CIGNA CORP
Form 10-K
February 28, 2013

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

þ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2012
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.	o	þ

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.

			Smaller Reporting
Large accelerated filer þ	Accelerated filer o	Non-accelerated filer o	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 29, 2012 was approximately $12.7 billion.

As of January 31, 2013, 285,954,499 shares of the registrant's Common Stock were outstanding.

Part III of this Form 10-K incorporates by reference information from the registrant's proxy statement to be dated on or about March 15, 2013.

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A. Description of Business

Cigna Corporation was incorporated in the State of Delaware in 1981. Various businesses that are described in this Annual Report on Form 10-K for the fiscal year ended December 31, 2012 ("Form 10-K") are conducted by its insurance and other subsidiaries. As used in this document, "Cigna", the "Company", "we" and "our" may refer to Cigna Corporation itself, one or more of its subsidiaries, or Cigna Corporation and its consolidated subsidiaries.

Cigna had consolidated shareholders' equity of $9.8 billion and assets of $53.7 billion as of December 31, 2012, and revenues of $29.1 billion for the year then ended. Cigna's revenues are derived principally from premiums, fees, mail order pharmacy, and investment income.

Strategy and Key Developments

Cigna is a global health services organization with a mission to help its customers improve their health, well-being and sense of security. Its insurance subsidiaries are major providers of medical, dental, disability, life and accident insurance and related products and services, the majority of which are offered through employers and other groups (e.g. governmental and non-governmental organizations, unions and associations). Cigna also offers Medicare and Medicaid products and health, life and accident insurance coverages primarily to individuals in the U.S. and selected international markets. In addition to its ongoing operations described above, Cigna also has certain run-off operations, including a Run-off Reinsurance segment.

Cigna's long-term growth strategy is based on: (1) repositioning the portfolio for growth in targeted geographies, product lines, buying segments and distribution channels; (2) improving its strategic and financial flexibility; and (3) pursuing additional opportunities in high growth markets with particular focus on individuals.

Cigna's mission and focus on delivering value by serving the emerging needs of our global customers is being accomplished through executing on our long-term growth strategy, that is:

GO DEEP: Cigna seeks to increase its presence and brand strength in key "go deep" geographic areas, grow in targeted segments or capabilities, and deepen its relationships with current customers through cross selling.

GO GLOBAL: Cigna delivers a range of differentiated products and superior service to meet the distinct needs of a growing global middle class and a globally mobile workforce through expansion in existing international markets as well as an extension of the Company's business model to new geographic areas.

GO INDIVIDUAL: Cigna strives to establish a deep understanding of its customers' unique needs and to be a highly customer-centric organization through simplifying the buying process by providing choice, transparency of information, and a personalized customer experience. The Company's goal is to build long-term relationships with each of the individuals it serves and meet their needs throughout the stages of their lives regardless of the customer's plan type: employer-based, government-sponsored, or individual coverage.

Executing on Cigna's strategy, including the goals of achieving better health outcomes for our global customers, improving employee productivity and realizing medical cost savings is being achieved by:

focusing on delivery of **innovative health and wellness solutions** tailored to each of our employer and government clients;

ensuring that we **focus on the individual customer** by providing deep customer insights through customer research and feedback; and

enhancing **collaboration with physicians and hospitals** to offer affordable access to value-based high-quality care.

In addition to investing in these capabilities, Cigna executed on its strategy during 2012 with three acquisitions that better position the Company in several key markets: seniors, individual and global supplemental. HealthSpring, the largest of the acquisitions, strengthens Cigna's ability to serve individuals across their life stages as well as deepens the Company's presence in a number of geographic markets. The addition of HealthSpring also brings industry leading physician partnership capabilities, deepens Cigna's existing client and customer relationships, and facilitates a broader deployment of Cigna's range of health and wellness capabilities and product offerings. The acquisition of Great American Supplemental Benefits strengthens Cigna's capabilities in the individual market in addition to allowing Cigna to expand into the Medicare supplemental business, and our

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joint venture with Finansbank expands Cigna's global footprint in Turkey.

Cigna is also focused on continuing to improve its strategic and financial flexibility by driving further operating expense efficiencies, improving its medical cost competitiveness in targeted markets and effectively managing balance sheet exposures. In 2013, Cigna reached a significant milestone in this strategy related to mitigating the financial exposure associated with the Run-off guaranteed minimum death benefit ("GMDB" also known as "VADBe") and guaranteed minimum income benefit ("GMIB") reinsurance businesses. Effective February 4, 2013, the Company entered into an agreement with Berkshire Hathaway Life Insurance Company of Nebraska ("Berkshire") to reinsure 100% of the Company's future exposures for these businesses, net of retrocessional arrangements in place as of February 4, 2013, up to a specified limit. See Note 25 to the Consolidated Financial Statements for additional information.

Financial Information about Business Segments

The financial information included herein is in conformity with accounting principles generally accepted in the United States of America ("GAAP"), unless otherwise indicated. Certain reclassifications have been made to prior years' financial information to conform to the 2012 presentation. Industry rankings and percentages set forth herein are for the year ended December 31, 2012 unless otherwise indicated. In addition, statements set forth in this document concerning Cigna's rank or position in an industry or particular line of business have been developed internally, based on publicly available information, unless otherwise noted.

Effective December 31, 2012, Cigna changed its external reporting segments to reflect the Company's realignment of its businesses to better leverage distribution and service delivery capabilities for the benefit of our global clients and customers. Management believes the realignment of its businesses will enable the Company to more effectively address global health services challenges by leveraging best practices across geographies to improve the health, well being and sense of security of the global customers that the Company serves. The changes in the Company's internal financial reporting structure, to support this realignment, took effect on December 31, 2012 and resulted in changes to our external reporting segments. The Company's results are now aggregated based on the nature of the Company's products and services, rather than its geographies.

The primary segment reporting change is that the two businesses that comprised the former International segment (international health care and supplemental health, life and accident) are now reported as follows:

substantially all of the international health care business (comprised primarily of the global health benefits business) is now reported with the former Health Care segment and renamed ***Global Health Care***; and

the supplemental health, life and accident business becomes a separate reporting segment named ***Global Supplemental Benefits***.

As a result of these changes, the financial results of Cigna's businesses are now reported in the following segments:

Global Health Care aggregates the following two operating segments:

Commercial (including the international health care business)

Government

Group Disability and Life

Global Supplemental Benefits

Run-off Reinsurance and

Other Operations, including Corporate-owned Life Insurance.

Financial data for each of Cigna's business segments is set forth in Note 23 to the Consolidated Financial Statements. Prior year segment information has been conformed to the new segment structure.

Available Information

Cigna's annual, quarterly and current reports, proxy statements and other filings, and any amendments to these filings, are made available free of charge on its website (http://www.cigna.com, under the "Investors Quarterly Reports and SEC Filings" captions) as soon as reasonably practicable after the Company electronically files these materials with, or furnishes them to, the Securities and Exchange Commission (the "SEC"). The Company uses its 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 130 of this Form 10-K for additional available information.

B. Global Health Care

As explained in Item 1A "Description of Business", in the fourth quarter of 2012 Cigna changed its external reporting segments. The new Global Health Care segment (previously Health Care) now includes substantially all of the international health care business previously reported in the former International segment. This business, that is included in the Commercial operating segment, consists principally of global health benefits, products and services designed to meet the needs of local and multinational companies and organizations and their domestic and globally mobile employees and dependents.

Global Health Care aggregates the following two operating segments:

The ***Commercial*** operating segment includes both the U.S. commercial and international health care businesses and offers

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insured and self-insured medical, dental, behavioral health, vision, and prescription drug benefit plans, health advocacy programs and other products and services that may be integrated to provide comprehensive global health care benefit programs to employers and their employees, including globally mobile individuals. Cigna, either directly or through its partners, offers some or all of these products and services in all 50 states, the District of Columbia, the U.S. Virgin Islands, Canada, Europe, the Middle East, and Asia. Cigna services its globally mobile customers virtually everywhere in the world. These products and services are offered through a variety of funding arrangements such as administrative services only (ASO), guaranteed cost and retrospectively experience rated.

The ***Government*** operating segment offers Medicare Advantage plans to seniors in 13 states and the District of Columbia, Medicare Part D plans in all 50 states and the District of Columbia and Medicaid plans.

Global Health Care seeks to differentiate itself by providing superior customer insights, care delivery, product integration and unique product offerings. Global Health Care expects to accomplish these goals by deepening its reach in selected geographies and market segments as well as accelerating its engagement with preferred health care professionals. For its globally mobile customers, Global Health Care's strategic advantages include unique health care solutions, seamless worldwide care delivery and superior customer service.

With the exception of Health Maintenance Organization ("HMO"), Medicare, Medicaid and stop loss products, each of Global Health Care's group health benefit products are offered with alternative funding options (i.e.: administrative services only ("ASO" or "self-insured"), insured experience rated, and insured guaranteed cost). These funding options are further described on page 5 of this Form 10-K. Approximately 86% of the Company's commercial medical customers are enrolled in self-insured and experience-rated plans, where lower costs of providing health care directly benefit our corporate clients and their employees, with the remainder being insured under guaranteed cost plans.

Principal Products and Services

Cigna's principal health care products (discussed below) include:

Health Plans group and individual medical coverage:

Commercial Medical: U.S. and International medical plans covering domestic-based employees and, for certain multinational employers, their globally mobile employees. In order to engage customers in their health care choices, consumer-driven core medical plans are often combined with the Cigna Choice Fund suite of accounts.

Government Medicare Advantage, Medicare Part D and Medicaid plans sold to Medicare or Medicaid-eligible individuals (primarily seniors).

Specialty Products products and services that improve quality, lower the cost of medical services and help customers achieve better health outcomes. These products can be sold on a standalone basis but are most effective when integrated with a Cigna-administered health plan.

Financial information, including premiums and fees, is presented in the Global Health Care section of the MD&A beginning on page 41 and in Note 23 to Cigna's Consolidated Financial Statements beginning on page 119 of this Form 10-K.

Health Plans

Commercial Medical U.S. and International

Managed Care Plans. Global Health Care offers a broad product line of managed care benefit plans that use meaningful coinsurance and copayment differences to encourage the use of "in-network" versus "out-of-network" health care providers and the use of primary care physicians. While these products offer access to a broad national network of "in-network" health care providers (that is somewhat smaller than the network used with the preferred provider ("PPO") plan product line), employers may elect to utilize a subset of Cigna's network to better manage costs and quality.

Preferred Provider Plans. Global Health Care also offers an open access product line that features a network with even broader access than the Managed Care Plans with no option to designate a primary care physician, in-network and out-of-network coverage, and may be at a somewhat higher medical cost.

Choice Fund® suite of Consumer-Driven Products. In connection with many of the health care products described above, Global Health Care offers the Cigna Choice Fund suite of consumer-driven products, including *Health Reimbursement Accounts* ("HRA"), *Health Savings Accounts* ("HSA") and *Flexible Spending Accounts* ("FSA"). These plans can be used to pay medical care expenses not covered by a base medical plan and are designed to encourage customers to understand and manage their health and health benefits.

1. Cigna's Choice Fund HRA is funded by employer contributions and is often combined with a high deductible plan. HRA dollars can be rolled over from year-to-year at the plan sponsors' discretion.

2. HSA plans combine a high deductible health plan with a tax-advantaged savings account funded by customer contributions that offers mutual fund investment options. Funds in an HSA can be used to pay the deductible and other IRS-approved health care expenses. The health savings account is portable and unused funds accumulate from year to year.

3. An FSA allows customers to pay for IRS-approved health care expenses with pre-tax employee contributions. Unused funds in an FSA do not accumulate from year to year, but are forfeited by the employee.

Stop Loss Coverage. Global Health Care offers stop loss insurance coverage for self-insured plans. This stop loss coverage reimburses the plan for claims in excess of a predetermined amount, for individuals ("specific"), the entire group ("aggregate"), or both. Global Health Care also includes stop loss features in its experience-rated policies (discussed below).

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Government

Medicare Advantage. Cigna offers Medicare Advantage coordinated care plans in 13 states and the District of Columbia. Under a Medicare Advantage plan, Medicare-eligible beneficiaries may receive health care benefits, including prescription drugs, through a managed care health plan such as the Company's coordinated care plans, and the Centers for Medicare and Medicaid Services ("CMS") reimburse the Company pursuant to a risk adjustment payment methodology. Cigna ensures that our Medicare Advantage customers receive quality medical care through 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. Approximately 75% of our Medicare Advantage customers are served by physicians in these innovative models, and Cigna is focused on expanding these models in the future. The HealthSpring acquisition expanded the size of Cigna's Medicare Advantage customer base. As of December 31, 2012, HealthSpring represented 89% of Cigna's Medicare Advantage customer base. Cigna also offers Medicaid coverage to low income individuals in selected markets in the U.S. Cigna's Medicaid customers benefit from many of the coordinated care aspects of the Company's Medicare Advantage programs discussed above.

Medicare Part D. Cigna's 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. Cigna's Part D plans are available in all 50 states and the District of Columbia. These plans offer the savings of Medicare combined with the flexibility to provide enhanced benefits and a drug list tailored to individuals' specific needs. Retirees benefit from broad network access and value-added services that help keep them well and save them money. The HealthSpring acquisition expanded the size of Cigna's Medicare Part D customer base. As of December 31, 2012, HealthSpring represented 49% of Cigna's Medicare Part D customer base.

Specialty Products

Medical Specialty

Health Advocacy. Global Health Care offers a wide array of medical management, disease management, and other health advocacy services to employers and other plan sponsors to help individuals improve their health, well-being and sense of security. These services are offered to customers covered under Global Health Care's administered plans or plans insured or administered by competing insurers or third-party administrators. Cigna offers seamless integration of services that address the clinical and administrative challenges inherent in coordinating multiple vendors. Through its health advocacy programs, Global Health Care works to help healthy people stay healthy; help people change behaviors that put their health at risk; and assist those with problems in accessing quality care.

Health advocacy programs and services include: 1) early intervention by Cigna's network of clinical professionals; 2) Cigna's online health assessment, powered by insights and analytics from the University of Michigan Health Management Research Center, that helps customers identify potential health risks and learn what they can do to live a healthier life; 3) Cigna's Well Informed program, that uses clinical rules-based software to identify potential gaps and omissions in customers' health care by analyzing integrated medical, behavioral, pharmacy and lab data allowing Cigna to communicate the gaps to customers and their doctors; and 4) an array of health coaching offerings to address lifestyle management issues such as stress, weight, and tobacco cessation.

Cost Containment Service. Cigna administers cost containment programs for health care services and supplies that are covered under health benefit plans. These programs, that may involve contracted vendors, are designed to control health costs by reducing out-of-network utilization, including educating customers regarding the availability of lower cost in-network services, reviewing provider bills, and recovering overpayments from other insurance carriers or health care professionals. Cigna charges fees for providing or arranging for these services.

Behavioral Specialty

Behavioral Health. Cigna arranges for behavioral health care services for customers through its network of participating behavioral health care professionals. Cigna offers 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. Cigna Behavioral Health focuses on integrating its programs and services with medical, pharmacy and disability programs to facilitate customized, holistic care.

As of December 31, 2012, Cigna's behavioral network had approximately 118,000 access points to independent psychiatrists, psychologists and clinical social workers and approximately 9,800 facilities and clinics that are reimbursed on a contracted fee-for-service basis.

Cigna Pharmacy Management

Cigna Pharmacy Management. Cigna Pharmacy Management offers prescription drug plans to its insured and self-funded customers both in conjunction with its medical products and on a stand-alone basis. With a network of over 64,000 contracted pharmacies, Cigna Pharmacy Management is a comprehensive pharmacy benefits manager (PBM) offering clinical integration programs, specialty pharmacy solutions, and fast, efficient home delivery of prescription medicines.

Programs that facilitate this integration of medical, behavioral and pharmacy offerings include the *Well Informed* program, that is focused on chronic conditions requiring strict compliance with a prescription drug therapy such as asthma, diabetes, back pain or high cholesterol, as well as *Step Therapy*, that encourages customers to use generic and/or preferred brand drugs rather than higher cost brand-named drugs. *Step Therapy* is implemented through claim management protocols, that may include communications with customers and their physicians. The Company coordinates pharmacy management with all of Cigna's health advocacy programs and tools by focusing on patient education, including emphasizing the importance of adhering to medication instructions.

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

Cigna Home Delivery Pharmacy. Cigna also offers cost-effective mail order, telephone and on-line pharmaceutical fulfillment services through its home delivery operation. Cigna Home Delivery Pharmacy provides a high-quality, efficient home delivery pharmacy distinguished by individual care relating to compliance and specialty medications. Orders may be submitted through the mail, via phone or through the internet at myCigna.com.

Dental and Vision

Dental. Cigna Dental Health offers a variety of dental care products including dental health maintenance organization plans ("Dental HMO"), dental preferred provider organization ("Dental PPO") plans, dental exclusive provider organization plans, traditional dental indemnity plans and a dental discount program. Employers and other groups can purchase Cigna Dental Health products as stand-alone products or integrated with Global Health Care's medical products. Additionally, individual customers can purchase Dental PPO plans in conjunction with individual medical policies. As of December 31, 2012, Cigna Dental Health customers totaled approximately 11.4 million. Most of these customers are in self-insured plans. All of Cigna's Dental HMO customers participate in guaranteed cost insured plans. Managed dental care products are offered in 37 states for Dental HMO and 42 states and the District of Columbia for Dental PPO through a network of independent health care professionals that have contracted with Cigna Dental Health to provide dental services.

Cigna Dental Health customers access care from one of the largest dental PPO networks and dental HMO networks in the U.S., with approximately 266,400 Dental PPO-contracted access points (approximately 99,200 unique health care professionals) and approximately 68,600 Dental HMO-contracted access points (approximately 18,000 unique health care professionals).

Cigna Dental Health stresses preventive dentistry; it believes that promoting preventive care contributes to a healthier workforce, an improved quality of life, increased productivity and fewer treatment claims and associated costs over time. Cigna Dental Health offers customers a dental treatment cost estimator to educate customers on oral health and aid them in their dental health care decision-making.

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. Cigna's national vision care network, which consists of approximately 57,500 health care professionals in approximately 23,500 locations, includes private practice ophthalmologist and optometrist offices, as well as retail eye care centers. Routine vision products are offered in conjunction with Global Health Care's medical and dental product offerings.

Funding Arrangements

The segment's commercial medical products and services are offered through the following funding arrangements:

Administrative Services Only (80% of commercial medical customers);

Insured Guaranteed Cost (14% of commercial medical customers); and

Insured Shared Returns℠ (6% of commercial medical customers).

Administrative Services Only. Global Health Care contracts with employers, unions and other groups sponsoring self-insured plans on an administrative services only ("ASO") basis to administer claims and perform other plan related services. The key features of an ASO funding arrangement are:

Global Health Care collects administrative service fees in exchange for providing these self-insured plans with access to Global Health Care's applicable participating provider network and for providing other services and programs including: claim administration; quality management; utilization management; cost containment; health advocacy; 24-hour help line; 24/7 call center; case management; disease management; pharmacy benefit management; behavioral health care management services (through its provider networks); or any combination of these services.

The self-insured plan sponsor is responsible for self-funding all claims, but may purchase stop loss insurance from Global Health Care or other insurers for claims in excess of a predetermined amount, for either individuals ("specific"), the entire group ("aggregate"), or both.

In some cases, Global Health Care 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, Global Health Care may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. Global Health Care does not recognize revenues for estimated payouts associated with these guarantees. See Note 2 to the Consolidated Financial Statements for details regarding these guarantees.

Insured Guaranteed Cost. Charges to policyholders under an insured, guaranteed cost policy are established at the beginning of the policy period and are not adjusted to reflect actual claim experience during the policy period. Accordingly, Global Health Care bears the risk for claims and costs. Generally, guaranteed cost policyholder groups are smaller than retrospectively experience-rated groups; accordingly, claim and expense assumptions may be based in whole or in part on prior experience of the policyholder or on a pool of accounts, depending on the policyholder's size and the statistical credibility of the experience.

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Insured Shared Returns℠ (also referred to as experience-rated). Under a Shared Returns funding arrangement, the premium determined at the beginning of the policy period may be adjusted for the actual claim and, in some cases, administrative cost experience of the policyholder. Favorable cost experience in relation to the premium rates may result in a portion of the initial premiums being credited to the policyholder as an experience refund. However, if claims and expenses exceed the initial premiums (an "experience deficit"), Global Health Care generally bears the risk. These experience deficits may be recovered through future year surpluses, according to contractual provisions, provided the policy remains in force.

Minimum premium funding arrangements combine insurance protection with an element of self-funding. Key features of insurance policies using a minimum premium funding arrangement are summarized below:

The policyholder is responsible for funding a bank account to pay all claims up to a predetermined aggregate, maximum monthly amount, and Global Health Care bears the risk for claim costs incurred in excess of that amount.

The policyholder must maintain an agreed-upon amount in the account.

The policyholder pays a significantly reduced monthly "residual" premium while the policy is in effect and a supplemental premium (to cover reserves for run-out claims and administrative expenses) upon termination.

Global Health Care may recover deficits from surplus amounts in future years if the policy is renewed.

Liabilities are established for estimated experience refunds based on the results of Shared Returns (retrospectively experience-rated) policies and applicable contract terms. Global Health Care credits interest on experience refund balances to these policyholders using rates that are set at Global Health Care's discretion, taking investment performance and market rates into consideration. For 2012, the rates of interest credited ranged from 0.5% to 3.5%, with a weighted average rate of approximately 1%.

Pricing and Reinsurance

Pricing. Premium rates for insured funding arrangements are based on assumptions about the expected utilization levels of medical services, costs of medical services and the Company's administrative costs. The profitability of these arrangements will vary by the actual utilization level of medical services, the cost of the services provided and the costs to administer the benefit programs and the premium charged. In some states, premium rates must be approved by the state insurance department and state laws may restrict or limit the use of rating methods. Premium rates for groups and individuals are subject to state and/or the United States Department of Health and Human Services ("HHS") review for unreasonable increases.

The Patient Protection and Affordable Care Act ("Health Care Reform") requires Cigna's comprehensive medical insurance products to meet a minimum medical loss ratio ("MLR") of 85% for large groups (generally defined as employers with more than 50 employees) and 80% for small groups and individuals. Regulations issued by the U.S. Department of Health and Human Service ("HHS") require the MLR to be calculated on a state-by-state basis for each separate insurance company or HMO, and then separately within each state for large groups, small groups and individuals. The MLR is determined generally as the sum of claims plus health care quality improvement expenses divided by premiums less taxes and assessments. HHS regulations permit adjustments to be made to the claims used in the calculation for Cigna's international health care and limited benefit plans subject to the MLR minimums. The adjustment for limited benefit plans is only permitted through 2014. To the extent the MLR minimums are not met for large groups, small groups or individual segments within each state, premium rebates are paid to both

employers and customers enrolled in the plans based on the portion of the premium each has contributed. Approximately 20% of Cigna's commercial customers are enrolled in insured plans subject to the MLR requirements. For additional information related to the effects of Health Care Reform on these businesses, see the Regulation section of this Form 10-K.

Medicare Advantage pricing is determined based upon expected medical services utilization and costs resulting from CMS-required services and Company-specific supplemental plan benefits, as well as expected administrative expenses and profit margin. Revenue for each plan customer is received from CMS, with CMS providing a subsidy payment based on customer demographic data and expected customer health risk factors compared to the broader Medicare population. Additional revenue from CMS may be earned by the Company related to quality performance measures. In many markets, the customer pays no premium. In some situations, additional premiums may be received from customers, representing the difference between CMS subsidy payments and the revenue assumed by the Company as part of its annual Medicare Advantage bid submissions. Profits from our Medicare Advantage plans vary depending on the actual utilization of medical services, the cost of services provided, the costs to administer the benefit programs, and the receipt of quality performance revenue from CMS. Beginning in 2014, Health Care Reform requires Medicare Advantage and Medicare Part D plans to meet a minimum MLR of 85%. Under the rules proposed by HHS, if the MLR for a CMS contract is less than 85%, the contractor is required to pay a penalty to CMS and could be subject to additional sanctions if the MLR continues to be less than 85% for successive years.

Pricing for self-funded arrangements is generally based on the expected cost to administer these arrangements and will vary by the services provided and the size and complexity of the benefit programs, among other factors.

Reinsurance. Cigna's international health care business reduces its exposure to large catastrophic losses under insurance contracts by purchasing reinsurance from unaffiliated reinsurers.

Service and Quality

Customer Service

For U.S.-based customers, Global Health Care operates 19 service centers that together processed approximately 154 million medical claims in 2012. Cigna recognizes that customers with significant

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health events may have additional customer service needs. As of December 31, 2012, Cigna operated 13 call centers and a virtual team that customers can call toll-free about their health care benefits, wellness programs and claims. Ten of these call centers are available 24 hours a day, 365 days a year. The remaining three, that service HealthSpring providers and customers, operate for extended hours during high volume periods to accommodate customer demands. Cigna offers the "My Personal Champion" program that provides qualified customers with a dedicated point of contact. Personal Champions serve as a resource for benefits and claims questions, assist with navigating the complex health care industry, and offer education and support to customers and their families. As of December 31, 2012, approximately 5 million Cigna customers had access to the My Personal Champion program.

With over 1.2 million customers across the globe, Cigna's international health care business continues to be a leader in providing quality customer service. Its globally mobile customers have access to medical professionals, case management experts and claims specialists 24 hours a day, 365 days a year, through service centers dedicated to their unique needs. Cigna uses a wide range of measurement tools to better understand customers' needs ranging from quick 5-minute surveys of a customer's call-center experience to more elaborate tracking of loyalty as measured by customers' likelihood to refer Cigna to a friend.

Technology. Global Health Care understands the important role that information technology plays in improving the level of service that Cigna can provide to its customers, which is critical to the continued growth of the Company's health care business and its focus on customer-centricity. Accordingly, Global Health Care continues to invest in its information technology infrastructure and capabilities including innovative mobile tools and Internet-enabled technology that support Global Health Care's focus on providing customers with a personalized experience in making health care decisions and leveraging customer insights to drive the Company's strategy and mission.

Quality Medical Care

Global Health Care's commitment to promoting quality medical care to its customers is reflected in a variety of activities. Most recently, Cigna has focused on collaborating with physicians and other health care professionals and facilities with the goal of improving quality and customer satisfaction while lowering medical costs. This focus has manifested itself through the rapid expansion of collaborative accountable care organizations developed by Cigna as well as the innovative physician engagement models acquired with HealthSpring in 2012. As of December 31, 2012, almost one million medical customers are serviced by physicians compensated under these types of arrangements.

Collaborative Accountable Care Organizations (CAC). As of December 31, 2012, Cigna has established over 50 CACs, and expects to continue to expand these arrangements. The overall objective of these organizations is to improve the quality of care and service experience for customers while lowering their costs, resulting in improved overall value. The goal is to identify health care delivery organizations (medical groups and hospital organizations) that can coordinate end-to-end care for a defined population of patients and share timely, patient-specific medical information with the physician group. Each CAC has an embedded care coordinator that supports patient care and care plan development. The coordinator uses patient-specific information supplied by Cigna to conduct proactive outreach to coordinate care for patients in three categories: i) patients who are being discharged from the hospital who are at risk for readmission; ii) patients with high priority gaps in care; and iii) patients with high health risk scores based on Cigna's predictive models. This approach leverages the role of the physician as the trusted advisor. With the innovative physician engagement models acquired with HealthSpring, we utilize a variety of business arrangements that shift the physician's reimbursement from the traditional fee-for-service approach to one that is focused on rewarding quality medical outcomes and an enhanced customer experience at a lower cost. In these arrangements, the physician group shares financial risk with Cigna. The HealthSpring clinical model also includes outreach to new and at-risk customers to ensure they are accessing their primary care physician.

Cigna also continues to engage in a variety of other medical quality activities, including: credentialing medical health care professionals and facilities that participate in Global Health Care's Managed Care and PPO networks as well as developing the Cigna Care Network[SM] specialist physician designation described below.

Participating Provider Network. Cigna has an extensive network of participating health care professionals and hospitals, as well as other facilities, pharmacies and vendors of health care services and supplies. In most instances, Global Health Care contracts directly with the participating hospital, health care professional or other facility to provide covered services to customers at agreed-upon rates of reimbursement. In some instances, however, Global Health Care companies contract with third parties for access to their provider networks and care management services. In addition, Global Health Care has entered into strategic alliances with several regional managed care organizations (Tufts Health Plan, HealthPartners, Inc., Health Alliance Plan, and MVP Health Plan) to gain access to their provider networks and discounts.

Cigna Medical Group. Cigna Medical Group is the multi-specialty medical group practice division of Cigna HealthCare of Arizona, Inc. that delivers primary care and certain specialty care services through 25 medical facilities and approximately 190 employed clinicians in the Phoenix, Arizona metropolitan area. Twenty-two of these multi-specialty health care centers and their affiliated primary care physicians have received the top level of accreditation (level 3) from the National Committee for Quality Assurance (NCQA) a private, nonprofit organization dedicated to improving health care quality. Cigna Medical Group currently holds the highest level of this accreditation for the greatest number of practices and physicians in the state of Arizona.

*Cigna Care Network*SM. Cigna Care Network is a benefit design option available for Global Health Care administered plans in 69 service areas across the U.S. Cigna Care Network's designated physicians are a subset of participating physicians in certain specialties who are so designated based on specific clinical quality and cost-efficiency selection criteria. Customers pay reduced co-payments or co-insurance when they receive care from a specialist designated as a

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Cigna Care Network provider. Participating specialists are evaluated regularly for the Cigna Care Network designation.

Provider Credentialing. Global Health Care credentials physicians, hospitals and other health care professionals in its 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.

External Validation. Cigna continues to demonstrate its commitment to quality and has a broad scope of quality programs validated through nationally recognized external accreditation organizations. Cigna was awarded Excellent, Commendable or Accredited for Health Plan accreditation from NCQA in 36 of our markets. Additional NCQA recognitions include Full Accreditation for Managed Behavioral Healthcare Organization accreditation for Cigna Behavioral Health, Performance Reporting for Wellness & Health Promotion accreditation for Cigna's wellness programs and Physician & Hospital Quality Certification for Cigna's provider transparency program. Cigna has Full Accreditation for Health Utilization Management, Case Management and Pharmacy Benefit Management from URAC, an independent, nonprofit health care accrediting organization dedicated to promoting health care quality through accreditation, certification and commendation.

HEDIS® Measures. In addition, Global Health Care participates 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. Global Health Care's national results compare favorably to industry averages.

Markets and Distribution

Global Health Care offers products in the following customer markets:

National segment these employers have 5,000 or more U.S.-based, full-time employees living in two or more states.

Middle Market segment comprised of employers with 250 to 4,999 U.S.-based, full-time employees located in one or more states with a majority of their full-time employees living and working in the same state. This segment also includes single site employers with more than 250 employees, Taft-Hartley plans and other third party payers.

Select segment focused on employers with 51-249 eligible employees and provides ASO and guaranteed cost funding solutions. Select also provides ASO funding to employers with a minimum of 25 employees.

Individual Global Health Care actively markets health and dental insurance to individuals in ten states as of December 31, 2012, including Arizona, California, Colorado, Connecticut, Florida, Georgia, North Carolina, South Carolina, Tennessee and Texas.

Seniors (Medicare) focused on the health care needs of individuals who are pre- or post-65 retirees and employers who offer coverage to their pre- and post-65 retirees.

International Health Care focused on health care products and services to meet the needs of local and multinational companies and organizations and their local and globally mobile employees and dependents.

Global Health Care employs sales representatives to distribute its products and services through insurance brokers and insurance consultants or directly to employers, unions and other groups. Global Health Care also employs representatives to sell utilization review services, managed behavioral health care, pharmacy, and employee assistance services directly to insurance companies, HMOs, third party administrators and employer groups. As of December 31, 2012, the field sales force for the products and services of this segment consisted of approximately 1,160 sales representatives in approximately 115 field locations. With respect to the acquired HealthSpring business, Medicare Advantage enrollment is generally a decision made individually by the customer, and accordingly, sales agents and representatives focus their efforts on in-person contacts with potential enrollees as well as telephonic and group selling venues.

Competition and Industry Developments

Global Health Care's 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. Global Health Care expects a continuing trend of consolidation in the industry given the current economic and political environment. Global Health Care also expects continued vertical integration, with the line blurring between clinicians and hospitals, and traditional insurers.

Competition in the health care market exists both for employers and other groups sponsoring plans and for the employees in those instances where the employer offers its employees a choice of products from more than one health care company. Most group policies are subject to annual review by the policyholder, who may seek competitive quotations prior to renewal. As Health Care Reform is implemented, Cigna expects competition to increase in the individual market as individual customers seek to purchase insurance for themselves or their families.

The primary competitive factors are quality and cost-effectiveness of service and provider networks; effectiveness of medical care management; products that meet the needs of clients and their employees; price; 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. Cigna believes that its health advocacy capabilities, holistic approach to consumer engagement, breadth of product offerings, clinical care and medical management capabilities and funding options are competitive advantages. These advantages allow Cigna to respond to the diverse needs of its customer base. Cigna also believes that its focus on helping to improve the health, well-being and sense of security of its customers will allow it to differentiate itself from its competitors.

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Cigna's principal competitors in its U.S.-based business are:

other large insurance companies that provide group health and life insurance products;

Blue Cross and Blue Shield organizations;

stand-alone HMOs and PPOs;

HMOs affiliated with major insurance companies and hospitals; and

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

The primary competitors of the international health care business include U.S.-based and European health insurance companies with global health benefits operations. For the Company's international health care operations in the United Kingdom and Spain, the primary competitors are regional and local insurers.

Competition also arises from smaller regional or specialty companies with strength in a particular geographic area or product line, administrative service firms and, indirectly, self-insurers. In addition to these traditional competitors, a new group of competitors is emerging. These new competitors 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 is accomplished primarily through financial incentives, access to enhanced medical quality data and other information sharing. The effective use of the Company's 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 Cigna believes its capabilities in these areas will be competitive differentiators.

On February 15, 2013, CMS issued its Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies (the "Notice"). CMS is accepting comments on the Notice, and final terms are expected to be published on April 1, 2013. While management believes that a significant number of comments from interested parties (including Cigna) will be provided to CMS, there can be no assurance that CMS will amend its current position. Given the uncertainty regarding the final terms of the Notice, the Company cannot estimate the impact that it will have on its business, revenues or results of operations but recognizes that any impacts could be materially adverse. Accordingly, the Company is currently evaluating the potential implications of the Notice, including adjustments that the Company may make to the programs and services it offers to offset any adverse impacts.

C. Group Disability and Life

Cigna's Group Disability and Life segment provides the following insurance products and their related services: group long-term and short-term disability insurance, group life insurance and accident and specialty insurance. These products and services are provided by subsidiaries of Cigna Corporation. Cigna markets products in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Canada.

Principal Products and Services

Disability

Long-term and short-term disability insurance products and services generally provide a fixed level of income to replace a portion of wages lost because of disability. Cigna also provides assistance to employees in returning to work and assistance to their employers in managing the cost of employee disability. Group disability coverage is typically employer-paid or a combination of employer and employee-paid, but may also include coverage paid for entirely by employees.

Cigna is an industry leader in returning employees to work quickly, resulting in higher productivity and lower cost for employers and a better quality of life for their employees. Cigna's disability insurance products may be integrated with other disability benefit programs, behavioral programs, medical programs, social security advocacy, and leave of absence administration. Cigna believes this integration provides customers with increased efficiency and effectiveness in disability claims management, enhances productivity and reduces overall costs to employers. Coordinating the administration of the segment's disability programs with medical programs offered by Cigna HealthCare provides enhanced opportunities to influence outcomes, reduce the cost of both medical and disability events and improve the return to work rate. Examples of the benefits of this integrated approach (for which Cigna may receive fees) include:

using information from the health care and disability databases to help identify, treat and manage disabilities before they become chronic, longer in duration and more costly; and

proactive outreach from Cigna Behavioral Health to assist employees suffering from a mental health condition, either as a primary condition or as a result of another condition.

As measured by 2012 premiums and fees, disability constituted approximately 45% of this segment's business. Approximately 12,300 insured disability policies covering approximately 6.5 million lives were outstanding as of December 31, 2012.

Life Insurance

Life insurance products offered by Group Disability and Life include group term life and group 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 a voluntary life insurance product in which the owner may accumulate 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 2012 premiums and fees, group life insurance constituted approximately 46% of this segment's business. Approximately 6,200 group life insurance policies covering approximately 5.6 million lives were outstanding as of December 31, 2012.

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Other Products and Services

Cigna offers personal accident insurance coverage, which consists primarily of accidental death and dismemberment and travel accident insurance to employers. Group accident insurance may be employer-paid or employee-paid.

Cigna also offers specialty insurance services that consist primarily of disability and life, accident, and hospital indemnity products to professional or trade associations and financial institutions.

Voluntary benefits are those paid by the employee and are offered at the employer's worksite. Cigna plans provide employers, among other services, flexible enrollment options, list billing, medical underwriting, and individual record keeping. Cigna designed its voluntary offerings to offer employers a complete and simple way to manage their benefits, including personalized enrollment communication and administration of the benefits program.

Financial information, including premiums and fees, is presented in the Group Disability and Life section of the MD&A beginning on page 44 and in Note 23 to Cigna's Consolidated Financial Statements.

Pricing and Reinsurance

This segment's products and services are offered on a fully insured, experience-rated and ASO basis. Under fully insured arrangements, policyholders pay a fixed premium and Cigna bears the risk for claims and costs. Under experience-rated funding arrangements, a premium that typically includes a margin to partially protect against adverse claim fluctuations is determined at the beginning of the policy period. Cigna generally bears the risk if claims and expenses exceed this premium. If premiums exceed claims and expenses, any surplus amount is generally first used to offset prior deficits and is otherwise generally returned to the policyholder if surplus exceeds minimum contractual levels. With experience-rated insurance products, Cigna may recover deficits from margins in future years if the policy is renewed. Under ASO arrangements, Cigna contracts with groups sponsoring self-insured plans to administer claims and perform other plan related services in return for service fees. The self-insured plan sponsor is responsible for self funding all claims. The majority of this segment's products and services are fully insured.

Premiums and fees charged for disability and life insurance products are generally established in advance of the policy period and are generally guaranteed for one to three years and selectively guaranteed for up to five years, but policies are generally subject to early termination by the policyholder or by the insurance company. Premium rates reflect assumptions about future claims, expenses, credit risk, investment returns and profit margins. 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, administrative and surrender charges assessed against the policyholder's fund balance. Interest credited and mortality charges for group universal life, and mortality charges on group variable universal life, may be adjusted prospectively to reflect expected interest and mortality experience. Mortality charges are subject to guaranteed maximum rates stated in the policy.

The profitability of this segment's products depends on the adequacy of premiums charged and investment returns relative to claims and expenses. The effectiveness of return to work programs and mortality levels also impact the profitability of disability insurance products. Cigna's 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 the impact of the current adverse economic conditions is not clear. For life insurance products, the degree to which future experience deviates from mortality, morbidity and expense assumptions also affects profitability.

In order to reduce its exposure to large individual and catastrophic losses under group life, disability and accidental death policies, Cigna purchases reinsurance from unaffiliated reinsurers.

Markets and Distribution

Cigna markets the group insurance products and services described above to employers, employees, professional and other associations and groups in the following customer segments:

National segment these are multi-site employers generally with more than 5,000 employees;

Middle Market segment generally defined as multi-site employers with more than 250 but fewer than 5,000 employees, and single-site employers with more than 250 employees; and

Select segment generally includes employers with more than 50 but fewer than 250 employees.

In marketing these products, Cigna primarily sells through insurance brokers and consultants and employs a direct sales force. As of December 31, 2012, the field sales force for the products and services of this segment consisted of approximately 200 sales professionals in 27 office locations.

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 Cigna's group disability, life and accident businesses are other large and regional insurance companies that market and distribute these or similar types of products. As of December 31, 2012, Cigna is one of the top five providers of group disability, life and accident insurance in the United States, based on premiums.

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Industry Developments and Strategic Initiatives

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. 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.

Employers are also expressing a growing interest in employee wellness, absence management and productivity and recognizing a strong link between health, productivity and their profitability. As this interest grows, Cigna believes it is well positioned to deliver integrated solutions that address these broad employer and employee needs through its programs that promote a healthy lifestyle, offer assistance in returning to work and integrate health care and disability programs. Cigna also believes that its strong disability management portfolio and fully integrated programs provide employers and employees tools to improve health status. This focus on managing the employee's total absence enables Cigna to increase the number and likelihood of interventions and minimize disabling events.

There is heightened review by state regulators of group disability insurance industry business and reporting practices. Cigna is frequently the subject of regulatory market conduct and other reviews, audits and investigations by state insurance departments.

D. Global Supplemental Benefits

As explained in Item 1A "Description of Business", in the fourth quarter of 2012, Cigna changed its external reporting segments. The Global Supplemental Benefits segment is comprised of the international supplemental health, life and accident businesses (previously reported in the former International segment) as well as the Medicare supplement business acquired in 2012.

This segment offers supplemental health, life and accident insurance products in the U.S. and selected international markets. With local licenses and partnerships in approximately 20 countries and jurisdictions, Cigna is able to offer products and services to local citizens and globally mobile individuals. These products and services are provided by subsidiaries of Cigna Corporation, including foreign operating entities.

Cigna continues to distinguish itself in the global supplemental health, life and accident businesses through its differentiated direct to consumer distribution, customer insights and marketing capabilities. Cigna enters new markets when the opportunity to bring its product and health solutions is attractive. In 2012, Cigna extended its reach in Turkey through the joint venture with Finansbank and expanded into the U.S. Medigap and supplemental lines of business through acquisition. The 2011 acquisition of FirstAssist in the U.K. added a travel insurance product line and expanded the Company's distribution channels.

Principal Products and Services

Supplemental Health, Life and Accident Insurance

These 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. Term life and individual private medical insurance as well as variable universal life insurance and other savings products are also included in the product portfolio. Cigna's supplemental health, life and accident insurance products are offered in South Korea, Taiwan, Indonesia, Hong Kong, the United States, the European Union, China, New Zealand, Thailand and Turkey. Cigna owns a 50% interest in a Chinese joint venture and a 51% interest in a joint venture in Turkey, through which its products and services are offered. Cigna continues to work with its partner in India to establish a health insurance company that will operate as a joint venture upon licensing. Licensing is expected to occur in 2013.

Medicare Supplement Plans

Through its 2012 acquisition, Cigna also offers individual Medicare Supplement plans that provide retirees with federally standardized Medigap-style plans. Retirees may select amongst the various plans with specific plan options to meet their unique needs and may visit any health care professional or facility that accepts Medicare throughout the U.S. with no referrals required.

Financial information, including premiums and fees, is presented in the Global Supplemental Benefits section of the MD&A beginning on page 46 and in Note 23 to Cigna's Consolidated Financial Statements.

Pricing and Reinsurance

Premium rates for Cigna's global supplemental benefits products are based on assumptions about mortality, morbidity, customer acquisition and retention, expenses and target profit margins, as well as interest rates. The profitability of these products is primarily driven by the adequacy of mortality and morbidity assumptions used, and customer retention.

Fees for variable universal life insurance products 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. The profitability of these products is primarily driven by the policyholders' fund balances on which fees are charged as well as customer retention.

Premium rates and fees for Medicare supplement products reflect assumptions about future claims, customer retention, expenses, customer demographics, investment returns, and profit margins.

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Most contracts permit premium rate changes at least annually. The profitability of Medicare supplement products is dependent upon the accuracy of projections for health care inflation (unit cost and utilization), customer retention, customer demographics, and the adequacy of fees charged for administration.

The operations of Cigna's Global Supplemental Benefits segment are diversified by line of business. South Korea, however, represents the single largest geographic market for this segment. In 2012, South Korea generated 54% of this segment's revenues and 90% of its segment earnings. For information on the concentration of risk with respect to 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 46 of this Form 10-K.

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

Markets and Distribution

Cigna's supplemental health, life and accident insurance products sold in foreign countries are generally marketed through distribution partners with whom the individual insured has an affinity relationship. These products are sold primarily through direct marketing channels, such as outbound telemarketing and in-branch bancassurance (where Cigna partners with a bank and uses the bank's sales channels to sell its insurance products). Marketing campaigns are conducted through these channels under a variety of arrangements with affinity partners. These affinity partners primarily include banks, credit card companies and other financial and non-financial institutions. Cigna also markets directly to consumers via direct response television and the Internet.

Cigna's Medicare supplement product line acquired in 2012 is primarily distributed through independent agents and telemarketing directly to the consumer.

For Cigna's supplemental health, life and accident insurance products sold in foreign markets, a significant portion of premiums are billed and collected through credit cards. A substantial contraction in consumer credit could impact Cigna's 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 around permitted distribution channels may also impact Cigna's business or results. See the Regulation section beginning on page 14 and the Risk Factors section beginning on page 19 of this Form 10-K.

Competition

Competitive factors in Cigna's supplemental health, life and accident and health care businesses include product and distribution innovation and differentiation, efficient management of marketing processes and costs, commission levels paid to distribution partners, and quality of claims and customer services. In most overseas markets, perception of financial strength is also an important competitive factor.

For Cigna's supplemental health, life and accident insurance businesses operating in foreign markets, competitors are primarily locally based insurance companies, including insurance subsidiaries of banks primarily in Asia and Europe as well as multi-national companies. Insurance company competitors in this segment primarily focus on traditional product distribution through captive agents, with direct marketing being secondary channels. Cigna estimates that it has less than 2% market share of the total life insurance premiums in any given market in which it operates.

The principal competitive factors that affect Cigna's Medicare supplement business are underwriting and pricing, relative operating efficiency, broker relations, and the quality of claims and customer service.

The primary competitors of the Medicare supplement business include U.S.-based health insurance companies.

Cigna expects that the competitive environment will intensify as U.S. and Europe-based insurance and financial services providers pursue global expansion opportunities.

Industry Developments

Pressure on social health care systems and increased wealth and education in emerging 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 are growing and attracting new competitors while industry consolidation among financial institutions and other affinity partners continues. See "Risk Factors" beginning on page 19 of this Form 10-K for a discussion of risks related to the Global Supplemental Benefits segment.

E. Run-off Reinsurance

Until 2000, Cigna offered reinsurance coverage for part or all of the risks written by other insurance companies (or "ceding companies") under life and annuity policies (both group and individual) and accident policies (workers' compensation, personal accident, and catastrophe coverages). The products and services related to these operations were offered by subsidiaries of Cigna Corporation.

In 2000, Cigna sold its U.S. individual life, group life and accidental death reinsurance businesses. Cigna placed its remaining reinsurance businesses (including its accident, international life, and annuity reinsurance businesses) into run-off as of June 1, 2000, and stopped underwriting new reinsurance business.

As of December 31, 2012, Cigna's remaining exposures resulted primarily from its annuity reinsurance business, including its reinsurance of GMDB and GMIB contracts. Effective February 4, 2013, the Company reinsured 100% of the Company's future exposures for the Run-off GMDB and GMIB businesses, net of retrocessional arrangements in place prior to February 4, 2013 up to a specified limit. For additional information regarding this reinsurance transaction, see Note 25 to the Consolidated Financial Statements.

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F. Other Operations

Cigna's Other Operations segment includes the following businesses:

corporate owned life insurance;

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.

The products and services related to these operations are offered by subsidiaries of Cigna Corporation.

Corporate-owned Life Insurance ("COLI")

The principal products of the COLI business are permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for the purpose of funding 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. In order to reduce its exposure to large individual and catastrophe losses, Cigna purchases reinsurance from unaffiliated reinsurers.

Individual Life Insurance & Annuity and Retirement Benefits Businesses

For more information regarding the sale of these businesses and the arrangements which secure Cigna's reinsurance recoverables, see Note 8 of the Consolidated Financial Statements.

Settlement Annuity Business

Cigna's settlement annuity business is a closed run-off block of single premium annuity contracts. These contracts are primarily liability settlements with approximately 28% of the liabilities associated with payments that are guaranteed and not contingent on survivorship. In the case of the contracts that involve non-guaranteed payments, such payments are contingent on the survival of one or more parties involved in the settlement.

G. Investments and Investment Income

General Accounts

Cigna's investment operations provide investment management and related services for Cigna's corporate invested assets and the insurance-related invested assets in its General Account ("General Account Invested Assets"). Cigna acquires or originates, directly or through intermediaries, a broad range of investments including private placements 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 Cigna subsidiaries and, to a lesser extent, external managers with whom Cigna's subsidiaries contract. Net investment income and realized investment gains (losses) are included as a component of earnings for each of Cigna's operating segments (Global Health Care, Group Disability and Life, Global Supplemental Benefits, Run-off Reinsurance, and Other Operations) and Corporate. For additional information about invested assets, see the "Investment Assets" section of the MD&A beginning on page 56 and Notes 11, 12, 13, 14 and 15 to Cigna's Consolidated Financial Statements.

Cigna's investment strategy is to maximize risk-adjusted yields for the portfolios. Cigna manages the 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 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. Cigna routinely monitors and evaluates the status of its investments, obtaining and analyzing relevant investment-specific information as well as assessing current economic conditions, trends in capital markets and other factors. Such factors include industry sector considerations for fixed maturity investments and mezzanine and private equity partnership investments, and geographic and property-type considerations for commercial mortgage loan and real estate investments.

Separate Accounts

Cigna subsidiaries or external managers manage Separate Account assets on behalf of contractholders. These assets are legally segregated from the Company's other businesses and are not included in the General Account Invested Assets. Income, gains and losses generally accrue directly to the contractholders.

As of December 31, 2012, Cigna's Separate Account assets consisted of:

$3.4 billion in separate account assets that constitute a portion of the assets of the Cigna Pension Plan;

$3.4 billion in separate account assets that support Variable Universal Life products sold as a part of the Company's corporate-owned life insurance business, as well as through the Company's Global Supplemental Benefits segment; and

$1.0 billion in separate account assets that support primarily health care and other disability and life products.

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H. Regulation

Cigna and its subsidiaries are subject to comprehensive state, federal and international regulations. The laws and regulations governing Cigna's business continue to increase each year and are subject to frequent change. Cigna has established policies and procedures to comply with applicable requirements.

Cigna's insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. These subsidiaries are subject to numerous state and federal 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, generally under 50 employees);

premium rates;

medical loss ratios;

the content of agreements with participating providers of covered services;

producer appointment and compensation;

claims processing and appeals;

underwriting practices;

reinsurance arrangements;

unfair trade and claim practices;

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

risk sharing arrangements with providers;

reimbursement or payment levels for Medicare services;

advertising; and

the operation of consumer-directed plans (including health savings accounts, health reimbursement accounts, flexible spending accounts and debit cards).

Cigna and its international subsidiaries comply with regulations in international jurisdictions where foreign insurers may be faced with more onerous regulations than their domestic competitors. The broader regulatory environment may include anti-corruption laws, economic sanctions laws, various privacy, consumer protection, insurance, tax, tariff and trade laws and regulations, corporate governance, employment, intellectual property and investment laws and regulation, discriminatory licensing procedures, compulsory cessions of reinsurance, required localization of records and funds, higher premium and income taxes, and requirements for local participation in an insurer's ownership. In addition, the expansion of Cigna's operations into foreign countries increases the Company's exposure to certain U.S. laws, such as the Foreign Corrupt Practices Act of 1977 (FCPA). See page 16 for further discussion of international regulations.

The business of administering and insuring employee benefit programs, particularly health care programs, is heavily regulated by state and federal laws and administrative agencies, such as state departments of insurance and the federal departments of Labor, Health and Human Services, Treasury and Justice and the Internal Revenue Service, as well as the courts. Health savings accounts, health reimbursement accounts and flexible spending accounts are also regulated by the U.S. Department of the Treasury and the Internal Revenue Service.

Cigna's operations, accounts and other books and records are subject to examination at regular intervals by regulatory agencies, including state insurance and health and welfare departments, state boards of pharmacy and the Centers for Medicare and Medicaid Services to assess compliance with applicable laws and regulations. In addition, Cigna's current and past business practices are subject to review by, and from time to time the Company receives subpoenas and other requests of information from, various state insurance and health care regulatory authorities, attorneys general, the Office of Inspector General, and other state and federal authorities, including inquiries by, and testimony before committees and subcommittees of the U.S. Congress regarding certain of its business practices. These examinations, reviews, subpoenas and requests may result in changes to or clarifications of Cigna's business practices, as well as fines, penalties or other sanctions.

Regulatory and Legislative Developments

The federal and state governments in the U.S. as well as governments in other countries where Cigna does business continue to enact and seriously consider many broad-based legislative and regulatory proposals that could materially impact various aspects of Cigna's business.

Health Care Reform

In the first quarter of 2010, Health Care Reform was signed into law. Health Care Reform mandates broad changes in the delivery of health care benefits that may impact the Company's current business model, including its relationship with current and future customers, producers and health care providers, products, services, processes and technology. Health Care Reform includes, among other requirements, provisions for guaranteed coverage and renewal requirements, prohibitions on some annual and all lifetime limits on the dollar amount of benefits for essential health services, increased restrictions on rescinding coverage, minimum medical loss ratio and customer rebate requirements, a requirement to

cover preventive services on a first dollar basis, and greater controls on premium rate increases for individual and small employer health insurance. It also reduces the Medicare Part D coverage gap and reduces payments to private plans offering Medicare Advantage, as well as provides for state insurance exchanges through which qualified insurers and HMOs will be able to offer insured plans to individuals and small employers. Certain of the law's provisions became effective between 2010 and 2012 and other provisions will take effect from 2013 to 2018. Health Care Reform left many of the details of the new law to be established through regulations. While federal agencies have published interim final regulations with respect to certain requirements, many issues remain uncertain.

The provisions of the new law that became effective between 2010 and 2012 included those requiring coverage of preventive services with no enrollee cost-sharing, banning the use of lifetime and annual

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limits on the dollar amount of essential health benefits, increasing restrictions on rescinding coverage and extending coverage of dependents to the age of 26. Minimum medical loss ratio requirements as prescribed by the Department of Health and Human Services ("HHS") became effective in January 2011 and required payment of premium rebates beginning in 2012 to employers and customers covered under the Company's comprehensive medical insurance if certain annual minimum medical loss ratios ("MLR") are not met. HHS regulations permit adjustments to be made to the claims used in the calculation for Cigna's international health care and limited benefit plans subject to the MLR minimums. The adjustment for limited benefit plans is only permitted through 2014.

Certain other provisions of Health Care Reform will not become effective until 2013 or later, including: (1) the annual health insurer fee on health insurers and HMOs to help fund the expanded coverage provided under this legislation; (2) reinsurance assessments on insurers and HMOs to help stabilize rates in the individual and small group markets beginning in 2014; (3) the guaranteed issue and renewal requirements and the requirement that individuals maintain coverage, and (4) an excise tax on high-cost employer-sponsored coverage. These fees and excise taxes will generally not be tax deductible with the exception of the reinsurance assessment on insurers and HMOs. Health Care Reform also changed certain tax laws that will effectively limit the amount of certain employee compensation that is tax deductible by health insurers.

Health Care Reform also impacts Cigna's Medicare Advantage and Medicare Part D prescription drug plan businesses acquired with HealthSpring in a variety of additional ways, including reduced Medicare premium rates (which began with the 2011 contract year), mandated minimum reductions to risk scores (beginning in 2014), transition of Medicare Advantage "benchmark" rates to Medicare fee-for-service parity, reduced enrollment periods and limitations on disenrollment, providing "quality bonuses" for Medicare Advantage plans with a rating for four or five stars from CMS and mandated consumer discounts on brand name and generic prescription drugs for Medicare Part D plan participants in the coverage gap. Beginning in 2014, Health Care Reform requires Medicare Advantage and Medicare Part D plans to meet a minimum MLR of 85%. Under the rules proposed by HHS, if the MLR for a CMS contract is less than 85%, the contractor is required to pay a penalty to CMS and could be subject to additional sanctions if the MLR continues to be less than 85% for successive years. Through Health Care Reform and other federal legislation, funding for Medicare Advantage plans has been and may continue to be altered.

Health Care Reform significantly affects states that can elect to establish their own state exchanges for individual and small employer insurance business or allow the federal government to establish and operate the exchange for them. Cigna, therefore, expects state legislatures to focus on legislation to implement Health Care Reform and to address the impact of Health Care Reform on state budgets.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of most parts of Health Care Reform, including the obligation to purchase health care coverage (the "individual mandate"). The Company has implemented the provisions of Health Care Reform that are currently in effect (including the commercial minimum MLR requirements) and continues its implementation planning for those provisions that must be adopted in the future. Management continues to closely monitor the implementation of Health Care Reform and is actively engaged with regulators and policymakers on the conversion of legislation to regulation. In addition, management is implementing the necessary capabilities to ensure that the Company is compliant with the law and assessing potential opportunities arising from Health Care Reform.

Dodd-Frank Act

In 2010, Congress enacted the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act") that provides for a number of reforms and regulations in the corporate governance, financial reporting and disclosure, investments, tax and enforcement areas that affect Cigna. The SEC and other regulatory authorities engaged in rulemaking efforts under the Dodd-Frank Act throughout 2011 and 2012, and additional rulemaking still continues. The Dodd-Frank Act established a Federal Insurance Office that will develop and coordinate federal policy on insurance matters. Cigna is closely monitoring how these regulations impact the Company, however the full impact of the legislation may not be known for several years until regulations become fully effective.

Regulation of Insurance Companies

Financial Reporting and Internal Control

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. Cigna's 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 accountants. 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. Cigna expects states to expand the scope of regulations relating to corporate governance and internal control activities of its insurance and HMO subsidiaries as a result of the National Association of Insurance Commissioners' ("NAIC") amendment to the Annual Financial Reporting Model Regulation to adopt elements of corporate governance and internal control requirements similar to those 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.

Several states also require HMOs to participate in guaranty funds, special risk pools and administrative funds. For additional information about guaranty fund and other assessments, see Note 24 to Cigna's Consolidated Financial Statements.

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Some states also 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.

Solvency and Capital Requirements

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

In addition, various non-U.S. jurisdictions prescribe minimum surplus requirements that are based upon solvency, liquidity and reserve coverage measures. During 2012, Cigna's HMOs and life and health insurance subsidiaries, as well as non-U.S. insurance subsidiaries, were compliant with applicable RBC and non-U.S. surplus rules.

In September 2012, the National Association of Insurance Commissioners adopted the Risk Management and Own Risk and Solvency Assessment Model Act. The Act provides requirements and principles for maintaining a group solvency assessment and a risk management framework and reflects a broader and more prospective approach to U.S. insurance regulation. The Act, which includes a requirement to file an annual ORSA Summary Report in the lead state of domicile, now must be adopted into law by each state. Cigna's insurance business in the U.S. will be subject to the requirements that are expected to become effective in 2015. Cigna will be prepared to file an ORSA Summary Report with its lead state regulator consistent with the requirements.

Cigna's businesses in the European Union will be subject to the directive on insurance regulation and solvency requirements known as Solvency II. This directive will impose economic risk-based solvency requirements and supervisory rules and is expected to become effective in January 2014, although certain regulators are requiring companies to demonstrate technical capability and comply with increased capital levels in advance of the effective date. Cigna's European insurance companies are capitalized at levels consistent with projected Solvency II requirements and in compliance with anticipated technical capability requirements.

Holding Company Laws

Cigna's domestic insurance companies and certain of its HMOs are subject to state laws regulating subsidiaries of insurance holding companies. Under such laws, certain dividends, distributions and other transactions between an insurance or HMO subsidiary and its affiliates may require notification to, or approval by, one or more state insurance commissioners.

In December 2010, the NAIC adopted revisions to the Model Insurance Holding Company System Regulatory Act and Regulation. The revisions were designed to allow a better understanding of the risks and activities of non-insurance entities within a holding company system. The main focus of the revisions has been to incorporate the concept of "enterprise risk" and to enact provisions designed to provide regulators with additional information and authority to manage this new concept. To date, a few states have taken action to adopt the amended Model Act and Regulation. Cigna continues to follow the states' activity in this area and will amend its processes as necessary to comply with revised state laws.

Marketing, Advertising and Products

In most states, Cigna's insurance companies and HMO subsidiaries are required to certify compliance with applicable advertising regulations on an annual basis. Cigna's insurance companies and HMO subsidiaries are also required in most states to file and secure regulatory approval of products prior to the marketing, advertising, and sale of such products. State and/or federal regulatory scrutiny of life and health insurance company and HMO marketing and advertising practices, including the adequacy of disclosure regarding products and their administration, may result in increased regulation. Products offering limited coverage, such as those Cigna issues through the Star HRG business, continue to attract increased regulatory scrutiny.

Licensing Requirements

Pharmacy Licensure Laws

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

International Licensure Laws

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

Claim Administration, Utilization Review and Related Services

Certain Cigna subsidiaries contract to provide claim administration, utilization management and other related services for the administration of self-insured benefit plans. These Cigna subsidiaries may be subject to state third-party administration and other licensing requirements and regulation.

International Regulations

Cigna's revenue from operations outside the United States exposes the Company to laws of multiple jurisdictions and the rules and regulations of various governing bodies and regulators, including those related to financial and other disclosures, corporate governance, privacy, data protection, data mining, data transfer, labor and

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employment, consumer protection and anti-corruption. The operations in countries outside the United States:

are subject to local regulations in the locations in which Cigna subsidiaries conduct business,

in some cases, are subject to regulations in the locations of customers, and

in all cases are subject to FCPA.

FCPA prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Cigna is also subject to applicable anti-corruption laws in the jurisdictions in which it operates. Additionally, in many countries outside of the U.S., health care professionals are employed by the government. Therefore, Cigna's dealings with them are subject to regulation under the FCPA. 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, which went into effect in 2011, is an anti-corruption law that applies to all companies with a nexus to the United Kingdom and whose scope is even broader than the FCPA. It is yet to be seen how the UK Bribery Act will be enforced, but any voluntary disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. Cigna has internal control policies and procedures and has implemented training and compliance programs for its employees to deter prohibited practices. However, if Cigna's employees or agents fail to comply with applicable laws governing its international operations, the Company 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 19 for a discussion of the risks related to operating globally.

Federal Regulations

Employee Retirement Income Security Act and the Public Health Service Act

Cigna subsidiaries sell most of their products and services to sponsors of employee benefit plans that are governed by ERISA. Many of the health insurance reform provisions of the Patient Protection and Affordable Care Act were incorporated in ERISA, Cigna subsidiaries are subject to requirements imposed by ERISA affecting claim and appeals procedures for individual insurance and insured and self-insured group health plans and are expected to comply with these requirements on behalf of the dental, disability, life and accident plans they administer. These health insurance reform provisions made applicable to group health plans 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).

Medicare Regulations

Several Cigna subsidiaries, including those acquired in the HealthSpring transaction, engage in businesses that are subject to federal Medicare regulations such as:

those offering individual and group Medicare Advantage (HMO) coverage;

contractual arrangements with the federal government for the processing of certain Medicare claims and other administrative services; and

those offering Medicare Pharmacy (Part D) products that are subject to federal Medicare regulations.

In Cigna's Medicare Advantage business, the Company contracts with the Centers for Medicare and Medicaid Services ("CMS") to provide services to Medicare beneficiaries pursuant to their Medicare program. As a result, the Company's right to obtain payment from CMS is subject to compliance with numerous and complex regulations and requirements that are frequently modified and subject to administrative discretion. The marketing and sales activities (including those of third-party brokers and agents) are also heavily regulated by CMS and other governmental agencies.

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

Federal Audits of Government Sponsored Health Care Programs

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

The Federal government has made investigating and prosecuting health care fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of customers, billing for unnecessary medical services, improper marketing, and violation of patient privacy rights. The regulations and contractual requirements in this area are complex and subject to change and compliance will continue to require significant resources.

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PART I

ITEM 1 Business

Health Insurance Portability and Accountability Act Regulations

The federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") impose requirements on health insurers, HMOs, health plans, health care providers and clearinghouses. Health insurers and HMOs are further subject to regulations related to guaranteed issuance (for groups with 50 or fewer lives), guaranteed renewal, and portability of health insurance.

HIPAA also imposes minimum standards for the privacy and security of protected health information. HIPAA's privacy and security requirements were expanded by the Health Information Technology for Economic and Clinical Health Act ("HITECH") that enhanced penalties for HIPAA violations and requires regulated entities to provide notification to various parties in the event of a breach of unsecured protected health information. Regulations pursuant to HITECH continue to be promulgated and are monitored and implemented as they are finalized.

HIPAA also established rules that standardize the format and content of certain electronic transactions, including, but not limited to, eligibility and claims. Federal regulations were issued requiring entities subject to HIPAA to update their transaction formats for electronic data interchange from HIPAA 4010 to version 5010 standards and convert from the ICD-9 diagnosis and procedure codes to the ICD-10 diagnosis and procedure codes. The ICD-10 conversion is required by October 1, 2013, though CMS has proposed a rule that would delay the implementation for one year until October 1, 2014.

Other Confidentiality Requirements

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

Antitrust Regulations

Cigna subsidiaries are also engaged 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.

Anti-Money Laundering Regulations

Certain Cigna products ("Covered Products" as defined in the Bank Secrecy Act) are subject to U.S. Department of the Treasury anti-money laundering regulations. Cigna has implemented anti-money laundering policies designed to ensure that its Covered Products are underwritten and sold in compliance with these regulations. Cigna may also be subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control

The Company is also subject to regulation put forth by the Office of Foreign Assets Control of the U.S. Department of the Treasury which administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, Cigna may be subject to similar regulations in non-U.S. jurisdictions in which it operates.

Investment-Related Regulations

Depending upon their nature, Cigna's 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.

I. Miscellaneous

Cigna and its principal subsidiaries are not dependent on business from one or a few customers. No one customer accounted for 10% or more of Cigna's consolidated revenues in 2012. Cigna and its principal subsidiaries are not dependent on business from one or a few brokers or agents. In addition, Cigna's 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 its approval and acceptance.

Cigna had approximately 35,800 employees as of December 31, 2012; 31,400 employees as of December 31, 2011; and 30,600 employees as of December 31, 2010.

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ITEM 1A Risk Factors

As a large company operating in a complex industry, Cigna encounters a variety of risks and uncertainties including those identified in this Risk Factor discussion and elsewhere in this report. Cigna has implemented and maintains enterprise-wide risk management processes, in addition to the risk management processes within its businesses. The factors discussed below represent significant risks and uncertainties that could have a material adverse effect on Cigna's business, liquidity, results of operations or financial condition. These risks and uncertainties are not the only ones Cigna faces. Additional risks and uncertainties not presently known to the Company or that it currently believes to be immaterial may also adversely affect Cigna.

Regulatory and Litigation Risks

Health Care Reform legislation, as well as potential additional changes in federal or state regulations, could have a material adverse effect on Cigna's business, results of operations, financial condition and liquidity.

In 2010, Health Care Reform was signed into law, and it is resulting in significant changes to the current U.S. health care system. Health Care Reform mandates broad changes in the delivery of health care benefits that may impact the Company's current business model, including its relationship with current and future customers, producers and health care providers, products, services, processes and technology. Health Care Reform includes, among other requirements, provisions for guaranteed coverage and renewal requirements, prohibitions on annual and lifetime limits on the dollar amount of benefits for essential health services, increased restrictions on rescinding coverage, minimum medical loss ratio and customer rebate requirements, a requirement to cover preventive services on a first dollar basis, and greater controls on premium rate increases for individual and small employer health insurance. It also reduces the Medicare Part D coverage gap and reduces payments to private plans offering Medicare Advantage, as well as provides for state insurance exchanges through which insurers and HMOs will, if qualified, be able to offer insured plans to individuals and small employers. In addition, the legislation imposes an excise tax on high-cost employer-sponsored coverage and annual fees on insurance companies and HMOs that will generally not be deductible for income tax purposes and therefore may adversely impact the Company's effective tax rate. It also limits the amount of compensation for executives of insurers that is tax deductible.

Certain of the law's provisions became effective between 2010 and 2012 and other provisions will take effect from 2013 to 2018. Health Care Reform left many of the details of the new law to be set forth through regulations. While federal agencies have published interim final regulations with respect to certain requirements, many issues remain uncertain, thus the full impact on the Company is not yet known. This legislation could impact the Company significantly by:

disrupting the employer-based market, which is currently the primary business model for the Company's Global Health Care segment;

causing employers to drop health care coverage for their employees;

driving potential cost shifting in the health care delivery system to health insurance companies and HMOs;

regulating business practices;

imposing new or increasing taxes and financial assessments;

limiting the ability to increase premiums to meet costs (including denial or delays in approval and implementation of those rates); and

significantly reducing the growth of Medicare program payments.

Accordingly, Health Care Reform, other regulatory reform initiatives or additional changes in existing laws or regulations, or their interpretations, could have a material adverse effect on the Company's business, results of operations, financial condition and liquidity.

The Medicare business acquired with HealthSpring presents additional risks for Cigna, as the Medicare program has been the subject of recent regulatory reform initiatives, including Health Care Reform. Because Medicare program premiums account for substantially all of the acquired business's revenue, reductions or less than expected increases in funding for Medicare programs (including the potential effect of sequestration) could significantly reduce the Company's profitability, and non-renewal or termination of Medicare contracts would substantially impair the acquired business.

In June 2012, the U.S. Supreme Court upheld the constitutionality of most parts of Health Care Reform, but considerable uncertainty remains and it is difficult to predict the impact of Health Care Reform on the business due to the law's complexity, continuing development of implementing regulations and interpretive guidance. Cigna is unable to predict how these events will develop and what impact they will have on Health Care Reform, and in turn, on Cigna.

For additional information on Health Care Reform, see "Business Regulation" in Section H beginning on page 14 of this Form 10-K and the "Introduction" section of MD&A beginning on page 32 of this Form 10-K. See also the description of minimum medical loss ratio and customer rebate requirements in the "Business B. Global Health Care" section beginning on page 2 of this Form 10-K.

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PART I

ITEM 1A Risk Factors

Cigna's business is subject to substantial government regulation that, along with new regulation, could increase its costs of doing business and have a material adverse effect on its profitability.

Cigna's business is regulated at the international, federal, state and local levels. The laws and rules governing Cigna's business and related interpretations are increasing in number and complexity, are subject to frequent change and can be inconsistent or even conflict with each other. As a public company with global operations, Cigna is subject to the laws of multiple jurisdictions and the rules and regulations of various governing bodies, including those related to financial and other disclosures, corporate governance, privacy, data protection, labor and employment, consumer protection, tax and anti-corruption. Cigna must identify, assess and respond to new trends in the legislative and regulatory environments as well as effectively comply with the various existing regulations applicable to its business. Existing or future laws, rules, regulatory interpretations or judgments could force Cigna to change how it does business, restrict revenue and enrollment growth, increase health care, technology and administrative costs, including pension costs and capital requirements, require enhancements to the Company's compliance infrastructure and internal controls environment. Existing or future laws and rules could also require Cigna to take other actions such as changing its business practices for disability payments thereby increasing Cigna's liability in federal and state courts for coverage determinations, contract interpretation and other actions.

In addition, Cigna must obtain and maintain regulatory approvals to market many of its products, to increase prices for certain regulated products and to consummate some of its acquisitions and divestitures. Delays in obtaining or failure to obtain or maintain these approvals could reduce the Company's revenue or increase its costs. For further information on regulatory matters relating to Cigna, see "Business Regulation" in Section H of this Form 10-K.

Cigna faces risks related to litigation, regulatory audits and investigations.

Cigna is routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal matters arising in the ordinary course of business, including that of administering and insuring employee benefit programs. These could include benefit claims, breach of contract actions, tort claims, disputes regarding reinsurance arrangements, employment and employment discrimination-related suits, employee benefit claims, wage and hour claims, tax, privacy, intellectual property and real estate related disputes. In addition, Cigna incurs and likely will continue to incur liability for claims related to its health care business, such as failure to pay for or provide health care, poor outcomes for care delivered or arranged, provider disputes, including disputes over compensation, and claims related to self-funded business. Also, there are currently, and may be in the future, attempts to bring class action lawsuits against the industry.

Court decisions and legislative activity may increase Cigna's exposure for any of these types of claims. In some cases, substantial non-economic or punitive damages may be sought. Cigna currently has insurance coverage for some of these potential liabilities. Other potential liabilities may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be sufficient 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 one or more of the legal matters and claims described could result in losses material to Cigna's results of operations, financial condition and liquidity.

A description of material pending legal actions and other legal matters in which Cigna is currently involved is included in Note 24 to Cigna's Consolidated Financial Statements included in this Form 10-K. The outcome of litigation and other legal matters is always uncertain, and outcomes that are not justified by the evidence or existing law can occur. Cigna believes that it has valid defenses to the legal matters pending against it and is defending itself vigorously.

In addition, there is heightened review by federal and state regulators of health care and group disability insurance industry business and reporting practices. Cigna is frequently the subject of regulatory market conduct and other reviews, audits and investigations by state insurance and health and welfare departments, attorneys general, the Centers for Medicare and Medicaid Services (CMS) and, the Office of Inspector General (OIG). With respect to Cigna's 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 (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 2012, Cigna significantly expanded its Medicare business with its acquisition of HealthSpring. This expansion of its Medicare business may increase the risks the Company faces from lawsuits, regulatory audits, investigations and other regulatory matters. These

regulatory reviews could result in changes to or clarifications of Cigna's business practices or retroactive adjustments to certain premiums, and also could result in significant fines, penalties, civil liabilities, criminal liabilities or other sanctions, that could have a material adverse effect on the Company's business, results of operation, financial condition and liquidity. Additionally, the employee benefits industry remains under scrutiny by various state and federal government agencies and could be subject to governmental efforts to bring criminal actions in circumstances that could previously have given rise only to civil or administrative proceedings.

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Business Risks

Future performance of Cigna's business will depend on the Company's ability to execute on its strategic and operational initiatives effectively.

The future performance of Cigna's business will depend in large part on Cigna's ability to effectively implement and execute its strategic and operational initiatives that include: (1) driving growth in targeted geographies, product lines, buying segments and distribution channels; (2) improving its strategic and financial flexibility; and (3) pursuing additional opportunities in high-growth markets with particular focus on individuals.

Successful execution of these strategic and operational initiatives depends on a number of factors including:

differentiating Cigna's products and services from those of its competitors by leveraging its health advocacy capabilities and other strengths in targeted markets, geographies and buyer segments;

developing and introducing new products or programs, particularly in response to government regulation and the increased focus on consumer directed products;

identifying and introducing the proper mix or integration of products that will be accepted by the marketplace;

attracting and retaining sufficient numbers of qualified employees;

attracting and engaging a sufficient number of qualified partners, including physicians partners in an environment with a growing shortage of primary care physicians;

effectively managing balance sheet exposures, including the Company's pension funding obligation;

improving medical cost competitiveness in targeted markets; and

reducing Cigna HealthCare's medical operating expenses to achieve sustainable benefits.

If these initiatives fail or are not executed effectively, it could harm the Company's consolidated financial position and results of operations. For example, reducing operating expenses while maintaining the necessary resources and the Company's talent pool is important to the Company and, if not managed effectively, could have long-term effects on the business such as failure to maintain or improve the quality of its products and limiting its ability to retain or hire key personnel. In addition, to succeed, the Company must align its organization to its strategy. Cigna must effectively integrate its operations, including its most recently acquired businesses, actively work to ensure consistency throughout the organization, and promote a global mind-set and a focus on individual customers. If the Company fails to do so, it may be unable to grow as planned, or the result of expansion may be unsatisfactory. Also, the current competitive, economic and regulatory environment will require Cigna's organization to adapt rapidly and nimbly to new opportunities and challenges. The Company will be unable to do so if it does not make important decisions quickly, define its appetite for risk specifically, implement new governance, managerial and organizational processes smoothly and communicate roles and responsibilities clearly.

As a global company, Cigna faces political, legal, operational, regulatory, economic and other risks that present challenges and could negatively affect its multinational operations or the Company's long-term growth.

As a global company, Cigna's business is increasingly exposed to risks inherent in foreign operations. These risks, which can vary substantially by market, include political, legal, operational, regulatory, economic and other risks, including government intervention and censorship that the Company does not face in its U.S. operations. The global nature of Cigna's business and operations presents challenges including, but not limited, to those arising from:

varying regional and geopolitical business conditions and demands;

discriminatory regulation, nationalization or expropriation of assets;

price controls or other pricing issues and exchange controls or other restrictions that prevent it from transferring funds from these operations out of the countries in which it operates 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 the Company's international operations, and any measures that it may implement to reduce the effect of volatile currencies and other risks of its international operations may not be effective;

reliance on local sales forces for some of its operations in countries that may have labor problems and less flexible employee relationships that can be difficult and expensive to terminate, or where changes in local regulation or law may disrupt the business operations;

risk associated with managing Cigna's partner relationships in accordance with business objectives in countries where our foreign businesses voluntarily operate or are required to operate with local business partners;

challenges associated with managing more geographically diverse operations and projects;

the need to provide sufficient levels of technical support in different locations;

political instability or acts of war, terrorism, natural disasters, pandemics in locations where Cigna operates; and

general economic and political conditions.

These factors may increase in importance as Cigna continues to expand globally, and any one of these challenges could negatively affect the Company's operations or its long-term growth. Currently, South Korea is the single largest geographic market in Cigna's Global

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PART I

ITEM 1A Risk Factors

Supplemental Benefits segment. South Korea generated 54% of the segment's revenues and 90% of the segment's earnings in 2012. Due to the concentration of business in South Korea, the Global Supplemental Benefits segment is exposed to potential losses resulting from economic 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 the Company's consolidated financial results. Further, expansion into new markets may require considerable management time before any significant revenues and earnings are generated, that could divert management's attention from other strategic activities.

International operations also require the Company to devote significant management resources to implement its controls and systems in new markets, to comply with the U.S. anti-bribery and anti-corruption as well as anti-money laundering provisions and similar laws in local jurisdictions and to overcome logistical and other challenges based on differing languages, cultures and time zones. Violations of these laws and regulations could result in fines, criminal sanctions against the Company, its officers or employees, prohibitions on the conduct of its business, and reputational harm. Cigna must regularly reassess the size, capability and location of its global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in its business and operations. Cigna's success depends, in part, on its ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on Cigna's business, results of operations, financial condition, liquidity and long-term growth.

Successful management of Cigna's outsourcing projects and key vendors including taking steps to ensure that third parties that obtain access to sensitive personal information maintain its confidentiality and security, is important to its business.

To improve operating costs, productivity and efficiencies, Cigna outsources selected functions to third parties. Cigna takes steps to monitor and regulate the performance of independent third parties who provide services or to whom the Company delegates selected functions. These third parties include information technology system providers, independent practice associations, providers of medical management services, call center and claim service providers and various types of other service providers.

Arrangements with key vendors may make Cigna's operations vulnerable if third parties fail to satisfy their obligations to the Company, including their obligations to maintain and protect the security and confidentiality of the Company's information and data, as a result of their performance, changes in their own operations, financial condition, or other matters outside of Cigna's control. The Company has limited control over the actions of third-party providers even though contracts provide certain protections. Noncompliance with any privacy or security laws and regulations or any security breach involving one of its third-party service providers could have a material adverse effect on its business, results of operations, financial condition, liquidity and reputation. In addition, to the extent Cigna outsources selected services or selected functions to third parties in foreign jurisdictions, the Company could be exposed to risks inherent in conducting business outside of the United States, including international economic and political conditions, and the additional costs associated with complying with foreign laws and fluctuations in currency values.

The expanding role of third party service vendors may also require changes to Cigna's existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed, in order to realize the potential productivity and operational efficiencies. Effective management, development and implementation of its outsourcing strategies are important to Cigna's business and strategy. If there are delays or difficulties in enhancing business processes or its third party providers do not perform as anticipated, Cigna may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships it enters into with key vendors, which 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 the Company. Terminating or transitioning arrangements with key vendors could result in additional costs and risks of operational delays, potential errors and possible control issues as a result of the termination or during the transition phase.

Acquisitions, including HealthSpring, involve risks and the Company may not realize the expected benefits because of integration difficulties, underperformance relative to Cigna's expectations and other challenges.

As part of the Company's growth strategy, Cigna regularly considers strategic transactions, including acquisitions, with the expectation that these transactions will result in various benefits. Cigna's ability to achieve the anticipated benefits of acquisitions is subject to a number of uncertainties, including whether Cigna integrates its acquired companies in an efficient and effective manner, the performance of the acquired

businesses and general competitive factors in the marketplace. Failure to achieve these anticipated benefits could result in increased costs, decreases in expected revenues, goodwill impairment charges, and diversion of management's time and energy.

In January 2012, Cigna acquired HealthSpring, an operator of Medicare Advantage coordinated care plans in 13 states and the District of Columbia. The success of the HealthSpring acquisition depends on Cigna's ability to integrate HealthSpring with its existing businesses and the performance of the acquired business. The potential difficulties of integrating the operations of HealthSpring and achieving the performance expected of the acquired businesses include: implementing the Company's business plan for the combined business; executing Cigna's growth plans by leveraging its capabilities and those of the businesses acquired in serving the Seniors segment; unanticipated issues in integrating logistics, information, communications and other systems; changes in applicable laws and regulations or conditions imposed by regulators; retaining key employees; operating risks inherent in HealthSpring's business and

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Cigna's business; retaining and growing membership; renewing or successfully rebidding for contracts with CMS, including maintaining or improving upon the CMS performance plan star ratings; leveraging the information technology platform of the acquired businesses; and unanticipated issues, costs, obligations and liabilities. If Cigna is unable to integrate the HealthSpring business successfully, or if the acquired business' performance evaluations under contracts with CMS are adverse, these factors could have a material adverse effect on Cigna's business, results of operations, financial condition and liquidity and could affect expectations for future revenue and earnings growth.

Effective internal controls are necessary for the Company to provide reliable and accurate financial reports and to mitigate the risk of fraud. The integration of acquired businesses is likely to result in Cigna's systems and controls becoming increasingly complex and more difficult to manage. Any difficulties in the assimilation of acquired businesses into the Company's control system could cause it to fail to meet its financial reporting obligations. Ineffective internal controls could also cause investors to lose confidence in the Company's reported financial information, which could have a negative effect on the trading price of Cigna's stock and its access to capital.

Cigna's business depends on its ability to properly maintain the integrity of its data and the uninterrupted operation of its systems and business functions, including information technology and other business systems.

Cigna's business depends on effective information systems and the integrity and timeliness of the data it uses to run its business. Cigna's business strategy requires providing customers and health care professionals with Internet-enabled products and information to meet their needs. Cigna's ability to adequately price its products and services, establish reserves, provide effective and efficient service to its customers, and to timely and accurately report its financial results also depends significantly on the integrity of the data in its information systems. If the information Cigna relies upon to run its businesses were found to be inaccurate or unreliable due to fraud or other error, or if Cigna (or the third-party service parties it utilizes) were to fail to maintain information systems and data integrity effectively, the Company could experience difficulties with: operational disruptions (that may impact customers and health care professionals); determining medical cost estimates and establishing appropriate pricing; retaining and attracting customers; regulatory compliance and other challenges.

In addition, Cigna's business is highly dependent upon its ability to perform, in an efficient and uninterrupted fashion, its necessary business functions, such as: claims processing and payment; internet support and customer call centers; and the processing of new and renewal business. Failure to comply with relevant regulations, a power outage, pandemic, cyber-attack or other failure of one or more of information technology, telecommunications or other systems could cause slower system response times resulting in claims not being processed as quickly as clients desire, decreased levels of client service and client satisfaction, and harm to Cigna's reputation. Because Cigna's information technology and telecommunications systems interface with and depend on third-party systems, Cigna 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 a business interruption, systems failure or service denial could result in a deterioration of Cigna's ability to pay claims in a timely manner, provide customer service, write and process new and renewal business, or perform other necessary corporate functions, and could have a material adverse effect on Cigna's business, results of operations, financial condition and liquidity.

Like other companies in our industry, we have been and may in the future be the subject of cybersecurity breaches. Computer systems may be vulnerable to physical break-ins, computer viruses, programming errors, attacks by third parties or similar disruptive problems. If a cybersecurity breach of Cigna's computer systems or the computer systems of a third-party service provider occurs, it could also interrupt Cigna's operations and damage Cigna's reputation. Cigna could also be subject to liability if sensitive customer information is misappropriated. Any publicized compromise of security could result in a loss of existing or new customers, increased operating expenses, financial losses, and additional litigation or other claims that could have a material adverse effect on Cigna's business, results of operations, financial condition and liquidity.

Effective investment in and execution of improvements in the Company's information technology infrastructure and functionality are important to its strategy and failure to do so may impede its ability to deliver the services required in the evolving marketplace at a competitive cost.

Cigna's information technology strategy and execution are critical to the continued success of the Company. Increasing regulatory and legislative mandated changes will place additional demands on Cigna's information technology infrastructure, which could have a direct impact on available resources for projects more directly tied to strategic initiatives. The Company must continue to invest in long-term solutions that will enable it to anticipate customer needs and expectations, enhance the customer experience and act as a differentiator in the market. Cigna's success is dependent, in large part, on maintaining the effectiveness of existing technology systems and continuing to deliver and enhance

technology systems that support the Company's business processes in a cost-efficient and resource-efficient manner. Cigna also must develop new systems to meet current market standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and customer needs. Failure to do so may impede the Company's ability to deliver services at a competitive cost. Furthermore, system development projects are long-term in nature, may be more costly than expected to complete and may not deliver the expected benefits upon completion.

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PART I

ITEM 1A Risk Factors

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

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

In addition, provider or customer fraud that is not prevented or detected could impact Cigna's medical costs or those of its self-insured customers. Further, during an economic downturn, Cigna's segments, including Global Health Care, Group Disability and Life and Global Supplemental Benefits, may see increased fraudulent claims volume that may lead to additional costs due to an increase in disputed claims and litigation.

Cigna's pharmacy benefit management business is subject to a number of risks and uncertainties, in addition to those Cigna faces with its health care business.

Cigna's pharmacy benefit management business is subject to federal and state regulation, including federal and state anti-remuneration laws, ERISA, HIPAA and laws related to the operation of Internet and mail-service pharmacies. Noncompliance with such regulations could have a material adverse effect on Cigna's business, results of operations, financial condition, liquidity and reputation.

The Company's pharmacy benefit management business would also be adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and could suffer claims and reputational harm in connection with purported errors by Cigna's mail order or retail pharmacy businesses. Disruptions at any of the Company's pharmacy business facilities due to failure of technology or any other failure or disruption to these systems or to the infrastructure due to fire, electrical outage, natural disaster, acts of terrorism or some other catastrophic event could reduce Cigna's ability to process and dispense prescriptions and provide products and services to customers, that could have a material adverse effect on Cigna's business, results of operations, financial condition and liquidity.

In operating its onsite clinics and medical facilities, the Company may be subject to additional liability, that could result in significant time and expense and divert management's attention from other strategic activities.

The Company employs physicians, nurse practitioners, nurses and other health care professionals at onsite low acuity and primary care clinics it operates for the Company's customers (as well as certain clinics for Company employees). Through the HealthSpring business acquired in 2012, Cigna also operates LivingWell health centers and health care practices for its customers. In addition, the Company owns and operates medical facilities in the Phoenix, Arizona metropolitan area, including multispecialty health care centers, outpatient surgery and urgent care centers, low acuity clinics, laboratory, pharmacy and other operations that employ primary care as well as specialty care physicians and other types of health care professionals. As a direct employer of health care professionals and as an operator of primary and low-acuity care clinics and other types of medical facilities, the Company is subject to liability for negligent acts, omissions, or injuries occurring at one of its clinics or caused by one of its employees. Even if any claims brought against the Company were unsuccessful or without merit, it would have to defend against such claims. The defense of any actions may be time-consuming and costly, and may distract management. As a result, Cigna may incur significant expenses that could have a material adverse effect on Cigna's business, results of operations, financial condition, and liquidity.

Cigna faces competitive pressure, particularly price competition, that could result in premiums which are insufficient to cover the cost of the health care services delivered to its members and inadequate medical claims reserves.

While health plans compete on the basis of many factors, including service quality of clinical resources, claims administration services and medical management programs, and quality, sufficiency and cost effectiveness of health care professional network relationships, Cigna expects that price will continue to be a significant basis of competition. Cigna's customer contracts are subject to negotiation as customers seek to contain their costs, and customers may elect to reduce benefits in order to constrain increases in their benefit costs. Such an election may result in lower premiums for the Company's products, and even though it may also reduce Cigna's costs, it could still adversely affect Cigna's financial results. Alternatively, the Company's customers may purchase different types of products that are less profitable, or move to a competitor to obtain more favorable premiums.

Factors such as business consolidations, strategic alliances, legislative reform and marketing practices create pressure to contain 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 that may lead to new competitors with significant financial resources in the insurance and health benefits fields. The Company's product margins and

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growth depend, in part, on its ability to compete effectively in its markets, set rates appropriately in highly competitive markets to keep or increase its market share, increase membership as planned, and avoid losing accounts with favorable medical cost experience while retaining or increasing membership in accounts with unfavorable medical cost experience.

Cigna's profitability depends, in part, on its ability to accurately predict and control future health care costs through underwriting criteria, provider contracting, utilization management and product design. Premiums in the health care business are generally fixed for one-year periods. Accordingly, future cost increases in excess of medical cost projections reflected in pricing cannot generally be recovered in the current contract year through higher premiums. Although Cigna bases the premiums it charges on its estimate of future health care costs over the fixed premium period, actual costs may exceed what was estimated and reflected in premiums. Factors that may cause actual costs to exceed premiums include: medical cost inflation; higher than expected utilization of medical services; the introduction of new or costly treatments and technology; and membership mix.

Cigna records medical claims reserves for estimated future payments. The Company continually reviews estimates of future payments relating to medical claims costs for services incurred in the current and prior periods and makes necessary adjustments to its reserves. However, actual health care costs may exceed what was estimated.

Significant stock market declines could result in additional pension obligations, increased funding for those obligations, and increased pension plan expenses.

Cigna currently has unfunded obligations in its frozen pension plans. A significant decline in the value of the plan's equity and fixed income investments or unfavorable changes in applicable laws or regulations could materially increase Cigna's expenses and change the timing and amount of required plan funding that could reduce the cash available to Cigna, including its subsidiaries. See Note 10 to Cigna's Consolidated Financial Statements for more information on the Company's obligations under the pension plan.

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

As an insurer, Cigna has substantial investment assets that support insurance and contractholder deposit liabilities. Generally low levels of interest rates on investments, such as those experienced in United States and foreign financial markets during recent years, have negatively impacted the level of investment income earned by the Company in recent periods, and such lower levels of investment income would continue if these lower interest rates were to continue.

Substantially all of the Company's investment assets are in fixed interest-yielding debt securities of varying maturities, fixed redeemable preferred securities and commercial mortgage loans. The value of these investment assets can fluctuate significantly with changes in market conditions. A rise in interest rates could reduce the value of the Company's investment portfolio and increase interest expense if Cigna were to access its available lines of credit.

The Company is also exposed to interest rate and equity risk associated with the Company's pension and other post-retirement obligations. Sustained declines in interest rates could have an adverse impact on the funded status of the Company's pension plans and the Company's reinvestment yield on new investments.

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

Financial strength, claims paying ability and debt ratings by recognized rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. Ratings information by nationally recognized ratings agencies is broadly disseminated and generally used throughout the industry. Cigna believes the claims paying ability and financial strength ratings of its principal insurance subsidiaries are an important factor in marketing its products to certain of Cigna's customers. In addition, Cigna

Corporation's debt ratings impact both the cost and availability of future borrowings, and accordingly, its cost of capital. Each of the rating agencies reviews Cigna's ratings periodically and there can be no assurance that current ratings will be maintained in the future. In addition, a downgrade of these ratings could make it more difficult to raise capital and to support business growth at Cigna's insurance subsidiaries.

Insurance ratings represent the opinions of the rating agencies on the financial strength of a company and its capacity to meet the obligations of insurance policies. The principal agencies that rate Cigna's insurance subsidiaries characterize their insurance rating scales as follows:

A.M. Best Company, Inc. ("A.M. Best"), A++ to S ("Superior" to "Suspended");

Moody's Investors Service ("Moody's"), Aaa to C ("Exceptional" to "Lowest");

Standard & Poor's Corp. ("S&P"), AAA to R ("Extremely Strong" to "Regulatory Action"); and

Fitch, Inc. ("Fitch"), AAA to D ("Exceptionally Strong" to "Order of Liquidation").

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PART I

ITEM 1A Risk Factors

As of February 28, 2013, the insurance financial strength ratings were as follows for the Cigna subsidiaries, Connecticut General Life Insurance Company ("CGLIC"), Life Insurance Company of North America ("LINA") and Cigna Health & Life Insurance Company ("CHLIC"):

	CGLIC Insurance Ratings [1]	LINA Insurance Ratings [1]	CHLIC Insurance Ratings [1]
A.M. Best	A ("Excellent," 3rd of 16)	A ("Excellent," 3rd of 16)	A ("Excellent," 3rd of 16)
Moody's	A2 ("Good," 6th of 21)	A2 ("Good," 6th of 21)	A2 ("Good," 6th of 21)
S&P	A ("Strong," 6th of 21)	(Not Rated)	A ("Strong," 6th of 21)
Fitch	A ("Strong," 6th of 19)	A ("Strong," 6th of 19)	(Not Rated)

(1)

Includes the rating assigned, the agency's characterization of the rating and the position of the rating in the agency's rating scale (e.g., CGLIC's rating by A.M. Best is the 3rd highest rating awarded in its scale of 16).

Global market, economic and geopolitical conditions may cause fluctuations in equity market prices, interest rates and credit spreads, which could impact the Company's ability to raise or deploy capital as well as affect the Company's overall liquidity.

If the equity markets and credit market 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 the Company's 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, such as the sovereign debt crisis in the European Union and uncertainty regarding the U.S. fiscal position, including with respect to the federal debt ceiling, could result in reduced opportunities to find suitable opportunities to raise capital.

In November 2011, Cigna issued $2.1 billion in aggregate principal amount of senior notes to finance part of the cost for the HealthSpring acquisition. As of December 31, 2012, the Company's outstanding long-term debt totaled $5.0 billion. Cigna's increased debt obligations could make the Company more vulnerable to general adverse economic and industry conditions and require the Company to dedicate increased cash flow from operations to the payment of principal and interest on its debt, thereby reducing the funds it has available for other purposes, such as investments in ongoing businesses, acquisitions, dividends and stock repurchases. In these circumstances, the Company's ability to execute on its strategy may be limited, its flexibility in planning for or reacting to changes in its business and market conditions may be reduced, or its access to capital markets may be limited such that additional capital may not be available or may only be available on unfavorable terms.

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

The economic conditions in the U.S. and globally continue to be challenging. Continued concerns about slow economic growth, high unemployment rates, the sovereign debt crisis in the European Union and uncertainty regarding the U.S. fiscal position, geopolitical issues, the availability and cost of credit and other capital, consumer spending and other factors continue to negatively impact expectations for the U.S. and global economy. Unfavorable economic conditions could cause lower enrollment in our plans and negatively impact the demand for certain of our products and services as employers try to reduce their operating costs. As a result, they may modify, delay or cancel plans to purchase the Company's products, may make changes in the mix of products purchased that are unfavorable to the Company, or may be forced to reduce their workforces. Specifically, higher unemployment rates as a result of an economic downturn could lead to lower enrollment in the Company's

employer group plans, lower enrollment in our non-employer individual plans and a higher number of employees opting out of Cigna's employer group plans. The adverse economic conditions could also cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. All of these developments could lead to a decrease in Cigna's membership levels and premium and fee revenues. Additionally, Cigna's previous disability claim experience and industry data indicate that submitted disability claims rise under adverse economic conditions, although the impact of the current adverse economic conditions is not clear. Further, if customers are not successful in generating sufficient revenue or are precluded from securing financing, they may not be able to pay, or may delay payment of, accounts receivable that are owed to the Company. Further, 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. All of these could lead to a decrease in our membership levels and revenues, and could materially and adversely affect our business, results of operations and financial condition. In addition, a prolonged unfavorable economic environment could adversely impact the financial position of hospitals and other care providers, which could increase our medical costs as hospitals and other care providers attempt to maintain revenue levels in their efforts to adjust to their own economic challenges. The same conditions that may affect Cigna's customers and network also could adversely affect its vendors, causing them to significantly and quickly increase their prices or reduce their output. Cigna's business depends on its ability to perform its necessary business functions in an efficient and uninterrupted fashion.

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During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in federal and state government coverage programs, such as Medicare and social security. In addition, the state and federal budgetary pressures 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 health maintenance organizations 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.

Cigna is subject to the credit risk of its reinsurers.

Cigna enters into reinsurance arrangements with other insurance companies, primarily to limit losses from large exposures or to permit recovery of a portion of direct losses. The Company may also enter into reinsurance arrangements in connection with acquisition or divestiture transactions where the underwriting company is not being acquired or sold. The run-off businesses that Cigna has effectively exited through reinsurance include, among others: the retirement benefit business reinsured by Prudential Retirement Insurance and Annuity Company; the individual life insurance and annuity business reinsured by Lincoln National Life Insurance Company and Lincoln Life and Annuity of New York; and the VADBe and GMIB businesses reinsured by Berkshire Hathaway Life Insurance Company of Nebraska on February 4, 2013.

Under all reinsurance arrangements, reinsurers assume insured losses, subject to certain limitations or exceptions that may include a loss limit. These arrangements also subject Cigna to various obligations, representations and warranties with the reinsurers. Reinsurance does not relieve the Company of liability as the originating insurer. Cigna remains liable to the underlying policyholders if a reinsurer defaults on obligations under the reinsurance arrangement. Although the Company regularly evaluates 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, the Company 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 the Company's reinsurance recoverable, such as by sufficient qualifying assets in trusts or letters of credit issued. Although a portion of the Company's reinsurance exposures are secured, the inability to collect a material recovery from a reinsurer could have a material adverse effect on the Company's results of operations, financial condition and liquidity.

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PART I
ITEM 1B Unresolved Staff Comments

ITEM 1B Unresolved Staff Comments

None.

ITEM 2 Properties

Cigna's global real estate portfolio consists of approximately 8.1 million square feet of owned and leased properties. Our domestic portfolio has approximately 6.7 million square feet in 40 states, the District of Columbia, and Puerto Rico. Our International properties contain approximately 1.4 million square feet located throughout the following countries: Belgium, Canada, China, France, Germany, Hong Kong, India, Indonesia, Ireland, Italy, Malaysia, Netherlands, New Zealand, Singapore, South Korea, Spain, Sweden, Switzerland, Taiwan, Thailand, Turkey, United Arab Emirates, and the United Kingdom.

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

Cigna believes its properties are adequate and suitable for its business as presently conducted. The foregoing does not include information on investment properties.

ITEM 3 Legal Proceedings

The information contained under "Litigation and Other Legal Matters" in Note 24 to Cigna's Financial Statements beginning on page 122 of this Form 10-K, is incorporated herein by reference.

ITEM 4 Mine Safety Disclosures

Not applicable.

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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.

MARK L. BOXER, 53, Executive Vice President and Global Chief Information Officer of Cigna beginning April 2011; Deputy Chief Information Officer, Xerox Corporation; Group President, Government Health Care, for Xerox Corporation/Affiliated Computer Services from March 2009 until April 2011; Executive Vice President and President of Wellpoint's Operations, Technology and Government Services unit, as well as other senior management roles at WellPoint from November 2000 until November 2008.

DAVID M. CORDANI, 47, Chief Executive Officer of Cigna beginning December 2009; Director since 2009; President beginning June 2008; Chief Operating Officer from June 2008 until December 2009; and President of Cigna HealthCare from July 2005 until June 2008.

HERBERT A. FRITCH, 61, President, Cigna HealthSpring beginning January 2012; Chairman of the Board and Chief Executive Officer of HealthSpring and its predecessor, NewQuest, LLC, from commencement of operations in September 2000 until HealthSpring was acquired by Cigna in January 2012; also served as President of HealthSpring, from September 2000 until October 2008.

DAVID D. GUILMETTE, 51, President, Global Employer Segment beginning July 2012; President, National, Pharmacy and Product from November 2011 until July 2012; President, National Segment from February 2010 until November 2011; and Managing Director of Towers Perrin Global Health & Welfare from January 2005 until January 2010.

NICOLE S. JONES, 42, 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; Vice President and Chief Counsel of Domestic Health Service, Securities and Investment Law of Cigna from September 2006 until April 2008; and Corporate Secretary of Cigna from September 2006 until April 2010.

MATTHEW G. MANDERS, 51, President, Regional and Operations beginning November 2011; President, U.S. Service, Clinical and Specialty from January 2010 until November 2011; President of Cigna HealthCare, Total Health, Productivity, Network & Middle Market from June 2009 until January 2010; and President, of Cigna's Customer Segments from July 2006 until June 2009.

JOHN M. MURABITO, 54, Executive Vice President, Human Resources and Services of Cigna beginning August 2003.

RALPH J. NICOLETTI, 55, Executive Vice President and Chief Financial Officer of Cigna beginning June 2011; Executive Vice President and Chief Financial Officer of Alberto-Culver, Inc. from August 2009 until May 2011; and Senior Vice President and Chief Financial Officer of Alberto-Culver, Inc. from February 2007 until August 2009;

JASON D. SADLER, 44, President, Global Individual Health, Life and Accident beginning July 2010, and Managing Director Insurance Business Hong Kong, HSBC Insurance Asia Limited from January 2007 until July 2010.

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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 127 and the number of shareholders of record as of December 31, 2012 appears under the caption "Highlights" on page 31 of this Form 10-K. Cigna's common stock is listed with, and trades on, the New York Stock Exchange under the symbol "CI".

Issuer Purchases of Equity Securities

The following table provides information about Cigna's share repurchase activity for the quarter ended December 31, 2012:

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, 2012	2,467,731	$ 49.55	2,464,898	$ 314,709,797
November 1-30, 2012	4,612	$ 53.07		$ 314,709,797
December 1-31, 2012	9,501	$ 53.13		$ 314,709,797
TOTAL	**2,481,844**	**$ 49.57**	**2,464,898**	**N/A**

(1)

Includes shares tendered by employees as payment of taxes withheld on the exercise of stock options and the vesting of restricted stock granted under the Company's equity compensation plans. Employees tendered 2,833 shares in October, 4,612 in November and 9,501 shares in December 2012.

(2)

Cigna has had a repurchase program for many years, and has had varying levels of repurchase authority and activity under this program. The program has no expiration date. Cigna suspends activity under this program from time to time and also removes such suspensions, generally without public announcement. Through December 31, 2012, the Company had repurchased approximately 4.4 million shares for approximately $208 million. Remaining authorization under the program was approximately $315 million as of December 31, 2012. On February 27, 2013, the Company's Board of Directors increased share repurchase authority by $500 million, making the remaining authorization $815 million as of February 28, 2013.

(3)

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

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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)	2012	2011	2010	2009	2008
Revenues					
Premiums and fees and other revenues	$ 26,308	$ 19,210	$ 18,528	$ 16,018	$ 16,880
Net investment income	1,144	1,146	1,105	1,014	1,063
Mail order pharmacy revenues	1,623	1,447	1,420	1,282	1,204
Realized investment gains (losses)	44	62	75	(43)	(170)
TOTAL REVENUES	**$ 29,119**	**$ 21,865**	**$ 21,128**	**$ 18,271**	**$ 18,977**
Results of Operations:					
Global Health Care	$ 1,418	$ 1,105	$ 940	$ 775	$ 732
Group Disability and Life	279	295	305	306	282
Global Supplemental Benefits	142	97	84	107	70
Run-off Reinsurance		(183)	26	185	(646)
Other Operations	82	89	85	86	87
Corporate	(329)	(184)	(211)	(142)	(162)
Realized investment gains (losses), net of taxes and noncontrolling interest	31	41	50	(26)	(110)
Shareholders' income from continuing operations	1,623	1,260	1,279	1,291	253
Income from continuing operations attributable to redeemable noncontrolling interest	1				
Income from continuing operations attributable to other noncontrolling interest		1	4	3	2
Income from continuing operations	1,624	1,261	1,283	1,294	255
Income from discontinued operations, net of taxes				1	4
NET INCOME	**$ 1,624**	**$ 1,261**	**$ 1,283**	**$ 1,295**	**$ 259**
Shareholders' income per share from continuing operations:					
Basic	$ 5.70	$ 4.65	$ 4.69	$ 4.71	$ 0.91
Diluted	$ 5.61	$ 4.59	$ 4.65	$ 4.69	$ 0.91
Shareholders' net income per share:					
Basic	$ 5.70	$ 4.65	$ 4.69	$ 4.71	$ 0.93
Diluted	$ 5.61	$ 4.59	$ 4.65	$ 4.69	$ 0.92
Common dividends declared per share	$ 0.04	$ 0.04	$ 0.04	$ 0.04	$ 0.04
Total assets	$ 53,734	$ 50,697	$ 45,393	$ 42,794	$ 41,206

Long-term debt	$ 4,986	$ 4,990	$ 2,288	$ 2,436	$ 2,090
Shareholders' equity	$ 9,769	$ 7,994	$ 6,356	$ 5,198	$ 3,392
Per share	$ 34.18	$ 28.00	$ 23.38	$ 18.95	$ 12.51
Common shares outstanding (in thousands)	285,829	285,533	271,880	274,257	271,036
Shareholders of record	7,885	8,178	8,568	8,888	9,014
Employees	35,800	31,400	30,600	29,300	30,300

Effective December 31, 2012, the Company changed its external reporting segments. See Note 23 to the Consolidated Financial Statements for additional information. Prior year segment information has been conformed to the new segment structure.

See Note 2 to the Consolidated Financial Statements for further discussion of changes resulting from the retrospective adoption of amended accounting guidance for deferred policy acquisition costs in 2012.

Beginning in 2010, the Company began reporting the expense associated with its frozen pension plans in Corporate. Prior periods were not restated. The effect on prior periods was not material.

In 2008, the Company recorded significant charges related to the guaranteed minimum income benefits and guaranteed minimum death benefits businesses of the Run-off Reinsurance segment, as well as an after-tax litigation charge of $52 million in Corporate related to the Cigna pension plan.

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Introduction

As used in this document, "Cigna" the "Company", "we" and "our" may refer to Cigna Corporation itself, one or more of its subsidiaries, or Cigna Corporation and its consolidated subsidiaries. The Company is a global health services organization with a mission to help its customers improve their health, well-being and sense of security. Its insurance subsidiaries are major providers of medical, dental, disability, life and accident insurance and related products and services, the majority of which are offered through employers and other groups (e.g. governmental and non-governmental organizations, unions and associations). Cigna also offers Medicare and Medicaid products and health, life and accident insurance coverages primarily to individuals in the U.S. and selected international markets. In addition to its ongoing operations described above, Cigna also has certain run-off operations, including a Run-off Reinsurance segment.

In this filing and in other marketplace communications, the Company makes certain forward-looking statements relating to its financial condition and results of operations, as well as to trends and assumptions that may affect the Company. Generally, forward-looking statements can be identified through the use of predictive words (e.g. "Outlook for 2013"). Actual results may differ from the Company's predictions.

Some factors that could cause results to differ are discussed throughout Management's Discussion and Analysis ("MD&A"), including in the Cautionary Statement. The forward-looking statements contained in this filing represent management's current estimate as of the date of this filing. Management does not assume any obligation to update these estimates.

The following discussion addresses the financial condition of the Company as of December 31, 2012, compared with December 31, 2011, and a comparison of results of operations for the years ended December 31, 2012, 2011 and 2010.

Unless otherwise indicated, financial information in the MD&A is presented in accordance with accounting principles generally accepted in the United States ("GAAP"). See Note 2 to the Consolidated Financial Statements for the effect of the January 2012 retrospective adoption of the amended accounting guidance for deferred policy acquisition costs. Certain reclassifications have been made to prior period amounts to conform to the presentation of 2012 amounts.

See Note 2 to the Consolidated Financial Statements for additional information.

Effective December 31, 2012, Cigna changed its external reporting segments to reflect the Company's realignment of its businesses to better leverage distribution and service delivery capabilities for the benefit of our global clients and customers. Management believes the realignment of its businesses will enable the Company to more effectively address global health services challenges by leveraging best practices across geographies to improve the health, well being and sense of security of the global customers that the Company serves. The changes in the Company's internal financial reporting structure, to support this realignment, took effect on December 31, 2012 and resulted in changes to our external reporting segments. The Company's results are now aggregated based on the nature of the Company's products and services, rather than its geographies.

The primary segment reporting change is that the two businesses that comprised the former International segment (international health care

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and supplemental health, life and accident) are now reported as follows:

substantially all of the international health care business (comprised primarily of the global health benefits business) is now reported with the former Health Care segment and renamed ***Global Health Care***; and

the supplemental health, life and accident business becomes a separate reporting segment named ***Global Supplemental Benefits***.

As a result of these changes, the financial results of Cigna's businesses are now reported in the following segments:

Global Health Care aggregates the following two operating segments:

Commercial (including the international health care business)

Government

Group Disability and Life

Global Supplemental Benefits

Run-off Reinsurance and

Other Operations, including Corporate-owned Life Insurance.

Prior year segment information has been conformed to the new segment structure.

Significant Factors Affecting the Company

For information on the Company's business strategy, see the "Description of Business" section of this Form 10-K beginning on page 1. The Company's ability to increase revenue, shareholders' net income and operating cash flows from ongoing operations is directly related to progress in executing its strategy as well as other key factors, including the Company's ability to:

profitably underwrite and price products and services at competitive levels that manage risk and reflect emerging experience;

cross sell its various health and related benefit products;

invest available cash at attractive rates of return for appropriate durations; and

effectively deploy capital.

In addition to the Company-specific factors cited above, overall results are influenced by a range of economic and other factors, especially:

cost trends and inflation for medical and related services;

utilization patterns of medical and other services;

employment levels;

the tort liability system;

developments in the political environment both domestically and internationally, including U.S. Health Care Reform;

interest rates, equity market returns, foreign currency fluctuations and credit market volatility, including the availability and cost of credit in the future;

Medicare reimbursement rates issued by the Centers for Medicare and Medicaid Services ("CMS"), including the bonus structure based on CMS performance ratings; and

federal, state and international regulation.

The Company regularly monitors the trends impacting operating results from the above mentioned key factors to appropriately respond to economic and other factors affecting its operations, both in its ongoing and run-off operations.

Run-off Operations

As of December 31, 2012 the Company's run-off reinsurance operations had significant exposures, primarily from its guaranteed minimum death benefits ("GMDB", also known as "VADBe") and guaranteed minimum income benefits ("GMIB") products. Effective February 4, 2013, the Company entered into an agreement to reinsure 100% of the Company's future exposures for these businesses, net of retrocessional arrangements in place prior to February 4, 2013, up to a specified limit. See Note 25 to the Consolidated Financial Statements for additional information.

Health Care Reform

In the first quarter of 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act ("Health Care Reform") were signed into law. Certain of the law's provisions are already effective while others will take effect from 2013 to 2018. The Company has implemented the provisions of Health Care Reform that are currently in effect (including the commercial minimum medical loss ratio requirements) and continues its implementation planning for those provisions that must be adopted in the future. Management is currently unable to estimate the full impact of Health Care Reform on the Company's future results of operations, and its financial condition and liquidity due to uncertainties related to interpretation, implementation and timing of its many provisions as well as the potential for the law to be amended. It is possible, however, that certain provisions of Health Care Reform could have a material impact on future results of operations.

Commercial minimum medical loss ratio requirements became effective in January 2011, requiring payment of premium rebates beginning in 2012 to employers and customers covered under the Company's comprehensive commercial medical insurance plans if certain annual minimum loss ratios are not met. The Company recorded its rebate accrual based on estimated medical loss ratios calculated as prescribed by the U.S. Department of Health and Human Services ("HHS") using full-year premium and claim information by state and market segment for each legal entity that issues comprehensive medical insurance. HHS regulations permit adjustments to be made to the claims used in the calculation for Cigna's international health care and limited benefits plans subject to the MLR minimums. The adjustments for limited benefit plans are only allowed through 2014. In 2012, the Company accrued an estimated rebate of $37 million pre-tax ($24 million after-tax), compared with an accrual of $63 million pre-tax ($41 million after-tax) in 2011. The Company paid $77 million in 2012, slightly higher than the estimated rebate accrual of $63 million, primarily due

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to the favorable claim run-out of 2011 estimated claim reserves in 2012. The decrease in the 2012 estimated rebate accrual compared to 2011 reflects changes to the 2012 minimum loss ratio calculation in accordance with HHS regulations that can include combined 2011 and 2012 experience including rebates paid for the 2011 plan year, lower premiums resulting from a change in business practice regarding the billing for broker commissions, as well as modestly higher loss ratios due to slightly higher utilization.

Health Care Reform imposes new fees on health insurers that become payable in 2013 and 2014. Payment of these fees will result in charges to the Company's financial results in future periods. These fees will generally not be tax deductible with the exception of the reinsurance assessments on insurers and HMOs. Accordingly, the Company's effective tax rate is expected to be adversely impacted in future periods. The amount of the fees is expected to be material, although the Company is unable to estimate the impact of these fees on shareholders' net income and the effective tax rate because guidance for these calculations has not been finalized.

Health Care Reform also impacts Cigna's Medicare Advantage and Medicare Part D prescription drug plan businesses acquired with HealthSpring in a variety of additional ways, including reduced Medicare premium rates (that began with the 2011 contract year), mandated minimum reductions to risk scores (beginning in 2014), 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. Beginning in 2014, Health Care Reform requires Medicare Advantage and Medicare Part D plans to meet a minimum MLR of 85%. Under the rules proposed by HHS, if the MLR for a CMS contract is less than 85%, the contractor is required to pay a penalty to CMS and could be subject to additional sanctions if the MLR continues to be less than 85% for successive years.

Effective in 2014, each state is required to establish a health insurance exchange for individuals and small employers with enrollment processes scheduled to commence in October of 2013. These exchanges may either be state-based, a state partnership, or federally facilitated. Of the ten states where the Company currently offers individual coverage, most currently expect to use a federally facilitated exchange. Cigna will continue to evaluate its potential participation in these exchanges in each market as they develop.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of most parts of Health Care Reform, including the obligation to purchase health care coverage (the "individual mandate"). Management continues to closely monitor the implementation of Health Care Reform and is actively engaged with regulators and policymakers on the conversion of legislation to regulation. In addition, management is implementing the necessary capabilities to ensure that the Company is compliant with the law and assessing potential opportunities arising from Health Care Reform. These opportunities include the continued evolution and innovation of our broad health and wellness portfolio to improve the health and productivity of our clients and customers, as well as the expansion of our physician partnership capabilities to improve the quality of care and service experience for our customers while lowering costs and improving overall value.

For additional information regarding Health Care Reform, see the "Regulation" section of the Company's 2012 Form 10-K.

Realignment and Efficiency Plan

During the third quarter of 2012, the Company, in connection with the execution of its strategy, committed to a series of actions to further improve its organizational alignment, operational effectiveness, and efficiency. As a result, the Company recognized charges in other operating expenses of $77 million pre-tax ($50 million after-tax) in the third quarter of 2012, consisting primarily of severance costs. The Global Health Care segment reported $65 million pre-tax ($42 million after-tax) of the charge. The remainder was reported as follows: $9 million pre-tax ($6 million after- tax) in Global Supplemental Benefits and $3 million pre-tax ($2 million after-tax) in Group Disability and Life. The severance costs are expected to be substantially paid in 2013. The Company expects to realize annualized after-tax savings of approximately $60 million, the majority of which is expected to be reinvested in the business in order to enhance the Company's ability to provide superior service and affordable products to our customers.

Acquisitions and Dispositions

In line with its growth strategy, the Company has strengthened its market position through various acquisition transactions. See Note 3 to the Consolidated Financial Statements for additional information.

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Consolidated Results of Operations Executive Summary

The Company measures the financial results of its segments using "segment earnings (loss)", that is defined as shareholders' net income (loss) before after-tax realized investment results. Adjusted income (loss) from operations is defined as consolidated segment earnings (loss) excluding special items (described in the table below) and the results of the GMIB business. Adjusted income (loss) from operations is another measure of profitability used by the Company's management because it presents the underlying results of operations of the Company's businesses and permits analysis of trends in underlying revenue, expenses and shareholders' net income. This measure is not determined in accordance with accounting principles generally accepted in the United States ("GAAP") and should not be viewed as a substitute for the most directly comparable GAAP measure, that is shareholders' net income.

The Company excludes special items because management does not believe they are representative of the Company's underlying results of operations. The Company also excludes the results of the GMIB business because the changes in the fair value of GMIB assets and liabilities are volatile and unpredictable. See the Run-off Reinsurance section of the MD&A for additional information on GMIB. Because of this volatility, and since the GMIB business is in run-off, management does not believe that its results are meaningful in assessing underlying results of operations.

Summarized below is a reconciliation between shareholders' income from continuing operations and adjusted income from operations.

Financial Summary

(In millions)	**2012**	**2011**	**2010**
Premiums and fees	$ 26,187	$ 18,966	$ 18,274
Net investment income	1,144	1,146	1,105
Mail order pharmacy revenues	1,623	1,447	1,420
Other revenues	121	244	254
Realized investment gains	44	62	75
Total revenues	29,119	21,865	21,128
Benefits and expenses	26,642	19,989	19,326
Income before income taxes	2,477	1,876	1,802
Income taxes	853	615	519
Net income	1,624	1,261	1,283
Less: net income attributable to redeemable noncontrolling interest	1	-	-
Less: net income attributable to other noncontrolling interest	-	1	4
Shareholders' net income	1,623	1,260	1,279
Less: realized investment gains, net of taxes	31	41	50
SEGMENT EARNINGS	**1,592**	**1,219**	**1,229**
Less: adjustments to reconcile to adjusted income from operations:			
Results of GMIB business (after-tax)	29	(135)	(24)
Special items (after-tax):			
Charge for realignment and efficiency plan (See Note 6 to the Consolidated Financial Statements)	(50)	-	-
Costs associated with acquisitions (See Note 3 to the Consolidated Financial Statements)	(40)	(31)	-
Resolution of a federal tax matter (See Note 20 to the Consolidated Financial Statements)	-	-	101
Loss on early extinguishment of debt (See Note 16 to the Consolidated Financial Statements)	-	-	(39)
Loss on reinsurance transaction (See Note 3 to the Consolidated Financial Statements)	-	-	(20)
Litigation Matters (See Note 24 to the Consolidated Financial Statements)	(81)	-	-

Completion of IRS examination (See Note 20 to the Consolidated Financial Statements)	-	24	-
ADJUSTED INCOME FROM OPERATIONS	**$ 1,734**	**$ 1,361**	**$ 1,211**

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Summarized below is adjusted income from operations by segment and other key consolidated financial data:

Adjusted Income (Loss) From Operations

(In millions)	**2012**	**2011**	**2010**
Global Health Care	$ 1,480	$ 1,104	$ 940
Group Disability and Life	281	290	305
Global Supplemental Benefits	148	100	84
Run-off Reinsurance	(29)	(48)	(27)
Other Operations	82	85	85
Corporate	(228)	(170)	(176)
TOTAL	**$ 1,734**	**$ 1,361**	**$ 1,211**

Other Key Consolidated Financial Data

Global medical customers (*in thousands)*	14,045	12,680	12,473
Cash flows from operating activities	$ 2,350	$ 1,491	$ 1,743
Shareholders' equity	$ 9,769	$ 7,994	$ 6,356

Consolidated Results of Operations 2012 Compared to 2011

Revenues increased 33% in 2012, primarily reflecting contributions from HealthSpring as well as higher revenues in each of the Company's ongoing businesses from continued growth in the Company's targeted global market segments. See further detailed discussion of revenues below and segment revenues in the individual segment discussions of this MD&A.

Shareholders' net income increased 29% in 2012, primarily resulting from substantially higher adjusted income from operations as discussed below and significantly improved GMIB results due to more favorable market conditions in 2012. See the Run-off Reinsurance section of this MD&A for additional information on GMIB results. These favorable effects were partially offset by the 2012 special items for litigation and the realignment and efficiency plan.

Adjusted income from operations increased 27% in 2012, largely attributable to earnings contributions from HealthSpring, as well as overall revenue growth in the other ongoing operating segments and lower charges related to the GMDB business. See the individual segment sections of this MD&A for further discussion.

Global medical customers increased 11% primarily attributable to growth in strategically targeted global markets reflecting solid customer persistency and strong new sales as well as the acquisition of HealthSpring.

Consolidated Results of Operations 2011 Compared to 2010

Revenues rose 3% in 2011 compared with 2010, reflecting solid growth in the Company's strategically targeted domestic and international customer segments of its ongoing global health care, global supplemental benefits, and group disability and life businesses. In addition, the increase in revenue reflects the effect of the programs to hedge equity and growth interest rate exposures in the run-off reinsurance operations. See the Run-off Reinsurance section of this MD&A beginning on page 47 for additional information. These increases were partially offset by the exit from certain non-strategic markets, primarily the Medicare Advantage Individual Private Fee For Service ("Medicare IPFFS") business.

Shareholders' net income decreased 1% in 2011 compared with 2010, due to significantly higher GMIB losses principally reflecting lower interest rates, substantially offset by higher adjusted income from operations.

Adjusted income from operations increased 12% in 2011 compared with 2010 primarily due to higher earnings contributions from the Company's Global Health Care and Global Supplemental Benefits segments. These results reflect solid business growth in strategically targeted markets and continued low medical services utilization trend.

Global medical customers increased 2%, reflecting growth in targeted markets, primarily the middle and select market segments domestically as well as growth in the international health care business. These increases were partially offset by exits from certain non-strategic markets, primarily Medicare IPFFS.

Liquidity and Financial Condition

During 2012, the following items affected the Company's liquidity and financial condition:

Cash flows from operating activities. For 2012, cash flows from operating activities were higher than 2011 primarily attributable to strong earnings and business growth in the Company's ongoing operating segments.

Acquisitions. During 2012, the Company acquired HealthSpring, Great American Supplemental Benefits and Finans Emeklilik for a combined purchase price of approximately $4.2 billion. See Note 3 to the Consolidated Financial Statement for additional information.

Repayment of Debt. During the first quarter of 2012, the Company repaid the acquired HealthSpring debt of $326 million. See Note 16 to the Consolidated Financial Statements for additional information.

Pension Plan Contributions. During 2012, the Company contributed $250 million to the Company's domestic qualified pension plans; See Note 10 to the Consolidated Financial Statements for additional information; and

Share Repurchase. The Company repurchased 4.4 million shares of stock for $208 million. See the Liquidity and Capital Resources section of this MD&A for additional information.

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Shareholders' equity increased since 2011, reflecting strong earnings in 2012 and net unrealized appreciation on investments. Cash at the parent company as of December 31, 2012 was approximately $700 million. As described in Note 25 to the Consolidated Financial Statements, on February 4, 2013, the Company entered into a reinsurance agreement for the Run-off GMDB and GMIB businesses. The reinsurance premium will ultimately be funded from the sale or internal transfer of investment assets that were supporting this book of business, as well as tax benefits related to the transaction, and cash. Based on known liquidity needs at the parent company for 2013, including the funding for the 2013 reinsurance transaction, management believes that the Company has adequate liquidity at the parent company level to satisfy its required obligations.

Outlook for 2013

The Company expects 2013 consolidated adjusted income from operations to be higher than 2012 results. Realized investment results in 2013 are expected to include after-tax gains ranging from $50 million to $150 million for investment asset sales to fund the reinsurance premium described above. In addition, special items in 2013 will include an after-tax charge of approximately $500 million related to the 2013 reinsurance transaction. Except for the items mentioned, information is not available for management to reasonably estimate realized investment results. In addition, the Company is not able to identify or reasonably estimate the financial impact of special items in 2013.

The Company's outlook for 2013 is subject to the factors cited above and in the Cautionary Statement of this Form 10-K and the sensitivities discussed in the Critical Accounting Estimates section of the MD&A. If unfavorable equity market and interest rate movements occur, the Company could experience losses related to investment impairments. These losses could adversely impact the Company's consolidated results of operations and financial condition and liquidity by potentially reducing the capital of the Company's insurance subsidiaries and reducing their dividend-paying capabilities.

Revenues

Total revenues increased by 33% in 2012, compared with 2011, and 3% in 2011 compared with 2010. Changes in the components of total revenue are described more fully below.

Premiums and Fees

Premiums and fees increased by 38% in 2012, compared with 2011, including contributions from the HealthSpring acquisition, customer growth in the other targeted market segments of the Global Health Care business and continued business growth in the Global Supplemental Benefits and Group Disability and Life segments.

Premiums and fees increased by 4% in 2011, compared with 2010, primarily reflecting business growth in the Company's targeted market segments, partially offset by the Company's exit from the Medicare IPFFS business beginning in 2011. Excluding this business, premiums and fees increased by 9% in 2011 compared with 2010.

Net Investment Income

Net investment income remained flat in 2012, compared with 2011, primarily reflecting higher average investment assets and improved results from partnership investments offset by lower reinvestment yields.

Net investment income increased by 4% in 2011, compared with 2010. The key factors causing the increase were higher investment assets and improved results from real estate investments, partially offset by lower reinvestment yields.

Mail Order Pharmacy Revenues

Mail order pharmacy revenues increased by 12% in 2012, compared with 2011, primarily reflecting higher prescription volume for injectible medications, partially offset by price decreases related to a shift to generic oral medications from brand names. In 2011, mail order pharmacy revenues increased by 2% compared with 2010 due in large part to price increases offset by a decline in volume.

Other Revenues

Other revenues included pre-tax losses of $119 million in 2012 compared with $4 million in 2011 and $157 million in 2010 related to futures and swaps entered into as part of a dynamic hedge program to manage equity and growth interest rate risks in the Company's run-off reinsurance operations. See the Run-off Reinsurance section of the MD&A for more information on this program.

Excluding the impact of these swaps and futures contracts, other revenues declined 3% in 2012, compared with 2011. The decline primarily reflects the absence of revenue in 2012 from Cigna Government Services, which was sold in the second quarter of 2011, partially offset by contributions from HealthSpring.

Other revenues, excluding the impact of these swaps and futures contracts, declined 40% in 2011, compared with 2010. The decline primarily reflects the absence of revenue in 2011 from the workers' compensation and case management business, which was sold in 2010 as well as lower revenues in 2011 from Cigna Government Services, which was sold in the second quarter of 2011.

Realized Investment Results

Realized investment results in 2012 were lower than in 2011, primarily due to the absence of gains on sales of real estate held in joint ventures reported in 2011and lower prepayment fees received on fixed maturities, partially offset by lower impairment losses and higher valuation on hybrid securities.

Realized investment results in 2011 were lower than in 2010 primarily due to higher impairment losses on fixed maturities and valuation declines on hybrid securities, partially offset by higher gains on sales of real estate properties held in joint ventures.

See Note 15 to the Consolidated Financial Statements for additional information.

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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 the Company's consolidated results of operations or financial condition.

Management has discussed the development and selection of its critical accounting estimates with the Audit Committee of the Company's 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 the Company's consolidated financial statements, including estimates of liabilities for future policy benefits, as well as estimates with respect to unpaid claims and claim expenses, postemployment and postretirement benefits other than pensions, certain compensation accruals, and income taxes.

As explained further in Note 25 to the Consolidated Financial Statements, effective February 4, 2013, the Company entered into an agreement to reinsure 100% of the Company's GMDB and GMIB businesses, net of retrocessional arrangements in place prior to February 4, 2013, up to a specified limit. As a result, the Company will no longer consider liabilities associated with these contracts to be a critical accounting estimate because changes in these estimates are not expected to have a material effect on the Company's consolidated results of operations or financial condition.

Management believes the current assumptions used to estimate amounts reflected in the Company's consolidated financial statements are appropriate. However, if actual experience differs from the assumptions used in estimating amounts reflected in the Company's consolidated financial statements, the resulting changes could have a material adverse effect on the Company's consolidated results of operations, and in certain situations, could have a material adverse effect on the Company's liquidity and financial condition.

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

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. The Company evaluates goodwill for impairment at least annually during the third quarter at the reporting unit level, based on discounted cash flow analyses and writes it down through results of operations if impaired. Discounted cash flow analyses use assumptions and estimates including discount rates and projections of future earnings considering operating plans, revenues, claims, operating expenses,	If the Company does not achieve its earnings objectives or its cost of capital rises significantly, the assumptions and estimates underlying these impairment evaluations could be adversely affected and result in impairment charges that would negatively impact the Company's operating results. The fair value estimates of the Company's reporting units could decrease by 40% to 80% before an indication of impairment of goodwill occurs. This potential outcome is estimated during the Company's annual testing process, by determining the magnitude of changes to certain assumptions and estimates necessary for the estimated fair value of a reporting unit to approach its carrying value.

taxes, capital levels and long-term growth rates.

Goodwill as of December 31 was as follows (in millions):

2012 $6,001

2011 $3,164

See Notes 2 (H) and 9 to the Consolidated Financial Statements for additional discussion of the Company's goodwill.

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Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Accounts payable, accrued expenses and other liabilities pension liabilities	Using past experience, the Company expects that it is reasonably possible that a favorable or unfavorable change in assumptions for the discount rate or expected return on plan assets of 50 basis points could occur. An unfavorable change is a decrease in these key assumptions with resulting impacts as discussed below.
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):	If discount rates for the qualified and nonqualified pension plans decreased by 50 basis points:
2012 $1,602	annual pension costs for 2013 would decrease by approximately $5 million, after-tax; and
2011 $1,769	the accrued pension benefit liability would increase by approximately $280 million as of December 31, 2012 resulting in an after-tax decrease to shareholders' equity of approximately $180 million as of December 31, 2012.
See Note 10 to the Consolidated Financial Statements for assumptions and methods used to estimate pension liabilities.	If the expected long-term return on domestic qualified pension plan assets decreased by 50 basis points, annual pension costs for 2013 would increase by approximately $11 million after-tax.
	If the Company used the market value of assets to measure pension costs as opposed to the market-related value, annual pension cost for 2013 would decrease by approximately $9 million after-tax.
	If the December 31, 2012 fair values of domestic qualified plan assets decreased by 10%, the accrued pension benefit liability would increase by approximately $365 million as of December 31, 2012 resulting in an after-tax decrease to shareholders' equity of approximately $235 million.
	An increase in these key assumptions would result in impacts to annual pension costs, the accrued pension liability and shareholders' equity in an opposite direction, but similar amounts.
Global Health Care medical claims payable	In 2012, actual experience differed from the Company's key assumptions as of December 31, 2011, resulting in $200 million of favorable incurred claims related to prior years' medical claims payable or 2.2% of the current year incurred claims as reported in 2011. In 2011, actual experience differed from the Company's key assumptions as of December 31, 2010, resulting in $140 million of
Medical claims payable for the Global Health Care segment include both reported claims and estimates for losses incurred but not yet reported.	

Liabilities for medical claims payable as of December 31 were as follows (in millions):

2012 gross $1,856; net $1,614

2011 gross $1,305; net $1,056

These liabilities are presented above both gross and net of reinsurance and other recoverables and generally exclude amounts for administrative services only business.

See Notes 2 and 5 to the Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.

favorable incurred claims related to prior years' medical claims, or 1.5% of the current year incurred claims reported in 2010. Specifically, the favorable impact is due to faster than expected completion factors and lower than expected medical cost trends, both of which included an assumption for moderately adverse experience.

The impact of this favorable prior year development was an increase to shareholders' net income of $66 million after-tax ($101 million pre-tax) in 2012. The change in the amount of the incurred claims related to prior years in the medical claims payable liability does not directly correspond to an increase or decrease in shareholders' net income as explained in Note 5 to the Consolidated Financial Statements.

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Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Valuation of fixed maturity investments Most fixed maturities are classified as available for sale and are carried at fair value with changes in fair value recorded in accumulated other comprehensive income (loss) within shareholders' equity. Fair value is defined as the price at which an asset could be exchanged in an orderly transaction between market participants at the balance sheet date. The determination of 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 the Company's fixed maturities are public securities, and one-third are private placement securities. See Note 11 to the Consolidated Financial Statements for a discussion of the Company's fair value measurements and the procedures performed by management to determine that the amounts represent appropriate estimates.	Typically, the most significant input in the measurement of fair value is the market interest rate used to discount the estimated future cash flows from the instrument. Such market rates are derived by calculating the appropriate spreads over comparable U.S. Treasury securities, based on the credit quality, industry and structure of the asset. If the spreads used to calculate fair value changed by 100 basis points, the fair value of the total fixed maturity portfolio of $17.7 billion would change by approximately $1.1 billion.
Assessment of "other-than-temporary" impairments of fixed maturities To determine whether a fixed maturity's decline in fair value below its amortized cost is other than temporary, the Company must evaluate the expected recovery in value and its intent to sell or the likelihood of a required sale of the fixed maturity prior to an expected recovery. To make this determination, the Company considers a number of general and specific factors including the regulatory, economic and market environment, length of time and severity of the decline, and the financial health and specific near term prospects of the issuer.	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, 2012 would have decreased by approximately $20 million after-tax.

See Notes 2 (C) and 12 to the Consolidated Financial Statements for additional discussion of the Company's review of declines in fair value, including information regarding the Company's accounting policies for fixed maturities.

Segment Reporting

The Company measures the financial results of its segments using "segment earnings (loss)", which is defined as shareholders' income (loss) from continuing operations excluding after-tax realized investment gains and losses. "Adjusted income from operations" for each segment is defined as segment earnings excluding special items and the results of the Company's GMIB business. Adjusted income from operations is the primary measure of profitability used by the Company's management because it presents the underlying results of operations of the segment and permits analysis of trends. Each segment provides a reconciliation between segment earnings and adjusted income from operations.

Effective December 31, 2012, the Company changed its reporting segments. See the Introduction section of the MD&A and Note 23 to the Consolidated Financial Statements for additional information.

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Global Health Care Segment

Segment Description

As discussed in the Introduction section of this MD&A and Note 23 to the Consolidated Financial Statements, effective December 31, 2012, the Company changed its reporting segments. The Global Health Care segment now includes the Company's international health care business, previously reported in the former International segment and excludes certain disability and life business that is now reported in the Group Disability and Life segment. Prior year information has been conformed to the new segment presentation. The international health care business is included in the Commercial operating segment.

Global Health Care aggregates the following two operating segments:

The ***Commercial*** operating segment includes both the U.S. commercial and international health care businesses that offer insured and self-insured medical, dental, behavioral health, vision, and prescription drug benefit plans, health advocacy programs and other products and services that may be integrated to provide comprehensive global health care benefit programs to employers and their employees, including globally mobile individuals. Cigna, either directly or through its partners, offers some or all of these products and services in all 50 states, the District of Columbia, the U.S. Virgin Islands, Canada, Europe, the Middle East, and Asia. Cigna services its globally mobile customers virtually everywhere in the world. These products and services are offered through a variety of funding arrangements such as administrative services only (ASO), guaranteed cost and retrospectively experience rated.

The ***Government*** operating segment offers Medicare Advantage plans to seniors in 13 states and the District of Columbia, Medicare Part D plans in all 50 states and the District of Columbia and Medicaid plans. Results for the Government operating segment include HealthSpring from the date of acquisition, January 31, 2012.

The Company measures the operating effectiveness of the Global Health Care segment using the following key factors:

segment earnings and adjusted income from operations;

customer growth;

sales of specialty products;

other operating expense as a percentage of segment revenues (operating expense ratio); and

medical expense as a percentage of premiums (medical care ratio) in the guaranteed cost and Medicare businesses.

Results of Operations

Financial Summary

(In millions)	2012	2011	2010
Premiums and fees	$ 20,973	$ 14,443	$ 14,134
Net investment income	259	263	230
Mail order pharmacy revenues	1,623	1,447	1,420
Other revenues	225	236	269
Segment revenues	23,080	16,389	16,053
Mail order pharmacy cost of goods sold	1,328	1,203	1,169
Benefits and other operating expenses	19,541	13,465	13,424
Benefits and expenses	20,869	14,668	14,593
Income before taxes	2,211	1,721	1,460
Income taxes	793	616	520
SEGMENT EARNINGS	**1,418**	**1,105**	**940**
Less: special items (after-tax) included in segment earnings:			
Charge for realignment and efficiency plan (See Note 6 to the Consolidated Financial Statements)	(42)	-	-
Costs associated with the HealthSpring acquisition (See Note 3 to the Consolidated Financial Statements)	(7)	-	-
Completion of IRS examination (See Note 20 to the Consolidated Financial Statements)	-	1	-
Charge related to litigation matter (See Note 24 to the Consolidated Financial Statements)	(13)	-	-
ADJUSTED INCOME FROM OPERATIONS	**$ 1,480**	**$ 1,104**	**$ 940**
Realized investment gains, net of taxes	$ 9	$ 23	$ 25

Segment earnings increased 28% in 2012 compared with 2011, due to higher adjusted income from operations, partially offset by the special items related to the realignment and efficiency plan charge, the costs associated with the acquisition of HealthSpring and a litigation matter. Segment earnings increased 18% in 2011 compared with 2010, due to higher adjusted income from operations.

The Global Health Care segment's adjusted income from operations increased 34% in 2012, as compared with 2011 reflecting:

strong earnings contributions from the government segment, primarily attributable to the acquired HealthSpring business reflecting effective medical cost and pharmacy management programs;

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revenue growth in the U.S. commercial business, primarily due to a higher ASO customer base resulting in higher fees, as well as additional sales of stop loss and specialty products;

growth in the international health care business; and

increased specialty margins including behavioral and pharmacy products.

These favorable impacts were partially offset by:

higher operating expenses, primarily attributable to investments in technology and initiatives to expand business capabilities as well as to support business growth; and

modestly higher medical care ratios in our commercial risk businesses due to slightly higher utilization.

The Global Health Care segment's adjusted income from operations increased 17% in 2011, as compared with 2010 reflecting:

growth in premiums and fees of 9% in 2011 (excluding the impact of exiting the Medicare IPFFS business), primarily due to higher average membership in the guaranteed cost and ASO commercial businesses, particularly in the targeted market segments: Middle, Select and Individual;

strong revenue growth in the international health care business;

growth in specialty revenues, as well as rate increases on most products consistent with underlying trend;

a lower guaranteed cost medical care ratio and higher experience-rated margins in the commercial business driven by low medical services utilization trend, as well as favorable prior year claim development. These favorable effects were partially offset by the estimated cost of premium rebates calculated under the minimum medical loss ratio requirements of Health Care Reform; and

higher net investment income of 14% in 2011, primarily reflecting increased average asset levels driven by membership growth, as well as higher income from partnership investments.

Revenues

The table below shows premiums and fees for the Global Health Care segment:

(In millions)	2012	2011	2010
Medical:			
Guaranteed cost [1]	$ 4,256	$ 4,176	$ 3,929
Experience-rated [2]	2,022	1,934	1,823
Stop loss	1,672	1,451	1,287
International health care	1,648	1,344	976
Dental	1,005	894	804
Medicare	4,969	489	1,470
Medicaid	207	-	-
Medicare Part D	1,421	685	615
Other	677	600	543
Total medical	17,877	11,573	11,447
Fees [3]	3,096	2,870	2,687
TOTAL PREMIUMS AND FEES	**20,973**	**14,443**	**14,134**
Less: Medicare IPFFS	-	-	827
Premiums and fees, excluding Medicare IPFFS	$ 20,973	$ 14,443	$ 13,307

(1)

Excludes international health care guaranteed cost premiums.

(2)

Includes minimum premium business that has a risk profile similar to experience-rated funding arrangements. The risk portion of minimum premium revenue is reported in experience-rated medical premium whereas the self funding portion of minimum premium revenue is reported in fees. Also, includes certain non-participating cases for which special customer level reporting of experience is required.

(3)

Includes fees related to the U.S. and international health care businesses. Fees related to Medicare Part D of $61 million in 2011 and $57 million in 2010 have been reclassified to premiums to conform to current presentation.

Premiums and fees increased 45% in 2012, compared with 2011, primarily reflecting growth in the government segment due to the acquisition of HealthSpring. Revenue growth in the U.S. commercial business was driven by rate increases on most products consistent with underlying cost trends and a higher ASO customer base, resulting in higher fees, stop loss revenues and specialty product penetration. In addition, revenue in the international health care business increased primarily due to the conversion of the Vanbreda business from service to insurance contracts and, to a lesser extent, other business growth.

Premiums and fees increased 2% in 2011 compared with 2010. Excluding the impact of exiting the Medicare IPFFS business, premiums and fees rose 9% in 2011, compared with 2010, due primarily to higher revenues in the international health care and U.S. commercial businesses. International health care revenues increased due to business growth and the acquisition of Vanbreda. In the U.S. commercial business, the increase in revenues was attributable primarily to membership growth in the ASO business and higher average membership in guaranteed cost, driven by strong retention and sales in targeted market segments. Rate increases on most products consistent with underlying cost trends and higher

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penetration of specialty products also contributed to the increase in revenues for the U.S. commercial business.

These increases in premiums and fees in 2012 and 2011 reflect the Company's sustained success in delivering differentiated value to its customers with a focus on providing cost-effective products and services that expand access and provide superior clinical outcomes.

Net investment income decreased 2% in 2012 compared with 2011 reflecting lower yields, partially offset by the impact of the HealthSpring acquisition and higher income from partnership investments. Net investment income increased 14% in 2011 compared with 2010 benefiting from increased average asset levels driven by membership growth and higher income from partnership investments.

Other revenues for the Global Health Care segment consist primarily of revenues earned on direct channel sales of certain specialty products, including behavioral health and disease management, as well as revenues for management services provided to independent physician associations and health plans. Other revenues decreased 5% in 2012 compared with 2011, driven primarily by the divestiture of Cigna Government Services in the second quarter of 2011, partially offset by revenue contributions from HealthSpring.

Other revenues decreased 12% in 2011 compared with 2010 mostly due to the sale of the Cigna Government Services business in the second quarter of 2011, as well as declines in certain stand-alone medical cost management business.

Benefits and Expenses

Health Care segment benefits and expenses consist of the following:

(In millions)	**2012**	**2011**	**2010**
Medical claims expense excluding Medicare IPFFS	$ 14,235	$ 9,144	$ 8,450
Medical claims expense Medicare IPFFS	(7)	(19)	772
Medical claims expense	14,228	9,125	9,222
Mail order pharmacy cost of goods sold	1,328	1,203	1,169
Other operating expenses, excluding Medicare IPFFS and special items	5,217	4,340	4,120
Other operating expenses, Medicare IPFFS	-	-	82
Other operating expenses, excluding special items	5,217	4,340	4,202
Special items	96	-	-
Total other operating expenses	5,313	4,340	4,202
TOTAL BENEFITS AND EXPENSES	**$ 20,869**	**$ 14,668**	**$ 14,593**
Selected ratios			
Guaranteed cost medical care ratio	80.2%	79.7%	80.1%
Medicare Advantage medical care ratio (excluding IPFFS)	80.9%	89.6%	90.9%
Medicare Part D medical care ratio	81.2%	83.4%	84.2%
Operating expense ratio including special items and Medicare IPFFS	23.0%	26.5%	26.2%
Operating expense ratio excluding special items and Medicare IPFFS	22.6%	26.5%	27.1%

Medical claims expense increased 56% in 2012 compared with 2011, primarily reflecting growth in the government segment due to the acquisition of HealthSpring, growth in the international health care business driven by the conversion of Vanbreda business from service to insurance contracts, and medical cost inflation. The guaranteed cost medical care ratio is modestly higher in 2012 compared with 2011, due to slightly higher utilization. The Medicare Advantage and Medicare Part D medical care ratios were lower in 2012 compared with 2011, driven by the acquisition of HealthSpring.

Medical claims expense decreased 1% in 2011 compared with 2010. Excluding the impact of Medicare IPFFS business, medical claims expenses increased 8% in 2011 compared with 2010, largely due to the acquisition of Vanbreda in the international health care business, as well as medical cost inflation, tempered by low medical services utilization trend in commercial risk businesses.

Operating expenses (including special items) increased by 22% in 2012 compared with 2011. Excluding special items, operating expenses increased by 20% in 2012 compared with 2011, primarily due to the acquisition of HealthSpring, investments in technology, business initiatives, and customer-driven volume growth, partially offset by the divestiture of Cigna Government Services in the second quarter of 2011 and expense management actions taken in 2012. Operating expenses increased 3% in 2011 compared with 2010. Excluding the impact of the Medicare IPFFS business, operating expenses increased 5% primarily due to business growth, strategic investments including brand strategy and Individual segment expansion, partially offset by the impact of exiting the Medicare IPFFS business and divestiture of Cigna Government Services.

One measure of the segment's overall operating efficiency is the operating expense ratio calculated as total other operating expenses divided by segment revenues. The table above shows the operating expense ratios for the Global Health Care Segment.

The operating expense ratios decreased for 2012 compared with 2011, primarily driven by the acquisition of HealthSpring, as well as organic revenue growth and operating expense efficiencies achieved through expense management actions taken in 2012, partially offset by higher investments in technology and business initiatives. The HealthSpring acquired business largely reflects fully insured, premium-based products with substantially lower operating expense ratios than the Company's commercial businesses. The Company's commercial businesses are heavily weighted to ASO fee-based products that have relatively higher operating expense ratios.

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The operating expense ratio increased from 2010 to 2011 primarily driven by a change in business mix resulting from the Company's decision to exit the non-strategic Medicare IPFFS business that was a fully-insured business. Excluding the impact of the Medicare IPFFS business, the operating expense ratio improved for 2011 compared with 2010 driven largely by continued focus on expense management.

Other Items Affecting Global Health Care Results

Global Health Care Medical Claims Payable

Medical claims payable increased 42% in 2012 compared with 2011, primarily reflecting the acquisition of HealthSpring. Medical claims payable decreased by 7% in 2011 compared with 2010, primarily reflecting the run-out of the Medicare IPFFS business that the Company exited in 2011.

Medical Customers

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

is covered under an insurance policy or service agreement issued by the Company;

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

has medical claims that are administered by the Company.

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

(In thousands)	2012	2011	2010
Commercial Risk:			
U.S. Guaranteed cost [1]	1,135	1,091	1,177
U.S. Experience-rated [2]	786	798	849
International health care Risk	744	582	480
Total commercial risk	2,665	2,471	2,506
Medicare	426	44	145
Medicaid	23	-	-
Total government	449	44	145
Total risk	3,114	2,515	2,651
Service, including international health care	10,931	10,165	9,822
TOTAL MEDICAL CUSTOMERS	**14,045**	**12,680**	**12,473**

(1)

Excludes customers from the international health care business.

(2)

Includes minimum premium customers, who have a risk profile similar to experience-rated members. Also, includes certain non-participating cases for which special customer level reporting of experience is required. Excludes international health care business.

The Company's overall medical customer base as of December 31, 2012 increased 11% when compared with December 31, 2011, primarily reflecting ASO customer growth driven by strong retention and sales in targeted market segments, increases in the government segment, primarily reflecting the impact of the acquisition of HealthSpring as well as growth in the international health care business. The increase in the international health care risk customers in 2012 also reflects the conversion of the Vanbreda business from service to insurance contracts. The Global Health Care segment's overall medical customers as of December 31, 2011 increased 2% when compared with December 31, 2010, primarily reflecting new business sales and growth in ASO in the targeted Middle and Select market segments, growth in the Individual market segment that is sold under the guaranteed cost funding arrangement, as well as growth in the international health care business.

Medicare Advantage Reimbursement Rates for 2014

On February 15, 2013, CMS issued its Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies (the "Notice"). CMS is accepting comments on the Notice, and final terms are expected to be published on April 1, 2013. While management believes that a significant number of comments from interested parties (including Cigna) will be provided to CMS, there can be no assurance that CMS will amend its current position. Given the uncertainty regarding the final terms of the Notice, the Company cannot estimate the impact that it will have on its business, revenues or results of operations but recognizes that any impacts could be materially adverse. Accordingly, the Company is currently evaluating the potential implications of the Notice, including adjustments that the Company may make to the programs and services it offers to offset any adverse impacts.

Group Disability and Life Segment

Segment Description

As explained in the Introduction section of this MD&A and in Note 23 to the Consolidated Financial Statements, effective December 31, 2012, the Company changed its external reporting segments. The Group Disability and Life segment includes group disability, life, accident and specialty insurance, including certain disability and life insurance business previously reported in the former Health Care segment. Prior year information has been conformed to the new segment structure.

Key factors for this segment are:

premium growth, including new business and customer retention;

net investment income;

benefits expense as a percentage of earned premium (loss ratio); and

other operating expense as a percentage of earned premiums and fees (expense ratio).

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Results of Operations

Financial Summary

(In millions)	**2012**	**2011**	**2010**
Premiums and fees	$ 3,109	$ 2,857	$ 2,770
Net investment income	300	291	287
Other revenues	-	-	123
Segment revenues	3,409	3,148	3,180
Benefits and expenses	3,014	2,740	2,748
Income before taxes	395	408	432
Income taxes	116	113	127
SEGMENT EARNINGS	**279**	**295**	**305**
Less: special items (after-tax) included in segment earnings:			
Charge for realignment and efficiency plan (See Note 6 to the Consolidated Financial Statements)	(2)	-	-
Completion of IRS examination (See Note 20 to the Consolidated Financial Statements)	-	5	-
ADJUSTED INCOME FROM OPERATIONS	**$ 281**	**$ 290**	**$ 305**
Realized investment gains, net of taxes	$ 18	$ 7	$ 13

Segment earnings for 2012 decreased 5% compared with 2011 reflecting lower adjusted income from operations, a special item for a realignment and efficiency plan charge in 2012 as well as the absence of the 2011 special item related to completing the 2007 and 2008 IRS examination. Segment adjusted income from operations decreased 3%, primarily attributable to a higher disability loss ratio and higher expense ratio, partially offset by a lower life loss ratio (see Benefits and Expenses below) and higher net investment income. Results in 2012 include the $43 million after-tax favorable impact of reserve studies. Results in 2011 include the $39 million after-tax favorable impact of reserve studies offset by a $7 million after-tax litigation accrual.

Segment earnings decreased 3% in 2011 compared with 2010 reflecting 5% lower adjusted income from operations offset by a $5 million favorable special item related to completing the 2007 and 2008 IRS examinations. Adjusted income from operations decreased as a result of:

the absence of the $11 million after-tax gain on the sale of the workers' compensation and case management business in 2010;

a higher disability loss ratio;

a higher expense ratio: and

an after-tax charge of $7 million for litigation matters.

Offsetting these factors were more favorable life and accident claims experience and higher net investment income driven largely by higher invested assets and partnership income.

Revenues

Premiums and fees increased 9% in 2012 compared with 2011 reflecting strong disability and life new sales, in-force growth and continued strong persistency.

Premiums and fees increased 3% in 2011 compared with 2010 reflecting disability and life sales growth and continued solid persistency partially offset by the impact of the Company's exit from a large, low-margin assumed government life insurance program. Excluding the impact of this item, premiums and fees increased 6%. Disability premiums and fees grew by 9%.

Net investment income increased 3% in 2012 compared with 2011 due to higher assets and higher partnership investment income, partially offset by lower yields. Net investment income increased 1% in 2011 compared with 2010 due to higher average assets reflecting business growth and higher prepayment fees partially offset by lower yields.

Other revenues. The absence of other revenues in 2012 and 2011 reflects the sale of the workers' compensation and case management business that was completed during the fourth quarter of 2010. Other revenues in 2010 include the $18 million pre-tax gain on the sale of the workers' compensation and case management business.

Benefits and Expenses

Benefits and expenses increased 10% in 2012 compared with 2011 as a result of premium growth in the disability and life business, a higher loss ratio in the disability business and a higher operating expense ratio, partially offset by a lower loss ratio in the life business. The higher disability loss ratio reflects less favorable claim experience primarily as a result of higher new claims. The higher operating expense ratio is driven by higher commissions and strategic information technology and claim office investments. The lower life loss ratio primarily reflects lower new claims. Benefits and expenses include the favorable impact of reserve studies of $60 million in 2012 as compared with the $59 million favorable impact of reserve studies offset by a $10 million litigation accrual in 2011.

Benefits and expenses were essentially flat in 2011 as compared with 2010 reflecting disability and life business growth, less favorable disability claims experience and a higher operating expense ratio, largely offset by the absence of operating expenses associated with the workers' compensation and case management business that was sold in 2010 and favorable life and accident claims experience. The disability claims experience reflects higher incidence rates, mitigated in part by higher resolution rates reflecting the sustained strong performance of the Company's disability claims management process.

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The higher operating expense ratio is driven by strategic investments. Benefits and expenses include the favorable before tax impact of reserve studies of $59 million in 2011 as compared with $55 million in 2010.

Global Supplemental Benefits Segment

Segment Description

As explained in the Introduction section of this MD&A and Note 23 to the Consolidated Financial Statements, effective December 31, 2012, the Company changed its external reporting segments. Prior year information has been conformed to the new segment structure.

The Global Supplemental segment includes supplemental health, life and accident insurance products offered in the U.S. and foreign markets, primarily in Asia as well as Medicare supplemental coverage following the 2012 acquisition of Great American Supplemental Benefits.

The key factors for this segment are:

premium growth, including new business and customer retention;

benefits expense as a percentage of earned premium (loss ratio);

operating expense as a percentage of earned premium (expense ratio); and

impact of foreign currency movements.

Throughout this discussion, the impact of foreign currency movements was calculated by comparing the reported results to what the results would have been had the exchange rates remained constant with the prior year's comparable period exchange rates.

Results of Operations

Financial Summary

(In millions)	**2012**	**2011**	**2010**
Premiums and fees	$ 1,984	$ 1,528	$ 1,231
Net investment income	90	83	69
Other revenues	21	15	22
Segment revenues	2,095	1,626	1,322
Benefits and expenses	1,916	1,492	1,192
Income before taxes	179	134	130

Income taxes	36	36	42
Income attributable to redeemable noncontrolling interest	1	-	-
Income attributable to other noncontrolling interest	-	1	4
SEGMENT EARNINGS	**142**	**97**	**84**
Less: special items (after-tax) included in segment earnings:			
Charge for realignment and efficiency plan (See Note 6 to the Consolidated Financial Statements)	(6)	-	-
Costs associated with the acquisition of FirstAssist	-	(3)	
ADJUSTED INCOME FROM OPERATIONS	**$ 148**	**$ 100**	**$ 84**
Impact of foreign currency movements using 2011 rates	$ (2)		
Impact of foreign currency movements using 2010 rates		$ 4	
Realized investment gains, net of taxes	$ 1	$ 1	$ 2

Global Supplemental Benefits segment earnings increased 46% in 2012 compared to 2011. Segment earnings for 2012 include an after-tax charge of $6 million associated with the realignment and efficiency plan, and an $8 million favorable adjustment related to the first quarter 2012 expansion of a capital management strategy to permanently invest the earnings of its China and Indonesia operations overseas (see further discussion in the Liquidity and Capital Resources section of the MD&A). Excluding these adjustments and the unfavorable impact of foreign currency movements (presented in the table above) adjusted income from operations increased 42% for the 2012 compared with 2011. These increases were primarily driven by the strong revenue growth, primarily in South Korea and, to a lesser extent, margin improvement largely attributable to disciplined management of solicitation spending. Excluding the first quarter 2012 implementation effect of the capital management strategy, the Global Supplemental Benefits segment's effective tax rate for the full year 2012 was 24.6%, compared with 27.3% for 2011.

Global Supplemental Benefits segment earnings increased 15% in 2011 compared with 2010. Segment earnings for 2010 include a $10 million unfavorable tax adjustment related to the first quarter 2010 expansion of a capital management strategy to permanently invest the earnings of its Hong Kong operations overseas (see further discussion in the Liquidity and Capital Resources section of the MD&A). Excluding the impact of this tax adjustment and foreign currency movements (presented in the table above), the Global

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Supplemental Benefits segment's adjusted income from operations increased 2% in 2011 compared with 2010. The increases in both segment earnings and adjusted income from operations were primarily due to revenue growth and higher persistency, particularly in South Korea, and higher net investment income, substantially offset by higher policy acquisition costs and expense ratios, as well as, by a higher effective tax rate primarily due to unfavorable changes in foreign tax law.

The unfavorable impacts of foreign currency movements in 2012 using 2011 rates, as well as the favorable impacts in 2011 using 2010 rates, primarily reflects the movement between the U.S. dollar and the South Korean won.

Revenues

Premiums and fees. Excluding the effect of foreign currency movements, premiums and fees increased by 32% in 2012, compared with 2011. These increases are primarily attributable to the higher revenue associated with the acquisitions of FirstAssist and Great American Supplemental Benefits (the acquisitions), strong persistency, and new sales growth, particularly in South Korea.

Excluding the effect of foreign currency movements, premiums and fees were $1.5 billion in 2011 compared with reported premiums and fees of $1.2 billion in 2010, an increase of 19%. The increase is primarily attributable to new sales growth, particularly in South Korea and Taiwan.

Net investment income increased by 8% in 2012, compared with 2011, and 20% in 2011, compared with 2010. These increases were primarily due to asset growth in South Korea.

Benefits and Expenses

Excluding the impact of foreign currency movements, benefits and expenses were $1.9 billion in 2012, compared to reported benefits and expenses of $1.5 billion in 2011, an increase of 30%. These increases were primarily due to the acquisitions and business growth.

Excluding the impact of foreign currency movements, benefits and expenses were $1.4 billion in 2011, compared with reported benefits and expenses of $1.2 billion in 2010, an increase of 20%. The increase was primarily due to business growth.

Loss ratios increased slightly in 2012, reflecting the inherently higher loss ratios of the acquisitions. Loss ratios were flat in 2011 compared with 2010.

Policy acquisition expenses increased in 2012 compared with 2011 reflecting the acquisitions and business growth, partially offset by lower acquisition costs in Europe reflecting a decision to cease selling activities in certain markets. Policy acquisition expenses increased in 2011 compared with 2010 reflecting business growth and foreign currency movements.

Excluding the special items (presented in the table above), expense ratios increased for 2012 compared to 2011. This increase was primarily driven by the impact of the higher expense ratios associated with FirstAssist. Excluding the special items (presented in the table above), expense ratios increased in 2011 compared with 2010, primarily due to strategic investments for future growth and costs to streamline operations, partially offset by higher revenues in South Korea.

Other Items Affecting Global Supplemental Benefits Results

For the Company's Global Supplemental Benefits segment, South Korea is the single largest geographic market, generating 54% of the segment's revenues and 90% of earnings in 2012. Due to the concentration of business in South Korea, the Global Supplemental Benefits segment is exposed to potential losses resulting from economic, regulatory and geopolitical developments in that country, as well as foreign currency movements affecting the South Korean currency, that could have a significant impact on the segment's results and the Company's consolidated financial results.

Run-off Reinsurance Segment

Segment Description

The Company's reinsurance operations were discontinued and are now an inactive business in run-off mode since the sale of the U.S. individual life, group life and accidental death reinsurance business in 2000. In 2010, the Company essentially exited from its workers' compensation and personal accident reinsurance business by purchasing retrocessional coverage from a Bermuda subsidiary of Enstar Group Limited. This segment is predominantly comprised of guaranteed minimum death benefit ("GMDB", also known as "VADBe") and guaranteed minimum income benefit ("GMIB") products.

Effective February 4, 2013, the Company reinsured 100% of the Company's future exposures for the Run-off GMDB and GMIB businesses, net of retrocessional arrangements in place prior to February 4, 2013, up to a specified limit. See Note 25 to the Consolidated Financial Statements for additional information. The Company describes the assumptions used to develop the reserves for GMDB in Note 7 to the Consolidated Financial Statements and for the assets and liabilities associated with GMIB in Note 11 to the Consolidated Financial Statements.

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The Company excludes the results of the GMIB business from adjusted income from operations because the fair value of GMIB assets and liabilities must be recalculated each quarter using updated capital market assumptions. The resulting changes in fair value, that are reported in shareholders' net income, can be volatile and unpredictable.

Results of Operations

Financial Summary

(In millions)	2012	2011	2010
Premiums and fees	$ 21	$ 24	$ 25
Net investment income	102	103	114
Other revenues	(119)	(4)	(158)
Segment revenues	4	123	(19)
Benefits and expenses	4	405	91
Loss before income tax benefits	-	(282)	(110)
Income tax benefits	-	(99)	(136)
SEGMENT EARNINGS (LOSS)	**-**	**(183)**	**26**
Less: special items (after-tax) included in segment earnings:			
Resolution of federal tax matters (See Note 20 to the Consolidated Financial Statements)	-	-	97
Loss on Reinsurance transaction (See Note 3 to the Consolidated Financial Statements)	-	-	(20)
Less: results of GMIB business	29	(135)	(24)
ADJUSTED LOSS FROM OPERATIONS	**$ (29)**	**$ (48)**	**$ (27)**
Realized investment gains, net of taxes	$ 1	$ 4	$ 5

Segment results improved in 2012 compared to 2011 due to significantly more favorable results for the GMIB business (presented in the table above) and lower reserve strengthening for GMDB.

Segment results in 2011 reflected higher losses for the GMIB and GMDB businesses compared to 2010 due to the significant declines in interest rates, periods of high volatility, and less favorable equity market conditions during 2011. In addition, segment results in 2010 reflect the favorable effect of resolving a federal tax matter.

See the Benefits and Expenses section for further discussion around the results of the GMIB and GMDB businesses.

Other Revenues

Other revenues consisted of gains and losses from futures and swap contracts used in the GMDB and GMIB equity and interest rate hedge programs. See Note 13 to the Consolidated Financial Statements for additional information. The components were as follows:

(In millions)	2012	2011	2010
GMDB Equity Hedge Program	$ (110)	$ (45)	$ (157)
GMDB Growth Interest Rate Hedge Program	5	31	-
GMIB Equity Hedge Program	(16)	4	-

GMIB	Growth Interest Rate Hedge Program	2	6	-
Other		-	-	(1)
TOTAL OTHER REVENUES		**$ (119)**	**$ (4)**	**$ (158)**

The hedging programs generally produce losses when equity markets and interest rates are rising and gains when equity markets and interest rates are falling. Amounts reflecting related changes in liabilities for GMDB contracts were included in benefits and expenses consistent with GAAP when a premium deficiency exists, resulting in no effect on shareholders' net income (see below "Other Benefits and Expenses"). Changes in liabilities for GMIB contracts, including the portion covered by the hedges, are recorded in GMIB fair value (gain) loss. These hedging programs were discontinued after February 4, 2013 due to the reinsurance transaction discussed above.

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Benefits and Expenses

Benefits and expenses were comprised of the following:

(In millions)	2012	2011	2010
GMIB fair value (gain) loss	$ (41)	$ 234	$ 55
Other benefits and expenses	45	171	36
BENEFITS AND EXPENSES	**$ 4**	**$ 405**	**$ 91**

GMIB fair value (gain) loss. Under the GAAP guidance for fair value measurements, the Company's results of operations have been volatile because capital market assumptions needed to estimate the assets and liabilities for the GMIB business are based largely on market observable inputs at the close of each reporting period including interest rates (LIBOR swap curve) and market implied volatilities. See Note 11 to the Consolidated Financial Statements for additional information about assumptions and asset and liability balances related to GMIB and Note 13 for additional information regarding the hedge programs to hedge a portion of equity and interest rate risks in GMIB contracts.

GMIB fair value gains of $41 million for 2012, were primarily due to the effect of increases in underlying account values, updates in the claim exposure calculation, and a reduction in annuitization rates, partially offset by a reduction in lapse rates and general declines in interest rates.

GMIB fair value losses of $234 million for 2011, were primarily due to a decline in both the interest rate used for projecting claim exposure (7-year Treasury rates) and the rate used for projecting market returns and discounting (LIBOR swap curve).

GMIB fair value losses of $55 million for 2010, were primarily due to declining interest rates, partially offset by increases in underlying account values resulting from favorable equity and bond fund returns.

The GMIB liabilities and related assets are calculated using an internal model and assumptions from the viewpoint of a hypothetical market participant. Payments for GMIB claims are expected to occur over the next 15 to 20 years and will be based on actual values of the underlying mutual funds and the 7-year Treasury rate at the dates benefits are elected. As explained above, on February 4, 2013, the Company reinsured 100% of the future exposures under these GMIB contracts, net of retrocessional arrangements in place prior to February 4, 2013.

Other Benefits and Expenses are comprised of the following:

(In millions)	2012	2011	2010
Results of GMDB equity and growth interest rate hedging programs	$ (105)	$ (14)	$ (157)
GMDB reserve strengthening	43	70	52
Other GMDB, primarily accretion of discount	79	82	85
GMDB benefit expense (income)	17	138	(20)
Loss on reinsurance of workers' compensation and personal accident business	-	-	31
Other, including operating expenses	28	33	25
OTHER BENEFITS AND EXPENSES	**$ 45**	**$ 171**	**$ 36**

Other Benefits and Expenses

Capital market movements. Benefits expense related to capital market movements as represented by the results of the hedging programs decreased in 2012 compared with 2011 due to more favorable equity market performance. The increase in benefits expense in 2011 compared with 2010 was due to turbulent conditions in an overall declining equity market. As explained in Other revenues above, these changes do not

affect shareholders' net income because they are offset by gains or losses on futures contracts used to hedge equity market and interest rate performance.

Reserve strengthening. The following highlights the impacts of GMDB reserve strengthening:

The 2012 reserve strengthening was driven primarily by reductions to the lapse rate assumptions, an update to management's consideration of the anticipated impact of continued low short-term interest rates, and to a lesser extent, an increase to the volatility and correlation assumptions, partially offset by favorable equity market conditions.

The 2011 reserve strengthening was driven primarily by volatility-related impacts due to the turbulent equity market conditions, an update to management's consideration of the anticipated impact of the continued low level of short-term interest rates, and the adverse impacts of overall market declines, including an increase in the provision for future partial surrenders and declines in the value of contract holders' non-equity investments such as bond funds, neither of which are included in the hedge program.

The 2010 reserve strengthening was driven primarily by management's consideration of the anticipated impact of the continued low level of current short-term interest rates, and to a lesser extent, a reduction in assumed lapse rates for policies that have taken or are assumed to take significant partial withdrawals.

See Note 7 to the Consolidated Financial Statements for additional information about assumptions and reserve balances related to GMDB.

Other, including operating expenses. The decrease in 2012 compared with 2011 was due to the favorable impact of reserve studies and lower operating expenses. The increase in 2011 compared with 2010 was due to the reduced favorable impacts of reserve studies.

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Other Operations Segment

Segment Description

Cigna's Other Operations segment includes the results of the following businesses:

corporate-owned life insurance ("COLI");

deferred gains recognized from the sale of the retirement benefits and individual life insurance and annuity businesses; and

run-off settlement annuity business.

Results of Operations

Financial Summary

(In millions)	**2012**	**2011**	**2010**
Premiums and fees	$ 100	$ 114	$ 114
Net investment income	388	400	404
Other revenues	55	55	60
Segment revenues	543	569	578
Benefits and expenses	418	451	454
Income before taxes	125	118	124
Income taxes	43	29	39
SEGMENT EARNINGS	**82**	**89**	**85**
Completion of IRS examination (See Note 20 to the Consolidated Financial Statements)	-	4	-
ADJUSTED INCOME FROM OPERATIONS	**$ 82**	**$ 85**	**$ 85**
Realized investment gains, net of taxes	$ 2	$ 6	$ 5

Segment earnings decreased 8% in 2012 compared with 2011, primarily reflecting lower COLI interest margins and mortality gains and the continued decline in deferred gain amortization associated with the sold businesses.

Segment earnings increased in 2011 compared with 2010, reflecting a $4 million increase from completing the Company's 2007 and 2008 IRS examination during the first quarter of 2011.

Revenues

Premiums and fees reflect fees charged primarily on universal life insurance policies in the COLI business. Premiums and fees decreased 12% in 2012, compared with 2011 due to lower policyholder death benefit exposures.

Net investment income decreased 3% in 2012 compared with 2011, primarily reflecting lower average yields and decreased 1% in 2011 compared with 2010 due to lower portfolio yields partially offset by higher average invested assets.

Other revenues were flat in 2012 compared with 2011 and decreased 8% in 2011 compared with 2010 primarily due to lower deferred gain amortization related to the sold retirement benefits and individual life insurance and annuity businesses. 2012 results were partially offset by higher investment management fees.

Benefits and expenses decreased 7% in 2012 compared with 2011 primarily due to favorable COLI claims experience and lower policyholder death benefit coverage and the absence of a charge recorded in the first quarter of 2011 to reimburse the buyer of the retirement benefits business with a portion of the tax benefits resulting from the completion of the 2007 and 2008 IRS examination as required under a tax sharing agreement.

For more information regarding the sale of these businesses see Note 8 to the Consolidated Financial Statements.

Corporate

Description

Corporate reflects amounts not allocated to operating segments, such as net interest expense (defined as interest on corporate debt less net investment income on investments not supporting segment operations), interest on uncertain tax positions, certain litigation matters, intersegment eliminations, compensation cost for stock options and certain corporate overhead expenses such as directors' expenses and pension expense related to the Company's frozen pension plans.

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Financial Summary

(In millions)	**2012**	**2011**	**2010**
Segment loss	$ (329)	$ (184)	$ (211)
Less: special items (after-tax) included in segment loss:			
Cost associated with HealthSpring acquisition (See Note 3 to the Consolidated Financial Statements)	(33)	(28)	-
Resolution of Federal Tax Matter (See Note 20 to the Consolidated Financial Statements)	-	-	4
Loss on early extinguishment of debt (See Note 16 to the Consolidated Financial Statements)	-	-	(39)
Charges related to litigation matters (See Note 24 to the Consolidated Financial Statements)	(68)	-	-
Completion of IRS examination (See Note 20 to the Consolidated Financial Statements)	-	14	-
ADJUSTED LOSS FROM OPERATIONS	**$ (228)**	**$ (170)**	**$ (176)**

In 2012, segment loss for Corporate was significantly higher than in 2011, primarily reflecting:

higher interest expense due to the $2.1 billion of long-term debt issued in the fourth quarter of 2011 to fund the HealthSpring acquisition;

charges associated with litigation matters due primarily to recent developments. See Note 24 to the Consolidated Financial Statements for additional information;

the absence of a tax benefit; and

estimated penalties for terminating a service contract.

Corporate's segment loss was lower in 2011 compared with 2010 primarily reflecting a tax benefit from completing the IRS examination and absence of the 2010 loss on debt extinguishment, partially offset by costs associated with the HealthSpring acquisition, all of which were reported as special items.

Corporate's adjusted loss from operations was lower in 2011 compared with 2010 primarily reflecting decreased pension expense and lower tax adjustments related to postretirement benefits and compensation resulting from Health Care Reform. These factors were partially offset by increased net interest expense due to higher average borrowings outstanding in 2011.

Liquidity and Capital Resources

Financial Summary

(In millions)	**2012**	**2011**	**2010**

Short-term investments	$ 154	$ 225	$ 174
Cash and cash equivalents	$ 2,978	$ 4,690	$ 1,605
Short-term debt	$ 201	$ 104	$ 552
Long-term debt	$ 4,986	$ 4,990	$ 2,288
Shareholders' equity	$ 9,769	$ 7,994	$ 6,356

Liquidity

The Company maintains liquidity at two levels: the subsidiary level and the parent company level.

Liquidity requirements at the subsidiary level generally consist of:

claim and benefit payments to policyholders;

operating expense requirements, primarily for employee compensation and benefits; and

dividends and federal tax payments to the parent company.

The Company's subsidiaries normally meet their operating requirements by:

maintaining appropriate levels of cash, cash equivalents and short-term investments;

using cash flows from operating activities;

selling investments;

matching investment durations to those estimated for the related insurance and contractholder liabilities; and

borrowing from its parent company.

Liquidity requirements at the parent level generally consist of:

debt service and dividend payments to shareholders;

pension plan funding; and

federal tax payments.

The parent normally meets its liquidity requirements by:

maintaining appropriate levels of cash, cash equivalents and short-term investments;

collecting dividends and federal tax payments from its subsidiaries;

using proceeds from issuance of debt and equity securities; and

borrowing from its subsidiaries.

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Capital Resources

The Company's capital resources (primarily retained earnings and the 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 the Company maintains. 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.

The Company prioritizes its use of capital resources to:

provide capital necessary to support growth and maintain or improve the financial strength ratings of its subsidiaries;

consider acquisitions that are strategically and economically advantageous; and

return capital to investors through share repurchase.

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

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

(In millions)	**2012**	**2011**	**2010**
Operating activities	$ 2,350	$ 1,491	$ 1,743
Investing activities	$ (3,857)	$ (1,270)	$ (1,342)
Financing activities	$ (228)	$ 2,867	$ 274

Cash flows from operating activities consist of cash receipts and disbursements for premiums and fees, mail order pharmacy and other revenues, gains (losses) recognized in connection with the Company's GMDB and GMIB equity hedge programs, investment income, taxes, and 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, that includes 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 net deposits and withdrawals to or from investment contract liabilities (that include universal life insurance liabilities) because such liabilities are considered financing activities with policyholders.

2012:

Operating activities

Cash flows from operating activities increased by $859 million in 2012 compared with 2011, primarily the result of strong earnings growth in the ongoing business segments in 2012. In addition, 2011 operating cash flows were adversely affected by significant claim run-out from the Medicare IPFFS business that the Company exited in 2011.

Investing activities

Cash used in investing activities was $3.9 billion in 2012, $3.6 billion of which was for the acquisitions (net of cash acquired) of HealthSpring, Great American Supplemental Benefits, and the joint venture in Turkey. Cash used in investing activities also included net purchases of investments of $132 million and net purchases of property and equipment (primarily internal-use software) of $408 million.

Financing activities

Cash used in financing activities in 2012 primarily reflects the repayment of debt assumed in the HealthSpring acquisition of $326 million and the repurchase of common stock for $208 million. These effects were partially offset by the change in short-term debt of $98 million primarily from the issuance of commercial paper, proceeds from the issuance of common stock from employee benefit plans of $121 million and net deposits to contractholder deposit funds of $73 million.

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

In 2012 the Company repurchased 4.4 million shares for $208 million. On February 27, 2013, the Company's Board of Directors increased share repurchase authority by $500 million. Accordingly, the total remaining share repurchase authorization as of February 28, 2013 was $815 million. In 2011 the Company

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repurchased 5.3 million shares for $225 million and 6.2 million shares for $201 million during 2010.

2011:

Operating activities

Cash flows from operating activities decreased by $252 million in 2011 compared with 2010. Excluding the results of the GMDB equity hedge program (that did not affect net income), cash flows from operating activities decreased by $364 million. This decrease in 2011 primarily reflects higher management compensation, income tax and pension payments in 2011 compared with 2010 and unfavorable operating cash flows in the Medicare IPFFS business in 2011 due to significant claim run-out compared to significant favorable operating cash flows from the growth of this business in 2010. Operating cash flows were favorably affected in 2010 because paid claims on this business growth lagged premium collections.

Investing activities

Cash used in investing activities was $1.3 billion. This use of cash primarily consisted of net purchases of investments of $746 million, cash used to fund acquisitions (net of cash acquired) of $114 million, and net purchases of property and equipment of $422 million.

Financing activities

Cash provided from financing activities primarily consisted of net proceeds from the issuance of long-term debt of $2.7 billion and proceeds on issuances of common stock of $734 million, primarily used to fund the acquisition of HealthSpring, Inc. See Notes 16 and 17 to the Consolidated Financial Statements for further information. Financing activities also included net deposits to contractholder deposit funds of $145 million. These inflows were partially offset by scheduled payments of debt of $451 million and common stock repurchases of $225 million.

Interest Expense

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

(In millions)	2012	2011	2010
Interest expense	$ 268	$ 202	$ 182

The increase in interest expense in 2012 was primarily due to the issuance of $2.1 billion of long-term debt in the fourth quarter of 2011 to fund the acquisition of HealthSpring, partially offset by a lower weighted average interest rate reflecting the more favorable rates of this debt issued. The weighted average interest rate for outstanding short-term debt (primarily commercial paper) was 0.47% at December 31, 2012 and 2011.

Liquidity and Capital Resources Outlook

At December 31, 2012, there was approximately $700 million in cash and short-term investments available at the parent company level. In 2013, the parent company's cash obligations are expected to consist of the following:

scheduled interest payments of approximately $265 million on outstanding long-term debt of $5.0 billion at December 31, 2012;

contributions to the domestic qualified pension plan of $250 million (most of which is voluntary); and

repayment of $200 million of commercial paper outstanding as of December 31, 2012. The Company expects to have at least $200 million outstanding as of March 31, 2013.

In addition, the parent company will be required to fund a portion of the $2.2 billion reinsurance premium due to Berkshire. The premium will ultimately be paid to Berkshire in cash, that will be funded by the sale or internal transfer of investment assets supporting this business, tax benefits related to the transaction, and parent cash of $100 million.

The Company expects, based on its current cash position and current projections for subsidiary dividends, to have sufficient liquidity to meet the obligations discussed above.

However, the Company's cash projections may not be realized and the demand for funds could exceed available cash if:

ongoing businesses experience unexpected shortfalls in earnings;

regulatory restrictions or rating agency capital guidelines reduce the amount of dividends available to be distributed to the parent company from the insurance and HMO subsidiaries (including the impact of equity market deterioration and volatility on subsidiary capital);

significant disruption or volatility in the capital and credit markets reduces the Company's ability to raise capital; or

a substantial increase in funding over current projections is required for the Company's pension plan.

In those cases, the Company expects 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 $750 million from its insurance subsidiaries without prior state approval. As of December 31, 2012, the parent company had no net intercompany loan balance with its insurance subsidiaries.

In addition, the Company 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, 2012, the Company had $1.4 billion of borrowing capacity under the credit agreement, reflecting $66 million of letters of credit issued out of the credit facility. Within the maximum debt leverage covenant in

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the line of credit agreement, the Company has an additional $5.3 billion of borrowing capacity in addition to the $5.2 billion of debt outstanding.

The Company maintains a capital management strategy to permanently invest the earnings for certain of its foreign operations overseas. During the first quarter of 2012 the Company expanded this strategy to its China and Indonesia operations. As of December 31, 2012 the Company's cash and cash equivalents in its foreign operations were $768 million, and permanently reinvested earnings were approximately $628 million. Repatriation of foreign cash via a dividend of these permanently reinvested earnings would result in a charge for the incremental U.S. taxes due on the repatriation. Because of the size, strength and diversity of earnings from domestic sources, management does not believe this global capital management strategy materially limits the Company's ability to meet its liquidity and capital needs in the United States.

Though the Company believes it has adequate sources of liquidity, continued significant disruption or volatility in the capital and credit markets could affect the Company's ability to access those markets for additional borrowings or increase costs associated with borrowing funds.

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

In addition, various non-U.S. jurisdictions prescribe minimum surplus requirements that are based upon solvency, liquidity and reserve coverage measures. During 2012, the Company's HMOs and life and health insurance subsidiaries, as well as non-U.S. insurance subsidiaries, were compliant with applicable RBC and non-U.S. surplus rules.

Solvency II. Cigna's businesses in the European Union will be subject to the directive on insurance regulation and solvency requirements known as Solvency II. This directive will impose economic risk-based solvency requirements and supervisory rules and is expected to become effective in January 2014, although certain regulators are requiring companies to demonstrate technical capability and comply with increased capital levels in advance of the effective date. Cigna's European insurance companies are capitalized at levels consistent with projected Solvency II requirements and in compliance with anticipated technical capability requirements.

Guarantees and Contractual Obligations

The Company is contingently liable for various contractual obligations entered into in the ordinary course of business. The maturities of the Company's primary contractual cash obligations, as of December 31, 2012, 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	$ 7,104	$ 677	$ 938	$ 817	$ 4,672
Future policy benefits	11,489	486	1,153	1,083	8,767
Global Health Care medical claims payable	1,864	1,796	29	9	30
Unpaid claims and claims expenses	4,379	1,321	857	590	1,611
Short-term debt	200	200	-	-	-
Long-term debt	8,955	269	549	1,352	6,785
Other long-term liabilities	1,037	433	166	111	327
Off-Balance Sheet:					
Purchase obligations	871	393	289	120	69
Operating leases	570	116	190	108	156
TOTAL	**$ 36,469**	**$ 5,691**	**$ 4,171**	**$ 4,190**	**$ 22,417**

As discussed further in Note 25 to the Consolidated Financial Statements, effective February 4, 2013, the Company entered into a reinsurance agreement for its GMDB and GMIB businesses. The reinsurance premium due to Berkshire of $2.2 billion is not included in the contractual obligations table presented above. In addition, the expected future cash flows for GMDB and GMIB contracts included in the table above do not consider this reinsurance arrangement.

On-Balance Sheet:

Insurance liabilities. Contractual cash obligations for insurance liabilities, excluding unearned premiums and fees, represent estimated net benefit payments for health, life and disability insurance policies and annuity contracts. Recorded contractholder deposit funds reflect current fund balances primarily from universal life customers. Contractual cash obligations for these universal life contracts are estimated by projecting future payments using assumptions for lapse, withdrawal and mortality. These projected future payments include estimated future interest crediting on

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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 $18 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. The Company manages its investment portfolios to generate cash flows needed to satisfy contractual obligations. Any shortfall from expected investment yields could result in increases to recorded reserves and adversely impact results of operations. The amounts associated with the sold retirement benefits and individual life insurance and annuity businesses, as well as the reinsured workers' compensation, personal accident and supplemental benefits businesses, are excluded from the table above as net cash flows associated with them are not expected to impact the Company. The total amount of these reinsured reserves excluded is approximately $6 billion.

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

Long-term debt includes scheduled interest payments. Capital leases are included in long-term debt and represent obligations for software licenses.

Other long-term liabilities. These items are presented in accounts payable, accrued expenses and other liabilities in the Company's Consolidated Balance Sheets. This table includes estimated payments for GMIB contracts, pension and other postretirement and postemployment benefit obligations, supplemental and deferred compensation plans, interest rate and foreign currency swap contracts, and certain tax and reinsurance liabilities.

Estimated payments of $75 million for deferred compensation, non-qualified and international pension plans and other postretirement and postemployment benefit plans are expected to be paid in less than one year. The Company's best estimate is that contributions to the qualified domestic pension plans during 2013 will be approximately $250 million. The Company expects to make payments subsequent to 2013 for these obligations, however subsequent payments have been excluded from the table as their timing is based on plan assumptions which may materially differ from actual activities (see Note 10 to the Consolidated Financial Statements for further information on pension and other postretirement benefit obligations).

The above table also does not contain $51 million of liabilities for uncertain tax positions because the Company cannot reasonably estimate the timing of their resolution with the respective taxing authorities. See Note 20 to the Consolidated Financial Statements for the year ended December 31, 2012 for further information.

Off-Balance Sheet:

Purchase obligations. As of December 31, 2012, purchase obligations consisted of estimated payments required under contractual arrangements for future services and investment commitments as follows:

(In millions)

Fixed maturities	$	58
Commercial mortgage loans		6
Real estate		7

Limited liability entities (other long-term investments)		509
Total investment commitments		580
Future service commitments		291
TOTAL PURCHASE OBLIGATIONS	**$**	**871**

The Company had commitments to invest in limited liability entities that hold real estate, loans to real estate entities or securities. See Note 12(D) to the Consolidated Financial Statements for additional information.

Future service commitments include an agreement with IBM for various information technology (IT) infrastructure services. The Company's remaining commitment under this contract is approximately $15 million over the next year. The Company has the ability to terminate this agreement with 90 days notice, subject to termination fees.

The Company's remaining estimated future service commitments primarily represent contracts for certain outsourced business processes and IT maintenance and support. The Company generally has the ability to terminate these agreements, but does not anticipate doing so at this time. Purchase obligations exclude contracts that are cancelable without penalty and those that do not specify minimum levels of goods or services to be purchased.

Operating leases. For additional information, see Note 22 to the Consolidated Financial Statements.

Guarantees

The Company, through its subsidiaries, is contingently liable for various financial and other guarantees provided in the ordinary course of business. See Note 24 to the Consolidated Financial Statements for additional information on guarantees.

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Investment Assets

The Company's investment assets do not include separate account assets. Additional information regarding the Company's investment assets and related accounting policies is included in Notes 2, 11, 12, 13, 14, 15 and 18 to the Consolidated Financial Statements.

Fixed Maturities

Investments in fixed maturities include publicly traded and privately placed debt securities, mortgage and other asset-backed securities, preferred stocks redeemable by the investor and hybrid and trading securities. 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. Internal pricing methods are performed by the Company's investment professionals, and generally involve using discounted cash flow analyses, incorporating current market inputs for similar financial instruments with comparable terms and credit quality, as well as other qualitative factors. In instances where there is little or no market activity for the same or similar instruments, fair value is estimated using methods, models and assumptions that the Company believes a hypothetical market participant would use to determine a current transaction price. These valuation techniques involve some level of estimation and judgment that becomes significant with increasingly complex instruments or pricing models.

The Company is responsible for determining fair value, as well as the appropriate level within the fair value hierarchy as defined in Note 11 to the Consolidated Financial Statements, based on the significance of unobservable inputs. The Company reviews methodologies and processes 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. These analyses include reviewing to ensure that prices do not become stale and whether changes from prior valuations are reasonable or require additional review. The Company also performs sample testing of sales values to confirm the accuracy of prior fair value estimates. Exceptions identified during these processes indicate that adjustments to prices are infrequent and do not significantly impact valuations.

The Company's fixed maturity portfolio continues to be diversified by issuer and industry type with the consumer sector representing the largest single industry concentration of approximately 10% of total invested assets as of December 31, 2012.

(In millions)	**2012**	**2011**
Federal government and agency	$ 902	$ 958
State and local government	2,437	2,456
Foreign government	1,322	1,274
Corporate	11,896	10,513
Federal agency mortgage-backed	122	9
Other mortgage-backed	89	80
Other asset-backed	937	927
TOTAL	**$ 17,705**	**$ 16,217**

As of December 31, 2012, $15.9 billion, or 90%, of the fixed maturities in the Company's investment portfolio were investment grade (Baa and above, or equivalent), and the remaining $1.8 billion were below investment grade. The majority of the bonds that are below investment grade are rated at the higher end of the non-investment grade spectrum. These quality characteristics have not materially changed during the year.

The net appreciation of the Company's fixed maturity portfolio increased $264 million during 2012, driven by a decrease in market yields. Although asset values are well in excess of amortized cost, there are specific securities with amortized cost in excess of fair value by approximately $30 million in aggregate as of December 31, 2012. See Note 12 to the Consolidated Financial Statements for further information.

Corporate fixed maturities includes private placement investments of $5.4 billion, which are generally less marketable than publicly-traded bonds, but yields on these investments tend to be higher than yields on publicly-traded bonds with comparable credit risk. The Company performs a credit analysis of each issuer, diversifies investments by industry and issuer and requires financial and other covenants that allow the Company to monitor issuers for deteriorating financial strength and pursue remedial actions, if warranted. Also included in corporate fixed maturities are investments in companies that are domiciled or have significant business interests in European countries with the most significant political or economic concerns (Portugal, Italy, Ireland, Greece and Spain). Fixed maturity investments in these companies represent approximately $400 million at December 31, 2012, have an average quality rating of BAA and are diversified by industry sector. Financial institutions comprised less than 2% of investments in these companies.

The Company invests in high quality foreign government obligations, with an average quality rating of AA as of December 31, 2012. These investments are primarily concentrated in Asia consistent with the geographic distribution of the international business operations, including government obligations of South Korea, Indonesia, Taiwan

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and Hong Kong. Foreign government obligations also include $167 million of investments in European sovereign debt, including $1 million in countries with the most significant political or economic concerns.

The Company's investment in state and local government securities is diversified by issuer and geography with no single exposure greater than $34 million. The Company assesses each issuer's credit quality based on a fundamental analysis of underlying financial information and does not rely solely on statistical rating organizations or monoline insurer guarantees. As of December 31, 2012, 97% of the Company's investments in these securities were rated A3 or better excluding guarantees by monoline bond insurers, consistent with December 31, 2011. As of December 31, 2012, approximately 63% or $1,538 million of the Company's total investments in state and local government securities were guaranteed by monoline bond insurers, providing additional credit quality support. The quality ratings of these investments with and without this guaranteed support as of December 31, 2012 were as follows:

		As of December 31, 2012	
		Fair Value	
	Quality	With	Without
(In millions)	**Rating**	**Guarantee**	**Guarantee**
State and local governments	Aaa	$ 131	$ 130
	Aa1-Aa3	1,108	1,037
	A1-A3	259	328
	Baa1-Baa3	40	20
	Ba1-Ba3	-	23
	Not available	-	-
TOTAL STATE AND LOCAL GOVERNMENTS		**$ 1,538**	**$ 1,538**

As of December 31, 2012, the Company's investments in other asset and mortgage-backed securities totaling $1,148 million included $508 million of private placement securities with an average quality rating of BAA- that are guaranteed by monoline bond insurers. Quality ratings without considering the guarantees for these other asset-backed securities were not available.

As of December 31, 2012, the Company had no direct investments in monoline bond insurers. Guarantees provided by various monoline bond insurers for certain of the Company's investments in state and local governments and other asset-backed securities as of December 31, 2012 were:

Guarantor	**As of December 31, 2012**
(In millions)	**Indirect Exposure**
National Public Finance Guarantee	$ 1,240
Assured Guaranty Municipal Corp	583
AMBAC	185
Financial Guaranty Insurance Co.	38
TOTAL	**$ 2,046**

Commercial Mortgage Loans

The Company's commercial mortgage loans are fixed rate loans, diversified by property type, location and borrower to reduce exposure to potential losses. Loans are secured by high quality commercial properties and are generally made at less than 75% of the property's value at origination of the loan. In addition to property value, debt service coverage, building tenancy and stability of cash flows are all important financial underwriting considerations. Property type, location, quality, and borrower are all important underwriting considerations as well. The

Company holds no direct residential mortgage loans and generally does not securitize or service mortgage loans.

The Company completed its annual in depth review of its commercial mortgage loan portfolio during the second quarter of 2012. This review included an analysis of each property's year-end 2011 financial statements, rent rolls, operating plans and budgets for 2012, a physical inspection of the property and other pertinent factors. Based on property values and cash flows estimated as part of this review and subsequent portfolio activity, the overall health of the portfolio improved from the 2011 review, consistent with recovery in many commercial real estate markets. The portfolio's average loan-to-value improved to 65% at December 31, 2012, decreasing from 70% as of December 31, 2011, due primarily to increased valuations for the majority of the underlying properties. Valuation changes varied by property type as office properties and apartments demonstrated the strongest recovery, hotel and retail properties showed modest improvement while industrial properties exhibited a decline, indicative of a slower recovery for rental rates and demand. The portfolio's average debt service coverage ratio was estimated to be 1.56 at December 31, 2012, substantially higher than 1.40 as of December 31, 2011, including improvement across all property types.

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Commercial real estate capital markets remain most active for well leased, quality commercial real estate located in strong institutional investment markets. The vast majority of properties securing the mortgages in the Company's mortgage portfolio possess these characteristics. While commercial real estate fundamentals continued to improve, the improvement has varied across geographies and property types. A broad recovery is dependent on continued improvement in the national economy.

The following table reflects the commercial mortgage loan portfolio as of December 31, 2012, summarized by loan-to-value ratio based on the annual loan review completed during the second quarter of 2012.

LOAN-TO-VALUE DISTRIBUTION

	Amortized Cost			% of Mortgage
Loan-to-Value Ratios	**Senior**	**Subordinated**	**Total**	**Loans**
Below 50%	$ 293	$ 62	$ 355	12%
50% to 59%	795	-	795	28%
60% to 69%	679	24	703	25%
70% to 79%	475	14	489	17%
80% to 89%	267	27	294	10%
90% to 99%	102	-	102	4%
100% or above	113	-	113	4%
TOTALS	**$ 2,724**	**$ 127**	**$ 2,851**	**100%**

As summarized above, $127 million or 4% of the commercial mortgage loan portfolio is comprised of subordinated notes that were fully underwritten and originated by the Company using its standard underwriting procedures and are secured by first mortgage loans. Senior interests in these first mortgage loans were then sold to other institutional investors. This strategy allowed the Company to effectively utilize its origination capabilities to underwrite high quality loans, limit individual loan exposures, and achieve attractive risk adjusted yields. In the event of a default, the Company would pursue remedies up to and including foreclosure jointly with the holders of the senior interest, but would receive repayment only after satisfaction of the senior interest.

In the table above, there are two loans in the "100% or above" category with an aggregate carrying value of $47 million that exceed the value of their underlying properties by $5 million. Both of these loans have current debt service coverage of 1.0 or greater, along with significant borrower commitment.

The commercial mortgage portfolio contains approximately 140 loans. Four impaired loans with a carrying value of $125 million are classified as problem or potential problem loans, including two loans totaling $60 million that are current based on restructured terms and two loans totaling $65 million, net of reserves, that are current but full collection of principal is not expected. All of the remaining loans continue to perform under their contractual terms. The Company has $419 million of loans maturing in the next twelve months. Given the quality and diversity of the underlying real estate, positive debt service coverage and significant borrower cash investment averaging nearly 30%, the Company remains confident that the vast majority of borrowers will continue to perform as expected under the contract terms.

Other Long-term Investments

The Company's other long-term investments include $1,166 million 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 its subordinate position in the capital structure of these underlying entities, the Company assumes a higher level of risk for higher expected returns. To mitigate risk, investments are diversified across approximately 80 separate partnerships, and approximately 50 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 7% of the Company's securities and real estate partnership portfolio.

Although the total fair values of investments exceeded their carrying values as of December 31, 2012, the fair value of the Company's ownership interest in certain funds that are carried at cost was less than carrying value by $39 million. Fund investment values continued to improve, but remained at depressed levels reflecting the impact of declines in value experienced predominantly during 2008 and 2009 due to economic weakness and disruption in the capital markets, particularly in the commercial real estate market. The Company expects to recover its carrying value over the average remaining life of these investments of approximately 5 years. Given the current economic environment, future impairments are possible; however, management does not expect those losses to have a material effect on the Company's results of operations, financial condition or liquidity.

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

request from the borrower for restructuring;

principal or interest payments past due by more than 30 but fewer than 60 days;

downgrade in credit rating;

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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.

The Company recognizes interest income on problem bonds and commercial mortgage loans only when payment is actually received because of the risk profile of the underlying investment. The amount that would have been reflected in net income if interest on non-accrual investments had been recognized in accordance with the original terms was not significant for 2012 or 2011.

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

	December 31, 2012			December 31, 2011		
(In millions)	**Gross**	**Reserve**	**Net**	**Gross**	**Reserve**	**Net**
Problem bonds	$ 35	$ (17)	$ 18	$ 40	$ (13)	$ 27
Problem commercial mortgage loans [(1)]	104	(16)	88	224	(19)	205
Foreclosed real estate	29	-	29	34	-	34
TOTAL PROBLEM INVESTMENTS	**$ 168**	**$ (33)**	**$ 135**	**$ 298**	**$ (32)**	**$ 266**
Potential problem bonds	$ 30	$ (9)	$ 21	$ 36	$ (10)	$ 26
Potential problem commercial mortgage loans	162	(7)	155	141	-	141
TOTAL POTENTIAL PROBLEM INVESTMENTS	**$ 192**	**$ (16)**	**$ 176**	**$ 177**	**$ (10)**	**$ 167**

(1)

At December 31, 2012, included $29 million and at December 31, 2011, included $10 million of restructured loans classified in Other long-term investments that were previously reported in commercial mortgage loans.

Net problem investments represent less than 1% of total investments excluding policy loans at December 31, 2012. Net problem investments decreased by $131 million during 2012, primarily due to a substantial paydown on a prior period problem mortgage loan and the subsequent reclassification of the remaining balance of that loan to good standing based on the results of the annual loan review completed during the second quarter of 2012.

Net potential problem investments represent less than 1% of total investments excluding policy loans at December 31, 2012. Net potential problem investments increased by $9 million in 2012, primarily due to the addition of two mortgage loans.

Commercial mortgage loans are considered impaired when it is probable that the Company will not collect all amounts due according to the terms of the original loan agreement. In the above table, problem and potential problem commercial mortgage loans totaling $125 million (net of valuation reserves) at December 31, 2012, are considered impaired. During 2012, the Company recorded a $10 million pre-tax ($7 million after-tax) increase to valuation reserves on impaired commercial mortgage loans. See Note 12 to the Consolidated Financial Statements of this Form 10-K for additional information regarding impaired commercial mortgage loans.

Included in after-tax realized investment gains (losses) were changes in valuation reserves related to commercial mortgage loans and other-than-temporary impairments on fixed maturity securities as follows:

(In millions)	2012	2011
Credit-related [(1)]	$ (13)	$ (18)
Other	(1)	(16)
TOTAL	**$ (14)**	**$ (34)**

(1)

Credit-related losses include other-than-temporary declines in fair value of fixed maturities and equity securities and changes in valuation reserves and asset write-downs related to commercial mortgage loans and investments in real estate entities. There were no credit losses on fixed maturities for which a portion of the impairment was recognized in other comprehensive income.

Investment Outlook

The financial markets continue to be impacted by economic uncertainty in the United States and Europe, however, asset values increased during 2012, reflecting a decrease in market yields. Future realized and unrealized investment results will be impacted largely by market conditions that exist when a transaction occurs or at the reporting date. These future conditions are not reasonably predictable. Management believes that the vast majority of the Company's fixed maturity investments will continue to perform under their contractual terms, and that declines in their fair values below carrying value are temporary. Based on the strategy to match the duration of invested assets to the duration of insurance and contractholder liabilities, the Company expects to hold a significant portion of these assets for the long term. Future credit-related losses are not expected to have a material adverse effect on the Company's financial condition or liquidity.

While management believes the commercial mortgage loan portfolio is positioned to perform well due to its solid aggregate loan-to-value ratio, strong debt service coverage and minimal underwater positions, broad commercial real estate market fundamentals continue to be under stress reflecting a slow economic recovery. Should these conditions remain for an extended period or worsen substantially, it could result in an increase in problem and potential problem loans. Given the current economic environment, future impairments are possible; however, management does not expect those losses to have a material adverse effect on the Company's financial condition or liquidity.

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Market Risk

Financial Instruments

The Company's assets and liabilities include financial instruments subject to the risk of potential losses from adverse changes in market rates and prices. Subsequent to the reinsurance transaction entered into on February 4, 2013 as further discussed in Note 25 to the Consolidated Financial Statements, the Company's 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 the Company's employee pension liabilities.

Foreign currency exchange rate risk of the U.S. dollar primarily to the South Korean won, Euro, British pound, Taiwan dollar, and Turkish lira. An unfavorable change in exchange rates reduces the carrying value of net assets denominated in foreign currencies.

Equity price risk for domestic equity securities and the plan assets of the Company's employee pension plans.

The Company's Management of Market Risks

The Company predominantly relies on three techniques to manage its exposure to market risk:

Investment/liability matching. The Company generally selects investment assets with characteristics (such as duration, yield, currency and liquidity) that correspond to the underlying characteristics of its related insurance and contractholder liabilities so that the Company can match the investments to its obligations. Shorter-term investments support generally shorter-term life and health liabilities. Medium-term, fixed-rate investments support interest-sensitive and health liabilities. Longer-term investments generally support products with longer pay out periods such as annuities and long-term disability liabilities.

Use of local currencies for foreign operations. The Company generally conducts its international business through foreign operating entities that maintain assets and liabilities in local currencies. While this technique does not reduce the Company's foreign currency exposure of its net assets, it substantially limits exchange rate risk to those net assets.

Use of derivatives. The Company generally uses derivative financial instruments to minimize certain market risks.

See Notes 2(C) and 13 to the Consolidated Financial Statements for additional information about financial instruments, including derivative financial instruments.

Effect of Market Fluctuations on the Company

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 debt and, in 2011, GMIB contracts;

a hypothetical strengthening of the U.S. dollar to foreign currencies, primarily for the net assets of foreign subsidiaries denominated in a foreign currency; and

a hypothetical decrease in market prices for equity exposures, primarily for equity securities and, in 2011, GMIB contracts.

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 the Company's financial instruments, subject to the exclusions noted above (particularly insurance liabilities), would have been as follows as of December 31(the effects of the GMIB business are presented as though the Company's 2013 reinsurance agreement was effective as of December 31, 2012):

	Loss in fair value	
Market scenario for certain non-insurance financial instruments ***(in millions)***	**2012**	**2011**
100 basis point increase in interest rates	$ 685	$ 575
10% strengthening in U.S. dollar to foreign currencies	$ 275	$ 220
10% decrease in market prices for equity exposures	$ 10	$ 30

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, 2012 was greater than that

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at December 31, 2011 reflecting the reinsurance of the remaining net GMIB liability in 2013.

The effect of a hypothetical strengthening of the U.S. dollar relative to the foreign currencies held by the Company was estimated to be 10% of the U.S. dollar equivalent fair value. The Company's foreign operations hold investment assets, such as fixed maturities, cash, and cash equivalents, that are generally invested in the currency of the related liabilities. Due to the increase in the fair value of these investments in 2012, that are primarily denominated in the South Korean won, the effect of a hypothetical 10% strengthening in U.S. dollar to foreign currencies at December 31, 2012 was greater than that effect at December 31, 2011.

In 2012, the primary effect of a hypothetical decrease in the market prices of equity exposures was a 10% decrease in the value of equity securities reported as investment assets because the equity exposures of the Company's GMIB contracts were significantly reduced by the 2013 reinsurance agreement.

In 2011, the effect of a hypothetical decrease in the market prices of equity exposures was estimated based on a 10% decrease in mutual fund values underlying GMIB contracts and the equity futures contracts used to partially hedge these GMIB equity exposures, as well as the value of equity securities held by the Company.

As noted above, the Company manages its exposures to market risk by matching investment characteristics to its obligations.

Cautionary Statement for Purposes of the "Safe Harbor" Provisions of the Private Securities Litigation Reform Act of 1995

Cigna Corporation and its subsidiaries (the "Company") and its representatives may from time to time make written and oral forward-looking statements, including statements contained in press releases, in the Company's filings with the Securities and Exchange Commission, in its reports to shareholders and in meetings with analysts and investors. Forward-looking statements may contain information about financial prospects, economic conditions, trends and other uncertainties. These forward-looking statements are based on management's beliefs and assumptions and on information available to management at the time the statements are or were made. Forward-looking statements include, but are not limited to, the information concerning possible or assumed future business strategies, financing plans, competitive position, potential growth opportunities, potential operating performance improvements, trends and, in particular, the Company's strategic initiatives, litigation and other legal matters, operational improvement initiatives in the health care operations, and the outlook for the Company's full year 2013 and beyond results. Forward-looking statements include all statements that are not historical facts and can be identified by the use of forward-looking terminology such as the words "believe", "expect", "plan", "intend", "anticipate", "estimate", "predict", "potential", "may", "should" or similar expressions.

By their nature, forward-looking statements: (i) speak only as of the date they are made, (ii) are not guarantees of future performance or results and (iii) are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Therefore, actual results could differ materially and adversely from those forward-looking statements as a result of a variety of factors. Some factors that could cause actual results to differ materially from the forward-looking statements include:

1. health care reform legislation, as well as additional changes in state or federal regulation, that could, among other items, affect the way the Company does business, increase costs, limit the ability to effectively estimate, price for and manage medical costs, and affect the Company's products, services, market segments, technology and processes;

2. adverse changes in state, federal and international laws and regulations, including increased medical, administrative, technology or other costs resulting from new legislative and regulatory requirements imposed on the Company's businesses;

3. risks associated with pending and potential state and federal class action lawsuits, disputes regarding reinsurance arrangements, other litigation and regulatory actions challenging the Company's businesses, including disputes related to payments to health care professionals, government investigations and proceedings, tax audits and related litigation, and regulatory market conduct and other

reviews, audits and investigations, including the possibility that the acquired HealthSpring business may be adversely affected by potential changes in risk adjustment data validation audit and payment adjustment methodology;

4. challenges and risks associated with implementing improvement initiatives and strategic actions in the ongoing operations of the businesses, including those related to: (i) growth in targeted geographies, product lines, buying segments and distribution channels, (ii) offering products that meet emerging market needs, (iii) strengthening underwriting and pricing effectiveness, (iv) strengthening medical cost results and a growing medical customer base, (v) delivering quality service to members and health care professionals using effective technology solutions, and (vi) lowering administrative costs;

5. the unique political, legal, operational, regulatory and other challenges associated with expanding our business globally;

6. challenges and risks associated with the successful management of the Company's outsourcing projects or key vendors;

7. the ability of the Company to execute its growth plans by successfully leveraging capabilities and integrating acquired businesses, including the HealthSpring businesses by, among other things, operating Medicare Advantage plans and HealthSpring's prescription drug plan, retaining and growing the customer base, realizing revenue, expense and other synergies, renewing contracts on competitive terms or maintaining performance under Medicare contracts, successfully leveraging the information technology platform of the acquired businesses, and retaining key personnel;

8. risks associated with security or interruption of information systems, that could, among other things, cause operational disruption;