CUSTOMER

TRANSPARENCY

REPORT 2025

ABOUT THIS REPORT

The Cigna Group® is a global health company with a mission to improve the health and vitality of those we serve. Through Evernorth Health Services® (“Evernorth”) and Cigna Healthcare℠, our two growth platforms—our global team of talented colleagues works tirelessly to deliver on our mission, every day.

We know the health care system is not working for everyone. Costs and demand have increased while consumer sentiment about the health care industry has declined. This caused us to take a step back in early 2025, assess the role The Cigna Group plays, and challenge ourselves to make it better. We conducted research and listened closely to the unfiltered comments of health care customers and clients. The feedback drove us to confront many of the challenges that people face when they navigate the health care system.

From that came our pledge to a multi-year effort to improve the health care experience: Our Commitments to Better. Each of our five commitments is backed by real actions that we will measure over time. While we know system-wide change won’t happen overnight, we are determined to continue to make progress.

LETTER FROM LEADERSHIP

For more than 230 years, The Cigna Group has been dedicated to serving others. Though our role has evolved over time, our purpose has remained the same: supporting individuals and families during key moments of their lives. Today, we are focused on leading the industry in driving sustainable change in health care for the benefit of all.

Let's be candid: When large companies publish reports like this, they can sometimes feel more self-affirming than self-reflective. That is not our intent. Our goal is to lift the veil—to be transparent, to invite scrutiny, and to hold ourselves and our industry to a higher standard.

The reality is that the U.S. health care system is not working the way it should. Today, our system rewards volume over outcomes. It intervenes too late instead of helping people stay well. It remains complex, expensive, and difficult to navigate—far more than consumers would tolerate in almost any other industry. Innovation has accelerated, but too often the result has been higher costs, not better experiences. It can and should work better to help each individual access and afford the care they need.

We are not observers of these shortcomings as we experience them, too. We are parents, spouses, children, caregivers, and patients, and like those we serve, we navigate friction and frustration in the system we rely on to support our physical and mental health. That shared experience is one reason we believe incremental change is no longer sufficient.

Knowing the health care system can—and must—improve, in early 2025 we introduced our Commitments to Better. Those commitments reflect a clear point of view: The status quo is unacceptable, and meaningful change requires accountability, not aspiration alone.

This Customer Transparency Report is part of that accountability. A first of its kind report, it includes metrics and data that The Cigna Group has not previously published. Some of these data points reflect meaningful progress. Others remain further from where we expect—and need—them to be. Where the data reveals gaps or shortcomings, it also points directly to where improvement is possible and necessary.

LETTER FROM LEADERSHIP

We are committed to being different in how we operate and how we hold ourselves accountable. That commitment shows up in action:

- We are **growing our digital and analytics capabilities** to better personalize the health care experience for each and every individual. This includes helping patients use their preferred communication channels to better connect individuals with the care they need, when they need it—and where they want it, including virtual care.
- We are **improving the prior authorization experience** to better support patients by delivering faster decisions, helping patients track their status digitally, and providing personalized support while redesigning coverage and care models to encourage better health, not just treatment.
- And **we will continue to lead the way in meaningful innovations to improve affordability**. This includes new approaches to lower costs across the health care journey for individuals and those that provide their health benefits, coordinating care to reduce fragmentation, and rewarding outcomes over volume.

This is not business as usual for our company. Transformation at this scale requires publishing data that invites scrutiny, acknowledging where progress is uneven, and committing to sustained efforts over time. It requires partnership and ongoing engagement with consumers.

Health care can—and must—work better than it does today. Transparency and accountability are not solutions by themselves, but they are necessary starting points. We are publishing this report in that spirit and invite you to hold us to the standards we are setting for ourselves.

BRIAN EVANKO
President and Chief Operating Officer,
The Cigna Group

DR. AMY FLASTER
Chief Medical Officer,
The Cigna Group

OUR COMMITMENTS TO BETTER

1. EASIER ACCESS TO CARE

We committed to helping our customers by making our processes simpler, easier, and faster.

Prior authorization is an important checkpoint to verify health coverage for certain procedures, treatments, and complex services before care is received. To speed the process for our Cigna Healthcare customers, we committed to:

- Investing resources to help more of our customers quickly resolve administrative issues with prior authorization and post-care claims.
- Introducing an enhanced digital status tracker so patients get faster and clearer updates about prior authorizations.
- Encouraging providers to submit prior authorizations electronically to simplify the process, expedite approvals, and reduce errors.

2. BETTER SUPPORT

We committed to providing our customers enhanced support and resources so they can navigate the health care system with greater ease and peace of mind.

- We pledged to expand our team of Care Advocates[1] to help Cigna Healthcare customers who face the most challenging or complex conditions, such as cancer. These highly trained advocates will care for more of our patients and help them navigate every stage of their treatment journey.

3. BETTER VALUE

We committed to provide better value for our customers and patients.

- The price of medications has skyrocketed, and Express Scripts® Pharmacy Benefit Services, part of Evernorth Health Services, works to lower them. Through our negotiations with drug manufacturers, about 82% of our pharmacy benefit customers spend less than $250/year out of pocket for their long-term prescriptions.[2]
    - To help lower costs for more of our customers, we committed to ensure that the savings we generate on prescription drugs translates into even lower prices at the pharmacy checkout.
    - We also committed to providing our customers a personalized year-end pharmacy benefit statement, detailing their annual benefit savings.

4. ACCOUNTABILITY

We committed to standing behind our commitments to our customers.

- To ensure that our priorities are unmistakably aligned, we tied more of our leaders' compensation to improving the satisfaction of our customers.

5. TRANSPARENCY

We committed to providing public information on how we are continuously improving to serve our customers better.

- We promised to publish an annual Customer Transparency Report that would detail the progress we made against our Commitments to Better, including important information relating to how we facilitate customer care and details about our services, data, and resolution statistics. We committed to publishing the first report in early 2026, based on our efforts in 2025.

  This is that report—the first of its kind in our industry. We are proud to provide a clear assessment of the progress we've made toward our commitments and goals. Our promise to our customers, our partners, and others, is that it will not be our last.

HOW WE LEAD

Health care affordability is one of the defining challenges of our time. At The Cigna Group, we're leading the way in making care more affordable by increasing access to preventive care, coordinating services around patient needs, and increasing transparency so everyone understands how every health care dollar is spent.

THE HEALTH CARE ENVIRONMENT

Change in any system starts with understanding it to address the underlying drivers. The U.S. health care system is under unprecedented pressure from many different directions, driving costs upwards and negatively affecting the quality and availability of care. For example, since 2000, the cost of hospital services has increased more than 220%.[3]

Health care in the U.S. is largely oriented toward treating illness rather than preventing it. As the incidence of chronic conditions rises and the need for behavioral health intensifies, care is too often delivered piecemeal and late, resulting in fragmented medical experiences and avoidable costs. In many markets, prevention and sustained engagement are still the exception and not the rule, as payment arrangements reward volume rather than outcomes. Customers become frustrated, care teams become strained, and resources become diverted from affordable, timely, and effective interventions.

At the same time, rapid advances in pharmaceuticals, including GLP-1 medications and a growing pipeline of specialty and biologic therapies, deliver meaningful, but increasingly more expensive, clinical promise. Launch prices for many new brand-name medicines have escalated—with the median list price of newly launched drugs around $370,000 in 2024[4] (vs. roughly $2,000 in 2008).[5] Moreover, delays in competition from generics and biosimilars can keep prices higher for longer. Those changes in the pricing dynamic make budgeting and cost control more difficult than ever.

THE HEALTH CARE ENVIRONMENT

Customer expectations also affect affordability and access. People increasingly expect health care interactions to match the clarity and convenience of other consumer interactions, and in many ways, they are getting it. The health care industry's rapid adoption of digital tools and artificial intelligence underscores a broad push toward easier, more transparent experiences. However, at the same time that demand is growing with an aging population and a higher prevalence of chronic disease, the health care system faces increasing physician burnout, with persistent staffing shortages and constrained access to care.

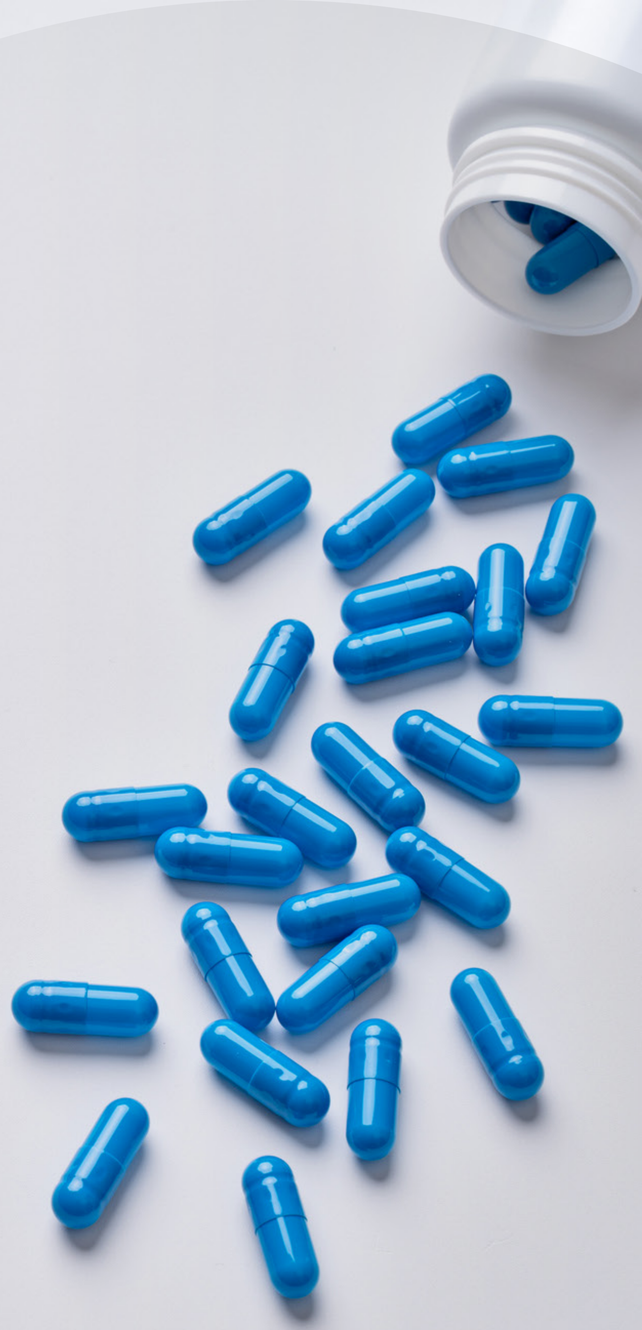
Together, these forces—reactive care, rapid drug innovation and cost pressure, rising customer expectations, and ongoing workforce constraints—signal a system under stress. Sustained progress will depend on greater transparency, earlier intervention, data-driven coordination, and the responsible adoption of technology. But equally important, it will depend on realigning payment with outcomes rather than volume and ensuring effective competition where it demonstrably lowers costs and improves value.

HELPING MAKE CARE MORE AFFORDABLE FOR THOSE WE SERVE

At The Cigna Group, we:

- Negotiate lower costs for medical services and prescription drugs than individuals or employers could achieve on their own—helping the U.S. achieve some of the lowest prices for generics in the world[6]
- Design lists of doctors, hospitals, pharmacies (provider and pharmacy networks), and medications (drug formularies) to ensure that patients receive high-quality, lower-cost care
- Coordinate care across medical, behavioral, and pharmacy services to reduce fragmentation and avoid duplicate or unnecessary use of resources
- Build incentives promoting a culture of health, engagement, and wellness to support healthier choices and health literacy
- Advance value-based payment models that reward outcomes rather than volume of services
- Process claims and payments efficiently across a complex supply chain. In fact, of the approximately 155 million medical claims that were processed by Cigna Healthcare in 2025,[7] approximately 95% were approved and paid[8]

These functions are essential in a fragmented system; without them, patients and employers would face even higher costs and inconsistent quality of care.



REDUCE HEALTH CARE WASTE

Prior authorizations are advance approvals for complex or expensive procedures; they seek to ensure that care is safe, medically necessary, and covered by a patient's health plan—while also helping avoid unnecessary services and costs. Prior authorizations can help:

- Ensure patients have undergone the right tests to get an accurate diagnosis in accordance with standard medical guidelines
- Avoid potentially dangerous medication combinations
- Avoid prescribed treatments that are unneeded or that could be addictive
- Guide patients to lower-cost alternatives

Our approach is grounded in evidence-based clinical policies and standards, with oversight by our more than 3,000[9] clinical colleagues at The Cigna Group: nurses, pharmacists, social workers, therapists, and physicians. Additionally, approximately 50% of patients who are prescribed chronic care medications do not follow their treatment plans consistently.[10] Evernorth provides support essential to helping people take their medications as prescribed, reducing the waste of unsuccessful treatment, and improving outcomes. Evernorth also provides robust clinical support, which includes thousands of safety checks that help prevent harmful drug interactions, flags allergies, and ensures that medications are taken correctly.

HOW WE SERVE OUR CUSTOMERS AND HOW WE ARE COMPENSATED

Our financial model is built around a simple idea: **When we improve outcomes and lower total health care costs, our customers and clients benefit—and so do we.**

Our combined pharmacy and medical benefit capabilities help us to create solutions that improve predictability, affordability, and transparency. Our focus helps us anticipate needs, accelerate innovation, and provide personalized experiences for customers and patients at scale—and ensures clear alignment with the value we deliver. As a result, today we are privileged to serve millions of employers, government agencies, health plans, customers, and patients.

To break down the value we deliver further, we:

1. **Create access to the right care, at the right time.** We support access to safe, affordable, and high-quality care, services, and medications through a variety of network and formulary options, securing better prices for care than our customers or clients could secure on their own.

2. **Deliver clinical programs that improve health and safety.** Our teams leverage evidence-based clinical solutions that enhance quality, drive better adherence and prevention, and ensure a safer experience for customers and patients.

3. **Enable the day-to-day administration of health care.** From claims processing to benefits administration, we support the essential transactions that allow the system to function smoothly and predictably.

4. **Share accountability for cost and outcomes.** Whether through fully insured products or innovative value-based solutions like Embarc Benefit Protection®[11] and Evernorth EncircleRx℠,[12] we step in to share and manage risk responsibly.

The sections that follow explain how this value translates into compensation across The Cigna Group. The connecting thread is simple: **our incentives are aligned to improving health outcomes and creating value.**

HOW WE SERVE OUR CUSTOMERS AND HOW WE ARE COMPENSATED

Evernorth Health Services

Evernorth Health Services primarily earns revenue by providing pharmacy benefit and specialty and care services to clients—including employers, government organizations, and health plans. In providing these services, we help clients manage the rising cost from manufacturers of prescription drugs while ensuring that people get the medications they need, safely, and when they need them. To meet the diverse needs of our clients, Evernorth offers a variety of payment choices, including administrative fees, value sharing arrangements such as discounts, or a combination of both. We also offer fee-for-service clinical solutions, such as drug utilization management and medication adherence counseling to identify and address potentially unsafe or wasteful prescribing, dispensing, and utilization of prescription drugs; as well as communicate with—or support communications with—physicians, pharmacies, and patients.

Evernorth's Pharmacy Benefit Services drives high-quality, cost-effective services including drug claim adjudication, retail pharmacy network administration, benefit design consultation, drug utilization review, drug formulary management, and access to our home delivery pharmacy. Our pharmacy benefits business performs the following services:

- Negotiating discounts with drug manufacturers to deliver value to clients
- Curating and managing pharmacy networks
- Formulary design and management led by clinical evidence-based guidelines
- Thousands of drug safety and clinical checks at the point of dispensing
- Operating clinical programs that improve safety and prevent waste
- Dispensing medications through our home delivery pharmacy

Evernorth's Specialty and Care Services provides specialty medications for the treatment of complex and rare diseases, specialty distribution of pharmaceutical and medical supplies, as well as clinical programs to help drive better whole-person health outcomes. Our specialty business performs the following services:

- Dispensing specialty medications safely and efficiently
- Providing high-touch clinical support to patients
- Supporting whole-person health by addressing not just clinical needs but social, behavioral, and financial challenges
- Coordinating with providers
- Ensuring therapies are used in the most effective and affordable settings

Our clients choose our company to access our best-in-class clinical expertise, for our access to life-changing drugs, and for our ability to effectively care for patients in every step of their journey. We also offer home infusion services to patients with quality clinical care in the convenience and comfort of their home. We verify benefits, provide medication, and arrange nurse visits as needed.

Evernorth's Specialty & Care Services business also receives fees for services provided to more than 12,000 health care professionals distributing some of the most complex and critical medications to their facilities.[13]

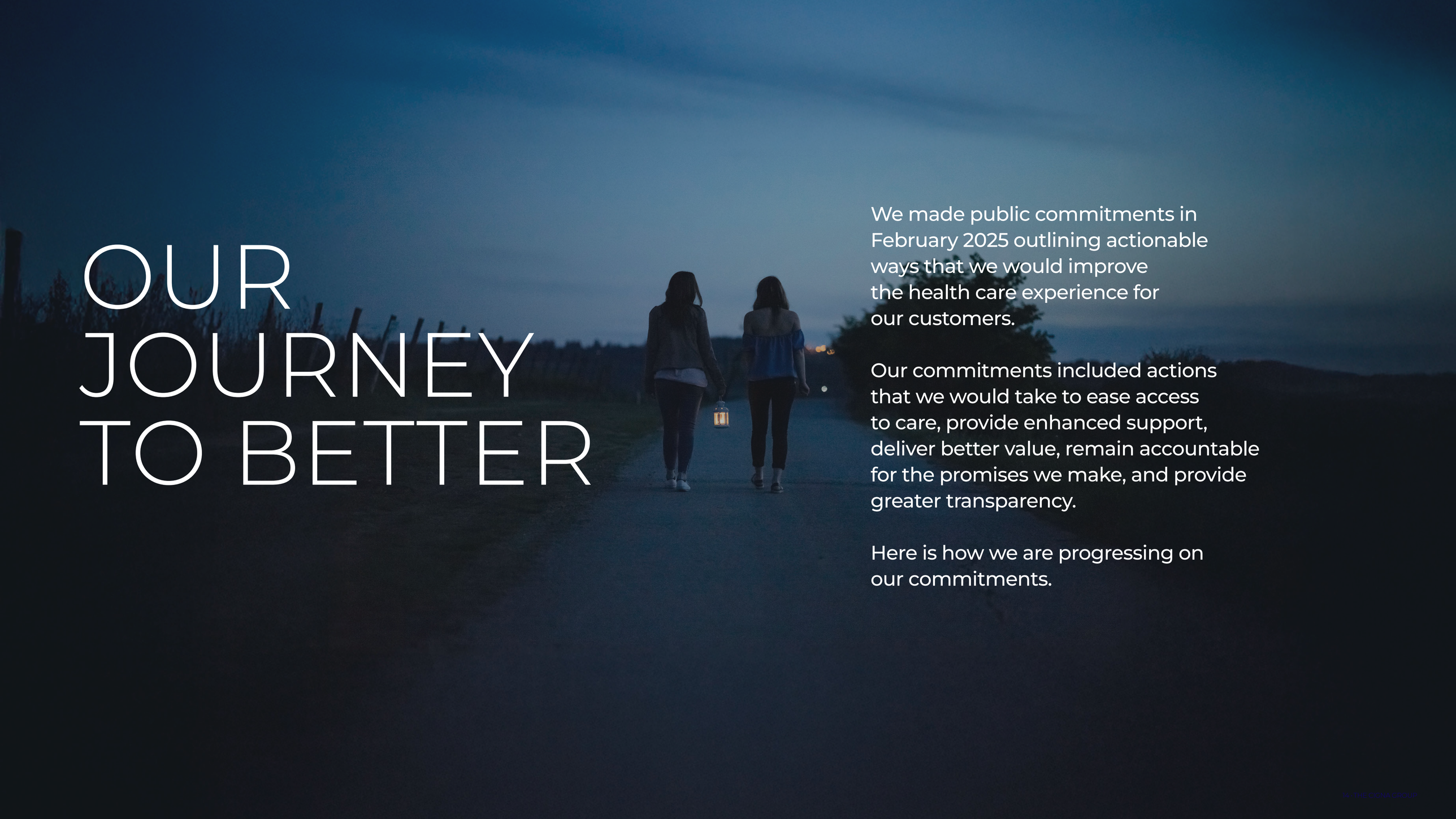
HOW WE SERVE OUR CUSTOMERS AND HOW WE ARE COMPENSATED

Cigna Healthcare

Cigna Healthcare earns revenue primarily through premiums and service fees from employers (inclusive of governmental organizations) and individuals who choose our health plans. Most medical customers— approximately 79%—receive coverage through employers that self-fund their health care.[14] In other words, these employers do not buy health insurance from Cigna Healthcare—but instead fund health care for employees and their families. The other approximately 21% of membership belongs to employers or individuals who pay monthly or annual premiums to insure the cost of care.[14]
Our profitability reflects what remains after we account for health care costs, service delivery, and clinical operations and administration. In both cases, Cigna Healthcare provides access to our participating provider networks and other services to help employers manage health care costs, coordinate care, and improve health outcomes.

Our most effective and affordable model brings together our medical, behavioral, and pharmacy benefits offerings. When an employer chooses this model, we can better support a patient's care—reducing duplicate services, avoiding unnecessary care, and ensuring medications and treatments work hand-in-hand. This approach consistently produces better health outcomes and meaningfully lowers total medical costs for employers and their employees.

OUR JOURNEY TO BETTER



We made public commitments in February 2025 outlining actionable ways that we would improve the health care experience for our customers.

Our commitments included actions that we would take to ease access to care, provide enhanced support, deliver better value, remain accountable for the promises we make, and provide greater transparency.

Here is how we are progressing on our commitments.

EASIER ACCESS TO CARE

We believe that our customers should be able to get the care they need when they need it, without delays or barriers.

Our efforts to enable access to care have been undertaken alongside our efforts to reduce health care waste, through tools like prior authorization (see page 10). In 2025, less than 6% of Cigna Healthcare and Express Scripts customers went through our prior authorization process,[15] and less than 2% of customers had a prior authorization that resulted in a denial.[16]

We also know that when it comes to health care, time is critical; that is why we have committed to making our prior authorization processes simpler, easier, and faster.

We have made meaningful progress.

Reducing Prior Authorizations: Over the past year, we reduced paperwork and the time providers and patients spend obtaining approvals for more routine services by removing 345 tests, procedures, and services[17] from the Cigna Healthcare U.S. prior authorization process. This change has decreased the volume of medical prior authorizations by approximately 521,000 (about 15%).[18]

In addition, in 2025 we were pleased to begin a partnership with America's Health Insurance Plans (AHIP), the U.S. Department of Health and Human Services (HHS), and industry peers to streamline, simplify, and reduce prior authorization by:[19]

- Standardizing electronic submissions
- Cutting prior authorization volume
- Honoring existing approvals during changes in insurance to ensure continuity of care
- Boosting real-time approvals

345[17]

tests, procedures, and services removed from the Cigna Healthcare U.S. prior authorization process.

Approximately

521,000[18]

fewer prior authorizations year over year.

EASIER ACCESS TO CARE

Electronic Communications: Today, nearly 65% of medical prior authorization requests are submitted electronically to Cigna Healthcare, an increase of 3.7% year over year.[20] One reason for this increase is due to the work we've done to enable more complex medical prior authorization requests to be submitted electronically, speeding decisions and reducing errors.

Starting in the fourth quarter of 2025, we enhanced our web portal to allow for nearly all medical prior authorization requests to be submitted online. Providers can now digitally check requirements, submit requests, view status, and add documents. The update is designed to streamline the provider experience, cut down on manual processes, and help patients get care more quickly.

Improved Turnaround Times: We continue to focus on making decisions faster; in 2025, 80% of Cigna Healthcare U.S. medical prior authorizations were approved in one day or less.[21] More than half of the submissions submitted electronically were approved within minutes.[22]

80%[21]

of Cigna Healthcare U.S. prior authorization decisions were approved within 24 hours.

Approximately

53%[22]

of Cigna Healthcare U.S. prior authorizations submitted electronically were approved within minutes.

EASIER ACCESS TO CARE

More Customer Support: Over the past year, we've strengthened our customer support, creating distinct teams to help customers navigate their health care and pharmacy benefits. We expanded a special high-touch support team solely dedicated to medical prior authorizations. Team members are available to help clarify and navigate particularly difficult prior authorization decisions, reducing the administrative burdens on customers.

We also formed a similar high-touch post-care medical claim team at Cigna Healthcare, made up of highly trained staff dedicated to helping customers who face complex and often expensive claims that arrive after care has been received. These advocates partner with customers and their provider team to help them understand the actions necessary for appropriate resolution.

Our high-touch advocate teams helped approximately 155,000 medical customers with prior authorization and post-care claim processes in 2025, 79% more customers than the year prior.[23]

Digital Status Tracker: In June 2025, we launched a medical prior authorization status tracker for Cigna Healthcare. This new tool shows timely updates and provides answers to frequently asked questions, as well as information on decisions and next steps. It's available to every Cigna Healthcare customer through our myCigna® platform that's used by 79% of customers.[24]

BETTER SUPPORT

The health care system is fragmented and complicated.
We believe that everyone deserves support to navigate it effectively.

These are the steps we took in 2025 to enhance the support we provide customers:

Expanded Care Advocates: We have grown our team of highly trained care advocates to help patients facing the most challenging or complex conditions, such as cancer. The Cigna Healthcare My Personal Champion® program is a group of dedicated single-point-of-contact advocates that delivers personalized guidance and support across customers' entire health care journey. The advocates educate patients about their health plan coverage, assist with prior authorizations, review claims, and help guide them to the right care.

Personal Champions have made a significant difference for patients, earning a 98% satisfaction rating from the customers they help based on survey responses.[25]

Expanded Care Support: Accredo®, Evernorth's specialty pharmacy, launched Accredo Smart Path℠, a new service model that helps anticipate the needs of patients. Using data and insights from our call centers to identify patients who may need extra support, Smart Path lets us reach out to them early and proactively. Since we launched Smart Path, customer service escalations have been reduced by 16%.[26]

Personal Champion customer satisfaction rating

98%[25]

from the customers they helped.

BETTER SUPPORT

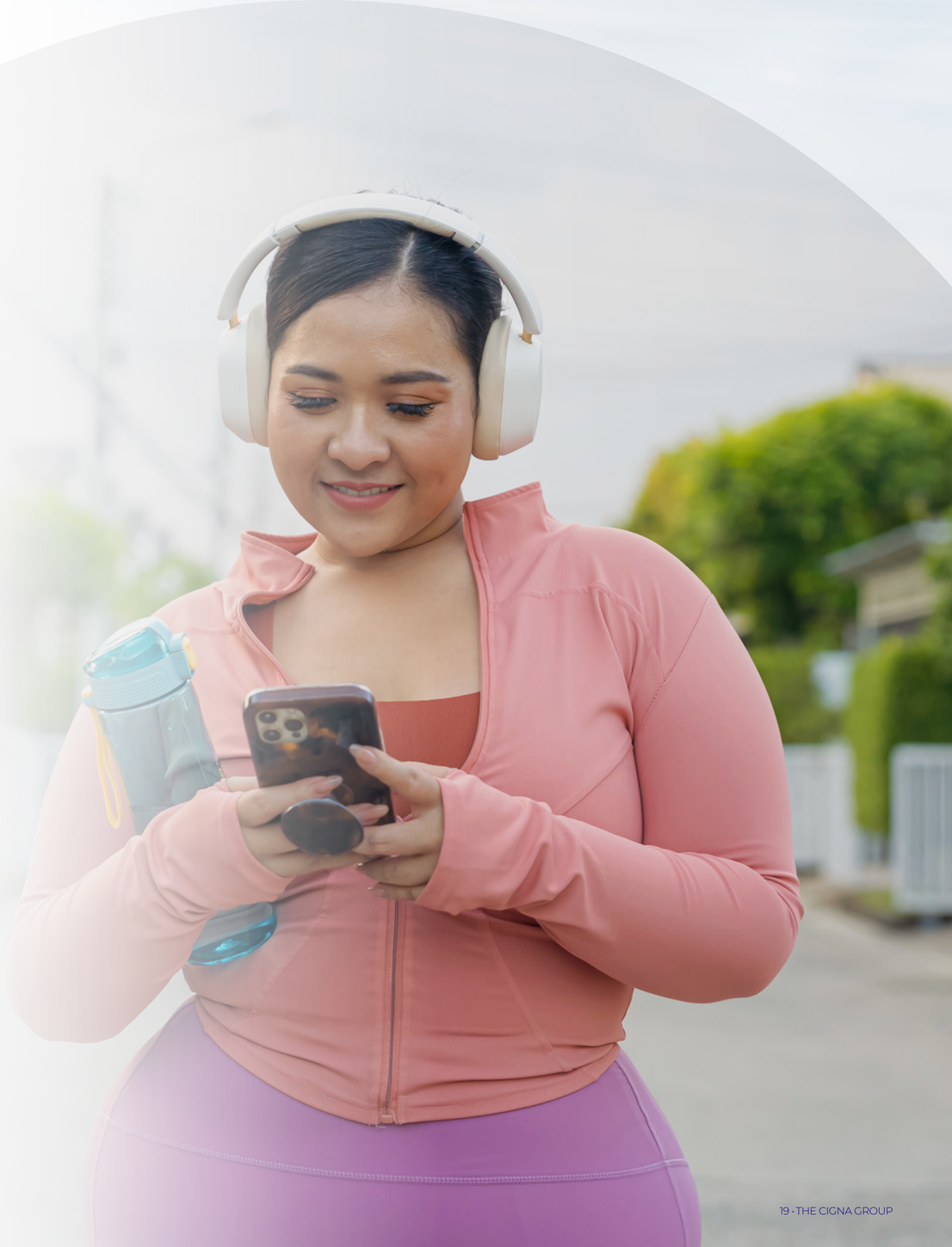
Expanded Treatment Support: We created Evernorth Therapy Link℠ to help identify patients who might benefit from advanced gene or cell therapy treatments that can potentially cure or dramatically improve serious diseases by altering genes or replacing damaged cells. Because these therapies have manufacturer prices that are very expensive (often $900,000 to $4 million[27]), Therapy Link also offers support to make the treatments more affordable and manageable, helping coordinate care and guiding patients through the complicated treatment process.

Additionally, we created a new specialized pharmacy dedicated to patients taking GLP-1 medications, providing them with enhanced clinical support including dose management, adherence monitoring, educational resources, and more.[28]

Expanded Navigation Support: To help customers better understand their care and benefits, Cigna Healthcare created a virtual assistant that translates coverage and claims information into clear, conversational, and personalized language.[29] If they need more help, the virtual assistant connects customers directly to a customer service advocate. This innovation also helps customers get access to the right care faster through our new proprietary matching tool that gives customers a tailored list of in-network providers and delivery methods based on their specific needs.

We also simplified the Express Scripts patient portal to improve our customers' experience regarding their medication. There are now clearer navigation tools, proactive and guided recommendations, and coverage, cost, and savings information personalized for each customer.

Expanded Virtual Care Support: Through Evernorth's virtual care service MD Live, we launched MD Live Preventive Health Screening to enable providers on the platform to order tests and screenings, instantly check patients' health plan coverage and eligibility, submit and schedule an order, and seamlessly submit a claim.



BETTER VALUE

We believe that everyone deserves quality care at an affordable price. With prescription drug costs being a growing driver of U.S. health care spending,[30] we continued our advocacy for lower prices in 2025. That meant delivering even more of the savings we generate on prescription drugs to our customers at the pharmacy counter.

Lowering Out-of-Pocket Costs: In 2025, Evernorth announced a new protection benefit to help reduce out-of-pocket costs for more of our customers, particularly those with high-deductible health plans. To ensure they always pay the lowest price available for both brand-name and generic medications, Evernorth automatically compares the negotiated-discount price, the cash-discount price, the drug manufacturer's direct-to-consumer price (if available), and the customer's copay. Eligible customers will pay the lowest available price at the pharmacy counter.

While the Evernorth-negotiated price is typically the lowest, other prices may be lower in some cases, especially for people with high-deductible health plans.

In 2027, Evernorth is beginning to transition to a new, standard pharmacy benefits model that cuts out post-purchase cost-savings processes and makes the lowest price of the drug readily available and transparent from the start.

Evernorth leverages technology to automatically compare multiple pricing options and charge the lowest cost at the pharmacy counter.

For example, a medication may have four potential prices:

An Evernorth negotiated price of	A cash discount price of	A drug company's "direct-to-consumer" price of	A copay of
$20	**$22**	**$50**	**$25**

In this case, our customers will pay **the Evernorth negotiated price of $20.**

BETTER VALUE

Transparent Annual Savings: Demonstrating the value of pharmacy benefits for customers, Evernorth Health Services announced in 2025 that it will provide customers with more information about their drug spend and drug costs. Beginning in 2026, customers will have access to a personalized, itemized statement detailing their 2025 pharmacy benefit savings, including negotiated savings with discounts and rebates secured on their behalf.

Providing Additional Assistance for Customers with Greater Needs: Our Accredo specialty pharmacy launched a partnership with TailorMed to help eligible patients seamlessly sign up for and manage copay assistance for certain drugs. We also started Accredo Care Equity, an internal program that works to mitigate barriers to health care, such as affordability challenges and transportation issues.

ACCOUNTABILITY

We believe that everyone deserves a health care partner who keeps their word and that accountability flows from the top.

That's why in 2025, more of our leaders' compensation incorporated customer experience measures, including a globally recognized customer advocacy metric known as Net Promoter Score (NPS). This methodology measures customer loyalty by asking how likely our customers are to recommend a company, product, or service.

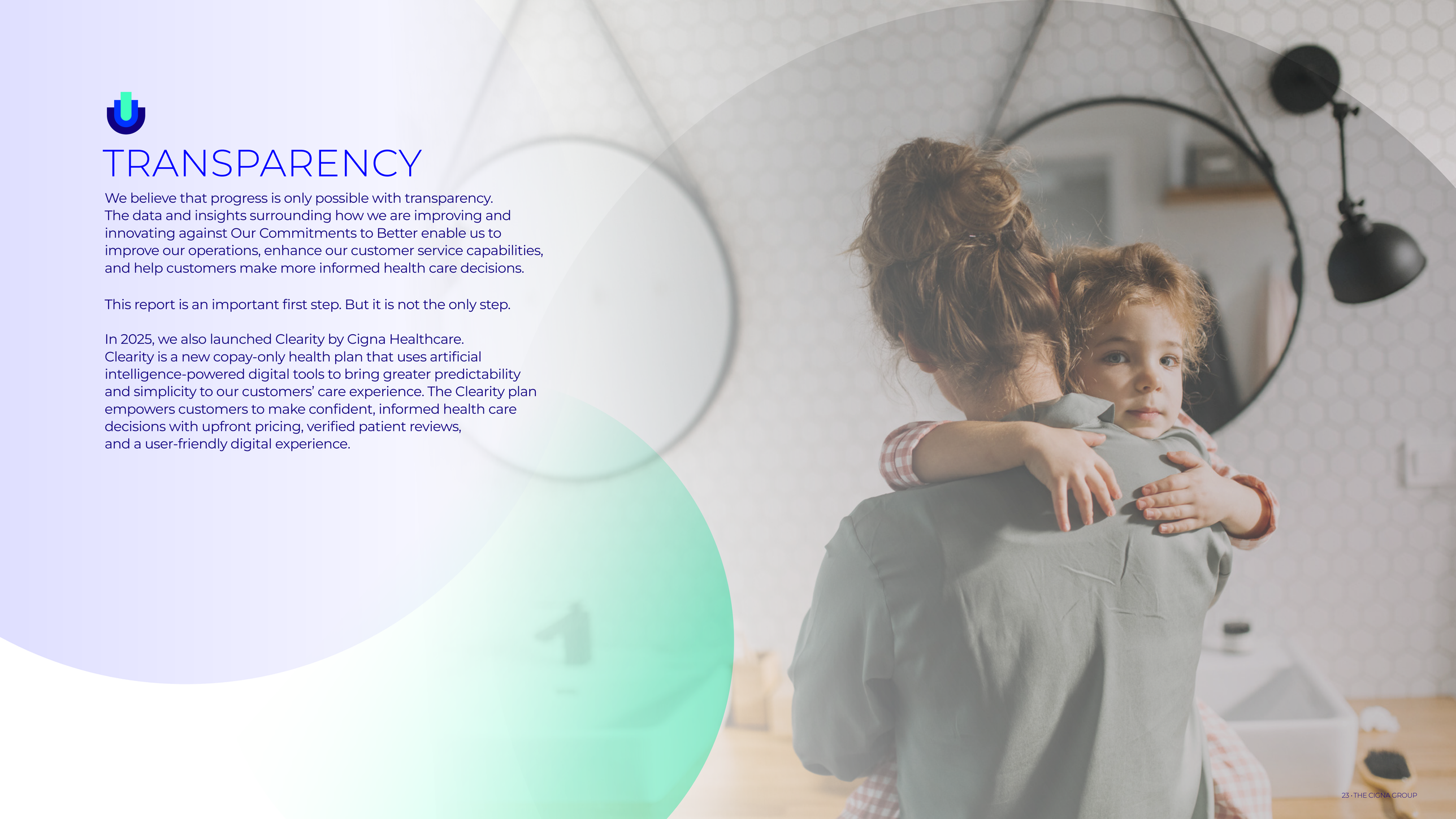
The Cigna Group's score as an organization increased in 2025 versus 2024.[31] While we are proud to have made incremental progress, we know there will always be more we can do.

TRANSPARENCY

We believe that progress is only possible with transparency. The data and insights surrounding how we are improving and innovating against Our Commitments to Better enable us to improve our operations, enhance our customer service capabilities, and help customers make more informed health care decisions.

This report is an important first step. But it is not the only step.

In 2025, we also launched Clearity by Cigna Healthcare. Clearity is a new copay-only health plan that uses artificial intelligence-powered digital tools to bring greater predictability and simplicity to our customers' care experience. The Clearity plan empowers customers to make confident, informed health care decisions with upfront pricing, verified patient reviews, and a user-friendly digital experience.



OUR CONTINUING COMMITMENT

At The Cigna Group, we are acutely aware that this report represents only the beginning of a long journey. With this report, we hope to continue to lead the way for our industry and to renew the commitments we made in 2025: easier access to care, better support, better value, accountability, and transparency.

The health care system is far from perfect, and we are dedicated to driving its transformation. Meaningful change is not simple. It will take time and sustained effort. Progress will not necessarily be as fast or as consistent as we would like, which is all the more reason to rededicate ourselves.

Health care is deeply personal. For many Americans, interactions with the system happen during moments of stress or vulnerability. As leaders in the health care industry, we are committed to being part of the solution, working tirelessly to improve our systems, our operations, and most importantly, the lives of the millions of Americans who depend on us every day.

DISCLAIMER

The Cigna Group makes no warranty, express or implied, with respect to any of the information contained in this Customer Transparency Report, including, without limitation, information obtained from third parties. Some of the information contained herein may have not been independently verified or assured by The Cigna Group or any third party. The Cigna Group does not accept any responsibility for the use of or reliance on the content of such information. The information contained in this Customer Transparency Report may change at any time without notice. The Cigna Group does not have any responsibility to update this Customer Transparency Report to account for any such changes.

Note on Forward-Looking Statements

This Customer Transparency Report contains forward-looking statements (within the meaning of the Private Securities Litigation Reform Act of 1995) that are subject to risks and uncertainties. Forward-looking statements are based on The Cigna Group's current expectations and projections about future trends, events and uncertainties. Forward-looking statements may include, among others, statements concerning our commitments to our customers and patients, our business strategy, and our strategic or operational initiatives. You may identify forward-looking statements by the use of words such as "believe," "expect," "plan," "project," "intend," "anticipate," "estimate," "predict," "potential," "may," "should," "will" or other words or expressions of similar meaning, although not all forward-looking statements contain such terms. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made, are not guarantees of future performance or results, and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual results may differ from those set forth in the forward-looking statements due to a variety of factors, including those described in The Cigna Group's Annual Report on Form 10-K for the year ended December 31, 2025, and The Cigna Group's other filings with the U.S. Securities and Exchange Commission, available on the Investor Relations section of http://www.TheCignaGroup.com. The Cigna Group undertakes no obligation to update or revise any forward-looking statement, whether as a result of new information, future events or otherwise, except as may be required by law. This report addresses a multitude of topics to meet the requests and interests of The Cigna Group's wide range of stakeholders. Due to the varied interests of these groups, this report includes certain information that The Cigna Group believes is not material to the company as such term is defined under applicable securities laws. Accordingly, the inclusion of information in this report should not be construed as a characterization regarding its materiality or significance for any other purpose, including for purposes of applicable securities laws.

CITATIONS

1 – A Care Advocate is a trained support professional who assists customers navigating complex health journeys by coordinating benefits, facilitating access to resources, and supporting administrative next steps.

2 – Based on Express Scripts internal analysis of pharmacy claims processed on behalf of Cigna Healthcare customers from January 1, 2025 to December 31, 2025. Population of pharmacy claims include maintenance prescriptions filled via mail or retail pharmacies. Certain exclusions apply including, but are not limited to, claims adjudicated using discount cards or filled through certain select pharmacies in designated states.

3 – Jenkins, D., Tapaneeyakul, S., & Ho, V. (2024, September 6). Prices Versus Costs: Unpacking Rising US Hospital Profits. Rice University's Baker Institute for Public Policy. https://www.bakerinstitute.org/research/hospital-price-increases-2000-outpaced-inflation-more-double-baker-institute-report-says

4 – Reuters. (2025). Prices for New US Drugs Doubled in 4 Years as Focus on Rare Disease Grows. U.S. News & World Report. https://www.reuters.com/business/healthcare-pharmaceuticals/prices-new-us-drugs-doubled-4-years-focus-rare-disease-grows-2025-05-22/

5 – Median Launch Price for a New Drug Was $2,115 in 2008. In 2021? $180K (2022, June 8). KFF Health News. https://kffhealthnews.org/morning-breakout/median-launch-price-for-a-new-drug-was-2115-in-2008-in-2021-180k/

6 – Generic Competition and Drug Prices. | U.S. Food and Drug Administration. https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/generic-competition-and-drug-prices International Prescription Drug Price Comparisons: Estimates Using 2022 Data | RAND. (2024). https://www.rand.org/pubs/periodicals/health-quarterly/issues/v11/n3/05.html

7 – A claim is a request submitted for payment of health care services and reviewed under the customer's benefit plan and applicable policies. The number of claims processed reflects approximate aggregate count of unique original claims from January 1, 2025 to December 31, 2025, for Cigna Healthcare's core medical book of business, excluding dental and international. Behavioral claims are included only if they are presented as medical claims. Amount represents original claims that have reached a decision in 2025. A decision is classified as approved/paid, denied or externally pended. Externally pended claims are requests that typically require additional information to process the claim.

8 – Based on the percentage of medical claims that are approved on original submission, prior to any pends, resubmissions, or appeals. Calculated as approved claims divided by the total of approved, denied, and pended claims at initial receipt from January 1, 2025 to December 1, 2025.

9 – Based on internal analysis of clinicians (nurses, pharmacists, physicians and social workers) directly involved in medical and behavioral Cigna Healthcare U.S. utilization management and prior authorization processes. Includes contractors and part-time as of December 31, 2025.

10 – Delivering Higher Adherence. How to Improve Medication Adherence with a Simple Switch. (n.d.). Evernorth Health Services. https://www.evernorth.com/sites/default/files/2024-05/1300446450_24%20HD%20Adherence%20White%20Paperv5.pdf

11 – Embarc Benefit Protection | Evernorth. (n.d.). https://www.evernorth.com/our-solutions/embarc-benefit-protection

12 – EncircleRX | Evernorth. (2021). https://www.evernorth.com/our-solutions/cardiovascular-disease-diabetes-obesity

13 – Evernorth opens high-tech specialty pharma site near Newark (2025, November 7). Delaware Business Times. https://delawarebusinesstimes.com/news/evernorth-pharma-site-newark/

14 – Based on Cigna Healthcare medical customers as of December 31, 2025

15 – The percentage of customers subject to our prior authorization process is calculated based on the number of unique customers who receive initial prior authorization decision(s) (i.e., approved or denied) and average quarterly membership for the year ended December 31, 2025. Prior authorization data reflects Express Scripts Pharmacy Benefit Services business and Cigna Healthcare U.S. core medical business, including behavioral services paid under a medical policy. Stand-alone behavioral prior authorizations are excluded. Customers with multiple prior authorizations are counted once, which is calculated separately for pharmacy and medical prior authorizations. Average quarterly membership includes customers of Cigna Healthcare U.S. core medical and Express Scripts Pharmacy Benefit Services, regardless of whether a client uses our prior authorization services.

16 – The percentage of customers to experience a prior authorization denial is based on the number of unique customers with an initial denied prior authorization and average quarterly membership. Prior authorization data reflects Express Scripts Pharmacy Benefit Services business and Cigna Healthcare U.S. core medical business, as described in footnote 15. An initially denied prior authorization can be later approved through reconsideration, appeal or peer to peer process, which determines the final decision.

17 – Based on absolute number of prior authorization codes removed during the year ended December 31, 2025, related to Cigna Healthcare U.S. business. Cigna Healthcare publishes a Master Precertification List quarterly. https://www.cigna.com/health-care-providers/coverage-and-claims/precertification

18 – Reflects estimated prior authorizations that would have been avoided in 2024 if the codes removed in 2025 had been removed for the calendar year 2024. Population consists of core medical prior authorizations and excludes pharmacy.

19 – Health Plans Take Action to Simplify Prior Authorization. (2025). AHIP. https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

20 – The percentage of medical prior authorization requests submitted electronically reflects the proportion of total prior authorizations for Cigna Healthcare U.S. core medical business including behavioral services paid under a medical policy that were submitted electronically via our web portal. Data is based on the twelve month period from October 1, 2024 through September 30, 2025, updated as of December 31, 2025 to reflect a 90 day run-out period. Voided requests and stand-alone behavioral prior authorizations are excluded.

21 – The percentage of medical prior authorizations approved in one day or less is based on the total approved volume that reached an approval status for the same population and time period described in footnote 20.

22 – The percentage of prior authorizations electronically submitted that were approved within minutes is based on the same population and time period described in footnote 20. It considers prior authorizations that were electronically submitted and reached a final approval decision. Near real-time decisions are generated without manual review through system-based rules and business logic.

23 – Based on internal analysis of the number of customers who called the Cigna Healthcare call center and interacted with a member of our high touch advocate teams during the year ended December 31, 2025.

24 – The percentage of customers who are digitally engaged by using the myCigna platform. This reflects Cigna Healthcare U.S. core medical customers over the age of 18 that have registered on the platform.

25 – Based on internal analysis of optional customer satisfaction scores captured from post-call survey results.

26 – Accredo customer service escalation is based on number of callers who request next-level support.

27 – Based on manufacturer list prices for gene and cell therapies, which typically range from approximately $900,000 to over $4 million per treatment, as described by Evernorth Health Services. https://www.evernorth.com/articles/leveraging-data-insights-and-clinical-expertise-support-gene-and-cell-therapy-treatment

28 – Evernorth Health Services Newsroom, New Evernorth EnReachRx model expands its suite of GLP-1 solutions, May 2, 2025. https://www.evernorth.com/articles/new-evernorth-enreachrx-model-expands-its-suite-glp-1-solutions-works-improve-patient

29 – Cigna Healthcare Newsroom, Cigna Healthcare Unveils Industry-Leading AI-Powered Digital Tools for a Simple and Reliable Customer Experience, June 12, 2025. https://newsroom.cigna.com/cigna-healthcare-unveils-industry-leading-ai-powered-digital-tools

30 – Tichy, E. M., Rim, M. H., Cuellar, S., Tadrous, M., Schumock, G. T., Johnson, T. J., Newell, M. K., & Hoffman, J. M. (2025). National trends in prescription drug expenditures and projections for 2025. American Journal of Health-System Pharmacy: AJHP: Official Journal of the American Society of Health-System Pharmacists. https://doi.org/10.1093/ajhp/zxaf092

31 – Net promoter score (NPS) is a market research metric that is based on a single survey question asking respondents to rate the likelihood that they would recommend a company, product, or service to a friend or colleague on a scale from 0 "Not at all likely" to 10 "Very likely." NPS is calculated as a percentage of respondents who are Promoters (ratings of 9-10) minus the percentage who are Detractors (ratings of 0-6) on a 0-10 likelihood-to-recommend scale. Scores range from -100 to +100.

CUSTOMER TRANSPARENCY REPORT 2025