience through technology.

Data Analytics

Cigna has transformed substantial investments in analytics talent, data infrastructure, and machine learning capabilities over the past several years into a closed loop, self-learning insights system that guides our decision making and executing on our strategy. Our Insights That Matter analytics process helps our business leaders identify the questions that matter most to our customers and partners. We focus our data science experts on answering those questions with innovative methodologies and transform our insights into targeted business actions.

Cigna is using advanced analytic capabilities throughout all facets of the business to:

Identify and quantify the financial and clinical cost of discrete health opportunities and insights into how to best engage individual customers (e.g., digitally, phone, physician based). We convert these insights into a Health Matters Score that is used to connect each customer to the right clinical services and drive better clinical, financial, and quality outcomes.

Enable customized service experiences. In our pharmacy business we are proactively offering our customers value added pharmacy and medical services during inbound customer calls, realizing the value of an integrated medical and pharmacy offering. To maximize impact, we apply our proprietary Customer Segmentation models to tailor customer communications to make interactions more meaningful.

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Build a deep understanding of risk adjusted total cost and quality performance metrics at the individual physician level and aggregate market level to develop relative benchmarks. This data is being used to fuel our drive to fee for value physician reimbursements and flexible provider networks.

Leverage advanced analytic models and tools to better identify prospects that best align with Cigna's mission and value proposition for our client engagement team.

Going forward, we view insights as a strategic imperative and will continue to heavily invest in expanding and strengthening our capabilities to meet and exceed our customer and partner expectations.

Quality Health Care

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

Health Improvement through Engaging Providers and Customers

Cigna improves health outcomes and reduces health care costs by engaging our customers in their health, connecting them with value-oriented providers, and improving how care is delivered and reimbursed. We are focused on executing our Connected Care strategy that engages both providers and customers, optimizing their interactions to drive better health, affordability, and experience. Cigna is committed to developing innovative solutions that span the health care delivery system and can be applied to different types of providers. Currently we have numerous collaborative arrangements with our participating health care providers and are actively developing new arrangements to support our Connected Care strategy. The key principles that guide our innovative solutions include:

Improving access to care at the local market level,

Collaborating with and supporting providers in their evolution to value-based care,

Leveraging actionable patient information, enhancing the patient experience,

Improving affordability and

Shifting reimbursement mechanisms to those that reward quality medical outcomes.

We continue to increase our engagement with physicians and hospitals by rapidly developing the types of arrangements discussed below. Over two million medical customers are currently serviced by more than 95,000 health care providers in these types of arrangements.

Cigna Collaborative Care.

Collaborative Accountable Care ("CAC") currently we have approximately 170 collaborative care arrangements with large primary care groups built on the patient-centered medical home and accountable care organization ("ACO") models. Our CAC arrangements span 30 states and reach 1.9 million customers and we are committed to increasing the number of CACs over the next several years. Our goal is to reach approximately 190 of these programs in 2017.

Hospital Quality Incentive Program compensation paid to approximately 390 hospitals is tied to quality metrics and we expect to reach approximately 450 hospitals by the end of 2017.

Specialty Care Collaboration Program we continue to develop arrangements with specialists including programs such as National Obstetrics/Gynecology and our program to reimburse providers for individual "episodes of care" (services performed to treat a specific medical condition).

Independent Practice Associations are innovative physician engagement models in our Cigna-HealthSpring business that allow the physician groups to 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.

CareAllies. On June 9, 2016, we announced the formation of CareAllies, the new U.S. based population health company focused on helping physicians manage the health of their patients and improve their health outcomes. CareAllies will partner with physicians, provider groups and health systems to develop customized solutions that help them meet their goals across all patients and all payers.

Delivery System Alliances. Cigna is collaborating with select health care delivery systems to develop compelling and unique strategic relationships focused on addressing the local market's unique health care needs. This includes jointly developed products designed to improve the experience of Cigna customers by offering integrated health care and providing access to quality, value-based care in local communities.

Customer Engagement Products Cigna One Guide®. Cigna is also delivering a personalized experience to help our customers navigate the complex health care system and make important health care choices. Starting January 1, 2017, 1.2 million Cigna commercial health plan customers will receive Cigna One Guide® access to guided consultations via phone, mobile app and "Click-to-Chat" for choosing their benefits, building a personal health team of doctors, clinicians and coaches and reducing their health expenses through reward programs.

In the international healthcare business we use the Net Promoter Score (NPS) approach to continually gather insights from customers and healthcare professionals around the world and to guide how we proactively enhance product and service offerings.

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

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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 74 markets across the U.S., is a subset of participating specialist physicians designated based on specific clinical quality and cost-efficiency criteria. Customers in Cigna Care Network® plans 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 locally-tailored network of select health care providers and facilities designed to provide cost-effective and quality care. It links multiple local networks across geographic markets to provide consistency for both employers and the customers. LocalPlus is available in 18 markets as of the end of 2016 and will be available in 21 markets by the end of 2017.

Cigna SureFit® is a local network built around particular health care delivery systems with a focus on the dynamics of local market care delivery. It is designed to deliver maximum value in a particular market. Cigna SureFit® is available in three U.S. Commercial markets in 2017, and will be available in 11 markets in 2018.

Medical Care and Onsite Services

Cigna Medical Group is a multi-specialty medical group practice that delivers primary care and certain specialty care services through 20 medical facilities and 156 clinicians in Phoenix, Arizona. These health care centers have received the highest accreditation (level 3) from the National Committee for Quality Assurance ("NCQA").

LivingWell Health Centers by HealthSpring®. Medicare Advantage customers may receive care from one of our four free-standing clinics and eight "embedded" clinics that incorporate the principles and resources of stand-alone clinics while allowing the customer access to their primary care physician.

Cigna Onsite Health provides employer-based onsite or nearby health centers and health and wellness coaches with nearly 52 health centers and 142 health coaches. Care delivery services include acute, episodic care, primary care, health and wellness coaching programs and biometric screenings. Virtual Health care services are also available to help extend access to care for both coaching and treatment services.

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 maintained Health Plan accreditation from the NCQA in 37 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, Pharmacy Benefit Management and Specialty Pharmacy 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.

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 offer primarily ASO funding solutions in this market segment.	23%
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 and Taft-Hartley plans and other groups. We offer ASO, experience-rated and guaranteed cost insured funding solutions in this market segment.	53%
Select	Employers generally with 51-249 eligible employees. We offer ASO (often with stop-loss insurance coverage) and guaranteed cost insured funding solutions in this market segment.	9%
Individual	Individuals in thirteen states for 2016: Arizona, California, Colorado, Connecticut, Florida, Georgia, North Carolina, Maryland, Missouri, New Jersey, South Carolina, Tennessee and Texas. In 2016, we offered coverage on seven public health insurance exchanges (Arizona, Colorado, Georgia, Maryland, Missouri, Tennessee and Texas). In 2017, we offer plans in fifteen states. We have plans on public health insurance exchanges in seven states (Colorado, Illinois, Maryland, Missouri, North Carolina, Tennessee, and Virginia) and off-exchange in eight states (Arizona, California, Connecticut, Florida, Georgia, New Jersey, South Carolina, and Texas). Consistent with the regulations for Individual PPACA compliant plans, we offer plans only on a guaranteed cost basis in this market segment.	1%
Government	Individuals who are post-65 retirees, as well as employer group sponsored pre- and post-65 retirees. We offer Medicare Advantage, Prescription Drug programs, and Medicaid products in this market segment including dual-eligible members who receive both Medicare and Medicaid benefits.	4%
International	Local and multinational companies and inter-governmental organizations and their local and globally-mobile employees and dependents working or travelling in more than 190 countries and jurisdictions. We offer guaranteed cost, experience-rated insured and ASO funding solutions in this market segment.	10%

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Cigna Guided Solutions® is Cigna's benefit administration and private exchange solution that targets clients who value fully integrated solutions and focus on engaging employees in their benefit offering. It leverages Cigna's ability to provide a fully integrated solution with our broad spectrum of products, benefit plans, services, and full suite of funding options focused on improving total cost, health, and productivity. Through Cigna Guided Solutions®, employers enjoy simplified administration and the convenience of single source purchasing while employees receive more choice via an easy-to-use shopping experience and year round engagement. Together with integrated robust decision-support tools, employees are able to make personalized decisions to select the right benefit offering and get the most value from their plans.

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.

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 access to our national participating provider network, utilization review services, behavioral health care and pharmacy management services, and employee assistance services directly to insurance companies, HMOs and third party administrators. As of December 31, 2016, our field sales force consisted of over 1,300 sales representatives in 124 field locations. In our Government 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

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 overall health care industry (including hospitals, pharmaceutical companies, and providers of medical technology and devices) given the current economic and political environment. We also expect continued vertical integration with the lines blurring between clinicians, hospitals and traditional insurers.

Competition in the health care market exists both for employers and other groups sponsoring plans and for employees in those instances where the employer offers a choice of products from more than one health care company. Most group policies are subject to annual review by the plan sponsor, who may seek competitive quotations prior to renewal. In 2017, product offerings are decreasing in certain individual markets due to volatility in the industry as some carriers have exited markets. With the results of the 2016 U.S. elections, it is likely that changes will occur in the future to the Health Care Reform Act. Given that the relatively immature individual market has not yet reached profitability for most carriers, we expect some uncertainty and competitive volatility to continue.

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 primary competitors in our U.S.-based health care businesses include:

- Other national insurance and health services companies that provide group health and life insurance products, including Aetna, Anthem, Humana, Kaiser Permanente and UnitedHealth Group;
- Not for profit managed care organizations;
- Other regional stand-alone managed care and specialty companies;

Managed care organizations affiliated with major insurance companies and hospitals; and

National managed pharmacy, behavioral health and utilization review services companies.

Our primary competitors in the international health care business include U.S.-based insurers such as Aetna, UnitedHealth Group and MetLife; global competitors such as BUPA and Allianz; and local insurers in a range of countries.

In addition to our traditional competitors, new competitors are emerging. 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.

Industry Developments

The health insurance marketplace will continue to be shaped by the Health Care Reform Act over the near term; however, its future remains uncertain given the outcome of the 2016 U.S. elections. Although we anticipate changes in the regulation of the health insurance markets over the next several years as Congress and the Trump administration consider repeal and replacement of the Health Care Reform Act, the nature of those changes remains largely unknown at this time. See the "Regulation" and "Risk Factors" sections of the Form 10-K for additional discussion about these developments.

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Global Supplemental Benefits

Leveraging **deep consumer insights** to drive product innovation

Targeting the **growing middle class and seniors populations globally**

Easy to understand, affordable products designed to fill gaps in either private or public coverage

Leading **innovative, direct to consumer distribution capabilities** (approximately 140 affinity partners)

Locally licensed and **managed by strong, locally developed talent**

Hospitalization	Asia: South Korea, China, Taiwan, Indonesia and India	Telemarketing
Dental	Europe: UK and Turkey	Home Shopping & Direct Response Television
Medicare Supplement	United States	Independent agents
Critical Illness		Bancassurance
Personal Accident		Internet
Term or Variable Universal Life		

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.

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.

Most of the businesses in this segment operate through foreign subsidiaries. We maintain a capital management strategy to retain overseas a significant portion of the earnings from these foreign operations. These undistributed earnings are deployed outside of the United States in support of the liquidity and capital requirements of our foreign operations. As a result, the effective tax rate for Global Supplemental Benefits reflects income tax expense that is generally lower than in the United States.

A global approach to underwriting risk management allows each local business to underwrite and accept risk within specified limits. Retentions are centrally managed through cost effective use of external reinsurance to limit our liability on 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 (when 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 and agents. Our Medicare supplement product line is distributed primarily through independent agents and telemarketing directly to the consumer.

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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 51 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 regionally-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 3% 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.

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

Disability absence management model that reduces overall costs to employers

Integration of disability products **with medical and specialty offerings**, promoting health and wellness and optimizing employee productivity

Complementary portfolio of group disability, life and accident offerings

Disciplined underwriting, pricing and investment strategies supporting profitable long-term growth

Short-term disability	Group universal life	Insurance brokers and consultants
Long-term disability	Personal and voluntary accident	Sales representatives
Leave administration	Business travel accident	
Basic-term life	Critical illness, Accidental injury and Hospital care	
Voluntary term life		
		National
		Middle Market
		Select

Our Group Disability and Life business markets its products and services in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Canada.

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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 the administration of 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 longer in duration or chronic 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 2016 premiums and fees, disability constituted 50% of this segment's business. Approximately 15,300 insured disability policies covering approximately 8.5 million lives were in force as of December 31, 2016.

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 2016 premiums and fees, group life insurance constituted approximately 44% of this segment's business. Approximately 10,800 group life insurance policies covering over 7 million lives were in force as of December 31, 2016.

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. In recent years, we have brought to market three additional voluntary offerings accidental injury insurance, critical illness coverage and hospital care. These 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 premiums for these products are typically collected within the coverage year and then invested in assets that match the duration of the expected benefit payments that occur over many future years (primarily for disability benefits). With significant investments in longer-duration securities, net investment income is a critical element of profitability for this segment.

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, as well as our newer accidental injury and critical illness policies, we purchase reinsurance from a diverse group of unaffiliated reinsurers. Our comprehensive

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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 260 sales professionals in 27 office locations as of December 31, 2016.

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, is also 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 and include Aetna, Unum, The Hartford, Prudential and MetLife. As of December 31, 2016, 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 tools for employers and employees to improve health status. This focus on managing the employee's total absence enables us to increase the number and effectiveness 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 recently been subject to such an examination. See Note 21 to the Consolidated Financial Statements for additional information.

The depressed level of interest rates in the United States over the last several years has constrained earnings growth in this segment due to lower yields on our fixed-income investments, and higher benefit expenses resulting from the discounting of future claim payments at lower interest rates.

Other Operations

Other Operations includes the following four businesses:

Corporate-owned Life Insurance

The principal products of the COLI business are permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for 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 Settlement Annuity Business

Our settlement annuity business is a closed, run-off block of single premium annuity contracts. These contracts are primarily liability settlements with approximately 20% of the liabilities associated with 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.

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Run-off Reinsurance

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

In February 2013, we effectively exited the guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("GMIB") business by reinsuring 100% of our future exposures, net of retrocessional arrangements in place at that time, up to a specified limit. For additional information regarding this reinsurance transaction and the arrangements that secure our reinsurance recoverables, see Note 9 to the Consolidated Financial Statements.

Individual Life Insurance and Annuity and Retirement Benefits Businesses

This business includes deferred gains recognized from the 1998 sale of the individual life insurance and annuity business and the 2004 sale of the retirement benefits business. For more information regarding the arrangements that secure our reinsurance recoverables for the retirement benefits business, see Note 9 to the Consolidated Financial Statements.

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 adjusted income from operations for each of our reporting segments and Corporate. Realized investment gains (losses) are reported by segment but excluded from adjusted income from operations. For additional information about invested assets, see the "Investment Assets" section of the MD&A beginning on page 53 and Notes 10 to 12 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 property-specific information.

Separate Accounts

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

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.

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, payment and appeals;

underwriting practices;

reinsurance arrangements;

solvency and financial reporting;

unfair trade and claim practices;

market conduct;

protecting the privacy and confidentiality of the information received from customers;

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- 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).

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, CMS and comparable international regulators 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, federal and international 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.

Our international subsidiaries are subject to regulations in international jurisdictions where foreign insurers may be faced with more onerous regulations than their domestic competitors. 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 19 for further discussion of international regulations.

The Health Care Reform Act

The Health Care Reform Act mandated 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. As a result of the 2016 U.S. elections, the future of the Health Care Reform Act is uncertain. Certain provisions of the Health Care Reform Act are likely to be retained, while others are likely to be repealed or replaced.

Key Provisions of the Health Care Reform Act

Various fees, including the health insurance industry tax and the reinsurance fee, were assessed beginning in 2014. The health insurance industry assessment, totaling $11.3 billion for the industry in 2016 and increasing to $14.3 billion by 2018, is not tax deductible. In December 2015, the federal appropriations legislation imposed a one-year moratorium on the industry tax for 2017, with reinstatement expected in 2018. 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 either on or off the exchanges are guaranteed to be issued a policy, the Health Care Reform Act provided 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 ("risk corridor"), and a permanent program that adjusts premiums based on the relative health status of the customer base ("risk adjustment"). 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.

MLR requirements, as prescribed by HHS, 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 Act requirements for expatriate health coverage (including the MLR requirements).

Other provisions of the Health Care Reform Act 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. The employer mandate, the phase in of which was complete in 2016, requires employers with 50 or more full-time employees to offer affordable health insurance that provides minimum value (each as defined under the Health Care Reform Act) to full-time employees and dependent children up to age 26 or be subject to penalties based on employer size. The Health Care Reform Act 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 the Health Care Reform Act in a variety of additional ways, 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 of 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. The Health Care Reform Act 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 required to make additional payments if the MLR continues to be less than 85% for successive years. Through the Health Care Reform Act and other federal legislation, funding for Medicare Advantage plans has been and may continue to be altered.

We have implemented the provisions of the Health Care Reform Act currently in effect. Management continues to be actively engaged with regulators and policymakers with respect to rule-making. However, ongoing legislative and regulatory challenges to the Health Care Reform

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Act, pending litigation challenging aspects of the law, the change in administration and the Congress following the 2016 U.S. elections will continue to create uncertainty about the ultimate impact of the Health Care Reform Act. Additionally, the executive order signed by President Trump in January 2017, which instructs agencies to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Health Care Reform Act that would impose a fiscal burden on any state or a cost, fee, tax, penalty, or regulatory burden on individuals, providers, insurers, recipients of healthcare services, purchasers of health insurers or makers of medical devices, products or medications, will create additional uncertainty.

For the financial effects of certain Health Care Reform Act provisions, see the "Executive Overview" section of our MD&A beginning on page 36 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. Many states have expanded regulations relating to corporate governance and internal control activities of insurance and HMO subsidiaries as a result of model regulations adopted by the National Association of Insurance Commissioners ("NAIC") with elements similar to corporate governance and risk oversight disclosure requirements under federal securities laws.

Guaranty Associations, Indemnity Funds, Risk Pools and Administrative Funds

Most states and certain non-U.S. jurisdictions require insurance companies to support guaranty associations or indemnity funds that are established to pay claims on behalf of insolvent insurance companies. In the United States, these associations levy assessments on member insurers licensed in a particular state to pay such claims. Certain states require HMOs to participate in guaranty funds, special risk pools and administrative funds. For additional information about guaranty fund and other assessments, see Note 21 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 the Health Care Reform Act.

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. Our HMOs and life and health insurance subsidiaries, as well as non-U.S. insurance subsidiaries, are compliant with applicable RBC and non-U.S. surplus rules.

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

Holding Company Laws

Our domestic insurance companies and certain of our HMOs are subject to state laws regulating subsidiaries of insurance holding companies. Under such laws, certain dividends, distributions and other transactions between an insurance company or an HMO subsidiary and its affiliates may require notification to, or approval by, one or more state insurance commissioners. In addition, the holding company acts of states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO subsidiary without prior regulatory approval.

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, U.S. Food and Drug Administration requirements and third party accreditation

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requirements. Other laws and regulations affecting our pharmacy-subsidiaries include federal and state laws concerning labeling, packaging, advertising, handling 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, as well as third party accreditation requirements.

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.

Other Federal and State 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 the Health Care Reform Act 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 will continue to be subject to court interpretation.

Medicare and Medicaid Regulations

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

- those offering individual and group Medicare Advantage coverage; and
- those offering Medicare Pharmacy (Part D) products.

In our Medicare Advantage and Medicare Part D business, we contract with CMS to provide services to Medicare beneficiaries. As a result, our ability to obtain payment (and the determination of the amount of such payments), 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 will continue to allocate significant resources to our compliance, ethics and fraud and waste and abuse programs to comply with the laws and regulations governing Medicare Advantage and Medicare Part D programs.

The Health Care Reform Act ties a portion of each Medicare Advantage plan's and Medicare Part D plan's reimbursement to the plan's "Star Rating" by CMS, with those plans receiving a rating of four or more stars eligible for quality-based bonus payments. The Star Rating system considers various measures adopted by CMS, including, for example, quality of care, preventative services, chronic illness management, coverage appeals and customer satisfaction.

Our Medicaid and dual eligible products are also regulated by CMS and state Medicaid agencies that audit our performance to determine compliance with contracts and regulations. We continue to work in collaboration with applicable state agencies regarding our Medicaid plans in

Texas and Illinois to ensure ongoing compliance and sustainability.

Several of our subsidiaries are also subject to reporting requirements pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007, that requires us to report specific information regarding claimants and claim settlements involving Medicare participants so CMS can recover Medicare funds expended to provide healthcare treatment to the claimant. Strict sanctions, including fines and penalties, exclusion from the Medicare and Medicaid programs and criminal penalties may be imposed for non-compliance with these reporting obligations.

Federal and State Audits of Government Sponsored Health Care Programs

Participation in government sponsored health care programs subjects us to a variety of federal and state laws and regulations and risks associated with audits conducted under these programs. These audits may occur in years subsequent to our providing the relevant services. These risks may include reimbursement claims as well as potential fines and penalties, such as restrictions on our ability to participate or expand our presence in certain programs. For example, with respect to our Medicare Advantage business, CMS and the 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") 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. In addition, negative performance points may be accumulated if we do not perform satisfactorily during an audit that could restrict our ability to expand our Medicare Advantage business geographically.

In January 2016, following an audit, CMS issued a Notice of Imposition of Immediate Intermediate Sanctions (the "Notice") to the Company. The Notice required us to suspend certain enrollment and marketing activities for Medicare Advantage-Prescription Drug and Medicare Part D Plans. The sanctions do not impact the right of current enrollees to remain covered by our Medicare Advantage-Prescription Drug or Medicare Part D Plans. We are working with CMS to address the audit findings as quickly as possible. See "Business Global Health Care" beginning on page 3 of this Form 10-K for additional information about our participation in government health-related programs.

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The federal government has made investigating and prosecuting health care fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for inducement to refer customers, billing for unnecessary medical services, coding, network adequacy, 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 and judicial interpretation. 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.

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. In addition, international laws, rules and regulations governing the use and disclosure of personal information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction.

Consumer Protection Laws

We engage in direct-to-consumer activities and are increasingly offering mobile and web-based solutions to our customers. We are therefore subject to federal and state regulations applicable to electronic communications and other consumer protection laws and regulations, such as the Telephone Consumer Protection Act and the CAN-SPAM Act. In particular, the Federal Trade Commission is increasingly exercising its enforcement authority in the areas of consumer privacy and data security, with a focus on web-based, mobile data and "big data."

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. In February 2017, President Trump signed an executive order directing the Secretary of the Treasury to conduct a review of the Dodd-Frank Act. We continue to monitor how these regulations might impact us.

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 that 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.

Antitrust Regulations

Federal and state antitrust regulators, such as the Department of Justice and certain state attorneys general, have opposed the proposed merger with Anthem. See Notes 3 and 21 to the Consolidated Financial Statements in this Form 10-K for additional information about the proposed merger. In addition, our subsidiaries also engage in activities that may be scrutinized under federal and state antitrust laws and regulations. These activities include the administration of strategic alliances with competitors, information sharing with competitors and provider contracting.

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, intellectual property, 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.

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Our operations in countries outside the United States:

- are subject to local regulations of the jurisdictions where customers reside,
- 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. Outside of the United States, we may interact with government officials in several different capacities: as regulators of our insurance business; as clients or partners who are state-owned or partially state-owned; as health care professionals who are employed by the government; and as hospitals that are state-owned. 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 21 for a discussion of risks related to our global operations.

Miscellaneous

Premiums and fees from CMS represented 20% of our total consolidated revenues for the year ended December 31, 2016 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 2016. 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 41,000 employees as of December 31, 2016; 39,300 employees as of December 31, 2015; and 37,200 employees as of December 31, 2014.

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

Strategic and Operational Risks

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

The future performance of our business will depend in large part on our ability to effectively implement and execute our strategic and operational initiatives 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. Successfully executing on 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 managing the uncertainties associated with mix and volume of business on 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;

attract new and maintain existing customer relationships;

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

manage our Global Health Care operating expense ratio effectively.

If these initiatives fail or are not executed on effectively, our consolidated financial position and results of operations could be negatively affected. 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 and/or services. 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 along with 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.

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 customers.

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. Increasingly, our clients seek to negotiate performance guarantees that require us to pay penalties if the guaranteed performance standard is not met. As brokers and benefit consultants seek to enhance their revenue streams, they look to take on services that we typically provide. Alternatively, our clients and customers may purchase different types of products that are less profitable, or move to a competitor to obtain more favorable pricing. 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, the Health Care Reform Act includes an annual rate review requirement to prohibit unreasonable rate increases in the individual and small group health insurance markets and established minimum medical loss ratios for certain plans. 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

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ITEM 1A. Risk Factors

levels, or a significant loss of customers 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 customers as planned, and avoid losing accounts with favorable medical cost experience while retaining or increasing our customer base in accounts with unfavorable medical cost experience.

Premiums in the health care business are generally set for one-year periods and are priced well in advance of the date on which the contract commences. Our revenue on Medicare policies is based on bids submitted mid-year in the year before the contract year. Although we base the premiums we charge and our Medicare bids on our estimate of future health care costs over the contract 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 drugs, treatments and technology, and customer 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 customers' health care utilization patterns and provider billing practices. Our profitability depends, in part, on our ability to accurately predict, price for and effectively manage future health care costs through disciplined underwriting, provider contracting, utilization management and product design.

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

We maintain and record medical claims reserves on our balance sheet for estimated future payments. Our estimates of health care costs payable are based on a number of factors, including historical claim experience, but this estimation process requires extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, changes in customer base and product mix, changes in the utilization of medical and/or other covered services, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited. In addition, 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.

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 directly and indirectly contract with physicians, hospitals and other health care professionals and facilities to provide health care services to our customers. Our results of operations are substantially dependent on our ability to contract for these services at competitive prices. In any particular market, physicians, hospitals and health 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. The formation and success of collaborative arrangements with physician groups, specialist groups, hospital arrangements and delivery system joint ventures are key to our strategic focus to transition from volume-based fee-for-service arrangements to a value-based health care system. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow our customer base, and our ability to profitably grow our business and/or our operating results may be 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 exacerbate the cost shift to private payors, thereby adversely impacting 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, emergence of accountable care organizations and other changes in the organizational structures chosen by physicians, hospitals and health care providers 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 and adversely affect our strategy or prospects.

Out-of-network providers are not limited in the amount they bill by any agreement with us. While benefit plans place limits on the amount of charges that will be considered for reimbursement, out-of-network providers have become increasingly sophisticated and aggressive and such

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limitations can be difficult to enforce. As a result, the outcome of disputes where we do not have a provider contract may cause us to pay higher medical or other benefit costs than we projected.

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 can vary substantially by market, and include political, legal, operational, regulatory, economic and other risks, including government intervention that we do not face in our U.S. operations. The global nature of our business and operations may present challenges including, but not limited to, those arising from:

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 may not be effective in reducing the effect of volatile currencies and other risks of our international operations;

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;

providing data protection on a global basis and sufficient levels of technical support in different locations;

the global trend for companies to enact local data residency requirements;

political change, including the June 2016 referendum in the United Kingdom to leave the European Union and the results of the November 2016 U.S. elections;

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 our international 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, data protection and data residency. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant reputational harm. 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 challenges. Our failure to comply with laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could have a material adverse effect on our business, results of operations, financial condition, liquidity and long-term growth.

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

To improve operating costs, productivity and efficiencies, we contract with third parties for the provision of specific services, such as certain pharmacy benefit management services, information technology, medical management services, call center and claim services. Our operations may be adversely affected if these third parties fail to satisfy their obligations to us or if the arrangement is terminated in whole or in part 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 services or functions outsourced 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 service providers and/or redistribute responsibilities to realize the potential productivity and operational efficiencies. If there are delays or difficulties in changing

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business processes or our third party vendors do not perform as expected, we may not realize, or not realize on a timely basis, the anticipated economic and other benefits of these relationships. This could result in 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 in services, we may not be able to meet the demands of our customers and, in turn, our business and results of operations could be adversely impacted.

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, licensing arrangements 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 regulations 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 that 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 cause increasing complexity in our systems and internal controls and make them more difficult to manage. Any difficulties in assimilating businesses into our control system could cause us to fail to meet our financial reporting obligations. Ineffective internal controls also could cause investors to lose confidence in our reported financial information that 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 our 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. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies including more sophisticated applications for mobile devices. 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. Connectivity among technologies is becoming increasingly important. The failure of our health care technologies to operate seamlessly with other products could adversely affect our results of operations, financial position and cash flows. We must also develop new systems to meet current market standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and customer needs. Failure to do so may present compliance challenges and impede our ability to deliver services 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.

As a large health services company, we are 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 or malware, programming errors, attacks by third

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parties or similar disruptive problems. We have been, and will likely continue to be, the target of computer viruses or other malicious codes, unauthorized access, cyber-attacks or other computer-related penetrations. As we increase the amount of personal information that we store and share digitally, our exposure to data security and related cybersecurity risks increases including the risk of undetected attacks, damage, loss or unauthorized access or misappropriation of proprietary or personal information, and the cost of attempting to protect against these risks also increases. 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. The techniques used change frequently or are often not recognized until launched, because cyber-attacks can originate from a wide variety of sources including third parties such as external service providers. Those parties may also attempt to fraudulently induce employees, customers or other users of our systems to disclose sensitive information in order to gain access to our data or that of our customers. In addition, while we have certain standards for all vendors that provide us services, our vendors, and in turn, their own service providers, may become subject to a security breach as a result of their failure to perform in accordance with contractual arrangements.

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

In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers or other third-parties could expose our customers' private information and our customers to the risk of financial or medical identity theft. Unauthorized dissemination of confidential and proprietary information about our business and strategy also could negatively affect the achievement of our strategic initiatives. Such events would also negatively affect our ability to compete, others' trust in us, our reputation, customer base and revenues and 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.

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 arrangement with a third-party vendor for certain pharmacy benefit management services, we remain responsible to regulators and our clients and customers for the delivery of those pharmacy benefit management services that we contract to provide. This business is subject to federal and state regulation, including without limitation, 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 state and federal laws concerning labeling, packaging, advertising, handling and adulteration of prescription drugs and dispensing of controlled substances. Noncompliance with applicable regulations by us or our third-party vendor(s) 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 liability exposure 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 Government 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, liquidity and reputation.

Legal and Compliance Risks

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

Our business is regulated at the federal, state, local and international levels. The laws and rules governing our business and related interpretations, including, among others, those associated with the Health Care Reform Act, 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.

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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 clients 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 reporting or administrative 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 have occurred in the health care system as a result of the Health Care Reform Act. Substantially all of the key provisions of the Health Care Reform Act are now effective. While federal agencies have published interim and final regulations with respect to certain requirements, many issues remain uncertain.

The new Trump Administration and the U.S. Congress may seek to modify, repeal or replace all or part of this health care reform legislation. These efforts began when President Trump signed an executive order in January 2017 that instructs agencies to waive, defer, grant exemptions from, or delay the implementation of any provision of the Health Care Reform Act that poses a financial burden. As a result, it is difficult to predict the continuing impact of the Health Care Reform Act on our business. In addition, the continuing development of implementing regulations and interpretive guidance and legal challenges has contributed to this uncertainty. We are unable to predict how these events will develop and what impact they will have on the Health Care Reform Act, and in turn, on our business including, but not limited to, our products, services, processes and technology and on our relationships with current and future customers, producers and health care providers.

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 the Health Care Reform Act 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 specific state laws and regulations and indirectly affected by other health care-related laws and regulations. State regulations mandate minimum capital or restricted cash reserve requirements. In

addition, state guaranty fund laws and related regulations subject us to assessments for certain obligations to policyholders and claimants of impaired or insolvent insurance companies (including state insurance cooperatives). Any such assessment could expose our insurance entities and other insurers to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty association assessments. We also participate in the private exchange marketplace. Whether 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 is also regularly subject to negative media attention, including as a result of the political environment and the ongoing debate concerning the Health Care Reform Act. 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 the Health Care Reform Act's minimum medical loss ratio and customer rebate requirements in the "Business Global Health Care" section beginning on page 3 of this Form 10-K.

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 the Health Care Reform Act, compliance with government contracts and increased regulatory oversight.

Through our Government 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 regulatory reform initiatives, including the Health Care Reform Act. The premium rates paid to Medicare Advantage plans and Medicare Part D plans are established by contract, although the rates differ depending on a combination of

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factors, many of which are outside our control. The Health Care Reform Act ties a portion of each Medicare Advantage plan's and Medicare Part D plan's reimbursement to the plan's "Star Rating" by CMS, with those plans receiving a rating of four or more stars eligible for quality-based bonus payments. The Star Rating system considers various measures adopted by CMS, including, for example, quality of care, preventative services, chronic illness management, coverage appeals and customer satisfaction. Our Medicare Advantage plans' and Medicare Part D plans' operating results, premium revenue and benefit offerings are likely to continue to be significantly determined by their Star Ratings. In October 2016, CMS announced 2017 Star Ratings and the projected Star Ratings for plans offered by certain subsidiaries of the Company included certain reductions that are primarily attributable to our CMS audit. There is no financial impact in 2017 because these ratings apply to plans for the 2018 payment year. However, if we are unsuccessful in restoring at least some of our downgraded Star Ratings measures, the effect in 2018 could be material to shareholders' net income. See Part II, Item 7 Management's Discussion and Analysis of Financial Condition and Results of Information Health Care Industry Developments and Other Matters Affecting our Global Health Care Segment for additional information on the impact of the downgraded 2018 Star Rating measures.

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 administrative actions, fines or other penalties that could impact our profitability.

The Health Care Reform Act required establishing health insurance exchanges for individuals and small employers. Insurers participating on the health insurance exchanges are required to offer a minimum level of benefits and comply with requirements with respect to premium rates and coverage limitations. Our participation in these exchanges involves uncertainties associated with mix and volume of business and could adversely affect our results of operations, financial position and cash flows.

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 Part D 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 that could have a material adverse effect on our business, financial condition and results of operations.

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 legal matters could include benefit claims, breach of contract actions, tort claims, claims arising from consumer protection laws, claims disputes under federal or state laws and disputes regarding reinsurance arrangements, employment and employment discrimination-related suits, antitrust claims, employee benefit claims, wage and hour claims, tax, privacy, intellectual property and whistle blower claims 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 our administration of self-funded business. There are currently, and may be in the future, attempts to bring class action lawsuits against the industry; or individual plaintiffs also may bring multiple claims regarding the same subject matter against us and other companies in our industry.

With respect to our global operations, contractual rights, laws and regulations may be subject to interpretation or uncertainty to a greater degree than in the U.S., and therefore subject us to disputes by customers, governmental authorities or others.

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, and the DOJ has requested information regarding these practices. 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 attorneys general) 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 our business practices, retroactive adjustments to certain premiums, significant fines, penalties, civil liabilities, criminal liabilities or other sanctions, including restrictions on our ability to market certain products or engage in business-related activities, that could have a material adverse effect on our business, results of operation, financial condition and liquidity. In addition, disclosure of an adverse investigation or audit or the imposition of fines or other sanctions in addition to the CMS sanctions discussed below could negatively affect our reputation in certain markets and make it more difficult for us to sell our products and services.

In January 2016, CMS issued to the Company a Notice of Imposition of Immediate Intermediate Sanctions (the "Notice"). The Notice requires the Company to suspend certain enrollment and marketing activities for its Medicare Advantage-Prescription Drug and Medicare Part D Plans.

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The Company is working to resolve these matters as quickly as possible. However, these matters were not resolved in time to participate in the 2017 Medicare Advantage and Part D annual enrollment period for 2017. See Part II, Item 7 Management's Discussion and Analysis of Financial Condition and Results of Information Health Care Industry Developments and Other Matters Affecting our Global Health Care Segment for additional information on the impact of the downgraded 2018 Star Rating measures.

A description of material pending legal actions and other legal and regulatory matters is included in Note 21 to our Consolidated Financial Statements included in this Form 10-K. The outcome of litigation and other legal or regulatory matters is always uncertain, and outcomes that are not justified by the evidence or existing law can occur.

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 clients. In some cases, such laws, rules, regulations and contractual requirements also apply to our vendors and require us to obtain written assurances of their compliance with such requirements 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. We also are subject to various other consumer protection laws that regulate our communications with customers.

These laws, rules, and contractual requirements are subject to change. Compliance with new privacy, security and data laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For 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.

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

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

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

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

Economic Risks

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 15 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.

A substantial portion 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.

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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, 2016, our outstanding long-term debt totaled $4.8 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 the Health Care Reform Act, 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 funds or are precluded from securing financing, they may not be able to pay, or may delay payment of, accounts receivable that are owed to us.

Our 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.

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PART I

ITEM 1A. Risk Factors

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 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.

Other Risks

The pendency of and uncertainty surrounding the proposed merger with Anthem, Inc. could adversely affect our business.

On February 8, 2017, the U.S. District Court for the District of Columbia (the "District Court") issued an order enjoining the proposed merger with Anthem. An appeal of the District Court's order is now pending before the Appeals Court. Cigna entered into the merger agreement in order to create a combined company that would expand choice, improve affordability and quality, and further accelerate value-based care. If the merger is not consummated as originally proposed, we will not realize any potential benefits of the merger. In addition, as discussed below under "*The ongoing litigation related to the merger agreement could adversely affect our business, financial results and operations*," we and Anthem are involved in pending litigation against each other. Cigna believes that, after the ruling by the District Court to enjoin the merger, terminating the merger agreement is in the best interest of our shareholders. Our inability to terminate the merger agreement could create uncertainty and disruptions to our business, delay or prevent us from pursuing other strategic opportunities or otherwise adversely affect our business, financial results and operations. It is uncertain whether the merger will be consummated or when or if we will be able to terminate the merger agreement, as further discussed below under "*The ongoing litigation related to the merger agreement could adversely affect our business, financial results and operations*".

The pendency of the merger, and the uncertainty surrounding whether the merger will be consummated or terminated, may cause disruptions to our business, which could adversely affect our relationships with our clients, customers, providers, lenders, vendors and/or employees. As a result of this uncertainty, we could also potentially lose or fail to attract new key employees, clients, vendors and our provider arrangements could be disrupted. In addition, we have diverted, and will continue to divert, management resources towards the proposed merger. The proposed merger will continue to divert management's attention and our resources from ongoing business and operations and other business opportunities. Any disruption to our workforce, business relationships or leadership could adversely affect our business, financial results and operations.

The merger agreement provides for ongoing restrictions on the conduct of our business including, among other things, certain restrictions on our ability to acquire other businesses, sell, transfer or license our assets, repurchase outstanding common stock, make capital expenditures, amend our organizational documents and incur indebtedness. We remain subject to these restrictions pursuant to the temporary restraining order from the Chancery Court, as further discussed below under "*The ongoing litigation related to the merger agreement could adversely affect our business, financial results and operations*". These restrictions could result in our inability to respond effectively to competitive pressures, industry developments and future opportunities.

Furthermore, we have incurred and will continue to incur significant transaction costs with respect to the proposed merger, including legal and other costs. The incurrence of these costs could adversely affect our business, financial results and operations.

The ongoing litigation related to the merger agreement could adversely affect our business, financial results and operations.

On February 14, 2017, we notified Anthem that we had terminated the merger agreement and filed suit in the Delaware Court of Chancery (the "Chancery Court") seeking, among other things, declaratory judgments that the Company's termination of the merger agreement is lawful and that Anthem is not permitted to extend the termination date to April 30, 2017. In the filed suit, we are also seeking payment by Anthem of the $1.85 billion reverse termination fee contemplated in the merger agreement, as well as additional damages. Later that day, Anthem filed suit against us seeking a temporary restraining order preventing the termination of the merger agreement, specific performance and damages. On February 15, 2017, the Chancery Court issued an order temporarily enjoining Cigna from terminating the merger agreement. Such litigation could be costly, create uncertainty with respect to the future of our business or otherwise adversely affect our business, financial results and operations.

While we believe in the merits of our claims and dispute Anthem's claims, the outcomes of lawsuits are inherently unpredictable, and we may be unsuccessful in the ongoing litigation or any future claims or litigation. The Chancery Court may find that we have not complied, in full or in part, with our obligations under the merger agreement, that we are liable for a breach, willful or otherwise, of the merger agreement, that we do not have a right to terminate the merger agreement, that we are not entitled to the reverse termination fee or other adverse findings. Failure to collect all or some of the reverse termination fee would adversely affect our business, financial results and operations. Anthem has claimed money damages in an amount to be proven at trial, including for actual damages, incidental damages, consequential damages, lost profits, lost goodwill, and other costs and damages incurred by Anthem by reason of Cigna's alleged breaches of the merger agreement. If Anthem prevails on any of these claims for damages, Cigna's liability could be substantial, and any such ruling could adversely affect our business, financial results and operations. Finally, any binding or non-binding decision that delays or eliminates our ability to terminate the merger agreement could create uncertainty and disruptions to our business, delay or prevent us from pursuing other strategic opportunities or otherwise adversely affect our business, financial results and operations.

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ITEM 1B. Unresolved Staff Comments

None.

ITEM 2. Properties

Our global real estate portfolio consists of approximately 7.8 million square feet of owned and leased properties. Our domestic portfolio has approximately 5.8 million square feet in 38 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Our International properties contain approximately 2.0 million square feet located throughout the following countries: Australia, Bahrain, Belgium, Canada, China, Hong Kong, India, Indonesia, Kenya, Malaysia, New Zealand, Singapore, South Korea, Spain, 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 893,000 square feet and is owned, while Two Liberty Place measures approximately 322,000 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", "Regulatory Matters" and "Other Legal Matters" in Note 21 to our Financial Statements beginning on page 106 of this Form 10-K, is incorporated herein by reference.

ITEM 4. Mine Safety Disclosures

Not applicable.

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PART I

EXECUTIVE OFFICERS OF THE REGISTRANT

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, 52, Executive Vice President and Global Chief Marketing Officer of Cigna beginning May 2013 and Chief Customer Officer beginning February 2017; Executive Vice President and Chief Marketer at American Family Insurance from February 2008 until May 2013.

MARK L. BOXER, 57, 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, 51, 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.

CHRISTOPHER HOCEVAR, 43, President, Strategy, Segments and Solutions beginning February 2017; President, Pharmacy and Select Business from June 2013 to February 2017; President, Select Business beginning February 2011.

NICOLE S. JONES, 46, 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.

MATTHEW G. MANDERS, 55, President, Government & Individual Programs and Group Insurance beginning February 2017; President, U.S. Markets from June 2014 until February 2017; President, Regional and Operations from November 2011 until June 2014; President, U.S. Service, Clinical and Specialty from January 2010 until November 2011; and President of Cigna HealthCare, Total Health, Productivity, Network & Middle Market from June 2009 until January 2010.

THOMAS A. McCARTHY, 60, 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.

ALAN M. MUNEY, MD, MHA, 63, Executive Vice President, Total Health & Network and Chief Medical Officer beginning February 2017; joined Cigna as Senior Vice President, Total Health & Network in 2010 and named Chief Medical Officer in 2011.

JOHN M. MURABITO, 58, Executive Vice President, Human Resources and Services of Cigna beginning August 2003.

JASON D. SADLER, 48, President, International Markets beginning June 2014; President, Global Individual Health, Life and Accident from July 2010 until June 2014, and Managing Director Insurance Business Hong Kong, HSBC Insurance Asia Limited from January 2007 until July 2010.

MICHAEL TRIPLETT, 55, President, U.S. Markets beginning February 2017; Regional Segment Lead from June 2009 to February 2017.

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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 113 of this Form 10-K. As of December 31, 2016, the number of shareholders of record was 6,029. 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, 2016:

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, 2016	235	$123.45		$725,000,122
November 1-30, 2016	21,463	$132.60		$725,000,122
December 1-31, 2016	1,952	$136.21		$725,000,122
Total	**23,650**	**$132.81**		**N/A**

(1)

Represents shares tendered by employees as payment of taxes withheld on vesting of restricted stock and strategic performance shares granted under the Company's equity compensation plans.

(2)

Additionally, the Company maintains a share repurchase program, authorized by the Board of Directors. Under this program, the Company may repurchase shares from time to time, depending on market conditions and alternate uses of capital. The timing and actual number of shares repurchased will depend on a variety of factors, including price, general business and market conditions and alternate uses of capital. The share repurchase program may be effected through open market purchases or privately negotiated transactions in compliance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended, including through Rule 10b5-1 trading plans. The program may be suspended or discontinued at any time. In 2016, the Company repurchased approximately 0.8 million shares for $110 million. Remaining authorization under the program was approximately $725 million as of December 31, 2016. In February 2017, the Board increased repurchase authority to $3.7 billion, however management has determined that it is prudent to cap the amount of

repurchase to $250 million per quarter until there is more clarity with respect to the litigation with Anthem. From January 1, 2017 through February 22, 2017, the Company repurchased 0.7 million shares for $106 million. Remaining authorization under the program was $3.7 billion as of February 22, 2017.

(3)

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

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

Five Year Cumulative Total Shareholder Return*
December 31, 2011 December 31, 2016

	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016
Cigna	$ 100	$ 127	$ 209	$ 245	$ 349	$ 318
S&P 500	$ 100	$ 116	$ 154	$ 175	$ 177	$ 198
S&P Managed Health Care, Life & Health Ins. Indexes**	$ 100	$ 108	$ 164	$ 205	$ 236	$ 285

*

Assumes that the value of the investment in Cigna common stock and each index was $100 on December 31, 2011 and that all dividends were reinvested.

**

Weighted average of S&P Managed Health Care (75%) and Life and Health Insurance (25%) Indexes.

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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)	2016	2015	2014	2013	2012
Total revenues	**$ 39,668**	$ 37,876	$ 34,914	$ 32,380	$ 29,119
Shareholders' net income	**$ 1,867**	$ 2,094	$ 2,102	$ 1,476	$ 1,623
Net income	**$ 1,843**	$ 2,077	$ 2,094	$ 1,478	$ 1,624
Shareholders' net income per share:					
Basic	**$ 7.31**	$ 8.17	$ 7.97	$ 5.28	$ 5.70
Diluted	**$ 7.19**	$ 8.04	$ 7.83	$ 5.18	$ 5.61
Common dividends declared per share	**$ 0.04**	$ 0.04	$ 0.04	$ 0.04	$ 0.04
Cash and investments	**$ 30,000**	$ 26,681	$ 25,762	$ 25,160	$ 26,638
Total assets	**$ 59,360**	$ 57,088	$ 55,870	$ 54,306	$ 53,700
Long-term debt	**$ 4,756**	$ 5,020	$ 4,979	$ 4,984	$ 4,952
Total liabilities	**$ 45,575**	$ 44,975	$ 44,991	$ 43,629	$ 43,817
Shareholders' equity	**$ 13,723**	$ 12,035	$ 10,774	$ 10,567	$ 9,769
Employees	**41,000**	39,300	37,200	36,500	35,800

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PART II

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

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 ("Form 10-K") and the "Risk Factors" contained in Part I, Item 1A of this 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. In some of our financial tables in this MD&A, we present either percentage changes or "N/M" when those changes are so large as to become not meaningful. Changes in percentages are expressed in basis points ("bps").

In this MD&A, our consolidated measures "operating revenues" and "adjusted income from operations" are not determined in accordance with GAAP and should not be viewed as substitutes for the most directly comparable GAAP measures "total revenues" and "shareholders' net income."

We define operating revenues as total revenues excluding realized investment results. We exclude realized investment results from this measure because our portfolio managers may sell investments based on factors largely unrelated to the underlying business purposes of each segment. As a result, gains or losses created in this process may not be indicative of past or future underlying performance of our businesses.

We use adjusted income (loss) from operations as our principal financial measure of operating performance because management believes it best reflects the underlying results of our business operations and permits analysis of trends in underlying revenue, expenses and profitability. We define adjusted income from operations as shareholders' net income (loss) excluding after-tax realized investment gains and losses, net amortization of other acquired intangible assets and special items. Income or expense amounts are excluded from adjusted income from operations for the following reasons:

Realized investment results are excluded because, as noted above, our portfolio managers may sell investments based on factors largely unrelated to the underlying business purposes of each segment.

Net amortization of other intangible assets is excluded because it relates to costs incurred for acquisitions and, as a result, it does not relate to the core performance of the Company's business operations. In 2015, the amortization amount was net of a bargain purchase gain on an acquisition.

Special items are excluded because management believes they are not representative of the underlying results of operations. See Note 22 to the Consolidated Financial Statements for descriptions of special items.

Executive Overview

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us") is a global health services organization 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. In addition to these ongoing operations, we also have certain run-off operations.

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

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Financial Summary

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

	For the Years Ended December 31,			Increase (Decrease)	Increase (Decrease)
(Dollars in millions, except per share amounts)	**2016**	2015	2014	2016 vs. 2015	2015 vs. 2014
Total revenues (1)	**$ 39,668**	$ 37,876	$ 34,914	5%	8%
Operating revenues (1)					
Global Health Care	**$ 31,199**	$ 29,929	$ 27,290	4%	10%
Global Supplemental Benefits	**3,385**	3,149	3,005	7	5
Group Disability and Life	**4,443**	4,271	3,970	4	8
Other Operations	**472**	485	510	(3)	(5)
Corporate		(15)	(15)	100	
Total operating revenues (1)	**$ 39,499**	$ 37,819	$ 34,760	4%	9%
Shareholders' net income (1)	**$ 1,867**	$ 2,094	$ 2,102	(11)%	%
Adjusted Income (Loss) From Operations (1)					
Global Health Care	**$ 1,852**	$ 1,848	$ 1,752	%	5%
Global Supplemental Benefits	**294**	262	243	12	8
Group Disability and Life	**125**	324	317	(61)	2
Other Operations	**70**	75	68	(7)	10
Corporate	**(237)**	(253)	(265)	6	5
Total adjusted income from operations (1)	**$ 2,104**	$ 2,256	$ 2,115	(7)%	7%
Earnings per share (diluted):					
Shareholders' net income (1)	**$ 7.19**	$ 8.04	$ 7.83	(11)%	3%
Adjusted income from operations (1)	**$ 8.10**	$ 8.66	$ 7.87	(6)%	10%
Global medical customers (in thousands)	**15,197**	14,999	14,456	1%	4%

(1)

See Consolidated Results of Operations beginning on page 41 for reconciliations of operating revenues to total revenues and adjusted income from operations to shareholders' net income on a dollar and per share basis.

2016 and 2015 both increased, primarily reflecting higher operating revenues driven by business growth across the Company as discussed further below.

2016 and 2015 both reflected business growth in each of our ongoing reportable segments. Rate actions for certain products within our Commercial segment to recover medical cost trend also contributed to these increases.

2016 vs. 2015 Decrease was due to lower adjusted income from operations, primarily in the Group Disability and Life segment. Increased special item charges in 2016 (primarily higher merger costs and the 2016 risk corridor allowance) also contributed to the decline.

2015 vs. 2014 The slight increase primarily reflected higher adjusted income from operations and, to a lesser extent, the impact of share repurchase. These favorable effects were partially offset by lower realized investment results and 2015 charges for merger and debt extinguishment costs reported as special items.

(1)

See Consolidated results of operations starting on page 41 for reconciliations of operating revenues to total revenues and adjusted income from operations to shareholders' net income on a dollar and per share basis.

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

2016 vs. 2015 Decrease was driven by significantly lower earnings in Group Disability and Life and costs related to the Government segment's CMS audit response. Increased earnings contributions in Global Supplemental Benefits and the Commercial segment partially offset those unfavorable impacts.

2015 vs. 2014 Increase was due to higher earnings in each of our ongoing reportable segments, reflecting continued customer growth in all of our reportable segments, including improved contributions from our specialty health care businesses. Share repurchase also contributed to the increase.

(1)

See Consolidated results of operations starting on page 41 for reconciliations of operating revenues to total revenues and adjusted income from operations to shareholders' net income on a dollar and per share basis.

2016 and 2015 both increased, including growth in the middle market, select and international market segments. The 2015 increase also reflected the acquisition of QualCare Alliance Networks, Inc. as well as growth in the government market segment.

Further discussion of detailed components of revenues and expenses can be found in the "Consolidated Results of Operations" section of this MD&A beginning on page 41. For further analysis and explanation of individual segment results, see the "Segment Reporting" section of this MD&A beginning on page 49.

Key Transactions

Proposed Merger with Anthem, Inc. ("Anthem")

On July 23, 2015, we entered into a definitive agreement to merge with Anthem, subject to certain terms, conditions and customary operating covenants, with Anthem continuing as the surviving company. At special shareholders' meetings in December 2015, Cigna shareholders approved the merger with Anthem and Anthem shareholders voted to approve the issuance of shares of Anthem common stock according to the merger agreement. Upon closing, our shareholders would receive $103.40 in cash and 0.5152 of a share of Anthem common stock for each common share of the Company. The closing price of Anthem stock on February 22, 2017 was $163.27.

Consummation of the merger is subject to certain customary conditions, including the receipt of certain necessary governmental and regulatory approvals, and the absence of a legal restraint prohibiting the consummation of the merger. On July 21, 2016, the U.S. Department of Justice ("DOJ") and certain state attorneys general filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia (the "District Court") seeking to block the merger and, on January 4, 2017, the parties concluded the District Court trial. On February 8, 2017, the District Court issued an order enjoining the proposed merger. Anthem appealed this ruling to the U.S. Court of Appeals for the District of Columbia Circuit (the "Appeals Court"). Additionally, Cigna appealed the District Court ruling following the Chancery Court ruling described below.

On February 14, 2017, Cigna delivered a notice to Anthem terminating the merger agreement and filed suit in the Delaware Court of Chancery (the "Chancery Court") seeking, among other things, declaratory judgment that Cigna's termination of the merger agreement is lawful and that Anthem does not have the right to extend the merger agreement termination date. Later that day, Anthem filed a lawsuit in the Chancery Court against us seeking, among other things, a temporary restraining order to enjoin Cigna from terminating the merger agreement, specific performance and damages, and, on February 15, 2017, the Chancery Court issued an order temporarily enjoining us from terminating the merger agreement. This order will be subject to further review at a preliminary injunction hearing.

See Notes 3 and 21 to the Consolidated Financial Statements in this Form 10-K for additional information about the proposed merger. See Item 1A. Risk Factors in this Form 10-K for risks to our business due to the proposed merger.

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Health Care Industry Developments And Other Matters Affecting Our Global Health Care Segment

The "Regulation" section of this Form 10-K provides a detailed description of The Patient Protection and Affordable Care Act (the "Health Care Reform Act" or "ACA") provisions and other legislative initiatives that impact our health care business, including regulations issued by the Centers for Medicare and Medicaid Services ("CMS") and the Departments of the Treasury and Health and Human Services ("HHS"). The table presented below provides further details related to the impact of key ACA-related items and certain other regulatory matters affecting our Global Health Care segment.

Item	Description
Medicare Advantage ("MA")	***CMS actions:*** In January 2016, CMS issued a Notice of Imposition of Immediate Intermediate Sanctions (the "Notice") to the Company. The Notice required us to suspend certain enrollment and marketing activities for Medicare Advantage-Prescription Drug and Medicare Part D Plans. The sanctions do not impact the right of current enrollees to remain covered by our Medicare Advantage-Prescription Drug or Medicare Part D Plans. Although we continue to devote resources to our remediation efforts, we expect remediation costs in 2017 to be significantly lower than 2016. For 2016, costs related to our CMS audit response were approximately $100 million after-tax. See Note 21 to the Consolidated Financial Statements for additional information. While these matters were not resolved in time to participate in the 2017 Medicare Advantage and Part D annual enrollment period, we continue to work with CMS to address the audit findings and have the sanctions lifted as quickly as possible. We expect to have these sanctions lifted in time to participate in the 2018 annual enrollment period. The impact of disenrollment was not material to 2016 consolidated revenues and earnings. In 2017, Medicare enrollment and consolidated revenues will be materially impacted due to our inability to participate in 2017 annual enrollment. However, management does not anticipate that 2017 shareholders' net income will be materially affected because we expect to offset the margin impact of the revenue loss with several factors including significantly lower costs to remediate the sanctions and other operational efficiencies. On October 12, 2016, CMS announced Medicare Star Quality Ratings ("Star Ratings") for 2017 (see Item 1 Business and Item 1A. Risk Factors in this Form 10-K for additional discussion of Star Ratings programs). While Star Ratings are based on a number of plan performance measures that are evaluated each year, the projected Star Ratings for our plans included certain reductions that are primarily attributable to our CMS audit discussed above. Under these revised Star Ratings, approximately 20% of our Medicare Advantage customers are expected to be in a 4 Stars or greater plan. We do not believe that these Star Ratings reflect the quality offerings Cigna-HealthSpring provides to beneficiaries. We filed a Reconsideration request with CMS, which was denied, and will work fully with CMS through their process as well as consider additional alternatives with the objective that the final Star Ratings more accurately reflect our

performance under the Star Ratings measures. We remain committed to our partnership with CMS and to delivering quality products and services to seniors, while working to mitigate the impact these Star Ratings could have on our offerings in 2018. There is no financial impact in 2016 or 2017 because these ratings apply to plans for the 2018 payment year. However, if we are unsuccessful in restoring at least some of the Star Ratings, the effect in 2018 could be material to shareholders' net income. The actual impact on earnings in 2018 could potentially be offset in part by our ability to restore some or all of our downgraded 2018 Star Rating measures, modify our product offerings and implement operational efficiencies in the government business.

2017 and 2018 MA Rates: Final MA reimbursement rates for 2017 were published by CMS in April 2016. Preliminary MA reimbursement rates for 2018 were published by CMS in February 2017. We do not expect the new rates to have a material impact on our consolidated results of operations in 2017 and 2018.

Health Care Reform Act Taxes and Fees

Health Insurance Industry Tax: 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. The industry assessment was $11.3 billion in both 2016 and 2015 and $8 billion in 2014. We recognized approximately $310 million in operating expenses for both 2016 and 2015 and $240 million in 2014. Because this tax is not deductible for federal income tax purposes, it negatively impacts our effective tax rate. Of the full year 2016 tax, $170 million relates to our Commercial business and $140 million to our Government business.

Industry Tax

For our Commercial business, we incorporated the industry tax into target 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 reduced margins in the Government operating segment in both 2016 and 2015.

In December 2015, federal appropriations legislation imposed a one-year moratorium on the industry tax for 2017, with reinstatement expected in 2018. Our target pricing actions related to 2017 and 2018 plan years will consider the impacts of this legislation. The moratorium in 2017 is expected to lower our effective tax rate.

Reinsurance Fee

Reinsurance Fee: This fee, applicable only for 2014-2016, was a fixed dollar per customer levy that applied to both insured and self-insured major medical plans excluding certain products such as Medicare Advantage and Medicare Part D. Proceeds from the fee were used to fund the reinsurance program for non-grandfathered individual business sold either on or off the public exchanges. For our insured business, the amount of the tax-deductible fee was approximately $45 million in 2016, $70 million in 2015 and $110 million in 2014. The declines from 2014 to 2016 reflect annual per-customer levies of $27 in 2016, $44 in 2015 and $63 in 2014.

Public Health Exchanges

Public Health Exchanges: For 2016, we offered individual coverage on seven public health insurance exchanges in the following states: Arizona, Colorado, Georgia, Maryland, Missouri, Tennessee and Texas. For 2017, we are offering individual coverage on seven public health insurance exchanges in the following states: Colorado, Illinois, Maryland, Missouri, North Carolina, Tennessee and Virginia.

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PART II

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

Risk Mitigation Programs

See Note 2 (K) to the Consolidated Financial Statements for a description of and our accounting policy for these programs that commenced in 2014.

The following table presents the after-tax benefits to shareholders' net income from these programs for the years ended December 31, 2016, 2015 and 2014 and our net receivable balances as of December 31, 2016 and 2015.

	Net Receivable Balance (2) As of December 31,		After-tax Impact on Shareholders' Net Income For the Years Ended December 31,		
(In millions)	**2016**	2015	**2016**	2015	2014
Risk Corridor (1)					
Risk corridor (gross)	**$ 124**	$ 134	**$ (6)**	$ 49	$ 40
Risk corridor allowance	**(124)**		**(80)**		
Net risk corridor		134	**(86)**	49	40
Reinsurance	**63**	158	**30**	125	109
Risk adjustment	**1**	118	**25**	92	49
Total	**$ 64**	$ 410	**$ (31)**	$ 266	$ 198

(1)

Starting in fourth quarter 2016, we did not record amounts due to us under the risk corridor program and recorded an allowance for previously due amounts. See discussion below.

(2)

For the reinsurance program, receivables are reported in reinsurance recoverables. Receivables, net of allowances, for the risk adjustment and risk corridor programs are reported in premiums, accounts and notes receivable. Payables for the risk adjustment program as of December 31, 2016 of $51 million are netted in the receivable balance presented above, but are reported in accounts payable, accrued expenses and other liabilities in the Consolidated Balance Sheets.

As of September 30, 2016, the Company's risk corridor receivable was $124 million pre-tax. An unfavorable court decision was issued during the fourth quarter rejecting another insurer's statutory, contractual and constitutional claims for payment of risk corridor receivables (Land of Lincoln Mutual Health Insurance Company v. United States). Based on this decision, as well as the large risk corridor program deficit, under applicable accounting rules, the Company determined it was required to establish an allowance for all of the $124 million of receivables associated with the risk corridor program. In addition, the Company was unable to recognize $25 million pre-tax income for incremental fourth quarter risk corridor receivables. This court case is under appeal and notwithstanding the accounting reflected, management continues to believe that the government has a binding obligation to satisfy the risk corridor receivable. We expect full payment of the remaining reinsurance and risk adjustment receivables.

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Consolidated Results of Operations

Financial Summary

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

	For the Years Ended December 31,			Increase (Decrease)		Increase (Decrease)	
(In millions)	**2016**	2015	2014	2016 vs. 2015		2015 vs. 2014	
Premiums	**$ 30,626**	$ 29,642	$ 27,214	$ 984	3%	$ 2,428	9%
Fees and other revenues	**4,760**	4,488	4,141	272	6	347	8
Net investment income	**1,147**	1,153	1,166	(6)	(1)	(13)	(1)
Mail order pharmacy revenues	**2,966**	2,536	2,239	430	17	297	13
Operating revenues	**39,499**	37,819	34,760	1,680	4	3,059	9
Net realized investment gains	**169**	57	154	112	196	(97)	(63)
Total revenues	**39,668**	37,876	34,914	1,792	5	2,962	8
Global Health Care medical costs	**19,009**	18,354	16,694	655	4	1,660	10
Other benefit expenses	**5,477**	4,936	4,640	541	11	296	6
Mail order pharmacy costs	**2,468**	2,134	1,907	334	16	227	12
Other operating expenses	**9,584**	8,982	8,174	602	7	808	10
Amortization of other acquired intangible assets, net	**151**	143	195	8	6	(52)	(27)
Benefits and expenses	**36,689**	34,549	31,610	2,140	6	2,939	9
Income before income taxes	**2,979**	3,327	3,304	(348)	(10)	23	1
Income taxes	**1,136**	1,250	1,210	(114)	(9)	40	3
Net income	**1,843**	2,077	2,094	(234)	(11)	(17)	(1)
Less: net (loss) attributable to noncontrolling interests	**(24)**	(17)	(8)	(7)	(41)	(9)	(113)
Shareholders' net income	**$ 1,867**	$ 2,094	$ 2,102	$ (227)	(11)%	$ (8)	%

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

	For the Years Ended December 31,			Increase (Decrease)	Increase (Decrease)
(In millions)	**2016**	2015	2014	2016 vs. 2015	2015 vs. 2014

Shareholders' net income	**$ 1,867**	$ 2,094	$ 2,102	$ (227)	(11)%	$ (8) %
After-tax adjustments required to reconcile to adjusted income from operations:						
Net realized investment (gains)	**(109)**	(40)	(106)	(69)		66
Amortization of other acquired intangible assets, net	**94**	80	119	14		(39)
Special items:						
Risk corridor allowance (See Note 22 to the Consolidated Financial Statements)	**80**			80		
Merger-related transaction costs (See Note 3 to the Consolidated Financial Statements)	**147**	57		90		57
Charges associated with litigation matters discussed in Note 21 to the Consolidated Financial Statements	**25**			25		
Debt extinguishment costs (See Note 5 to the Consolidated Financial Statements)		65		(65)		65
Adjusted income from operations	**$ 2,104**	$ 2,256	$ 2,115	$ (152)	(7)%	$ 141 7%

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
Other Key Consolidated Financial Data	**2016**	2015	2014	2016 vs. 2015		2015 vs. 2014	
Earnings per share (diluted):							
Shareholders' net income	**$ 7.19**	$ 8.04	$ 7.83	$ (0.85)	(11)%	$ 0.21	3%
Per share impact of after-tax adjustments to shareholders' net income							
Net realized investment (gains)	**(0.42)**	(0.15)	(0.40)	(0.27)		0.25	
Amortization of other acquired intangible assets, net	**0.36**	0.30	0.44	0.06		(0.14)	
Special items see Note 22 for details	**0.97**	0.47		0.50		0.47	
Adjusted income from operations	**$ 8.10**	$ 8.66	$ 7.87	$ (0.56)	(6)%	$ 0.79	10%
Effective tax rate	**38.1%**	37.6%	36.6%	(50) bps		(100) bps	

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Consolidated Results of Operations: 2016 Compared to 2015 and 2015 Compared to 2014

Revenues. The components of revenue changes are discussed further below:

Premiums. The increases in both 2016 and 2015, compared with each prior year, reflected premium growth in each of our ongoing reporting segments: Global Health Care, Global Supplemental Benefits and Group Disability and Life. These results were primarily attributable to customer growth in our targeted market segments within Global Health Care, as well as growth in Global Supplemental Benefits and Group Disability and Life. Rate actions in our commercial health care businesses consistent with medical cost trend also contributed to these increases.

Fees and other revenues. The increases in both 2016 and 2015, compared with each prior year, largely reflected growth from specialty products offered through our Global Health Care segment and an increased customer base for our administrative services only business.

Net investment income decreased slightly in both 2016 and 2015, compared with each prior year, as lower investment yields in the continued low interest rate environment were partially offset by higher average invested assets. Unfavorable foreign currency effects also contributed to these declines.

Mail order pharmacy revenues increased in both 2016 and 2015, compared with each prior year, driven by greater volume, primarily for specialty medications (e.g., certain injectables) due to our higher customer base and increased utilization.

Realized investment results increased in 2016 compared with 2015 due to significantly lower impairment losses. In 2015, realized investment results decreased compared with 2014, primarily due to higher impairment losses on certain externally managed fixed maturities, particularly within the energy sector. These impairments were driven by increased market yields. See Note 11 to the Consolidated Financial Statements for additional information.

Global Health Care medical costs. The increase in 2016 compared with 2015 resulted primarily from medical cost trend and customer growth in our commercial health care businesses. The 2015 increase compared with 2014 was primarily due to customer growth in our government business and, to a lesser extent, medical cost trend.

Other benefit expenses. The increase in 2016 compared with 2015 was driven by unfavorable disability and life claim experience due primarily to changes in the disability claims management process in 2016 and elevated life claims during the second quarter of 2016. Business growth in our Group Disability and Life and Global Supplemental Benefits segments also contributed to the increase. In 2015, the increase compared with 2014 primarily reflected business growth in our Group Disability and Life and Global Supplemental Benefits segments.

Mail order pharmacy costs. The increases in both 2016 and 2015 compared with each prior year were primarily due to increased volume, primarily for specialty medications (e.g., certain injectables) due to our higher customer base and increased utilization. In 2015, higher unit costs also contributed to the increase.

Other operating expenses. The increases in both 2016 and 2015 compared with each prior year were due to business growth, strategic investment across our segments and special items described in Note 22 to the Consolidated Financial Statements. In 2016, the increase also reflected costs associated with our CMS audit response as discussed in the Executive Overview section of this MD&A beginning on page 36.

Amortization of other acquired intangible assets, net. The increase in 2016 compared with 2015 was driven by the absence of the $23 million bargain purchase gain recorded in 2015 for an acquisition. This factor was partially offset by the expected continuing decline in amortization from our 2012 acquisition of HealthSpring, Inc. The decrease in 2015 compared with 2014 reflects the impact of both the $23 million bargain purchase gain and the decline in HealthSpring amortization.

Special items. Special item charges were higher in 2016 compared with 2015 primarily due to higher merger costs and the 2016 risk corridor allowance. Special items charges were higher in 2015 compared with 2014 due to merger costs and losses on the early extinguishment of debt in 2015 and the absence of special items in 2014. See Note 22 to the Consolidated Financial Statements for additional details about special items.

Consolidated effective tax rate. The increase in our effective tax rate in 2016 compared with 2015 was largely driven by an increase in certain merger-related transaction costs reported in 2016 that are not tax deductible, partially offset by the tax benefits associated with adopting Accounting Standard Update ("ASU") 2016-09 as discussed in Note 2 to the Consolidated Financial Statements. The increase in the consolidated effective tax rate in 2015 was primarily driven by merger-related transaction costs in 2015 and the non-deductible health insurance industry tax assessed under the Health Care Reform Act. This tax was first assessed in 2014 and increased in 2015. See Note 20 to the Consolidated Financial Statements for additional information about income taxes.

We expect our effective tax rate to decline in 2017 as a result of the moratorium on the health insurance industry tax.

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Liquidity And Capital Resources

Financial Summary

(In millions)	**2016**	**2015**	**2014**
Short-term investments	**$ 691**	$ 381	$ 163
Cash and cash equivalents	**$ 3,185**	$ 1,968	$ 1,420
Short-term debt	**$ 276**	$ 149	$ 147
Long-term debt	**$ 4,756**	$ 5,020	$ 4,979
Shareholders' equity	**$ 13,723**	$ 12,035	$ 10,774

Consolidated short-term investments increased in both 2016 and 2015 as a result of investing excess cash balances at the parent company level.

Liquidity

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

Liquidity requirements at the subsidiary level generally consist of:

- medical costs and benefit payments to policyholders;
- expense requirements, primarily for employee compensation and benefits, information technology and facilities costs; and
- income taxes.

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;
- matching investment durations to those estimated for the related insurance and contractholder liabilities;
- selling investments; and
- borrowing from affiliates, subject to applicable regulatory limits.

Liquidity requirements at the parent company level generally consist of:

- debt service and dividend payments to shareholders;
- pension plan funding; and
- repurchases of common stock.

The parent company normally meets its liquidity requirements by:

maintaining appropriate levels of cash and various types of marketable investments;

collecting dividends from its subsidiaries;

using proceeds from issuance of debt and equity securities; and

borrowing from its subsidiaries.

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

(In millions)	**2016**	**2015**	**2014**
Net cash provided by operating activities (1)(2)	**$ 4,026**	$ 2,933	$ 2,158
Net cash (used in) investing activities (2)	**$ (2,574)**	$ (1,736)	$ (1,866)
Net cash (used in) financing activities (1)	**$ (225)**	$ (609)	$ (1,635)

(1)

As required in adopting ASU 2016-09, we retrospectively reclassified $79 million in 2015 and $53 million in 2014 of cash payments from operating to financing activities. These payments were related to employee tax obligations associated with stock compensation. The comparable amount reported in financing activities in 2016 was $72 million. See Note 2 to the Consolidated Financial Statements for further discussion.

(2)

As required in adopting ASU 2016-15, the Company retrospectively reclassified from investing to operating activities $137 million in 2015 and $111 million in 2014 of cash distributions from partnership earnings. The comparable amount reported in operating activities in 2016 was $144 million. See Note 2 to the Consolidated Financial Statements for further discussion.

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. 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 in 2016 compared with 2015 due to higher receipts from Medicare Part D and Medicare Advantage programs.

Cash flows from operating activities increased in 2015 compared with 2014 primarily driven by the volume and timing of government reimbursements and pharmacy considerations.

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Investing activities

Cash used in investing activities increased in 2016 compared with 2015, due to higher purchases of fixed maturity investments. Net cash used in investing activities decreased in 2015 compared with 2014 due to lower net purchases of fixed maturities.

Financing activities

Cash used in financing activities decreased in 2016 compared with 2015, primarily due to lower share repurchases offset by lower proceeds from employees' exercise of stock options. Cash used in financing activities decreased in 2015 compared with the same period in 2014, primarily reflecting lower share repurchases.

Share repurchase

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

In 2016, we repurchased 0.8 million shares for $110 million. In February 2017, the Board of Directors increased repurchase authority to $3.7 billion, however management has determined that it is prudent to cap the amount of repurchase to $250 million per quarter until there is more clarity with respect to the litigation with Anthem. From January 1, 2017 through February 22, 2017 we repurchased 0.7 million shares for $106 million. The total remaining share repurchase authorization as of February 22, 2017 was $3.7 billion. We repurchased 5.5 million shares for $683 million in 2015 and 18.5 million shares for $1.6 billion in 2014.

Interest Expense

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

(In millions)	**2016**	**2015**	**2014**
Interest expense	**$ 251**	$ 252	$ 265

Interest expense reported above for the year ended 2015 excluded losses on the early extinguishment of debt.

The weighted average interest rate for outstanding short-term debt (primarily commercial paper) was 0.69% at December 31, 2015. There was no commercial paper outstanding as of December 31, 2016.

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 and to fund pension obligations;

consider acquisitions that are strategically and economically advantageous; and

return capital to investors through share repurchase.

See Note 3 to the Consolidated Financial Statements for information regarding capital restrictions imposed by our merger agreement with Anthem. 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, 2016, there was approximately $2.8 billion in cash and marketable investments available at the parent company level. In 2017, the parent company's combined cash obligations are expected to approximate $660 million for repayment of debt, interest, pension contributions and dividends.

We expect, based on the parent company's current cash position and current projections for subsidiary dividends, 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, 2016, the parent company had $277 million of net intercompany loans

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payable to 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, 2016, $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 as described in Note 5 to the Consolidated Financial Statements, we have $9.7 billion of borrowing capacity in addition to the $5 billion of debt outstanding. This additional borrowing capacity includes the $1.5 billion available under the credit agreement.

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

We maintain a capital management strategy to retain overseas a significant portion of the earnings from our foreign operations. As of December 31, 2016, undistributed earnings were approximately $2.5 billion. These undistributed earnings are deployed outside of the U.S. predominantly in support of the liquidity and regulatory capital requirements of our foreign operations. Approximately $305 million of cash and cash equivalents held overseas would be subject to additional tax expense representing the difference between the U.S. and foreign tax rates, if repatriated. We continue to expect most of the undistributed earnings and future earnings to be reinvested to support growth initiatives overseas. This strategy does not materially limit our ability to meet our liquidity and capital needs in the U.S.

Unfunded Pension Plan Liability. As of December 31, 2016, our unfunded pension liability was $911 million, reflecting a decrease of $42 million from December 31, 2015. The decrease in the unfunded liability reflected strong asset returns in line with our expectations and changes to our mortality assumptions based on an updated pension mortality improvement scale published in the fourth quarter of 2016. These factors were partially offset by a decrease of approximately 20 basis points in the weighted average assumed discount rate. In February 2017, we made a voluntary pension contribution of $150 million. We do not expect to make any additional pension contributions for the remainder of 2017, as there are no contributions required under the Pension Protection Act of 2006. See Note 15 to the Consolidated Financial Statements for additional information regarding our pension plans.

Solvency II. Beginning in 2016, our businesses in the European Union became subject to the directive on insurance regulation, solvency and governance requirements known as Solvency II. This directive imposes economic risk-based solvency and governance requirements and supervisory rules. 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, 2016, 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	$ 6,680	$ 786	$ 1,006	$ 807	$ 4,081
Future policy benefits	11,319	553	1,390	1,163	8,213
Global Health Care medical costs payable	2,554	2,458	39	12	45
Unpaid claims and claim expenses	5,354	1,678	1,035	695	1,946
Short-term debt	276	276			
Long-term debt	7,886	247	617	1,350	5,672
Other long-term liabilities	879	306	116	88	369
Off-Balance Sheet:					
Purchase obligations	1,443	542	573	230	98
Operating leases	661	135	215	147	164

Total	$ 37,052	$ 6,981	$ 4,991	$ 4,492	$ 20,588

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 insurance 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 $21 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 their related net cash flows associated with them are not expected to impact our cash flows. The total amount of these reinsured reserves excluded is approximately $5 billion. The expected future cash flows for guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("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.

Short-term debt represents current maturities of long-term debt, and current obligations under capital leases.

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Long-term debt includes scheduled interest payments. Capital leases are included in long-term debt and primarily 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 reinsurance liabilities. These items are presented in accounts payable, accrued expenses and other liabilities in our Consolidated Balance Sheets.

Estimated payments of $75 million for deferred compensation, qualified, non-qualified and international pension plans and other postretirement and postemployment benefit plans are expected to be paid in less than one year, including a voluntary contribution to the qualified pension plan of $150 million made in February 2017. We do not expect to make any additional contributions to the qualified domestic pension plans during 2017. We expect to make payments subsequent to 2017 for these obligations, however subsequent payments have been excluded from the table as their timing is based on plan assumptions that may materially differ from actual activities. See Note 15 to the Consolidated Financial Statements for further information on pension and other postretirement benefit obligations.

Off-Balance Sheet:

Purchase obligations. As of December 31, 2016, purchase obligations consisted of estimated payments required under contractual arrangements for future services and investment commitments as follows:

(In millions)

Fixed maturities	**$**	**26**
Commercial mortgage loans		**69**
Limited liability entities (other long-term investments)		**1,073**
Total investment commitments		**1,168**
Future service commitments		**275**
Total purchase obligations	**$**	**1,443**

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

Our estimated future service commitments primarily represent contracts for certain outsourced business processes and 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 contractually require minimum levels of goods or services to be purchased.

Operating leases. For additional information, see Note 18 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 21 to the Consolidated Financial Statements for additional information on guarantees.

Critical Accounting Estimates

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

it requires assumptions to be made that were uncertain at the time the estimate was made; and

changes in the estimate or different estimates that could have been selected could have a material effect on our consolidated results of operations or financial condition.

Management has discussed 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 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. The table below presents the adverse impacts of certain changes in assumptions. Except as noted, the effect of an assumption change in the opposite direction would be a positive impact to our consolidated results of operations, liquidity or financial condition.

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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 2016. These evaluations were performed at the reporting unit level, based on discounted cash flow analyses and market data. The evaluations indicated that no impairment was required. During the fourth quarter, we updated our analysis of the Government reporting unit, reflecting an increase in market interest rates. The updated analysis for the Government reporting unit continued to indicate 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 unit. 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. In addition to these assumptions, we considered market data to evaluate the fair value of each reporting unit. In our Government operating segment (which is a reporting unit) 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. Estimated future cash flows for this business incorporated the	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. Based on our most recent evaluations, the fair value estimates of our reporting units exceed their carrying values by adequate margins. Changes in the funding for our Medicare programs by the federal government, or our inability to resolve the matters arising from the CMS Notice in a timely and satisfactory manner, could materially reduce revenues and profitability in our Government reporting unit and have a significant impact on its fair value.

potential effects of Medicare Advantage reimbursement rates for 2017 and beyond as discussed in the "Executive 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. This evaluation also considered management's assessment of the impact of the CMS sanctions and updated Star Ratings discussed in Note 21 to the Consolidated Financial Statements. 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):

2016 $5,980

2015 $6,019

See Note 17 to the Consolidated Financial Statements for additional discussion of our goodwill.

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):

2016 $911

2015 $953

See Note 15 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 $195 million as of December 31, 2016 resulting in an after-tax decrease to shareholders' equity of approximately $125 million.

If the December 31, 2016 fair values of domestic qualified plan assets decreased by 10%, the accrued pension benefit liability would increase by approximately $395 million as of December 31, 2016 resulting in an after-tax decrease to shareholders' equity of approximately $255 million.

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Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Global Health Care medical costs payable	
Medical costs payable for the Global Health Care segment include both reported claims and estimates for losses incurred but not yet reported. Liabilities for medical costs payable as of December 31 were as follows (in millions): **2016 gross $2,532; net $2,257** 2015 gross $2,355; net $2,112 These liabilities are presented above both gross and net of reinsurance and other recoverables and generally exclude amounts for administrative services only business. See Note 7 to the Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.	As described in Note 7, Global Health Care medical costs payable are primarily impacted by assumptions related to completion factors and medical cost trend. Changes in either assumption from actual results could impact the Global Health Care medical costs payable balance as noted below. A large number of factors may cause the medical cost trend to vary from the Company's estimates, including: changes in medical management practices, changes in the level and mix of benefits offered and services utilized, and changes in medical practices. Completion factors may be affected if actual claims submission rates from providers differ from estimates (that can be influenced by a number of factors, including provider mix, and electronic versus manual submissions), or if changes to the Company's internal claims processing patterns occur. Based on studies of our claim experience, it is reasonably possible that a 100 basis point change in the medical cost trend and a 50 basis point change in completion factors could occur in the near term. A 100 basis point increase in the medical cost trend rate would increase this liability by approximately $30 million, resulting in a decrease in net income of approximately $20 million after-tax, and a 50 basis point decrease in completion factors would increase this liability by approximately $70 million, resulting in a decrease in net income of approximately $45 million after-tax.
Unpaid claims and claim expenses long-term disability reserves The liability for long-term disability reserves is the present value of estimated future benefits payments over the expected disability period and includes estimates for both reported claims and for claims incurred but not yet reported. Long-term disability reserves as of December 31 were as follows (in millions):	As described in Note 8, key assumptions in the calculation of long-term disability reserves include the discount rate and claim resolution rates, both of which are reviewed annually and updated when experience or future expectations would indicate a necessary change. Based on recent and historical resolution rate patterns and changes in investment portfolio yields, it is reasonably possible that a 5 percent change in claim

2016 gross $3,708; net $3,622

2015 gross $3,481; net $3,403

See Note 8 to the Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.

resolution rates and a 25 basis point change in the discount rate could occur.

The discount rate is the interest rate used to discount the projected future benefit payments to their present value. The discount rate assumption is based on the projected investment yield of the assets supporting the reserves. A 25 basis point decrease in the discount rate would increase long-term disability reserves by approximately $45 million and decrease net income by approximately $30 million after-tax.

Claim resolution rate assumptions involve many factors including claimant demographics, the type of contractual benefit provided and the time since initially becoming disabled. The Company uses its own historical experience to develop its claim resolution rates. A 5 percent decrease in the claim resolution rate would increase long-term disability reserves by approximately $90 million and decrease net income by approximately $60 million after-tax.

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

Typically, the most significant input in the measurement of fair value is the market interest rate used to discount the estimated future cash flows of the instrument. Such market rates are derived by calculating the appropriate spreads over comparable U.S. Treasury securities, based on the credit quality, industry and structure of the asset.

If the interest rates used to calculate fair value increased by 100 basis points, the fair value of the total fixed maturity portfolio of $21 billion would decrease by approximately $1.2 billion, resulting in an after-tax decrease to shareholders' equity of approximately $0.8 billion.

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.

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Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Assessment of "other-than-temporary" impairments on 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 Note 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, 2016 would have decreased by approximately $115 million after-tax. Unlike impairments, there is no impact to shareholders' net income for holding fixed maturities with a fair value in excess of cost because we classify our fixed maturities as available for sale.

SEGMENT REPORTING

The following section of this MD&A discusses the results of each of our reporting segments. In these segment discussions, we present "operating revenues," defined as total revenues excluding realized investment results and "adjusted income from operations," defined as shareholders' net income (loss) excluding after-tax realized investment results, net amortization of other acquired intangible assets and special items. Ratios presented in this segment discussion exclude the same items as adjusted income from operations. See Note 22 to the Consolidated Financial Statements for additional discussion of these metrics.

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

See the MD&A Executive Overview beginning on page 36 for summarized financial results of each of our reporting segments.

Global Health Care Segment

As described in the Segment Reporting introduction above, the performance of the Global Health Care segment is measured using adjusted income from operations. The key factors affecting adjusted income from operations for this segment are:

- customer growth;
- sales of specialty products;
- operating expense as a percentage of operating revenues (operating expense ratio); and

medical costs as a percentage of premiums (medical care ratio or "MCR") for our commercial and government businesses.

Results of Operations

Financial Summary

(In millions)	For the Years Ended December 31, 2016	2015	2014	Change Favorable (Unfavorable) 2016 vs. 2015		Change Favorable (Unfavorable) 2015 vs. 2014	
Operating revenues	**$ 31,199**	$ 29,929	$ 27,290	$ 1,270	4%	$ 2,639	10%
Adjusted income from operations	**$ 1,852**	$ 1,848	$ 1,752	$ 4	%	$ 96	5%
Adjusted margin	**5.9%**	6.2%	6.4%	(30)bps		(20)bps	
Medical Care Ratios:							
Commercial	**79.3%**	78.1%	78.5%	(120)bps		40bps	
Government	**85.3%**	85.2%	84.3%	(10)bps		(90)bps	
Consolidated Global Health Care	**81.6%**	80.9%	80.6%	(70)bps		(30)bps	
Operating expense ratio	**21.5%**	21.4%	21.4%	(10)bps		bps	

(Dollars in millions, customers in thousands)	As of December 31, 2016	2015	2014	Increase (Decrease) 2016 vs. 2015		Increase (Decrease) 2015 vs. 2014	
Global Health Care medical costs payable	**$ 2,532**	$ 2,355	$ 2,180	$ 177	8%	$ 175	8%
Customers:							
Total commercial risk	**2,576**	2,502	2,534	74	3%	(32)	(1)%
Total government	**566**	567	518	(1)		49	9
Total risk	**3,142**	3,069	3,052	73	2	17	1
Service	**12,055**	11,930	11,404	125	1	526	5
Total medical customers	**15,197**	14,999	14,456	198	1%	543	4%

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Adjusted income from operations was essentially flat in 2016 compared with 2015, reflecting earnings growth in our Commercial segment, primarily due to increased contributions from specialty products partially offset by lower margins in our U.S. Individual business. This increase was offset by lower earnings in our Government segment primarily driven by costs related to our CMS audit response.

Adjusted income from operations increased in 2015 compared with 2014, reflecting U.S. Commercial business growth, including increased contributions from pharmacy, stop loss and other specialty products. Results in 2015 also reflect the impact of increased investments in business initiatives.

Operating revenues. The increase in operating revenues in 2016 compared with 2015 was due to growth in our Commercial segment primarily from increased specialty revenues. Growth in Medicare Advantage customer volumes and higher premium rates for most products in our U.S. health care businesses primarily to recover underlying medical cost trend also contributed to the increase. These increases were partially offset by lower customer volumes in our Medicare Part D and U.S. Individual businesses. Operating revenues include amounts related to the Risk Mitigation Programs under the Health Care Reform Act. See the Risk Mitigation section on page 40 for further discussion of the Risk Corridor program.

The increase in operating revenues in 2015, compared with 2014 was primarily due to a higher customer base in our Government segment, as well as revenue growth in specialty businesses and higher premiums in the U.S. Commercial segment reflecting rate actions on most risk products primarily to recover underlying medical cost trends.

Medical care ratios. The Commercial medical care ratio increased in 2016 compared with 2015 reflecting a less favorable medical care ratio in our stop loss business as expected, lower premium due to the anticipated reduction of the Health Care Reform Act mandated fees in 2017, and less favorable prior year reserve development. The Commercial medical care ratio decreased slightly in 2015 compared with 2014 primarily due to a lower medical care ratio in our stop loss business.

The Government medical care ratio increased slightly in 2016 compared with 2015 reflecting higher medical costs in our Medicaid business and less favorable prior year development, mostly offset by improvements in the Medicare Part D business. The Government medical care ratio increased in 2015 compared with 2014 due to an increase in Medicare Part D utilization.

As discussed in the Regulation section of this Form 10-K, both the Commercial and Government segments are subject to minimum medical loss ratio requirements under the Health Care Reform Act. As of December 31, 2016 and 2015, liabilities under these requirements were not material.

Operating expense ratio. The operating expense ratio increased slightly in 2016 compared with 2015, reflecting costs related to our CMS audit response. Excluding those costs, the operating expense ratio decreased, reflecting higher revenue and operating efficiencies, partially offset by business initiative investments to enhance our capabilities. The operating expense ratio was flat in 2015 compared with 2014, reflecting business-initiative investments offset by higher revenue and disciplined expense management.

Other Items Affecting Health Care Results

Global Health Care Medical Costs Payable

Medical costs payable was higher as of December 31, 2016 compared with 2015, primarily due to medical cost trend across all businesses and customer growth in our Commercial group business. Medical costs payable increased in 2015 compared with 2014, primarily driven by growth in the stop loss book of business and the Government segment. See Note 7 to the Consolidated Financial Statements for additional information.

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 us;

has access to the Company's provider network for covered services under their medical plan; or

has medical claims that are administered by us.

Our medical customer base as of December 31, 2016 was higher than 2015, primarily driven by growth in our middle market, select, and international market segments. Our medical customer base as of December 31, 2015 was higher than 2014, driven by strong overall retention and sales in our targeted market segments, as well as the acquisition of QualCare Alliance Networks, Inc. on February 28, 2015.

Global Supplemental Benefits Segment

As described in the Segment Reporting introduction on page 49, the performance of the Global Supplemental Benefits segment is measured using adjusted income from operations. The key factors affecting adjusted income from operations for this segment are:

premium growth, including new business and customer retention;

benefit expenses as a percentage of premiums (loss ratio);

operating expense and acquisition expense as a percentage of operating revenues (expense ratio and acquisition cost ratio); and

the impact of foreign currency movements.

Throughout this discussion and the table presented below, prior period currency adjusted income from operations and operating revenues are calculated by applying the current period's exchange rates to reported results in the prior period. A strengthening U.S. Dollar against foreign currencies decreases these measures, while a weakening U.S. Dollar produces the opposite effect.

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	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2016**	**2015**	**2014**	**2016 vs. 2015**		**2015 vs. 2014**	
Operating revenues	**$ 3,385**	$ 3,149	$ 3,005	$ 236	7%	$ 144	5%
Adjusted income from operations	**$ 294**	$ 262	$ 243	$ 32	12%	$ 19	8%
Operating revenues, using actual 2016 currency exchange rates	**$ 3,385**	$ 3,069	$ 2,738	$ 316	10%	$ 331	12%
Adjusted income from operations, using actual 2016 currency exchange rates	**$ 294**	$ 255	$ 219	$ 39	15%	$ 36	16%
Adjusted margin	**8.7%**	8.3%	8.1%	40bps		20bps	
Loss ratio	**55.3%**	55.3%	54.3%	bps		(100)bps	
Acquisition cost ratio	**18.6%**	19.3%	21.0%	70bps		170bps	
Expense ratio (excluding acquisition costs)	**17.9%**	18.3%	17.7%	40bps		(60)bps	

Adjusted income from operations increased in 2016 compared with 2015 primarily due to business growth, largely in South Korea, and lower acquisition and operating cost ratios. These factors were partially offset by higher income taxes and the unfavorable impact of foreign currency movements, primarily in South Korea. The increase in adjusted income from operations in 2015 compared with 2014 was primarily due to business growth and lower acquisition costs, partially offset by the unfavorable impact of foreign currency movements and higher expense ratios as discussed below.

Operating revenues were higher in 2016 compared with 2015 primarily due to new sales, particularly in South Korea and the U.S., reflecting both customer growth and sales of higher premium products. These higher premiums were partially offset by lower persistency in the U.K. and the unfavorable impact of foreign currency movements, primarily in South Korea and the U.K.

Operating revenues were higher in 2015 compared with 2014, primarily attributable to new sales, particularly in South Korea and the U.S., reflecting both customer growth and sales of higher premium products, partially offset by the unfavorable impact of foreign currency movements.

Loss ratios were flat in 2016 compared with 2015 reflecting favorable claims in South Korea, largely offset by higher claims in the U.S. Loss ratios increased in 2015 compared with 2014, primarily due to a business mix shift toward products with higher expected loss ratios in South Korea and the U.S.

Acquisition cost ratios decreased in both 2016 and 2015 compared with each prior year. The decline in each year's ratio largely represents a shift toward higher premium products with lower acquisition costs primarily in South Korea and the U.S.

The ***expense ratio*** (excluding acquisition costs) decreased in 2016 compared with 2015 primarily driven by operating efficiencies. The expense ratio (excluding acquisition costs) increased in 2015 compared with 2014 reflecting strategic business investments partially offset by operating efficiencies.

Other Items Affecting Global Supplemental Benefits Results

South Korea is the single largest geographic market for our Global Supplemental Benefits segment. South Korea generated 51% of the segment's operating revenues and 85% of the segment's adjusted income from operations in 2016. In 2016, our Global Supplemental Benefits segment operations in South Korea represented 4% of our consolidated operating revenues and 12% of consolidated adjusted income from operations.

As a global company, our business is exposed to risks inherent in foreign operations. While we continue to monitor and evaluate the impacts of the U.K. vote to exit the European Union and the political unrest in Turkey, we do not expect these events to materially impact the results of the Global Supplemental Benefits segment in 2017.

Significant movements in foreign currency exchange rates could materially affect the reported results of the Global Supplemental Benefits segment.

Group Disability and Life Segment

As described in the Segment Reporting introduction on page 49, the performance of the Group Disability and Life segment is measured using adjusted income from operations. The key factors affecting adjusted income from operations for this segment are:

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

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	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2016**	**2015**	**2014**	**2016 vs. 2015**		**2015 vs. 2014**	
Operating revenues	**$ 4,443**	$ 4,271	$ 3,970	$ 172	4%	$ 301	8%
Adjusted income from operations	**$ 125**	$ 324	$ 317	$ (199)	(61)%	$ 7	2%
Adjusted margin	**2.8%**	7.6%	8.0%	(480)bps		(40)bps	
Loss ratio	**83.8%**	76.3%	76.5%	(750)bps		20bps	
Operating expense ratio	**22.4%**	21.9%	21.9%	(50)bps		bps	

During the first half of 2016, the Group Disability and Life segment experienced significant unfavorable claims in its disability and life businesses. While claims experience moderated during the second half of 2016, the first half results caused full year earnings to decline significantly from the prior year.

Disability: We implemented modifications to our disability claims management process in the first quarter of 2016 to drive improved quality and consistency. These modifications extended the claims processing cycle and lowered the disability claim resolution rate. As our modified disability claims management process continued to mature during the latter half of 2016, our claim resolution rate significantly improved compared with the first half of 2016. As overall claim metrics continue to improve, management expects disability operational margins to normalize over the course of 2017.

Life: We experienced a period of elevated life claims in the second quarter of 2016, driven by substantially higher new claim incidence and sizes, both of which improved in the second half of 2016.

2016 vs. 2015

Adjusted income from operations. Results decreased in 2016 compared with 2015 due primarily to unfavorable disability and life claims experience as well as the absence of favorable reserve reviews and a higher operating expense ratio. Results in 2016 included the unfavorable impact of reserve reviews of $18 million after-tax compared with a favorable impact of $55 million after-tax in 2015.

Operating revenues. Premiums and fees increased in 2016 compared with 2015 driven by new business growth due to disability and life sales. Net investment income also increased in 2016 compared with 2015 primarily due to higher average assets partially offset by lower yields.

The ***loss ratio*** increased in 2016 compared with 2015 due to lower claim resolutions in disability, higher life claim incidence and sizes in the second quarter, and the unfavorable impact of reserve reviews as discussed above.

Operating expense ratio. The operating expense ratio increased in 2016 compared with 2015 primarily reflecting higher disability claim management costs.

2015 vs. 2014

Adjusted income from operations. Results in 2015 increased compared with 2014 due primarily to favorable life claims experience. Results also included the favorable after-tax effects of reserve reviews of $55 million in 2015 and $52 million in 2014.

Operating revenues. The increase in 2015 compared with 2014 was driven by new business growth due to disability and life sales. Net investment income also increased in 2015 compared with 2014 primarily due to higher average assets partially offset by lower yields.

The ***loss ratio*** decreased in 2015 compared with 2014 due to lower life claim incidence.

Operating expense ratio. The operating expense ratio was flat in 2015 compared with 2014 driven by effective cost management.

Other Operations

As described in the Segment Reporting introduction on page 49, the performance of the Other Operations segment is measured using adjusted income from operations. Cigna's corporate-owned life insurance ("COLI") business contributes the majority of earnings in Other Operations. Cigna's Other Operations segment also includes the results from the run-off reinsurance and settlement annuity businesses, as well as the remaining deferred gains recognized from the sale of the individual life insurance and annuity and retirement benefits businesses.

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	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2016**	**2015**	**2014**	**2016 vs. 2015**		**2015 vs. 2014**	
Operating revenues	**$ 472**	$ 485	$ 510	$ (13)	(3)%	$ (25)	(5)%
Adjusted income from operations	**$ 70**	$ 75	$ 68	$ (5)	(7)%	$ 7	10%
Adjusted margin	**14.8%**	15.5%	13.3%	(70)bps		220bps	

Adjusted income from operations decreased in 2016 compared with 2015, reflecting less favorable mortality experience and lower interest margins in COLI. Adjusted income from operations increased in 2015 compared with 2014, reflecting favorable mortality experience in COLI.

Operating revenues decreased in 2016 compared with 2015 due to lower net investment income driven by lower investment yields. The decrease in operating revenues in 2015 compared with 2014 is largely due to lower net investment income driven by lower investment yields and, to a lesser extent, lower premiums in COLI driven by favorable experience-rating results.

Corporate

Corporate reflects amounts not allocated to operating segments, including net interest expense (defined as interest on corporate debt less net investment income on investments not supporting segment 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

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2016**	**2015**	**2014**	**2016 vs. 2015**		**2015 vs. 2014**	
Adjusted loss from operations	**$ (237)**	$ (253)	$ (265)	$ 16	6%	$ 12	5%

Corporate's ***adjusted loss from operations*** decreased in 2016 compared with 2015, primarily due to adopting ASU 2016-09 effective January 1, 2016, as further discussed in Note 2 to the Consolidated Financial Statements, and higher net investment income partially offset by higher pension and project expenses.

Corporate's adjusted loss from operations decreased in 2015 compared with 2014, primarily due to lower pension and interest expenses.

Investment Assets

The following table presents our invested asset portfolio, excluding separate account assets, as of December 31, 2016 and 2015. An increase in investable funds has led to an increase across all asset types, except for commercial mortgages, that have continued to decline due to a competitive investment environment and our assessment of relative value versus other fixed income opportunities.

Additional information regarding our investment assets and related accounting policies is included in Notes 2, 10, 11, 12, 13, and 14 to the Consolidated Financial Statements.

(In millions)	2016	2015
Fixed maturities	**$ 20,961**	$ 19,455
Equity securities	**583**	190
Commercial mortgage loans	**1,666**	1,864
Policy loans	**1,452**	1,419
Other long-term investments	**1,462**	1,404
Short-term investments	**691**	381
Total	**$ 26,815**	$ 24,713

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, 2016 and 2015.

(In millions)	2016	2015
Federal government and agency	**$ 877**	$ 779
State and local government	**1,435**	1,641
Foreign government	**2,113**	2,014
Corporate	**16,050**	14,448
Mortgage and other asset-backed	**486**	573
Total	**$ 20,961**	$ 19,455

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As of December 31, 2016, $18.6 billion, or 89%, of the fixed maturities in our investment portfolio were investment grade (Baa and above, or equivalent), and the remaining $2.4 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 from the prior year and are consistent with our investment strategy.

State and local government. 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 $30 million as of December 31, 2016. 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.

Foreign government. We invest in high quality foreign government obligations with an average quality rating of Aa3 as of December 31, 2016. These investments are concentrated in Asia, primarily South Korea, consistent with the geographic locations of our international business operations. Foreign government obligations also include $221 million of investments in European sovereign debt, none of which are in countries with significant political or economic concerns such as Portugal, Italy, Ireland, Greece, Spain and Turkey.

Corporate. As of December 31, 2016, corporate fixed maturities included the following.

Private placement investments were $5.3 billion. These investments are generally less marketable than publicly-traded bonds, however yields on these investments tend to be higher than yields on publicly-traded bonds with comparable credit risk. We perform a credit analysis of each issuer, 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.

Investments in companies that are domiciled or have significant business interests in Italy, Ireland, Spain and Turkey were $354 million. These investments have an average quality rating of Baa3 and are diversified by industry sector, including approximately 1% invested in financial institutions.

Investments in the energy and natural gas sector were $1.7 billion with gross unrealized losses of $18 million. These investments have an average quality rating of Baa2 and are diversified by issuer with no single exposure greater than $40 million.

In addition to amounts classified in fixed maturities on our Consolidated Balance Sheets, we operate a joint venture in China in which we have a 50% ownership interest. We account for this joint venture on the equity basis of accounting and report it in other assets, including other intangibles. This entity has an investment portfolio of approximately $3.3 billion that is primarily invested in local Chinese corporate and government fixed maturities and has no investments with a material unrealized loss as of December 31, 2016.

Equity Securities

Equity securities increased approximately $400 million during 2016 to $583 million as of December 31, 2016, largely due to investing in an exchange traded fund ("ETF") as part of a temporary program to invest available funds in high quality and liquid assets. The underlying assets of the ETF are primarily U.S. investment grade corporate bonds and there is a gross unrealized loss of $5 million as of December 31, 2016 due to an increase in market yields since purchase.

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 70% 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 2016. For further information on the property type, location and credit quality of our commercial mortgage loans, as well as a discussion of the results of the annual portfolio review, see Note 11 to the Consolidated Financial Statements.

Commercial real estate capital markets remain very 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.

The $1.7 billion commercial mortgage loan portfolio consists of approximately 60 loans, including one impaired loan with a carrying value of $21 million, net of a $5 million reserve, that is classified as a problem loan. We have $92 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 investment generally ranging between 30 and 40%, we remain confident that borrowers will continue to perform as expected under their 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 in return for higher expected returns. To mitigate risk, investments are diversified across approximately 120 separate partnerships, and approximately 70 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 4% of our securities and real estate partnership portfolio.

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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 is 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 their original terms was not significant for 2016 or 2015.

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

	December 31, 2016			**December 31, 2015**		
(In millions)	**Gross**	**Reserve**	**Net**	Gross	Reserve	Net
Problem bonds	**$ 70**	**$ (9)**	**$ 61**	$ 3	$ (1)	$ 2
Problem commercial mortgage loans	**26**	**(5)**	**21**	90	(11)	79
Foreclosed real estate	**49**		**49**			
Total problem investments	**$ 145**	**$ (14)**	**$ 131**	$ 93	$ (12)	$ 81
Potential problem bonds	**$ 12**	**$ (7)**	**$ 5**	$ 55	$ (23)	$ 32
Potential problem commercial mortgage loans				64	(4)	60
Total potential problem investments	**$ 12**	**$ (7)**	**$ 5**	$ 119	$ (27)	$ 92

The increase in problem bonds was primarily due to three additional problem bonds in the energy sector. The increase in foreclosed real estate during 2016 reflects the foreclosure of a commercial mortgage loan classified as a problem loan as of December 31, 2015. The decrease in potential problem commercial mortgage loans in 2016 was due to a full payoff of one loan and partial payoff, and subsequent reclassification to good standing, of another loan.

Investment Outlook

Global financial markets exhibited volatility throughout 2016 resulting from global economic and political uncertainty. The volatility began early in the year led by concerns related to slowing economic global growth, with particular concerns regarding China, potentially destabilizing impacts from cyclically low energy prices, followed in mid-year by concerns regarding the United Kingdom's decision to exit the European Union, and then finished the year with strong market reactions anticipating growth-oriented policy changes in the United States following our recent elections. The near-term impact of these events has not materially impacted our financial condition or liquidity; however, we continue to closely monitor global macroeconomic trends and the potential impact to our investment portfolio. Future realized and unrealized investment results will be driven largely by market conditions that exist when a transaction occurs or at the reporting date. These future conditions are not reasonably predictable; however, we believe that the vast majority of our investments will continue to perform under their contractual terms. Based on our strategy to match the duration of invested assets to the duration of insurance and contractholder liabilities, we expect to hold a significant portion of these assets for the long term. Although future impairment losses resulting from interest rate movements and credit deterioration due to both company-specific and the global economic uncertainties discussed above remain possible, we do not expect these losses to have a material adverse effect on our financial condition or liquidity.

Market Risk

Financial Instruments

Our assets and liabilities include financial instruments subject to the risk of potential losses from adverse changes in market rates and prices. 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, Chinese yuan renminbi, Taiwan dollar and British pound. An unfavorable change in exchange rates reduces the carrying value of net assets denominated in foreign currencies.

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

Our Management of Market Risks

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

Investment/liability matching. We generally select investment assets with characteristics (such as duration, yield, currency and liquidity) that correspond to the underlying characteristics of our related insurance and contractholder liabilities so that we can match the investments to our obligations. Shorter-term investments generally support shorter-term life and health liabilities. Medium-term, fixed-rate investments support interest-sensitive and health liabilities. Longer-term investments generally support products with longer 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 use derivative financial instruments to minimize certain market risks.

See Note 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, largely 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 billions)	**2016**	2015
100 basis point increase in interest rates	**$ 1.0**	$ 0.9
10% strengthening in U.S. dollar to foreign currencies	**$ 0.4**	$ 0.3

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, 2016 was greater than that at December 31, 2015 reflecting increased purchases of fixed maturities, in addition to valuation decreases of our long-term debt resulting from higher market yields during 2016.

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. The effect of a hypothetical 10% strengthening in the U.S. dollar to foreign currencies at December 31, 2016 was greater than that effect at December 31, 2015 due to increased amounts of investments that are primarily denominated in the South Korean won.

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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.

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ITEM 8. Financial Statements and Supplementary Data

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, 2016 and 2015, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2016 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, 2016, 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
Hartford, Connecticut
February 23, 2017

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Cigna Corporation
Consolidated Statements of Income

	For the Years Ended December 31,		
(In millions, except per share amounts)	**2016**	2015	2014
Revenues			
Premiums	**$ 30,626**	$ 29,642	$ 27,214
Fees and other revenues	**4,760**	4,488	4,141
Net investment income	**1,147**	1,153	1,166
Mail order pharmacy revenues	**2,966**	2,536	2,239
Realized investment gains (losses):			
Other-than-temporary impairments on fixed maturities	**(35)**	(112)	(36)
Other realized investment gains, net	**204**	169	190
Net realized investment gains	**169**	57	154
TOTAL REVENUES	**39,668**	37,876	34,914
Benefits and Expenses			
Global Health Care medical costs	**19,009**	18,354	16,694
Other benefit expenses	**5,477**	4,936	4,640
Mail order pharmacy costs	**2,468**	2,134	1,907
Other operating expenses	**9,584**	8,982	8,174
Amortization of other acquired intangible assets, net	**151**	143	195
TOTAL BENEFITS AND EXPENSES	**36,689**	34,549	31,610
Income before Income Taxes	**2,979**	3,327	3,304
Income taxes (benefits):			
Current	**1,062**	1,229	1,232
Deferred	**74**	21	(22)
TOTAL TAXES	**1,136**	1,250	1,210
Net Income	**1,843**	2,077	2,094
Less: Net (Loss) Attributable to Noncontrolling Interests	**(24)**	(17)	(8)
SHAREHOLDERS' NET INCOME	**$ 1,867**	$ 2,094	$ 2,102
Shareholders' Net Income Per Share:			
Basic	**$ 7.31**	$ 8.17	$ 7.97

Diluted	**$ 7.19**	$ 8.04	$ 7.83	
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.

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ITEM 8. Financial Statements and Supplementary Data

Cigna Corporation
Consolidated Statements of Comprehensive Income

	For the Years Ended December 31,		
(In millions)	**2016**	2015	2014
Shareholders' net income	**$ 1,867**	$ 2,094	$ 2,102
Shareholders' other comprehensive income (loss), net of tax:			
Net unrealized appreciation (depreciation) on securities	**(56)**	(202)	143
Net unrealized appreciation (depreciation) on derivatives	**(4)**	15	11
Net translation of foreign currencies	**(95)**	(212)	(144)
Postretirement benefits liability adjustment	**23**	85	(426)
Shareholders' other comprehensive (loss), net of tax	**(132)**	(314)	(416)
Shareholders' comprehensive income	**1,735**	1,780	1,686
Comprehensive income attributable to noncontrolling interests:			
Net income (loss) attributable to redeemable noncontrolling interests	**(7)**	(6)	1
Net (loss) attributable to other noncontrolling interests	**(17)**	(11)	(9)
Other comprehensive (loss) attributable to redeemable noncontrolling interests	**(10)**	(17)	(7)
Other comprehensive income (loss) attributable to other noncontrolling interests		(1)	1
Total comprehensive (loss) attributable to noncontrolling interests	**(34)**	(35)	(14)
TOTAL COMPREHENSIVE INCOME	**$ 1,701**	$ 1,745	$ 1,672

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

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Cigna Corporation
Consolidated Balance Sheets

(In millions, except per share amounts)	As of December 31, **2016**	2015
Assets		
Investments:		
Fixed maturities, at fair value (amortized cost, $19,942; $18,456)	**$ 20,961**	$ 19,455
Equity securities, at fair value (cost, $583; $190)	**583**	190
Commercial mortgage loans	**1,666**	1,864
Policy loans	**1,452**	1,419
Other long-term investments	**1,462**	1,404
Short-term investments	**691**	381
Total investments	**26,815**	24,713
Cash and cash equivalents	**3,185**	1,968
Premiums, accounts and notes receivable, net	**3,077**	3,694
Reinsurance recoverables	**6,478**	6,813
Deferred policy acquisition costs	**1,818**	1,659
Property and equipment	**1,536**	1,534
Deferred tax assets, net	**304**	379
Goodwill	**5,980**	6,019
Other assets, including other intangibles	**2,227**	2,476
Separate account assets	**7,940**	7,833
TOTAL ASSETS	**$ 59,360**	$ 57,088
Liabilities		
Contractholder deposit funds	**$ 8,458**	$ 8,443
Future policy benefits	**9,648**	9,479
Unpaid claims and claim expenses	**4,917**	4,574
Global Health Care medical costs payable	**2,532**	2,355
Unearned premiums	**634**	629
Total insurance and contractholder liabilities	**26,189**	25,480
Accounts payable, accrued expenses and other liabilities	**6,414**	6,493
Short-term debt	**276**	149
Long-term debt	**4,756**	5,020
Separate account liabilities	**7,940**	7,833
TOTAL LIABILITIES	**45,575**	44,975

Contingencies Note 21

Redeemable noncontrolling interests	**58**	69
Shareholders' equity		
Common stock (par value per share, $0.25; shares issued, 296; authorized, 600)	**74**	74
Additional paid-in capital	**2,892**	2,859
Accumulated other comprehensive loss	**(1,382)**	(1,250)
Retained earnings	**13,855**	12,121
Less: treasury stock, at cost	**(1,716)**	(1,769)
TOTAL SHAREHOLDERS' EQUITY	**13,723**	12,035
Noncontrolling interests	**4**	9
Total equity	**13,727**	12,044
Total liabilities and equity	**$ 59,360**	$ 57,088
SHAREHOLDERS' EQUITY PER SHARE	**$ 53.42**	$ 46.91

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

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ITEM 8. Financial Statements and Supplementary Data

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 Interests	Total Equity	Redeemable Noncontrolling Interests
Balance at January 1, 2014	$ 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				
Other transactions impacting noncontrolling interests		(4)				(4)	9	5	
BALANCE AT DECEMBER 31, 2014	**74**	**2,769**	**(936)**	**10,289**	**(1,422)**	**10,774**	**15**	**10,789**	**90**
2015 Activity:									
Effect of issuing stock for employee benefit plans		99		(252)	336	183		183	
Other comprehensive income (loss)			(314)			(314)	(1)	(315)	(17)
Net income (loss)				2,094		2,094	(11)	2,083	(6)
Common dividends declared				(10)		(10)		(10)	

(per share: $0.04)									
Repurchase of common stock					(683)	(683)		(683)	
Other transactions impacting noncontrolling interests		(9)				(9)	6	(3)	2
BALANCE AT DECEMBER 31, 2015	**74**	**2,859**	**(1,250)**	**12,121**	**(1,769)**	**12,035**	**9**	**12,044**	**69**
2016 Activity:									
Effect of issuing stock for employee benefit plans		**51**		**(123)**	**163**	**91**		**91**	
Other comprehensive (loss)			**(132)**			**(132)**		**(132)**	**(10)**
Net income (loss)				**1,867**		**1,867**	**(17)**	**1,850**	**(7)**
Common dividends declared (per share: $0.04)				**(10)**		**(10)**		**(10)**	
Repurchase of common stock					**(110)**	**(110)**		**(110)**	
Other transactions impacting noncontrolling interests		**(18)**				**(18)**	**12**	**(6)**	**6**
BALANCE AT DECEMBER 31, 2016	**$ 74**	**$ 2,892**	**$ (1,382)**	**$ 13,855**	**$ (1,716)**	**$ 13,723**	**$ 4**	**$ 13,727**	**$ 58**

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

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Cigna Corporation
Consolidated Statements of Cash Flows

	For the years ended December 31,		
(In millions)	**2016**	2015	2014
Cash Flows from Operating Activities			
Net income	**$ 1,843**	$ 2,077	$ 2,094
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	**610**	585	588
Realized investment gains, net	**(169)**	(57)	(154)
Deferred income taxes	**74**	21	(22)
Net changes in assets and liabilities, net of non-operating effects:			
Premiums, accounts and notes receivable	**663**	(945)	(780)
Reinsurance recoverables	**142**	55	22
Deferred policy acquisition costs	**(213)**	(182)	(176)
Other assets	**134**	16	(265)
Insurance liabilities	**683**	657	457
Accounts payable, accrued expenses and other liabilities	**124**	423	202
Current income taxes	**1**	(25)	111
Loss on extinguishment of debt		100	
Distributions from partnership investments(2)	**144**	137	111
Other, net(1)	**(10)**	71	(30)
NET CASH PROVIDED BY OPERATING ACTIVITIES(1)(2)	**4,026**	2,933	2,158
Cash Flows from Investing Activities			
Proceeds from investments sold:			
Fixed maturities and equity securities	**1,544**	1,555	1,769
Investment maturities and repayments:			
Fixed maturities and equity securities	**1,755**	1,435	1,640
Commercial mortgage loans	**316**	640	453
Other sales, maturities and repayments (primarily short-term and other long-term investments)(2)	**1,431**	1,160	2,595
Investments purchased or originated:			
Fixed maturities and equity securities	**(5,191)**	(4,234)	(5,424)
Commercial mortgage loans	**(165)**	(500)	(287)
Other (primarily short-term and other long-term investments)	**(1,698)**	(1,183)	(2,115)
Property and equipment purchases, net	**(461)**	(510)	(473)
Acquisitions, net of cash acquired	**(4)**	(99)	
Other, net	**(101)**		(24)
NET CASH (USED IN) INVESTING ACTIVITIES(2)	**(2,574)**	(1,736)	(1,866)

Cash Flows from Financing Activities			
Deposits and interest credited to contractholder deposit funds	**1,460**	1,429	1,482
Withdrawals and benefit payments from contractholder deposit funds	**(1,362)**	(1,359)	(1,456)
Net change in short-term debt	**(148)**	(21)	(112)
Net proceeds on issuance of long-term debt		894	
Repayment of long-term debt		(938)	
Repurchase of common stock	**(139)**	(671)	(1,612)
Issuance of common stock	**36**	154	110
Other, net(1)	**(72)**	(97)	(47)
NET CASH (USED IN) FINANCING ACTIVITIES(1)	**(225)**	(609)	(1,635)
Effect of foreign currency rate changes on cash and cash equivalents	**(10)**	(40)	(32)
Net increase / (decrease) in cash and cash equivalents	**1,217**	548	(1,375)
Cash and cash equivalents, January 1,	**1,968**	1,420	2,795
Cash and cash equivalents, December 31,	**$ 3,185**	$ 1,968	$ 1,420
Supplemental Disclosure of Cash Information:			
Income taxes paid, net of refunds	**$ 1,064**	$ 1,194	$ 1,085
Interest paid	**$ 244**	$ 245	$ 259

(1)

As required in adopting Accounting Standard Update ("ASU") 2016-09, the Company retrospectively reclassified $79 million in 2015 and $53 million in 2014 of cash payments from operating to financing activities. These payments were related to employee tax obligations associated with stock compensation. The comparable amount reported in financing activities in 2016 was $72 million. See Note 2 for further discussion.

(2)

As required in adopting ASU 2016-15, the Company retrospectively reclassified from investing to operating activities $137 million in 2015 and $111 million in 2014 of cash distributions from partnership earnings . The comparable amount reported in operating activities in 2016 was $144 million. See Note 2 for further discussion.

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

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ITEM 8. Financial Statements and Supplementary Data

Notes to the Consolidated Financial Statements

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NOTE 1 Description of Business

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us") is a global health services organization 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 such as governmental and non-governmental organizations, unions and associations. Cigna also offers commercial health and dental insurance, Medicare and Medicaid products and health, life and accident insurance coverages to individuals in the U.S. and selected international markets. In addition to these ongoing operations, Cigna also has certain run-off operations.

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 guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("GMIB") business effectively exited through reinsurance with Berkshire Hathaway Life Insurance Company of Nebraska ("Berkshire") in 2013;

- 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 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 frozen pension plans and certain costs for corporate projects, including overhead.

NOTE 2 Summary of Significant Accounting Policies

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.

Variable interest entities. See Note 13 for a discussion of consolidated variable interest entities.

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Recent Accounting Changes

The following tables provide information about recently adopted and recently issued accounting guidance applicable to Cigna.

Recently Adopted Accounting Guidance

Accounting Standard and Adoption Date	Requirements and Effects of Adopting New Guidance
Classification of Certain Cash Receipts and Cash Payments (a consensus of the Emerging Issues Task Force) (Accounting Standards Update ("ASU") 2016-15) **Early adopted as of December 31, 2016**	Specifies how certain transactions should be classified in the statement of cash flows. While the standard addresses multiple types of transactions, only a change in the treatment of distributions from equity method investments will impact the Company. Effects of adoption: using the nature of distribution approach, the Company reported $144 million of cash receipts related to distributions from partnership earnings in operating activities in 2016. The Company reclassified $137 million for 2015 and $111 million for 2014 from investing to operating activities in the Consolidated Statements of Cash Flows.
Improvements to Employee Share-Based Payment Accounting (ASU 2016-09) **Early adopted on January 1, 2016**	Requires: Excess tax benefits or deficiencies to be recorded prospectively in the income statement when awards vest or are settled; previously these effects were reported in additional paid-in capital Cash flows related to excess tax benefits to be classified prospectively as an operating activity in the statement of cash flows (previously financing) All cash payments made on an employee's behalf for withheld shares to be presented retrospectively as a financing activity in the statement of cash

	flows
	Prospective changes to the calculation of common stock equivalents for earnings per share
	Permits:
	Repurchasing more of an employee's shares for tax withholding purposes than previously allowed without triggering liability accounting
	An accounting policy election to record forfeitures as they occur instead of estimating
	Effects of adoption:
	$29 million of excess tax benefits recorded in net income during 2016 (in Corporate)
	$72 million of tax withholding cash flows reported in financing activities in 2016; reclassified $79 million for 2015 and $53 million for 2014 of tax withholding from operating to financing activities in the Consolidated Statements of Cash Flows
	Approximately one million additional weighted average shares in 2016 for the diluted earnings per share calculations
	No changes in our employee tax withholding practices for stock compensation
	The amount of compensation cost recognized in each period continues to be determined based on

	estimated forfeitures
	Requires additional information about an insurance entity's initial claim estimates and subsequent adjustments to those estimates; methodologies and judgments in estimating claims; and the timing, frequency and severity of claims.
Disclosures about Short-Duration Insurance Contracts (ASU 2015-09) **Adopted December 31, 2016**	Effects of adoption: See Note 7 for these disclosures about our Global Health Care medical cost payable liabilities
	See Note 8 for these disclosures about our unpaid claims and claim expense liabilities
Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent) (ASU 2015-07) **Adopted January 1, 2016**	Removes fair value disclosure requirement for all investments measured using the practical expedient of net asset value ("NAV") per share. Certain additional disclosures are now required for such investments. Effects of adoption: see Note 10 for these disclosures about separate account investments that use NAV as a practical expedient; comparable prior year amounts are also disclosed.
Amendments to the Consolidation Analysis (ASU 2015-02) **Adopted January 1, 2016**	Defines limited partnerships as variable interest entities unless substantive kick-out rights or participating rights exist. Effects of adoption: No material effect on the Company's financial statements
	See Note 13 for disclosures about various limited partnerships newly identified as variable interest entities for which the Company is not the primary beneficiary

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Recently Issued Accounting Guidance Not Yet Adopted

Accounting Standard and Effective Date Applicable for Cigna	Requirements and Expected Effects of New Guidance Not Yet Adopted
Simplifying the Test for Goodwill Impairment (ASU 2017-04) **Required as of January 1, 2020, with early adoption permitted as of January 1, 2017**	Simplifies the accounting for goodwill impairment by eliminating the need to determine the fair value of individual assets and liabilities of a reporting unit to measure a goodwill impairment. Expected effects: the Company is evaluating this new standard and its expected timing of adoption.
Clarifying the Definition of a Business (ASU 2017-01) **Required as of January 1, 2018, with early adoption permitted as of January 1, 2017**	Revises the definition of a business and provides a more robust framework for entities to use in determining when a set of assets and activities is a business. Expected effects: if a group of assets acquired after adoption is not considered a business, no goodwill will be recorded and most intangible assets recorded from the acquisition will be amortized to shareholders' net income over their useful lives. The Company is evaluating this new standard and its expected timing of adoption.
Intra-Entity Asset Transfers of Assets Other than Inventory (ASU 2016-16) **Required as of January 1, 2018, with early adoption permitted as of January 1, 2017**	Requires: Entities to recognize the tax impacts of all intra-entity sales of assets other than inventory even though the pre-tax effects of those transactions are eliminated in consolidation Modified retrospective approach for adoption, with a cumulative-effect adjustment recorded in retained earnings Expected effects: the Company is evaluating this new standard, its expected timing of adoption and

	effects on its financial statements and disclosures.
	Requires:
	A new approach (based on expected credit losses) to estimate and recognize credit losses for certain financial instruments such as mortgage loans, reinsurance recoverables and other receivables
Measurement of Credit Losses on Financial Instruments (ASU 2016-13) **Required as of January 1, 2020, with early adoption permitted as of January 1, 2019**	Changes in the criteria for impairment of available-for-sale debt securities
	Modified retrospective approach for adoption, with a cumulative-effect adjustment recorded in retained earnings
	Expected effects: the Company is evaluating this new standard, its expected timing of adoption and effects on its financial statements and disclosures. It is possible that an additional allowance for future expected credit losses for certain financial instruments may be required at adoption.
Leases (ASU 2016-02) **Required as of January 1, 2019**	Requires:
	Balance sheet recognition of assets and liabilities arising from leases, including from leases embedded in other contracts
	Additional disclosures of the amount, timing and uncertainty of cash flows from leases will be required
	Modified retrospective approach for leases in effect as of and after the date of adoption, with a cumulative-effect adjustment recorded in retained earnings

	Expected effects: the Company is still evaluating the impact the standard could have on the Consolidated Financial Statements; however, while the Company has not yet quantified the amount, we do expect the standard will have a material impact on our Consolidated Balance Sheets due to the recognition of additional assets and liabilities for operating leases. The actual increase in assets and liabilities will depend on the volume and terms of leases in place at adoption.
	Requires:
	Entities to measure equity investments at fair value in net income if they are neither consolidated nor accounted for under the equity method
	Cumulative effect adjustment to the beginning balance of retained earnings at adoption
Recognition and Measurement of Financial Assets and Financial Liabilities (ASU 2016-01)	Expected effects:
Required as of January 1, 2018	
	Certain limited partnership interests carried at cost of $260 million as of December 31, 2016 will be reported at fair value at adoption
	An increase to retained earnings of approximately $60 million, after-tax, if implemented as of December 31, 2016. Actual cumulative effect adjustment will depend on investments held and market conditions at adoption.

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Accounting Standard and Effective Date Applicable for Cigna	Requirements and Expected Effects of New Guidance Not Yet Adopted
Revenue from Contracts with Customers (ASU 2014-09 and related amendments)	Requires:
Required as of January 1, 2018, with early adoption permitted as of January 1, 2017	Companies to estimate and allocate the expected customer contract revenues among distinct goods or services based on relative standalone selling prices
	Revenues to be recognized as goods or services are delivered
	Extensive new disclosures including the presentation of additional categories of revenues and information about related contract assets and liabilities
	Adoption through retrospective restatement with or without using certain practical expedients or adoption with a cumulative effect adjustment
	Expected effects:
	Applies to the Company's non-insurance, administrative service contracts but does not apply to certain contracts within the scope of other GAAP, such as insurance contracts
	The Company will adopt the new guidance as of January 1, 2018 but has not yet selected a method of adoption

	The Company does not currently expect the adoption of the new guidance to have a material impact to its pattern of revenue recognition
	The Company is continuing to evaluate the new requirements. Specifically, the Company is evaluating the combination of contract guidance for certain customers where the Company provides both insurance and non-insurance products, the deferral of revenue for services provided after the termination of certain administrative contracts and the Company's status as principal or agent for certain performance obligations.

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Significant Accounting Policies

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

A. Investments Policy Loans

Policy loans are carried at unpaid principal balances plus accumulated interest, the total of which approximates fair value. These loans are collateralized by life insurance policy cash values and therefore have minimal exposure to credit loss. Interest rates are reset annually based on an index.

B. Cash and Cash Equivalents

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

C. 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 $203 million as of December 31, 2016 and $78 million as of December 31, 2015. 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. See Note 22 for additional discussion of the allowance established in 2016 for the risk corridor receivable.

D. 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

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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 certain acquisitions.

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 $292 million in 2016, $286 million in 2015 and $289 million in 2014 primarily in other operating expenses.

E. Other Assets, including Other Intangibles

Other assets, including other intangibles consist primarily of GMIB assets, accrued net investment income, other intangible assets and various other insurance-related assets. See Note 17 for the Company's accounting policy for other intangibles. Additionally, these other assets include the carrying value of our equity-method investments in joint ventures in China and other foreign jurisdictions.

F. 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.

G. Future Policy Benefits

Future policy benefits represent the present value of estimated future obligations under long-term life and supplemental health insurance policies and annuity products currently in force. These obligations are estimated using actuarial methods and consist primarily of reserves for annuity contracts, life insurance benefits, GMDB contracts (see Note 9 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 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 9%. Obligations for the run-off settlement annuity business include adjustments for realized and unrealized investment returns consistent with GAAP when a premium deficiency exists.

H. Redeemable Noncontrolling Interests

Products and services are offered in Turkey and India through joint venture entities for which the Company is the principal equity holder or primary beneficiary. Accordingly, these entities are consolidated. The redeemable noncontrolling interests on our Consolidated Balance Sheets represent 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 as of 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 with an offsetting reduction to additional paid-in capital. When an adjustment is made to the carrying value of the redeemable noncontrolling interest, the calculation of shareholders' net income per share will be adjusted if the redemption value exceeds the greater of the carrying value or fair value.

I. Accounts Payable, Accrued Expenses and Other Liabilities

Accounts payable, accrued expenses and other liabilities include liabilities for pension, other postretirement and postemployment benefits (see Note 15), GMIB contract liabilities (see Note 9), self-insured exposures, management compensation, cash overdraft positions and various insurance-related liabilities, including experience-rated refunds, reinsurance contracts and the minimum medical loss ratio rebate accrual under The Patient Protection and Affordable Care Act (the "Health Care Reform Act" or "ACA"). 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.

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J. 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.

K. 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 insured business, medical costs are presented net of pharmaceutical manufacturer rebates. For experience-rated contracts, premium revenue includes an adjustment for experience-rated refunds based on contract terms and calculated using the customer's experience (including estimates of incurred but not reported claims).

Premium revenue also includes an adjustment to reflect the estimated effect of rebates due to customers under the commercial minimum medical loss ratio provisions of the Health Care Reform Act. 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 the Centers for Medicare and Medicaid Services ("CMS") and customers are recognized as revenue ratably over the contract period. CMS provides risk-adjusted premium payments for Medicare Advantage Plans and Medicare Part D products based on the demographics and wellness 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 premiums include 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 the Health Care Reform Act.

Accounting for the Health Care Reform Act's Risk Mitigation Programs. Beginning in 2014, as prescribed by the Health Care Reform Act, 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, Health Maintenance Organizations ("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.

A permanent risk adjustment program reallocates funds from insurers with lower risk populations to insurers with higher risk populations based on the relative risk scores of participants in non-grandfathered plans in the individual and small group markets, both on and off the exchanges. We estimate our receivable or payable based on the risk of our members compared to the risk of other members in the same state and market, considering data obtained from industry studies and HHS.

A three-year (2014-2016) risk corridor program is 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.

Reinsurance contributions associated with non-grandfathered individual plans are reported as reductions in premium revenues, and estimated reinsurance recoveries are established with offsetting reductions in Global Health Care medical costs. 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. For the risk adjustment and risk corridor programs, 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. For additional discussion on our revenue recognition considerations for the risk corridor program in 2016, see Note 22.

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

Revenue for universal life products is recognized as follows:

Investment income on assets supporting universal life products is recognized in net investment income as earned.

Charges for mortality, administration and policy surrender are recognized in premiums as earned. Administrative fees are considered earned when services are provided.

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

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

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L. 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 estimated pharmaceutical manufacturer rebates payable to ASO clients using our network of retail pharmacies and estimated refunds under performance guarantees. Expenses associated with these programs and services are recognized in other operating expenses as incurred, net of estimated pharmaceutical rebates from manufacturers for prescriptions filled through our network of retail pharmacies.

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 defers revenues for estimated payouts associated with these performance guarantees. Approximately 10% of ASO fees reported for the year ended December 31, 2016 were at risk under performance guarantees, with reimbursements estimated to be less than 1% of revenues.

Revenues for investment-related products are recognized as follows:

Investment income on assets supporting investment-related products is recognized in net investment income 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. Mail order pharmacy revenues are presented net of estimated pharmaceutical manufacturer rebates payable to ASO clients using our mail order business. Mail order pharmacy costs include the cost of prescriptions sold and other costs to operate this business including supplies, shipping and handling, net of estimated pharmaceutical rebates from manufacturers for prescriptions filled through our mail order business.

NOTE 3 Mergers and Acquisitions

Proposed Merger

On July 23, 2015, the Company entered into a merger agreement with Anthem, Inc. ("Anthem") and Anthem Merger Sub Corp. ("Merger Sub"), a direct wholly-owned subsidiary of Anthem.

The merger agreement provides (a) for the merger of the Company and Merger Sub, with the Company continuing as the surviving corporation and (b) if certain tax opinions are delivered, immediately following the completion of the initial merger, for the surviving corporation to be merged with and into Anthem, with Anthem continuing as the surviving corporation (collectively, the "merger"). Subject to certain terms, conditions, and customary operating covenants, each share of Cigna common stock issued and outstanding immediately prior to the effective time of the merger would be converted into the right to receive (a) $103.40 in cash, without interest, and (b) 0.5152 of a share of Anthem common stock. The closing price of Anthem common stock on February 22, 2017 was $163.27.

At special shareholders' meetings held in December 2015, Cigna shareholders approved the merger and Anthem shareholders approved the issuance of shares of Anthem common stock in connection with the merger. Completing the merger remains subject to certain customary conditions, including the receipt of certain necessary governmental and regulatory approvals and the absence of a legal restraint prohibiting the merger. Completing the merger is not subject to a financing condition.

On July 21, 2016, the U.S. Department of Justice ("DOJ") and certain state attorneys general filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia (the "District Court") seeking to block the merger and, on January 4, 2017, the parties concluded the District Court trial.

On January 18, 2017, the Company received a written notice from Anthem seeking to extend the termination date of the merger agreement from January 31, 2017 to April 30, 2017.

On February 8, 2017, the District Court issued an order enjoining the proposed merger. Anthem filed a notice of appeal of the District Court's order with the U.S. Court of Appeals for the District of Columbia Circuit (the "Appeals Court") and requested an expedited appeal.

On February 14, 2017, the Company delivered a notice to Anthem terminating the merger agreement and filed suit in the Delaware Court of Chancery (the "Chancery Court") seeking, among other things, declaratory judgment that Cigna's termination of the merger agreement is lawful and that Anthem does not have the right to extend the merger agreement termination date. Later that day, Anthem filed a lawsuit in the Chancery Court against the Company seeking, among other things, a temporary restraining order to enjoin Cigna from terminating the merger agreement, specific performance and damages, and, on February 15, 2017, the Chancery Court issued an order temporarily enjoining the Company from terminating the merger agreement. This order will be subject to further review at a preliminary injunction hearing.

On February 17, 2017, the Appeals Court granted Anthem's motion for an expedited appeal and set oral arguments for March 24, 2017. That same day, the Company filed its notice of appeal of the District Court's order enjoining the merger with the Appeals Court.

The merger agreement contains customary covenants, including covenants that Cigna conduct its business in the ordinary course during the period between entering into the merger agreement and closing. In addition, Cigna's ability to take certain actions prior to closing without Anthem's consent is subject to certain limitations. These limitations relate to, among other matters, the payment of dividends, capital expenditures, the payment or retirement of indebtedness or the incurrence of new indebtedness, settlement of material claims or proceedings, mergers or acquisitions, and certain employment-related matters.

The Company incurred pre-tax costs of $166 million ($147 million after-tax) for the year ended December 31, 2016, and $66 million ($57 million after-tax) for the year ended December 31, 2015 directly related to the proposed merger. These costs consisted primarily of fees for financial advisory, legal and other professional services. If the merger is consummated, most of the merger-related costs are not deductible for federal income tax purposes. If the merger is not consummated, most of these costs would become deductible for federal income tax purposes, resulting in a tax benefit of approximately $50 million.

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Acquisitions

The Company completed certain acquisitions during the three years ended December 31, 2016 that were not material to the Company's results of operations, liquidity or financial condition. In accordance with GAAP, the purchase price for each acquisition was allocated to the tangible and intangible net assets acquired based on management's estimates of their fair values.

NOTE 4 Earnings Per Share

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

Basic and diluted earnings per share were computed as follows:

	2016			**2015**			**2014**		
(Shares in thousands, dollars in millions, except per share amounts)	**Basic**	**Effect of Dilution**	**Diluted**	**Basic**	**Effect of Dilution**	**Diluted**	**Basic**	**Effect of Dilution**	**Diluted**
Shareholders' net income	**$ 1,867**	**$**	**$ 1,867**	$ 2,094	$	$ 2,094	$ 2,102	$	$ 2,102
Shares:									
Weighted average	**255,360**		**255,360**	256,149		256,149	263,889		263,889
Common stock equivalents		**4,287**	**4,287**		4,443	4,443		4,714	4,714
Total shares	**255,360**	**4,287**	**259,647**	256,149	4,443	260,592	263,889	4,714	268,603
EPS	**$ 7.31**	**$ (0.12)**	**$ 7.19**	$ 8.17	$ (0.13)	$ 8.04	$ 7.97	$ (0.14)	$ 7.83

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)	**2016**	2015	2014
Anti-dilutive options	**2.3**	0.4	1.0

NOTE 5 Debt

The outstanding amounts of debt and capital leases for the years ended December 31 were as follows:

(In millions)	**2016**	2015

Short-term:				
Commercial paper	**$**		$	100
Current maturities of long-term debt		**250**		
Other, including capital leases		**26**		49
Total short-term debt	**$**	**276**	$	149
Long-term:				
Uncollateralized debt:				
$250 million, 5.375% Notes due 2017	**$**		$	249
$131 million, 6.35% Notes due 2018		**131**		131
$250 million, 4.375% Notes due 2020 (1)		**252**		254
$300 million, 5.125% Notes due 2020 (1)		**301**		303
$78 million, 6.37% Notes due 2021		**78**		78
$300 million, 4.5% Notes due 2021 (1)		**302**		304
$750 million, 4% Notes due 2022		**744**		743
$100 million, 7.65% Notes due 2023		**100**		100
$17 million, 8.3% Notes due 2023		**17**		17
$900 million, 3.25% Notes due 2025		**893**		892
$300 million, 7.875% Debentures due 2027		**299**		299
$83 million, 8.3% Step Down Notes due 2033		**82**		82
$500 million, 6.15% Notes due 2036		**498**		498
$300 million, 5.875% Notes due 2041		**296**		295
$750 million, 5.375% Notes due 2042		**743**		743
Other, including capital leases		**20**		32
Total long-term debt	**$**	**4,756**	$	5,020

(1)

The Company has 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.

The Company has a five-year 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 to increase the commitment amount to $2 billion and to extend the term past December 2019, subject to consent by the administrative agent and the committing banks. The credit agreement is available for general corporate purposes including for the issuance of letters of credit. The credit agreement contains customary covenants and restrictions, including a financial covenant that the Company may not permit its leverage ratio that is total consolidated debt

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to total consolidated capitalization (each as defined in the credit agreement) to exceed 0.50. The leverage ratio excludes the following items that are included in accumulated other comprehensive loss on the Company's Consolidated Balance Sheets: net unrealized appreciation in fixed maturities and the portion of the post-retirement benefits liability adjustment attributable to pension. The Company was in compliance with its debt covenants as of December 31, 2016.

The Company had $9.7 billion of borrowing capacity within the maximum debt coverage covenant in the letter of credit agreement, in addition to the $5 billion of debt outstanding as of December 31, 2016. This additional borrowing capacity includes the $1.5 billion available under the credit agreement. Letters of credit outstanding as of December 31, 2016 totaled $14 million.

On March 11, 2015, the Company issued $900 million of 10-Year Notes due April 15, 2025 at a stated interest rate of 3.25% ($892 million, net of discount and issuance costs, with an effective annual interest rate of 3.36%). Interest is payable on April 15 and October 15 of each year beginning October 15, 2015. The proceeds of this debt were used to repay debt maturing in 2016 and in 2019 as described below.

The Company may redeem these Notes, at any time, in whole or in part, at a redemption price equal to the greater of:

100% of the principal amount of the Notes to be redeemed; or

the present value of the remaining principal and interest payments on the Notes being redeemed discounted at the applicable Treasury rate plus 17.5 basis points.

The following debt transactions occurred in April 2015:

The Company redeemed its 2.75% Notes due 2016, including accrued interest from November 15, 2014 through the settlement date of April 13, 2015. The redemption price equaled the present value of the remaining principal and interest payments on the Notes being redeemed, discounted at a rate equal to the 10-year Treasury Rate plus a fixed spread of 30 basis points. The Company paid $626 million including accrued interest and expenses, resulting in a pre-tax loss on early debt extinguishment of $21 million ($14 million after-tax) that was recognized in the second quarter of 2015.

The Company redeemed its 8.50% Notes due 2019, including accrued interest from November 1, 2014 through the settlement date of April 13, 2015. The redemption price equaled the present value of the remaining principal and interest payments on the Notes being redeemed, discounted at a rate equal to the 10-year Treasury Rate plus a fixed spread of 50 basis points. The Company paid $329 million including accrued interest and expenses, resulting in a pre-tax loss on early debt extinguishment of $79 million ($51 million after-tax) that was recognized in the second quarter of 2015.

Maturities of long-term debt and capital leases are as follows:

Scheduled Maturities

(In millions)	**Long-term Debt (1)**	Capital Leases
2017	**$ 255**	$ 21
2018	**$ 131**	$ 10
2019	**$**	$ 10
2020	**$ 549**	$
2021	**$ 378**	$
Maturities after 2021	**$ 3,694**	$

(1)

Long-term debt maturity amounts exclude capital leases.

Interest expense on long-term and short-term debt was $251 million in 2016, $252 million in 2015, and $265 million in 2014. The 2015 expense excludes losses on the early extinguishment of debt.

NOTE 6 Common and Preferred Stock

As of December 31, the Company had issued the following shares:

(Shares in thousands)	**2016**	2015	2014
Common: Par value $0.25; 600,000 shares authorized			
Outstanding January 1,	**256,544**	259,276	275,526
Issued for stock option and other benefit plans	**1,110**	2,751	2,284
Repurchased common stock	**(785)**	(5,483)	(18,534)
Outstanding December 31,	**256,869**	256,544	259,276
Treasury stock	**39,276**	39,601	36,869
Issued December 31,	**296,145**	296,145	296,145

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

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, 2016, 2015 or 2014.

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NOTE 7 Global Health Care Medical Costs Payable

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

This 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 more recent months, the Company relies more heavily 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 costs payable to actual experience. When actual experience differs from these assumptions, medical costs 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 process used to determine this liability requires the Company to make critical accounting estimates that involve considerable judgment, reflecting the variability inherent in forecasting future claim payments. These estimates are highly sensitive to changes in the Company's key assumptions, specifically completion factors and medical cost trends.

Liability balance details. The liability for Global Health Care medical costs payable as of December 31 is comprised of the following:

(In millions)	**2016**	2015
Incurred but not reported	**$ 1,858**	$ 1,757
Reported claims in process	**556**	470
Physician incentives and other medical care expense and services payable	**118**	128
Medical costs payable	**$ 2,532**	$ 2,355

Activity in medical costs payable was as follows:

(In millions)	**2016**	2015	2014
Balance at January 1,	**$ 2,355**	$ 2,180	$ 2,050
Less: Reinsurance and other amounts recoverable	**243**	252	194
Balance at January 1, net	**2,112**	1,928	1,856
Incurred costs related to:			
Current year	**19,087**	18,564	16,853
Prior years	**(78)**	(210)	(159)
Total incurred	**19,009**	18,354	16,694
Paid costs related to:			
Current year	**17,052**	16,588	14,966

Prior years	**1,812**	1,582	1,656
Total paid	**18,864**	18,170	16,622
Balance at December 31, net	**2,257**	2,112	1,928
Add: Reinsurance and other amounts recoverable	**275**	243	252
Balance at December 31,	**$ 2,532**	$ 2,355	$ 2,180

Reinsurance and other amounts recoverable reflect amounts due from reinsurers and policyholders to cover incurred but not reported and pending claims for certain business where the Company administers the plan benefits but the right of offset does not exist. See Note 9 for additional information on reinsurance.

For the years ended December 31, variances in incurred costs related to prior years' medical costs payable that resulted from the differences between actual experience and the Company's key assumptions were as follows:

	2016		**2015**	
($ in millions)	**$**	**% (1)**	$	% (2)
Actual completion factors	**$ 59**	**0.3%**	$ 62	0.4%
Medical cost trend	**27**	**0.1%**	115	0.7%
Other (3)	**(8)**	**0.0%**	33	0.2%
Total favorable (unfavorable) variance	**$ 78**	**0.4%**	$ 210	1.3%

(1)

Percentage of current year incurred costs as reported for 2015.

(2)

Percentage of current year incurred costs as reported for 2014.

(3)

In 2015, the other balance primarily relates to an increase in the 2014 reinsurance reimbursement rate from CMS under the Health Care Reform Act.

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Incurred costs related to prior years in the table above, although adjusted through shareholders' net income, do not directly correspond to an increase or decrease to shareholders' net income. The primary reason for this difference is that decreases to prior year incurred costs pertaining to the portion of the liability established for moderately adverse conditions are not considered as impacting shareholders' net income if they are offset by increases in the current year provision for moderately adverse conditions.

The net impact of prior year development on shareholders' net income was not significant for the year ended December 31, 2016 compared with a $60 million increase for the year ended December 31, 2015. Favorable prior year development implies primarily lower than expected utilization of medical services and vice versa while amounts close to zero imply utilization of medical services that are consistent with expectations.

The table below depicts the incurred and paid claims development as of December 31, 2016 (net of reinsurance), claims frequency metrics and incurred but not reported liabilities for Cigna's Global Health Care medical costs payable. The information about incurred and paid claims development for the year ended December 31, 2015 is presented as supplementary information and is unaudited.

	Incurred Costs			
($ in millions, except for claims frequency) ***Incurral Year***	**2015 (Unaudited)**	**2016**	**Medical Costs Payable**	**Claims Frequency**
2015	$ 18,564	$ 18,487	$ 182	2.5 million
2016		19,087	$ 2,035	2.9 million
Cumulative incurred costs for the periods presented		$ 37,574		

	Cumulative Paid Costs	
Incurral Year	**2015 (Unaudited)**	**2016**
2015	$ 16,588	$ 18,305
2016		17,052
Cumulative paid costs for the periods presented		$ 35,357
Outstanding liabilities prior to 2015		40
Net outstanding liabilities for Global Health Care medical costs payable		2,257
Reinsurance and other amounts recoverable		275
Total liability for Global Health Care medical costs payable		$ 2,532

More than 95% of health claims for an accident year are paid within one year of their incurred date.

There is no single or common claim frequency metric used in the health care industry. The Company believes a relevant metric for the Global Health Care segment is the number of customers for whom an insured medical claim was paid. This metric will generally be consistent and comparable over time.

NOTE 8 Liabilities for Unpaid Claims and Claim Expenses

As discussed in Note 2, the Company is newly required by ASU 2015-09 to present additional information about its claim estimates related to short-duration insurance contracts. The following information relates to the Company's unpaid claims and claim expense liabilities.

Accounting policy. Liabilities for unpaid claims and claim expenses are established by book of business within the Company's Group Disability and Life, Global Supplemental Benefits and Other Operations segments. The Group Disability and Life segment's liability for unpaid claims and claim expenses consists of the following primary products: long-term and short-term disability, life insurance, and accident coverages. Unpaid claims and claim expenses consist of (1) case or claims reserves for known claims that are unpaid as of the balance sheet date; (2) incurred but not reported reserves for claims when the insured event has occurred but has not been reported to the Company; and (3) loss adjustment expense reserves for the expected costs of settling these claims. The Company consistently estimates incurred but not yet reported losses using actuarial principles and assumptions based on historical and projected claim incidence patterns, claim size and the expected payment period. The Company recognizes the actuarial best estimate of the ultimate liability within a level of confidence, consistent with actuarial standards of practice that the liabilities be adequate under moderately adverse conditions. When estimates of these liabilities change, the Company immediately records the adjustment in benefits and expenses.

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, the cause of disability, the benefit design and the claimant's age, gender and income level. The gross monthly benefit is reduced (offset) by disability income received under other benefit programs, most commonly Social Security Disability Income, workers' compensation, statutory disability or other group benefit plans. For certain offsets not yet finalized, the Company estimates the probability and amount of future offset awards and lapses based on the Company's experience.

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Liability balance details. The liability for unpaid claims and claim expenses by segment as of December 31 is as follows:

(In millions)	**2016**	2015
Group Disability and Life	**$ 4,342**	$ 4,006
Global Supplemental Benefits	**384**	353
Other Operations	**191**	215
Unpaid claims and claim expenses	**$ 4,917**	$ 4,574

The Company discounts certain liabilities, predominantly long-term disability, because benefits payments are made over extended periods. Discount rate assumptions for these liabilities are based on projected investment returns for the supporting asset portfolios. Details of the Company's unpaid claim discounted liability balances as of December 31 were as follows:

(In billions)	**2016**	2015
Discounted liabilities	**$ 3.9**	$ 3.7
Aggregate amount of discount	**$ 1.1**	$ 1.0
Range of discount rates	**3.3% - 5.8%**	3.5% - 5.7%

Interest is accreted and recognized in other benefit expenses in the Consolidated Statements of Income.

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

(In millions)	**2016**	2015	2014
Balance at January 1,	**$ 4,359**	$ 4,178	$ 4,038
Less: Reinsurance	**115**	104	99
Balance at January 1, net	**4,244**	4,074	3,939
Incurred claims related to:			
Current year	**4,258**	3,813	3,512
Prior years:			
Interest accretion	**161**	163	149
All other incurred	**93**	(91)	(165)
Total incurred	**4,512**	3,885	3,496
Paid claims related to:			
Current year	**2,575**	2,325	2,078
Prior years	**1,560**	1,382	1,271
Total paid	**4,135**	3,707	3,349
Acquisitions		11	
Foreign currency	**(16)**	(19)	(12)
Balance at December 31, net	**4,605**	4,244	4,074
Add: Reinsurance	**121**	115	104

Balance at December 31,	**$ 4,726**	$ 4,359	$ 4,178

Reinsurance in the table above reflect amounts due from reinsurers related to unpaid claims liabilities. The Company's insurance subsidiaries enter into agreements with other companies primarily to limit losses from large exposures and to permit recovery of a portion of incurred losses. See Note 9 for additional information on reinsurance.

The majority of the liability for unpaid claims and claim expenses is related to disability claims with long-tailed payouts. Interest earned on assets backing these liabilities is an integral part of pricing and reserving. Therefore, interest accreted on prior year balances is shown as a separate component of prior year incurred claims. This interest is calculated by applying the average discount rate used in determining the liability balance to the average liability balance over the period. The remaining prior year incurred claims amount primarily reflects updates to the Company's liability estimates and variances between actual experience during the period relative to the assumptions and expectations reflected in determining the liability. Assumptions reflect the Company's expectations over the life of the book of business and will vary from actual experience in any period, both favorably and unfavorably, with variation in resolution rates being the most significant driver for the long-term disability business. Prior year incurred claims reported in 2016 included the impact of modifications made to our disability claims management process and a period of elevated life claims.

Long-Term Disability Development Tables. The table below presents information about incurred and paid claims development as of December 31, 2016 (net of reinsurance) cumulative claim frequency and total incurred but not reported liabilities for the Company's long-term disability book of business. The information about incurred and paid claims development for the years ended December 31, 2012 through 2015, is presented as supplementary information and is unaudited. As permitted under the standard in the initial year of adoption, the Company

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presented development table information for five years because obtaining information beyond this period was impracticable as historical data was not maintained in such detail at this level.

(In millions, except for claims frequency)

	Incurred Claims (undiscounted)					Incurred But Not	
Accident Year	**2012 (Unaudited)**	**2013 (Unaudited)**	**2014 (Unaudited)**	**2015 (Unaudited)**	**2016**	**Reported Liabilities**	**Claims Frequency**
2012	$ 995	$ 951	$ 889	$ 876	$ 883	$	21,170
2013		1,063	1,037	1,062	1,072		23,493
2014			1,158	1,129	1,167	3	25,175
2015				1,184	1,154	17	25,133
2016					1,246	524	13,734
Cumulative incurred claims for the periods presented					$ 5,522		

Cumulative Paid Claims

Accident Year	**2012 (Unaudited)**	**2013 (Unaudited)**	**2014 (Unaudited)**	**2015 (Unaudited)**	**2016**
2012	$ 81	$ 288	$ 429	$ 504	$ 571
2013		92	342	503	600
2014			111	379	575
2015				114	417
2016					122
Cumulative paid claims for the periods presented					2,285
All outstanding liabilities prior to 2012, net of reinsurance					1,361
Impact of discounting					(976)
Liability for long-term disability unpaid claims and claim expenses, net of reinsurance					$ 3,622

The claims frequency metric used for the Company's long-term disability line of business represents the number of unique claim events for which benefits have been approved and payments made. Claim events are identified using a unique claimant identifier and incurral date. Thus, if an individual has multiple claims for different disabling events (and therefore different incurral dates), each will be determined to be a unique claim event. However, if an individual receives multiple benefits under more than one policy (for example for supplemental disability benefits such as pension contribution benefits or survivor benefits), the Company treats this as a single claim occurrence because they related to the same claim event. Claims frequency metrics for the most recent year are expected to be low, reflecting the long-term disability product features including waiting and elimination periods that result in delayed eligibility for contract benefits.

The following is supplementary and unaudited information about average historical claims payout patterns for the long-term disability business for the years presented in the development table as of December 31, 2016. The average annual percentage payout of incurred claims, net of reinsurance, is approximately 9% in year one, 24% in year two, 16% in year three, 9% in year four and 8% in year five.

The following reconciles the long-term disability net incurred and paid claims development table to the liability for unpaid claims and claim expenses in the Company's Consolidated Balance Sheets as of December 31, 2016.

(In millions)

Net outstanding liabilities	**Group Disability and Life segment**	
Long-term disability liabilities, net of reinsurance		$ 3,622
Other short-duration insurance books of business, net of reinsurance		620
Liabilities for unpaid claims and claim expenses, net of reinsurance		4,242
Reinsurance recoverable on unpaid claims	**Group Disability and Life segment**	
Long-term disability		86
Other short-duration insurance books of business		14
Total reinsurance recoverable on unpaid claims		100
Total liability for unpaid claims and claim expenses	Group Disability and Life segment	4,342
Global Supplemental Benefits segment		384
Other Operations segment		191
Total liability for unpaid claims and claim expenses		$ 4,917

The other short-duration insurance books of business, net of reinsurance, primarily include liabilities for life, accident and short-term disability insurance products. Liabilities for these products are typically complete within one year. Claim development on these liabilities is largely driven by completion factors and loss ratio assumptions. In 2016, development on these liabilities was driven by a period of elevated life claims.

NOTE 9 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

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insurer of liability. Therefore, reinsured liabilities must continue to be reported along with the related reinsurance recoverables. The Company regularly evaluates the financial condition of its reinsurers and monitors concentrations of its credit risk.

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, 2016**	**December 31, 2015**	**Collateral and Other Terms at December 31, 2016**
Ongoing operations:				
Global Health Care, Global Supplemental Benefits, Group Disability and Life	Various	**$ 478**	$ 553	Recoverables from approximately 80 reinsurers, including the U.S. Government, used in the ordinary course of business. Current balances range from less than $1 million up to $96 million. Excluding the recoverable from the U.S. Government of $63 million, 13% is secured by assets in trusts or letters of credit.
Total recoverables related to ongoing operations		**478**	553	
Acquisition, disposition or runoff activities:				
Individual Life and Annuity (sold in 1998)	Lincoln National Life and Lincoln Life & Annuity of New York	**3,586**	3,705	Both companies' ratings were sufficient to avoid triggering a contractual obligation to fully secure the outstanding balance.
GMDB (effectively exited in 2013)	Berkshire	**1,085**	1,123	100% secured by assets in a trust.
	Other	**44**	41	100% secured by assets in a trust or letters of credit.
Retirement Benefits Business (sold in 2004)	Prudential Retirement Insurance and Annuity	**921**	995	100% secured by assets in a trust.
Supplemental Benefits Business (2012 acquisition)	Great American Life	**297**	315	99% secured by assets in a trust.
	Various	**67**	81	99% secured by assets in a trust or other deposits.

Other run-off reinsurance		
Total recoverables related to acquisition, disposition or runoff activities	**6,000**	6,260
Total reinsurance recoverables	**$ 6,478**	$ 6,813

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. Over 90% of the Company's reinsurance recoverables were from companies rated A or higher by Standard & Poors at December 31, 2016. The Company reviews its reinsurance arrangements and establishes reserves against the recoverables if recovery is not considered probable. As of December 31, 2016 and December 31, 2015, the Company's recoverables were net of a reserve of $3 million.

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

(In millions)	**2016**	**2015**	**2014**
Premiums			
Short-duration contracts:			
Direct	**$ 27,496**	$ 26,751	$ 24,294
Assumed	**247**	289	429
Ceded	**(229)**	(254)	(226)
Total short-duration contract premiums	**27,514**	26,786	24,497
Long-duration contracts:			
Direct	**3,259**	3,061	2,921
Assumed	**137**	111	173
Ceded:			
Individual life insurance and annuity business sold	**(153)**	(158)	(254)
Other	**(131)**	(158)	(123)
Total long-duration contract premiums	**3,112**	2,856	2,717
Total premiums	**$ 30,626**	$ 29,642	$ 27,214
Reinsurance recoveries			
Individual life insurance and annuity business sold	**$ 279**	$ 301	$ 366
Other	**261**	436	292
Total reinsurance recoveries	**$ 540**	$ 737	$ 658

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.

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Effective Exit of GMDB and GMIB Business

In 2013, the Company entered into an agreement with Berkshire to effectively exit the GMDB and GMIB business via a reinsurance transaction for a payment of $2.2 billion. Berkshire reinsured 100% of the Company's future claim payments in this business, net of retrocessional arrangements existing at that time. The reinsurance agreement is subject to an overall limit with approximately $3.5 billion remaining at December 31, 2016.

A discussion of each of these businesses follows. While GMDB is accounted for as reinsurance, GMIB assets and liabilities are reported as derivatives at fair value as discussed below. Accordingly, GMIB assets are reported in other assets, including intangibles, and GMIB liabilities are reported in accounts payable, accrued expenses and other liabilities.

GMDB

The majority of the GMDB exposure arises under annuities written by ceding companies that guarantee 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's exposure arises when the highest anniversary account value exceeds the fair value of the related mutual fund investments at the time of a contractholder's death.

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

Because the product is premium deficient, the Company records an increase to the net retained reserve if it is inadequate based on the model.

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

(In millions)	**2016**	2015	2014
Balance at January 1,	**$ 1,252**	$ 1,270	$ 1,396
Add: Unpaid claims	**18**	16	18
Less: Reinsurance and other amounts recoverable	**1,164**	1,186	1,317
Balance at January 1, net	**106**	100	97
Add: Incurred benefits	**4**	3	3
Less: Paid benefits / (recoveries)	**(1)**	(3)	
Ending balance, net	**111**	106	100
Less: Unpaid claims	**16**	18	16
Add: Reinsurance and other amounts recoverable	**1,129**	1,164	1,186
Balance at December 31,	**$ 1,224**	$ 1,252	$ 1,270

Benefits paid and incurred are net of ceded amounts.

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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)	**2016**	2015
Account value	**$ 10,650**	$ 11,355
Net amount at risk	**$ 2,458**	$ 2,870
Average attained age of contractholders (weighted by exposure)	**75**	74
Number of contractholders	**285,000**	324,000

GMIB

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

Accounting policy. The Company reports GMIB liabilities and assets as derivatives at fair value because cash flows of these liabilities and assets are affected by equity markets and interest rates, but are without significant life insurance risk and are settled in lump sum payments. Periodically, the Company 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. Cash flows on these contracts are reported in operating activities.

As of December 31, 2016, there were three reinsurers for GMIB as follows:

(In millions)

Line of Business	**Reinsurer(s)**	**December 31, 2016**	**December 31, 2015**	**Collateral and Other Terms at December 31, 2016**
GMIB	Berkshire	**$ 370**	$ 420	100% were secured by assets in a trust.
	Sun Life Assurance Company of Canada	**227**	257	
	Liberty Re (Bermuda) Ltd.	**202**	230	100% were secured by assets in a trust.
Total GMIB recoverables reported in other assets		**$ 799**	$ 907	

Assumptions used in fair value measurement. 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. The only assumption expected to impact future shareholders' net income is non-performance risk. The non-performance risk adjustment reflects a market participant's view of nonpayment risk by adding an additional spread to the discount rate in the calculation of both (a) the GMIB liabilities to be paid by the Company, and (b) the GMIB assets to be paid by the reinsurers, after considering collateral.

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 in the fair value hierarchy presented in Note 10.

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 of the Company, or significant increases in assumed annuity election rates or spreads used to calculate the non-performance risk of the reinsurers, 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 guarantees. Future payments are not fixed and determinable under the terms of these contracts. Accordingly, the Company calculated exposure, without considering any reinsurance coverage, using the following hypothetical assumptions:

- no annuitants surrendered their accounts;
- all annuitants lived to elect their benefit;
- all annuitants elected to receive their benefit on the next available date (2017 through 2021); and
- all underlying mutual fund investment values remained at the December 31, 2016 value of $810 million with no future returns.

The Company has reinsurance coverage in place that covers the exposures on these contracts. Using these hypothetical assumptions, GMIB exposure is $703 million, which is lower than the recorded liability for GMIB calculated using fair value assumptions.

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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 only 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 for assigning the appropriate level within the fair value hierarchy, based on the significance of unobservable inputs. The Company reviews methodologies, processes and controls of third-party pricing services and compares prices on a test basis to those obtained from other external pricing sources or internal estimates. The Company performs ongoing analyses of both prices received from third-party pricing services and those developed internally to determine that they represent appropriate estimates of fair value. The controls executed by the Company include evaluating changes in prices and monitoring for potentially stale valuations. The Company also performs sample testing of sales values to confirm the accuracy of prior fair value estimates. The minimal exceptions identified during these processes indicate that adjustments to prices are infrequent and do not significantly impact valuations. Annually, we conduct an on-site visit of the most significant pricing service to review their processes, methodologies and controls. This on-site review includes a walk-through of inputs of a sample of securities held across various asset types to validate the documented pricing process.

A. Financial Assets and Financial Liabilities Carried at Fair Value

The following tables provide information as of December 31, 2016 and 2015 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, 2016

(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	**$ 374**	**$ 503**	**$**	**$ 877**
State and local government		**1,435**		**1,435**
Foreign government		**2,066**	**47**	**2,113**
Corporate		**15,552**	**498**	**16,050**
Mortgage and other asset-backed		**329**	**157**	**486**
Total fixed maturities (1)	**374**	**19,885**	**702**	**20,961**
Equity securities	**396**	**113**	**74**	**583**
Subtotal	**770**	**19,998**	**776**	**21,544**
Short-term investments		**691**		**691**
GMIB assets			**799**	**799**
Other derivative assets		**10**		**10**
Total financial assets at fair value, excluding separate accounts	**$ 770**	**$ 20,699**	**$ 1,575**	**$ 23,044**
GMIB liabilities	**$**	**$**	**$ 780**	**$ 780**
Other derivative liabilities		**5**		**5**
Total financial liabilities at fair value	**$**	**$ 5**	**$ 780**	**$ 785**

(1)

Fixed maturities included $524 million of net appreciation required to adjust future policy benefits for the run-off settlement annuity business including $14 million of appreciation for securities classified in Level 3. See Note 11A for additional information.

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December 31, 2015

(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	$ 251	$ 528	$	$ 779
State and local government		1,641		1,641
Foreign government		2,010	4	2,014
Corporate		14,122	326	14,448
Mortgage and other asset-backed		246	327	573
Total fixed maturities (1)	251	18,547	657	19,455
Equity securities	32	89	69	190
Subtotal	283	18,636	726	19,645
Short-term investments		381		381
GMIB assets			907	907
Other derivative assets		16		16
Total financial assets at fair value, excluding separate accounts	$ 283	$ 19,033	$ 1,633	$ 20,949
GMIB liabilities	$	$	$ 885	$ 885
Total financial liabilities at fair value	**$**	**$**	**$ 885**	**$ 885**

(1)

Fixed maturities included $483 million of net appreciation required to adjust future policy benefits for the run-off settlement annuity business including $30 million of appreciation for securities classified in Level 3. See Note 11A 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 93% 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 that 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, 2016 or 2015. 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.

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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 4% of fixed maturities and equity securities are priced using significant unobservable inputs and classified in this category.

Fair values of mortgage and other asset-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 mortgage and other-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 in its evaluation, as well as the issuer's financial statements.

Quantitative Information about Unobservable Inputs

The following tables summarize the fair value and significant unobservable inputs used in pricing the following securities that were developed directly by the Company as of December 31, 2016 and 2015. The range and weighted average basis point amounts ("bps") 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 these fair values.

Mortgage and other asset-backed securities. The significant unobservable inputs used to value the following mortgage and other asset-backed securities are liquidity and weighting of credit spreads. 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 price to EBITDA is used to estimate value based on company circumstances and relative risk characteristics.

As of December 31, 2016

(Fair value in millions)	**Fair Value**	**Unobservable Input**	**Unobservable Adjustment Range (Weighted Average)**
Fixed maturities:			
Mortgage and other asset-backed securities	**$ 157**	Liquidity	60 330 (90) bps

			Weighting of credit spreads	160	470 (230) bps	
Corporate and government fixed maturities	**490**		Liquidity	80	1,300 (340) bps	
Total fixed maturities	**647**					
Equity securities	**74**		Price-to-EBITDA multiples		4.2	11.6 (8.5)
Subtotal	**721**					
Securities not priced by the Company (1)	**55**					
Total Level 3 securities	**$ 776**					

(1)

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

As of December 31, 2015

Fixed maturities:					
Mortgage and other asset-backed securities	$ 327	Liquidity	60	440 (200) bps	
		Weighting of credit spreads	170	630 (220) bps	
Corporate and government fixed maturities	285	Liquidity	70	930 (280) bps	
Total fixed maturities	612				
Equity securities	69	Price-to-EBITDA multiples		4.2	11.6 (8.3)
Subtotal	681				
Securities not priced by the Company (1)	45				
Total Level 3 securities	$ 726				

(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 lower fair value measurements while decreases in these inputs would result in higher fair value measurements. Significant decreases in equity price-to-EBITDA multiples would result in lower fair value measurements while increases in these inputs would result in higher fair value measurements. 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.

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GMIB contracts. See discussion in Note 9.

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, 2016 and 2015. Separate account asset changes are reported separately under the heading "separate account assets" as the changes in fair values of these assets generally 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, 2016	$ 726	$ 907	$ (885)	$ 22
Gains (losses) included in shareholders' net income:				
GMIB fair value gain/(loss)		**(47)**	**47**	
Other	**(18)**		**(3)**	**(3)**
Total gains (losses) included in shareholders' net income	**(18)**	**(47)**	**44**	**(3)**
Losses included in other comprehensive income	**(1)**			
Gains required to adjust future policy benefits for settlement annuities (1)	**29**			
Purchases, sales, settlements:				
Purchases	**96**			
Sales	**(140)**			
Settlements	**(74)**	**(61)**	**61**	
Total purchases, sales and settlements	**(118)**	**(61)**	**61**	
Transfers into/(out of) Level 3:				
Transfers into Level 3	**338**			
Transfers out of Level 3	**(180)**			
Total transfers into/(out of) Level 3	**158**			
Balance at December 31, 2016	$ 776	$ 799	$ (780)	$ 19
Total gains (losses) included in shareholders' net income attributable to instruments held at the reporting date	**$ (18)**	**$ (47)**	**$ 44**	**$ (3)**
Balance at January 1, 2015	$ 857	$ 953	$ (929)	$ 24
Gains (losses) included in shareholders' net income:				
GMIB fair value gain/(loss)		(5)	2	(3)

Other	24	1		1
Total gains (losses) included in shareholders' net income	24	(4)	2	(2)
Losses included in other comprehensive income	(11)			
Losses required to adjust future policy benefits for settlement annuities (1)	(1)			
Purchases, sales, settlements:				
Purchases	153			
Sales	(230)			
Settlements	(21)	(42)	42	
Total purchases, sales and settlements	(98)	(42)	42	
Transfers into/(out of) Level 3:				
Transfers into Level 3	49			
Transfers out of Level 3	(94)			
Total transfers into/(out of) Level 3	(45)			
Balance at December 31, 2015	$ 726	$ 907	$ (885)	$ 22
Total gains (losses) included in shareholders' net income attributable to instruments held at the reporting date	$ (6)	$ (4)	$ 2	$ (2)

(1)
Amounts do not accrue to shareholders.

As noted in the preceding tables, 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, 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.

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.

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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 year ended 2016, transfers between Level 2 and Level 3 primarily reflect changes in liquidity and credit risk estimates for certain private placement issuers in the metals, mining, energy, electric and consumer sectors. For the year ended 2015, transfers out of Level 3 primarily reflect a change in the significance of the unobservable inputs related to liquidity and credit estimates used to value several private corporate bonds.

Separate Accounts

Accounting policy. Separate account assets and liabilities are contractholder funds maintained in accounts with specific investment objectives. The assets of these accounts are legally segregated and are not subject to claims that arise out of any of the Company's other businesses. These separate account assets are carried at fair value with equal amounts recorded for related separate account liabilities. The investment income and fair value gains and losses of these accounts generally accrue directly to the contractholders and, together with their deposits and withdrawals, are excluded from the Company's Consolidated Statements of Income and Cash Flows. Fees and charges earned for mortality risks, asset management or administrative services are reported in either premiums or fees and other revenues. Beginning in 2016, investments that are measured using the practical expedient of NAV (see Note 2 for additional information) are excluded from the fair value hierarchy. Prior periods have been reclassified to conform to the current presentation.

At December 31, fair values of separate account assets were as follows:

(In millions)	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**	**Total**
2016				
Guaranteed separate accounts (See Note 21)	**$ 238**	**$ 262**	**$**	**$ 500**
Non-guaranteed separate accounts (1)	**1,368**	**4,885**	**331**	**6,584**
Subtotal	**$ 1,606**	**$ 5,147**	**$ 331**	**$ 7,084**
Non-guaranteed separate accounts priced at NAV as a practical expedient (1)				**856**
Total separate account assets				**$ 7,940**
2015				
Guaranteed separate accounts (See Note 21)	$ 235	$ 274	$	$ 509
Non-guaranteed separate accounts (1)	1,401	4,698	297	6,396
Subtotal	$ 1,636	$ 4,972	$ 297	$ 6,905

Non-guaranteed separate accounts priced at NAV as a practical expedient (1)	
Total separate account assets	$ 7,833

(1)

Non-guaranteed separate accounts included $3.7 billion as of December 31, 2016 and $3.6 billion as of December 31, 2015 in assets supporting the Company's pension plans, including $0.3 billion classified in Level 3 and $0.9 billion priced at NAV as a practical expedient for both periods.

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 that is the exit price.

Separate account assets classified in Level 3 primarily support Cigna's pension plans, and include certain newly issued, privately-placed, complex, or illiquid securities that are priced using methods discussed above, as well as commercial mortgage loans that are valued according to the methodologies discussed below. The following tables summarize the changes in separate account assets reported in Level 3 for the years ended December 31, 2016 and 2015.

(In millions)	**2016**	**2015**
Balance at January 1	**$ 297**	$ 255
Policyholder gains (losses)	**2**	(6)
Purchases, issuances, settlements:		
Purchases	**22**	59
Sales	**(11)**	
Settlements	**(18)**	(16)
Total purchases, sales and settlements	**(7)**	43
Transfers into/(out of) Level 3:		
Transfers into Level 3	**65**	17
Transfers out of Level 3	**(26)**	(12)
Total transfers into/(out of) Level 3:	**39**	5
Balance at December 31	**$ 331**	$ 297

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Separate account investments in securities partnerships, real estate, and hedge funds are generally valued based on the separate account's ownership share of the equity of the investee (NAV as a practical expedient), including changes in the fair values of its underlying investments. Substantially all of these assets support the Cigna Pension Plans. The table below provides additional information on these investments.

	Fair Value as of				
(In millions)	December 31, 2016	December 31, 2015	Unfunded Commitments	Redemption Frequency (if currently eligible) (1)	Redemption Notice Period (1)
Security Partnerships	**$ 424**	$ 406	$ 286	Not applicable	Not applicable
Real Estate Funds	**231**	261		Quarterly Up to Annually, varying by fund	45-90 days
Hedge Funds	**201**	261			30-90 days
Total	**$ 856**	$ 928	$ 286		

(1) *The attributes noted are effective as of December 31, 2016 and 2015.*

B. Assets and Liabilities Measured at Fair Value under Certain Conditions

Some financial assets and liabilities are not carried at fair value each reporting period, but may be measured using fair value only under certain conditions, such as investments in real estate, partnership entities and commercial mortgage loans when they become impaired. Impaired values for these asset types classified as Level 3 representing less than 1% of total investments, were written down to their fair values, resulting in realized investment losses of $4 million after-tax in 2016 and $16 million after-tax in 2015.

C. Fair Value Disclosures for Financial Instruments Not Carried at Fair Value

The following table includes the Company's financial instruments not recorded at fair value that are subject to fair value disclosure requirements at December 31, 2016 and 2015. In addition to universal life products and capital leases, financial instruments that are carried in the Company's Consolidated Financial Statements at amounts that approximate fair value are excluded from the following table.

		December 31, 2016		December 31, 2015	
(In millions)	Classification in Fair Value Hierarchy	Fair Value	Carrying Value	Fair Value	Carrying Value

Commercial mortgage loans	Level 3	**$**	**1,682**	**$**	**1,666**	$	1,911	$ 1,864
Contractholder deposit funds, excluding universal life products	Level 3	**$**	**1,215**	**$**	**1,212**	$	1,151	$ 1,148
Long-term debt, including current maturities, excluding capital leases	Level 2	**$**	**5,460**	**$**	**4,991**	$	5,515	$ 5,020

The fair values for all financial instruments 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 70% 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, 2016 and 2015.

NOTE 11 Investments, Investment Income and Gains and Losses

Cigna's investment portfolio consists of a broad range of investments including fixed maturities and equity securities, commercial mortgage loans, other long-term investments and short-term investments. The sections below provide more detail regarding our accounting policies, investment balances, net investment income and realized investment gains and losses. See Note 10 for information about the valuation of the Company's investment portfolio.

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A. Investment Portfolio

Fixed Maturities and Equity Securities

Accounting policy. 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. Net unrealized appreciation on investments supporting the Company's run-off settlement annuity business is reported in future policy benefit liabilities rather than accumulated other comprehensive income (loss).

Equity securities 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, 2016, fair values of these securities were $36 million and amortized cost was $49 million. As of December 31, 2015, fair values of these securities were $52 million and amortized cost was $66 million.

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.

The amortized cost and fair value by contractual maturity periods for fixed maturities were as follows at December 31, 2016:

(In millions)	Amortized Cost	Fair Value
Due in one year or less	$ 1,570	$ 1,574
Due after one year through five years	6,481	6,731
Due after five years through ten years	8,036	8,189
Due after ten years	3,394	3,981
Mortgage and other asset-backed securities	461	486
Total	$ 19,942	$ 20,961

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.

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

	December 31, 2016			
(In millions)	Amortized Cost	Unrealized Appreciation	Unrealized Depreciation	Fair Value

Federal government and agency	**$ 658**	**$ 223**	**$ (4)**	**$ 877**
State and local government	**1,342**	**99**	**(6)**	**1,435**
Foreign government	**1,998**	**129**	**(14)**	**2,113**
Corporate	**15,483**	**716**	**(149)**	**16,050**
Mortgage and other asset-backed	**461**	**29**	**(4)**	**486**
Total	**$ 19,942**	**$ 1,196**	**$ (177)**	**$ 20,961**

(In millions)	**December 31, 2015**			
Federal government and agency	$ 528	$ 251	$	$ 779
State and local government	1,496	147	(2)	1,641
Foreign government	1,870	147	(3)	2,014
Corporate	14,022	632	(206)	14,448
Mortgage and other asset-backed	540	41	(8)	573
Total	$ 18,456	$ 1,218	$ (219)	$ 19,455

The above table includes investments with a fair value of $2.7 billion at December 31, 2016 and 2015 supporting liabilities of the Company's run-off settlement annuity business. These investments had gross unrealized appreciation of $539 million and gross unrealized depreciation of $15 million at December 31, 2016, compared with gross unrealized appreciation of $521 million and gross unrealized depreciation of $38 million at December 31, 2015.

As of December 31, 2016, the Company had commitments to purchase $26 million of fixed maturities, all of which bear interest at a fixed market rate.

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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 at December 31, 2016 by the length of time these securities have been in an unrealized loss position. These fixed maturities are primarily corporate securities with a decline in fair value that reflects an increase in market yields since purchase.

(Dollars in millions)	Fair Value	Amortized Cost	Unrealized Depreciation	Number of Issues
Fixed maturities:				
One year or less:				
Investment grade	**$ 4,346**	**$ 4,475**	**$ (129)**	**992**
Below investment grade	**$ 724**	**$ 736**	**$ (12)**	**591**
More than one year:				
Investment grade	**$ 308**	**$ 327**	**$ (19)**	**53**
Below investment grade	**$ 186**	**$ 203**	**$ (17)**	**28**

Equity securities include an investment of approximately $400 million in an exchange traded fund ("ETF") with a gross unrealized loss of $5 million at December 31, 2016. The underlying assets of the ETF are primarily U.S. investment grade corporate bonds and the gross unrealized loss is due to an increase in market yields since purchase. There were no other available for sale equity securities with a significant unrealized loss reflected in accumulated other comprehensive income at December 31, 2016.

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.

Accounting policy. 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. See the "Impaired commercial mortgage loans" section below for the Company's accounting policy for impaired commercial mortgage loans.

At December 31, commercial mortgage loans were distributed among the following property types and geographic regions:

(In millions)	**2016**	2015
Property type		

Office buildings	**$ 592**	$ 697
Apartment buildings	**428**	366
Industrial	**302**	322
Hotels	**205**	259
Retail facilities	**139**	213
Other		7
Total	**$ 1,666**	$ 1,864
U.S. geographic region		
Pacific	**$ 714**	$ 738
South Atlantic	**268**	366
New England	**227**	276
Central	**239**	205
Middle Atlantic	**186**	227
Mountain	**32**	52
Total	**$ 1,666**	$ 1,864

At December 31, 2016, scheduled commercial mortgage loan maturities were as follows:

(In millions)	**Scheduled Maturities**
2017	**$ 92**
2018	**138**
2019	**251**
2020	**97**
2021 and thereafter	**1,088**
Total	**$ 1,666**

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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, 2016, the Company had commitments to extend credit under commercial mortgage loan agreements of $69 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 a consistent and 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, 2016 and 2015:

Debt Service Coverage Ratio

December 31, 2016

(In millions) **Loan-to-Value Ratio**	**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%	**$ 335**	**$ 15**	**$**	**$**	**$**	**$ 350**
50% to 59%	**517**	**46**		**30**		**593**
60% to 69%	**624**	**14**				**638**
70% to 79%			**29**		**35**	**64**
80% to 89%						
90% to 100%					**21**	**21**
Total	**$ 1,476**	**$ 75**	**$ 29**	**$ 30**	**$ 56**	**$ 1,666**

December 31, 2015

Below 50%	$ 261	$ 2	$	$ 67	$	$ 330
50% to 59%	683			24		707
60% to 69%	590	14		19		623
70% to 79%				30	36	66
80% to 89%	40					40
90% to 100%					98	98
Total	$ 1,574	$ 16	$	$ 140	$ 134	$ 1,864

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 2016 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. The results of the 2016 review showed improvement from the prior review in each of the key metrics and confirmed the overall strength of the portfolio. Based on property values 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 to 57% at December 31, 2016 from 58% at December 31, 2015. The portfolio's average debt service coverage ratio improved to 1.95 at December 31, 2016 from 1.78 at December 31, 2015. These improvements are primarily attributable to improvements in property operations and the relative stability of these metrics is primarily due to low portfolio turnover.

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.

Potential problem mortgage loans are considered current (no payment is more than 59 days past due), but they exhibit certain characteristics that increase the likelihood of future default. The characteristics management considers include, but are not limited to, 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 that 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 $21 million at December 31, 2016 and $139 million at December 31, 2015.

Impaired commercial mortgage loans. A commercial mortgage loan is considered impaired when it is probable that the Company will not collect all amounts due according to the terms of the original loan agreement. These loans are included in either problem or potential problem

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loans. The Company monitors credit risk and assesses the impairment of loans individually and on a consistent basis for all loans in the portfolio. Impaired loans are carried at the lower of unpaid principal balance or the fair value of the underlying real estate. 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. Because of the risk profile of the underlying investment, the Company recognizes interest income on impaired mortgage loans only when payment is actually received.

The carrying value of the Company's impaired commercial mortgage loans and related valuation reserves were as follows:

	2016			**2015**		
(In millions)	**Gross**	**Reserves**	**Net**	Gross	Reserves	Net
Impaired commercial mortgage loans with valuation reserves	**$ 26**	**$ (5)**	**$ 21**	$ 113	$ (15)	$ 98
Impaired commercial mortgage loans with no valuation reserves						
Total	**$ 26**	**$ (5)**	**$ 21**	$ 113	$ (15)	$ 98

The average recorded investment in impaired loans was $72 million during 2016 and $126 million during 2015. The decrease in the average recorded investment was partially due to the foreclosure of one impaired loan. Interest income on impaired commercial mortgage loans was not significant for 2016 or 2015.

Changes in valuation reserves for commercial mortgage loans were not material for the years ended December 31, 2016 and 2015.

Other Long-Term Investments

Accounting policy. 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, 2016 and 2015 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.

As of December 31, other long-term investments consisted of the following:

(In millions)	**2016**	2015
Real estate investments	**$ 738**	$ 814

Securities partnerships	**650**	501
Other	**74**	89
Total	**$ 1,462**	$ 1,404

As of December 31, 2016, the Company had commitments to contribute:

- $263 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
- $810 million to entities that hold securities diversified by issuer and maturity date.

The Company expects to disburse approximately 26% of the committed amounts in 2017.

Short-Term Investments and Cash Equivalents

Accounting policy. Security investments with maturities of greater than three months to one year from time of purchase are classified as short-term, available for sale and carried at fair value that approximates cost. Cash equivalents consist of short-term investments with maturities of three months or less from the time of purchase and are carried at cost that approximates fair value.

Short-term investments and cash equivalents included corporate securities of $2.2 billion, federal government securities of $378 million and money market funds of $11 million as of December 31, 2016. The Company's short-term investments and cash equivalents as of December 31, 2015 included corporate securities of $925 million, federal government securities of $220 million and money market funds of $55 million.

Concentration of Risk

As of December 31, 2016 and 2015, the Company did not have a concentration of investments in a single issuer or borrower exceeding 10% of shareholders' equity.

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PART II

ITEM 8. Financial Statements and Supplementary Data

B. Net Investment Income

Accounting policy. When interest and principal payments on investments are current, the Company recognizes interest income when it is earned. The Company recognizes interest income on a cash basis when interest payments are delinquent based on contractual terms or when certain terms (interest rate or maturity date) of the investment have been restructured.

The components of pre-tax net investment income for the years ended December 31 were as follows:

(In millions)	2016	2015	2014
Fixed maturities	**$ 899**	$ 879	$ 876
Equity securities	**4**	3	3
Commercial mortgage loans	**91**	112	133
Policy loans	**72**	72	72
Other long-term investments	**98**	116	105
Short-term investments and cash	**26**	14	17
Total investment income	**1,190**	1,196	1,206
Less investment expenses	**43**	43	40
Net investment income	**$ 1,147**	$ 1,153	$ 1,166

Real estate investments and securities partnerships with a carrying value of $220 million at December 31, 2016 and $277 million at December 31, 2015 were non-income producing during the preceding twelve months.

Net investment income for separate accounts that is excluded from the Company's revenues was $236 million for 2016, $262 million for 2015, and $225 million for 2014.

C. Realized Investment Gains And Losses

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

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)	2016	2015	2014
Fixed maturities	**$ 23**	$ (82)	$ 14
Equity securities	**(1)**	36	13
Commercial mortgage loans	**4**	(2)	(6)
Other investments, including derivatives	**143**	105	133
Net realized investment gains, before income taxes	**169**	57	154
Less income taxes	**60**	17	48
Net realized investment gains	**$ 109**	$ 40	$ 106

Included in these realized investment gains (losses) were pre-tax asset write-downs as follows:

(In millions)	2016	2015	2014
Other-than-temporary impairments on fixed maturities:			
Credit-related	**$ (19)**	$ (11)	$
Non credit-related (1)	**(16)**	(101)	(36)
Total other-than-temporary impairments on fixed maturities	**(35)**	(112)	(36)
Other asset write-downs (2)	**(23)**	(28)	(16)
TOTAL	**$ (58)**	$ (140)	$ (52)

(1)

These write-downs pertain to other-than-temporary declines in fair values due to increases in market yields (widening of credit spreads), particularly within the energy sector, for certain below investment grade fixed maturities with an increased probability of sales activity prior to recovery of amortized cost basis.

(2)

Other asset write-downs include other-than-temporary declines in the fair values of equity securities, increases in valuation reserves on commercial mortgage loans, and asset write-downs related to security partnerships and real estate investments.

Realized investment gains in other investments, including derivatives, represent primarily 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)	2016	2015	2014
Separate accounts	**$ 16**	$ 117	$ 376
Investment gains required to adjust future policy benefits for the run-off settlement annuity business	**$ 63**	$ 114	$ 86

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The following table presents sales information for available-for-sale fixed maturities and equity securities for the years ended December 31. Gross gains on sales and gross losses on sales exclude amounts required to adjust future policy benefits for the run-off settlement annuity business.

(In millions)	2016	2015	2014
Proceeds from sales	**$ 1,544**	$ 1,555	$ 1,769
Gross gains on sales	**$ 83**	$ 85	$ 62
Gross losses on sales	**$ 7**	$ 13	$ 6

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 GMIB reinsurance contracts in its run-off reinsurance business that are accounted for as freestanding derivatives and discussed in Note 9. 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.

Accounting policy. 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. Changes in the fair value of a derivative instrument may not always equal changes in the fair value of the hedged item. This is referred to as "hedge ineffectiveness" and is generally recorded in realized investment gains and losses. In the event of an early hedge termination, the changes in fair value of derivatives that qualified for hedge accounting are reported in shareholders' net income, generally as a part of realized investment gains and losses. Derivative cash flows are generally reported in operating activities.

The following tables provide information on the Company's specific applications of derivative financial instruments during the years ended December 31.