SETTLEMENT AGREEMENT

This Settlement Agreement ("Agreement") is entered into by the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General (OIG-HHS) of the Department of Health and Human Services (HHS) (collectively, the "United States"), and The Cigna Group (hereafter collectively referred to as "the Parties"), through their authorized representatives.

RECITALS

A. The Cigna Group is a Delaware corporation with its principal place of business in Bloomfield, Connecticut. The Cigna Group owns and operates Medicare Advantage ("MA") organizations, which offer MA managed healthcare and prescription drug plans ("MA plans") to Medicare beneficiaries under Parts C and D of the Medicare Program. Hereinafter, The Cigna Group and its MA organizations shall be referred to as "Cigna."

B. Under the MA Program, private health-insurance organizations known as "MA organizations" agree to provide Medicare coverage to Medicare beneficiaries in exchange for capitated payments (i.e., fixed monthly payments for each enrollee) from the Centers for Medicare & Medicaid Services (CMS), which is the component within HHS that administers the program. CMS adjusts these payments for various "risk" factors that affect expected healthcare expenditures to ensure that MA organizations are paid more for sicker enrollees expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower costs. As a part of obtaining these adjustments, MA organizations submit "risk adjustment" data, including medical diagnosis codes, to CMS.

C. The United States contends that Cigna knowingly submitted or caused to be submitted false claims for payment to the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395lll ("Medicare"), and made or caused to be made false attestations

material to Medicare's payments of false claims. The United States also contends that Cigna knowingly and improperly avoided or decreased an obligation to repay Medicare.

D. The United States contends that it has certain civil claims against Cigna arising from the conduct described below. That conduct is referred to in this Agreement as the "Covered Conduct."

At all relevant times, Cigna entered annual written contracts with CMS pursuant to which it offered its MA plans to Medicare beneficiaries. To ensure that the government is paying for only accurate and truthful diagnosis codes, federal regulations require that the codes submitted by MA organizations be supported by the medical records of the beneficiaries enrolled in their MA plans. Given the critical importance of accurate data, a prerequisite to payment under the program is that MA organizations expressly certify "based on best knowledge, information, and belief" that the information they have provided is "accurate, complete, and truthful," 42 C.F.R. § 422.504(l)(2). This requirement was also set forth in the contracts between Cigna and CMS. Cigna submitted such a signed certification to CMS every year.

The United States contends that, for payment years 2014 to 2019, Cigna operated a "chart review" program, pursuant to which it retrieved medical records (also known as charts) from healthcare providers documenting services they had previously rendered to Medicare beneficiaries enrolled in Cigna's plans. Cigna retained professional healthcare coders to conduct retrospective reviews of those charts to identify all risk-adjusting medical conditions that the charts supported. Cigna relied on the results of its chart reviews to submit additional diagnosis codes to CMS that the healthcare providers had not reported. Cigna did this to obtain additional payments from CMS. However, Cigna's chart reviews also did not substantiate some diagnosis codes reported by healthcare providers. In other words, healthcare providers had reported diagnosis codes for beneficiaries enrolled in Cigna's MA plans that Cigna's coders did not find when reviewing those beneficiaries' charts for all supported diagnosis codes. But Cigna did not investigate or withdraw the unsubstantiated, invalid diagnoses codes that it had previously submitted to CMS for payments. Cigna then submitted false certifications to CMS that its data was "accurate, complete, and truthful." The allegations in this paragraph are hereinafter "the United States' Chart Review Claims."

The United States further contends that, for payment years 2016 to 2021, Cigna knowingly submitted and/or failed to delete inaccurate and untruthful diagnosis codes for morbid obesity (ICD-10 E66.01 & E66.2, ICD-9 278.01 & 278.03) to increase the payments it received from CMS for numerous beneficiaries enrolled in its MA plans. The medical records for individuals diagnosed as morbidly obese typically include one or more Body Mass Index ("BMI") recordings. Individuals with a BMI below 35 cannot properly be diagnosed as morbidly obese. However, Cigna submitted and/or failed to delete inaccurate, false, or otherwise invalid diagnosis codes for morbid obesity; it did so with actual knowledge of the falsity of the diagnosis code or reckless disregard for or

deliberate ignorance of the truth or falsity of the diagnosis code; and these codes increased the payments made by CMS for these beneficiaries. For example, some of these inaccurate and untruthful morbid obesity diagnosis codes were from Cigna's "chart review" program. In some other instances, chart reviews showed that the morbid obesity diagnosis codes were inaccurately reported by doctors and were unsubstantiated by their charts. In other instances, Cigna did not investigate the accuracy of the morbid obesity diagnosis code reported by the doctor notwithstanding that the highest reported BMI was less than 35 for the beneficiary during the same service year. The allegations in this paragraph are hereinafter the "United States' Morbid Obesity Claims."

E. This Settlement Agreement is neither an admission of liability by Cigna nor a concession by the United States that its claims are not well founded.

To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, and in consideration of the mutual promises and obligations of this Settlement Agreement, the Parties agree and covenant as follows:

TERMS AND CONDITIONS

1. In settlement of the United States' Chart Review Claims, Cigna shall pay to the United States $115,794,350 and interest on the Settlement Amount at a rate of 3.625% per annum from February 28, 2023 ("Chart Review Settlement Amount"), of which $57,897,175 is restitution, no later than fourteen (14) business days after the Effective Date of this Agreement by electronic funds transfer pursuant to written instructions to be provided by the Office of the United States Attorney for the Eastern District of Pennsylvania. In settlement of the United States' Morbid Obesity Claims, Cigna shall pay to the United States $19,500,000 and interest on the Settlement Amount at a rate of 3.625% per annum from March 1, 2023 ("Morbid Obesity Settlement Amount"), of which $9,750,000 is restitution, no later than fourteen (14) business days after the Effective Date of this Agreement by electronic funds transfer pursuant to written instructions to be provided by the Office of the United States Attorney for the Eastern District of Pennsylvania.

2. Subject to the exceptions in Paragraph 4 (concerning reserved claims) below, and upon the United States' receipt of the Chart Review Settlement Amount and the Morbid Obesity Settlement Amount, plus interest due under Paragraph 1, the United States releases Cigna together with its current and former parent corporations; direct and indirect subsidiaries; brother or sister corporations; divisions; current or former corporate owners; and the corporate successors and assigns of any of them from any civil or administrative monetary claim the United States has for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; or the common law theories of payment by mistake, unjust enrichment, and fraud.

3. In consideration of the obligations of Cigna in this Agreement and the Corporate Integrity Agreement (CIA), entered into between OIG-HHS and The Cigna Group, and upon the United States' receipt of full payment of the Settlement Amount, plus interest due under Paragraph 1, the OIG-HHS shall release and refrain from instituting, directing, or maintaining any administrative action seeking exclusion from Medicare, Medicaid, and other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) against The Cigna Group under 42 U.S.C. § 1320a-7a (Civil Monetary Penalties Law) or 42 U.S.C. § 1320a-7(b)(7) (permissive exclusion for fraud, kickbacks, and other prohibited activities) for the Covered Conduct, except as reserved in this paragraph and in Paragraph 4 (concerning reserved claims), below. The OIG-HHS expressly reserves all rights to comply with any statutory obligations to exclude The Cigna Group from Medicare, Medicaid, and other Federal health care programs under 42 U.S.C. § 1320a-7(a) (mandatory exclusion) based upon the Covered Conduct. Nothing in this paragraph

precludes the OIG-HHS from taking action against entities or persons, or for conduct and practices, for which claims have been reserved in Paragraph 4, below.

4. Notwithstanding the releases given in Paragraphs 2 and 3 of this Agreement, or any other term of this Agreement, the following claims and rights of the United States are specifically reserved and are not released:

a. Any liability arising under Title 26, U.S. Code (Internal Revenue Code);

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any administrative liability or enforcement right, including mandatory exclusion from Federal health care programs;

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;

e. Any liability based upon obligations created by this Agreement;

f. Any liability of individuals; and

g. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services;

h. Any liability for failure to deliver goods or services due;

i. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct;

j. Any liability for the United States' and the Relator's claims against Cigna in *United States ex rel. Cutler v. Cigna Corp. et al*., No. 3:21-cv-00748 (M.D. Tenn.); and

k. Any liability from future risk adjustment model runs and reruns of final risk scores or any payment adjustments due to The Cigna Group's submission of auditable estimates pursuant to the Risk Adjustment Overpayment Reporting (RAOR) process.

5. Cigna waives and shall not assert any defenses it may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action.

6. Cigna fully and finally releases the United States, its agencies, officers, agents, employees, and servants, from any claims (including attorney's fees, costs, and expenses of every kind and however denominated) that Cigna has asserted, could have asserted, or may assert in the future against the United States, and its agencies, officers, agents, employees, and servants related to the Covered Conduct and the United States' investigation and prosecution thereof.

7. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by the Medicare program, any Medicare contractor (e.g., Medicare Administrative Contractor, fiscal intermediary, carrier) or any state payer, related to the Covered Conduct; and Cigna agrees not to resubmit to the Medicare program, any Medicare contractor or any state payer any previously denied claims related to the Covered Conduct, agrees not to appeal any such denials of claims, and agrees to withdraw any such pending appeals.

8. Cigna agrees to the following:

a. Unallowable Costs Defined: All costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395lll and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of Cigna, its present or former officers, directors, employees, shareholders, and agents in connection with:

(1) the matters covered by this Agreement;

(2) the United States' audit(s) and civil investigations of the matters covered by this Agreement;

(3) Cigna's investigation, defense, and corrective actions undertaken in response to the United States' audit(s) and civil investigations in connection with the matters covered by this Agreement (including attorneys' fees);

(4) the negotiation and performance of this Agreement;

(5) the payment Cigna makes to the United States pursuant to this Agreement; and

(6) the negotiation of, and obligations undertaken pursuant to the CIA to: (i) retain an independent review organization to perform annual reviews as described in Section III of the CIA; and (ii) prepare and submit reports to the OIG-HHS,

are unallowable costs for government contracting purposes and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (FEHBP) (hereinafter referred to as Unallowable Costs). However, nothing in paragraph 8.a.(6) that may apply to the obligations undertaken pursuant to the CIA affects the status of costs that are not allowable based on any other authority applicable to Cigna.

b. Future Treatment of Unallowable Costs: Unallowable Costs shall be separately determined and accounted for by Cigna, and Cigna shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information

statement, or payment request submitted by Cigna or any of its subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or FEHBP Programs.

c. Treatment of Unallowable Costs Previously Submitted for Payment: Cigna further agrees that within 90 days of the Effective Date of this Agreement it shall identify to the Medicare program, applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this Paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Cigna or any of its subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. Cigna agrees that the United States, at a minimum, shall be entitled to recoup from Cigna any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by Cigna or any of its subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this paragraph) on Cigna or any of its subsidiaries or affiliates' cost reports, cost statements, or information reports.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine Cigna's books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this paragraph.

9. Cigna agrees to cooperate fully and truthfully with the United States' investigation of individuals and entities not released in this Agreement. Upon reasonable notice, Cigna shall encourage, and agrees not to impair, the cooperation of its directors, officers, and employees, and shall use its best efforts to make available, and encourage, the cooperation of former directors, officers, and employees for interviews and testimony, consistent with the rights and privileges of such individuals. Cigna further agrees to furnish to the United States, upon request, complete and unredacted copies of all non-privileged documents, reports, memoranda of interviews, and records in its possession, custody, or control concerning any investigation of the Covered Conduct that it has undertaken, or that has been performed by another on its behalf.

10. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraph 11 (waiver for beneficiaries paragraph), below.

11. Cigna agrees that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

12. Each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

13. Each Party and signatory to this Agreement represents that it freely and voluntarily enters into this Agreement without any degree of duress or compulsion.

14. This Agreement is governed by the laws of the United States. The exclusive venue for any dispute relating to this Agreement is the United States District Court for the Eastern District of Pennsylvania. For purposes of construing this Agreement, this Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute.

15. This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of the Parties.

16. The undersigned counsel represent and warrant that they are fully authorized to execute this Agreement on behalf of the persons and entities indicated below.

17. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement.

18. This Agreement is binding on Cigna's successors, transferees, heirs, and assigns.

19. All Parties consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

20. This Agreement is effective on the date of signature of the last signatory to the Agreement (Effective Date of this Agreement). Facsimiles and electronic transmissions of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

THE UNITED STATES OF AMERICA

DATED: _____ BY: CAROL WALLACK Digitally signed by CAROL WALLACK Date: 2023.09.29 14:18:32 -04'00'

CAROL WALLACK
Senior Trial Counsel
Civil Division, Commercial Litigation Branch
United States Department of Justice

DATED: _____ BY: _____

EDWARD C. CROOKE
Assistant Director
Civil Division, Commercial Litigation Branch
United States Department of Justice

DATED: _____ BY: _____

JACQUELINE C. ROMERO
United States Attorney for the Eastern District of Pennsylvania

DATED: _____ BY: _____

GREGORY B. DAVID
Assistant United States Attorney
Chief, Civil Division

DATED: _____ BY: _____

CHARLENE KELLER FULLMER
Assistant United States Attorney
Deputy Chief, Civil Division

DATED: _____ BY: _____

DEBORAH W. FREY
Assistant United States Attorney

THE UNITED STATES OF AMERICA

DATED: _____ BY: _____
CAROL WALLACK
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DATED: 9/29/23 BY: Edward Crooke
EDWARD C. CROOKE
Assistant Director
Civil Division, Commercial Litigation Branch
United States Department of Justice

DATED: _____ BY: _____
JACQUELINE C. ROMERO
United States Attorney for the Eastern District of Pennsylvania

DATED: _____ BY: _____
GREGORY B. DAVID
Assistant United States Attorney
Chief, Civil Division

DATED: _____ BY: _____
CHARLENE KELLER FULLMER
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Deputy Chief, Civil Division

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JACQUELINE C. ROMERO
United States Attorney for the Eastern District of Pennsylvania

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Chief, Civil Division

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CHARLENE KELLER FULLMER
Assistant United States Attorney
Deputy Chief, Civil Division

DATED: 9/29/23 BY: _____
DEBORAH W. FREY
Assistant United States Attorney

DATED: Sept. 29, 2023 BY: _____

MATTHEW E.K. HOWATT
Assistant United States Attorney

DATED: _____ BY: _____

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

DATED: _____ BY: _____

MATTHEW E.K. HOWATT
Assistant United States Attorney

DATED: _____ BY: LISA RE Digitally signed by LISA RE Date: 2023.09.29 17:25:48 -04'00'

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

THE CIGNA GROUP

DATED: 9/29/2023 BY: _____

NICOLE S. JONES
Executive Vice President, Chief Administrative Officer and General Counsel
The Cigna Group

DATED: 9/29/2023 BY: _____

DAVID W. OGDEN
WilmerHale
Counsel for The Cigna Group