



## **B.31 – Aetna Inc. Two Years of Audited Financial Statements**

# AETNA INC /PA/ (AET)

## 10-K

Annual report pursuant to section 13 and 15(d)

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UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549

FORM 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2009

or

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from \_\_\_\_\_ to \_\_\_\_\_

Commission file number 1-16095

**Aetna Inc.**

(Exact name of registrant as specified in its charter)

**Pennsylvania**

(State or other jurisdiction of incorporation or organization)

**23-2229683**

(I.R.S. Employer Identification No.)

**151 Farmington Avenue, Hartford, CT**

(Address of principal executive offices)

**06156**

(Zip Code)

Registrant's telephone number, including area code

**(860) 273-0123**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class

**Common Shares, \$.01 par value**

Name of each exchange on which registered

**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:

**None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.  Yes  No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.  Yes  No

Indicate by check mark 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.  Yes  No

Indicate by check mark 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 (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).  Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) 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.

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

Large accelerated filer  Accelerated filer  Non-accelerated filer  Smaller reporting company

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act)  Yes  No

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2009) was \$10.6 billion.

There were 431.0 million shares of the registrant's voting common stock with a par value of \$.01 per share outstanding at January 31, 2010.

**DOCUMENTS INCORPORATED BY REFERENCE**

The 2009 Annual Report, Financial Report to Shareholders (the "Annual Report") is incorporated by reference in Parts I, II and IV to the extent described therein. The definitive proxy statement related to Aetna Inc.'s 2010 Annual Meeting of Shareholders, to be filed on or about April 12, 2010 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

**Aetna Inc.**  
**Annual Report on Form 10-K**  
**For the Year Ended December 31, 2009**

*Unless the context otherwise requires, references to the terms “we,” “our” or “us” used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) (“Aetna”) and its subsidiaries (collectively, the “Company”).*

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## Part I

### Item 1. Business

**We are one of the nation's leading diversified health care benefits companies**, serving approximately 36.1 million people with information and resources to help them make better informed decisions about their health care. We offer a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and health care management services for Medicaid plans. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

We are dedicated to helping people achieve health and financial security by providing easy access to safe, cost-effective, quality health care and protecting their finances against health-related risks. We seek to achieve superior customer satisfaction through innovative products, comprehensive health and related benefits choices, effective service and easy-to-understand information.

**The health insurance and related benefits industry continues to experience significant change.** During 2009, the federal government became increasingly focused on broad-based health care reform, and both the U.S. House of Representatives and Senate passed extensive health reform measures in November and December of 2009, respectively. On February 22, 2010, President Obama published an alternative proposal for broad-based health care reform legislation. If enacted, this proposal, which is similar to the legislation passed by the U.S. Senate, would significantly affect our business and results of operations. Some of the proposed changes in this legislation include a provision for guaranteed issue of coverage in the individual and small group market with a weak mandate that requires coverage. It would also specify required benefit designs, limit rating and pricing practices and impose minimum requirements for medical benefit ratios, create new ways in which health insurance is distributed (for example, state-based health insurance exchanges), encourage additional competition (including potential incentives for new market entrants) and expand eligibility for Medicaid programs. In addition, President Obama's proposal would create a new federal Health Insurance Rate Authority that would significantly increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately increase health plan premiums. Financing for these reforms was expected to come, in part, from material additional fees and taxes on us and other health insurers and health plans, as well as reductions in certain levels of reimbursement under Medicare. Given recent political developments in Washington, D.C., the fate of this legislation and the nature and extent of any other new health care reform is uncertain, though it is reasonably possible that federal health care reform in some form could be enacted. We cannot predict whether federal health care reform will be enacted, and if it is, what provisions it will contain or what effect it will have on our business or results of operations, although it could have a material adverse effect. If enacted, health care reform would most likely require significant rule making, and we will continue to work with health care policy makers to ensure Americans have access to affordable insurance.

At the state level, forty-four states and the District of Columbia will hold a regular legislative session in 2010. We expect state legislatures to focus on the impact of federal health care reform legislation and state budget deficits in 2010. Proposals under consideration in U.S. Congress could significantly alter the federal structure that shapes the state regulation of health insurance. While the federal debate is ongoing and the outcome uncertain, if federal health care reform legislation is enacted, states may be required to significantly amend numerous existing statutes and regulations. Independent of federal efforts, we expect many states to consider legislation to, among other things, extend coverage to the uninsured through health insurance exchanges, increase the limiting age for dependent eligibility, restrict health plan rescission of individual coverage, increase mandatory medical benefit ratios, implement rating reforms and enact an autism benefit mandate. We cannot predict whether health care reform will be enacted at the state level, and if it is, what provisions it will contain in any state or what effect it will have on our business or results of operations.

In addition, employers, consumers and state governments continue to increase their focus on health care costs and providing health insurance to the uninsured; and they continue to drive changes in the structure of health insurance and related benefits products and services. Product features continue to evolve that are directed at containing rising health care costs, addressing affordability problems, enhancing access to quality health care services and

giving members greater control and responsibility in directing their benefit dollars. For employer-based health coverage, employers are continuing to require covered employee members to assume a greater portion of the cost of their health care and/or coverage. These economic factors and greater consumer awareness are leading to increased popularity of products that offer flexibility in design features such as deductibles and co-payments, health savings accounts, consumer access to a broader network of health care providers and quality-based physician networks. The industry is also subject to other forces including adverse economic conditions in the U.S. and abroad, federal and state legislative and regulatory reforms, advances in pharmaceutical and medical technology, and industry consolidation. All of these factors can affect the competitiveness of product and service offerings, the range of industry competitors and the bases of competition.

We believe that these factors will exist for some time and will drive a continuing evolution in the health insurance and related benefits industry. We place significant emphasis on developing and maintaining our product and service offerings to serve existing and new customer markets and have done so through organic growth and acquisitions.

Over the last five years, this focus has led to the introduction of new products, such as Aetna *Ones*<sup>SM</sup>, our suite of integrated products such as disease management and prevention, wellness and health promotion, and health, disability and absence assessments, designed to help improve member health and productivity and lower benefit trend over time; our Personal Health Record, which provides members with online access to personal information to help them make better informed decisions about their health care; Aetna Health Connections,<sup>SM</sup> our integrated disease management program; and Medicare Part D prescription drug plans and private fee-for-service Medicare plans (“PFFS”). We continue to develop and enhance our existing products, such as our Aexcel<sup>SM</sup> physician networks, which are comprised of specialist providers who have demonstrated effectiveness in the delivery of care based on measures of clinical performance and efficiency. We are also continuing to expand our initiative to improve the transparency of our products and pricing by utilizing our Aetna Navigator online tool to give our members access to physician-specific cost, clinical quality and efficiency information in additional select markets.

We continually evaluate acquisitions and other transactions that present strategic growth opportunities. During 2009, we expanded our behavioral health capabilities by acquiring a leading provider of employee assistance programs to mid-sized and large employers. More details about this acquisition are included in Note 3 of Notes to Consolidated Financial Statements on page 55 of the Annual Report which is incorporated herein by reference.

**Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions.** We derive our revenues primarily from insurance premiums, administrative service fees, net investment income and other revenue. Refer to Management’s Discussion and Analysis of Financial Condition and Results of Operations (“MD&A”) and Note 19 of Notes to Consolidated Financial Statements beginning on pages 2 and 80, respectively, of the Annual Report, which are incorporated herein by reference, regarding revenue, profit and total asset information for each of our business segments. The following is a description of each of our business segments.

### **Health Care**

#### **Products and Services**

Health Care products consist of medical, pharmacy benefits management, dental, behavioral health and vision plans offered on both an insured basis and an employer-funded, or administrative, basis. Medical products include point of service (“POS”), preferred provider organization (“PPO”), health maintenance organization (“HMO”) and indemnity benefit (“Indemnity”) plans. Medical products also include health savings accounts (“HSAs”) and Aetna HealthFund®, consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account. We also offer Medicare and Medicaid products and services and specialty products, such as medical management and data analytics services, medical stop loss insurance, as well as products that provide access to our provider networks in select markets. We refer to insurance products as “Insured” and administrative products as “ASC.”

Our principal products and services are targeted specifically to large multi-site national, mid-sized and small employers. We also serve individual insureds, expatriates and, in certain markets, Medicare and Medicaid beneficiaries. Medicare and Medicaid products and services are categorized separately from our other Health Care products and services, which we refer to as Commercial.

The primary Commercial products we offer are POS, PPO, HMO and Indemnity plans. We also offer other products and services. Our other Commercial products and services include:

#### *ActiveHealth Management*

Through the use of our patented CareEngine® system, our ActiveHealth Management business provides evidence-based medical management and data analytics products and services to a broad range of customers, including health plans, employers and others.

#### *Behavioral Health*

Our behavioral health products provide members who experience mental health illness with integrated behavioral health benefit administration, access to a network of providers and innovative wellness programs. On November 1, 2009, we acquired Horizon Behavioral Services, LLC (“Horizon”), a leading provider of employee assistance programs to mid-sized and large employers. Horizon provides customized behavioral health solutions to employees in all 50 states.

#### *Personal Health Record*

Our Personal Health Record provides members with online access to personal information, including individual personalized messages and alerts, detailed health history based on available claims data and voluntarily submitted information, and integrated information and resources to help members make informed decisions about their health care.

#### *Pharmacy*

We offer pharmacy benefit management and specialty and mail order pharmacy services to our members. Our pharmacy fulfillment services are delivered by Aetna Specialty Pharmacy (“ASP”) and Aetna Rx Home Delivery®. ASP compounds and dispenses specialty medications and offers certain support services associated with specialty medications. Specialty medications are generally injectable or infused medications that may not be readily available at local pharmacies. Aetna Rx Home Delivery® provides mail order prescription drug services.

#### *Dental*

We offer managed dental plans on an Insured and ASC basis. We are one of the nation’s largest providers of dental coverage, based on membership at December 31, 2009.

#### *Cofinity*

Cofinity provides access to a regional health care provider network to other insurance companies, third party administrators, health plans and employers. It has operations in Michigan, Colorado and other states.

#### *Stop Loss*

We offer medical stop loss insurance coverage for certain employers. Under this product, we assume the costs associated with large individual claims and/or aggregate loss experience within the employer’s plan above a pre-set annual threshold.

#### *International*

We offer comprehensive health benefits and health management solutions worldwide through several different arrangements and offerings that include medical, dental, vision, life, disability and emergency assistance to expatriates, local residents and other constituents. Our health management business collaborates with health care systems, government entities and plan sponsors around the world to design and build locally-applied health management solutions to improve health, quality and cost outcomes.

#### *Other Commercial Products and Services*

We offer a variety of other health care coverage products either as supplements to health products or as stand-alone products. Such products, which may be offered on an Insured or an ASC basis, include indemnity and vision programs. We also offer, directly or in cooperation with third parties, our Aetna Health Connectionssm disease management program which addresses over 35 chronic conditions, including asthma, diabetes, congestive heart failure and lower back pain.

In addition to Commercial health products, in select markets we also offer HMO, PPO, PFFS and prescription drug coverage for Medicare beneficiaries and participate in Medicaid and subsidized State Children's Health Insurance Programs ("SCHIP"). SCHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. Our Medicare and Medicaid products include:

#### *Medicare*

Through annual contracts with the Centers for Medicare & Medicaid Services ("CMS"), we offer HMO and PPO plans for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over standard Medicare fee-for-service coverage, including reduced cost-sharing for preventive care, vision and other services. We offered these plans in 219 counties in 19 states and Washington, D.C. in 2009 and are expanding to 246 counties in 22 states and Washington, D.C. in 2010. In anticipation of changes in the PFFS network requirements that will become effective in 2011, we decided to cease offering Medicare Advantage plans in certain geographic areas in 2010. We sold mainly individual PFFS plans in these geographic areas.

We are a national provider of the Medicare Part D Prescription Drug Program ("PDP") in all 50 states to both individuals and employer groups. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment.

We offer PFFS in select markets nationally for employer groups. When combined with our PDP product, PFFS forms an integrated national fully-insured Medicare product for employers that provides medical and pharmacy benefits.

#### *Medicaid and SCHIP*

We offer healthcare management services for eligible Medicaid and SCHIP individuals under multi-year contracts which are subject to annual appropriations. We offered these services on an Insured basis in five states, ASC basis in four states and targeted medical management services in four states in 2009.

#### *Provider Networks*

We contract with physicians, hospitals and other health care providers for services to our customers. The health care providers who participate in our networks are independent contractors and are neither our employees nor our agents, except for providers who work in our mail-order and specialty pharmacy facilities.

We use a variety of techniques designed to help encourage appropriate utilization of health care resources and maintain affordability of quality coverage. In addition to contracts with health care providers for negotiated rates of reimbursement, these techniques include the development and implementation of guidelines for the appropriate utilization of health care resources and the provision of data to providers to enable them to improve health care quality.

At December 31, 2009, we had extensive nationwide provider networks of more than 952 thousand participating health care providers, including over 539 thousand primary care and specialist physicians and over five thousand hospitals.

#### *PCPs*

We compensate primary care physicians ("PCPs") participating in our networks on both a fee-for-service and capitated basis, with capitation generally limited to HMO products in certain geographic areas. In a fee-for-service arrangement, physicians are paid for health care services provided to the member based upon a set fee for the services provided. Under a capitation arrangement, physicians receive a monthly fixed fee for each member, regardless of the medical services provided to the member. We continue to eliminate or reduce the use of capitation arrangements in many areas. The percentage of health care costs related to capitation arrangements was 4.7% for the year ended December 31, 2009 compared to 5.0% and 5.5% for the years ended December 31, 2008 and 2007, respectively.

### *Specialist Physicians*

Specialist physicians participating in our networks are generally reimbursed at contracted rates per visit or per procedure.

### *Hospitals*

We typically enter into contracts with hospitals that provide for per day and/or per case rates, often with fixed rates for ambulatory, surgery and emergency room services. We also have hospital contracts that provide for reimbursement based on a percentage of the charges billed by the hospital.

Our medical plans generally require notification of elective hospital admissions, and we monitor the length of hospital stays. Physicians who participate in our networks generally admit their patients in network-based products to participating hospitals using referral procedures that direct the hospital to contact our patient management unit in order to confirm the patient's membership status and facilitate the patient management process. This unit also assists members and providers with related activities, including, if necessary, the subsequent transition to the home environment and home care. Case management assistance for complex cases is provided by a special case unit.

### *Other Providers*

Laboratory, imaging, urgent care and other freestanding health facility providers are generally paid under fee-for-service arrangements, except for certain laboratory services.

### *Quality Assessment*

We seek accreditation for most of our HMO plans from the National Committee for Quality Assurance ("NCQA"), a national organization established to review the quality and medical management systems of health care plans. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance. As of December 31, 2009, approximately 99.9% of our HMO members participated in HMOs that had received accreditation by the NCQA.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of Aetna, has received NCQA PPO Full Accreditation through December 11, 2010. ALIC will undergo its resurvey in September 2010.

We also seek accreditation and certification for other products from NCQA and URAC, another national organization founded to establish standards for the health care industry. Purchasers and consumers look to URAC's and NCQA's accreditation and certification as an indication that a health care organization has the necessary structures and processes to promote high-quality care and preserve patient rights. In addition, regulators in over 70% of the states recognize NCQA's accreditation and certification standards.

Our provider selection and credentialing/recredentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal requirements. In addition, we are certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options through January 29, 2011. Our URAC CVO accreditation is valid through October 1, 2012.

Our quality assessment programs for contracted providers who participate in our networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by us or in some cases by the practitioner's affiliated group or organization. We generally require participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

We also offer quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

### *Principal Markets and Sales*

Our medical membership generally is dispersed throughout the United States, although we serve a limited number of members in countries outside the United States. Refer to Note 19 of Notes to Consolidated Financial Statements, beginning on page 80 of the Annual Report, which is incorporated herein by reference, for additional information on our foreign customers. We offer a broad range of traditional and consumer-directed health

insurance products and related services, many of which are available nationwide. Depending on the product, we market to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by geographic region and funding arrangement at December 31, 2009, 2008 and 2007:

(Thousands)	2009			2008			2007		
	Insured	ASC	Total	Insured	ASC	Total	Insured	ASC	Total
Northeast	1,200	1,624	2,824	1,138	1,533	2,671	1,154	1,471	2,625
Mid-Atlantic	1,107	1,903	3,010	1,062	1,776	2,838	1,074	1,767	2,841
Southeast	947	1,968	2,915	969	1,814	2,783	949	1,726	2,675
North Central	902	2,503	3,405	877	2,227	3,104	783	2,271	3,054
Southwest	672	2,311	2,983	683	2,058	2,741	669	1,880	2,549
West	1,243	2,130	3,373	1,181	1,990	3,171	987	1,852	2,839
Other	286	118	404	258	135	393	133	137	270
<b>Total medical membership</b>	<b>6,357</b>	<b>12,557</b>	<b>18,914</b>	<b>6,168</b>	<b>11,533</b>	<b>17,701</b>	<b>5,749</b>	<b>11,104</b>	<b>16,853</b>

Additional information on Health Care’s membership is included in the “Membership” section of the MD&A, on page 7 of the Annual Report, which is incorporated herein by reference.

We market both Insured and ASC products and services primarily to employers that sponsor our products (also called “plan sponsors”) for the benefit of their employees and their employees’ dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly. We also sell Insured plans directly to individual consumers in a number of states.

We sell Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and SCHIP members are enrolled on an individual basis.

Health Care products are sold through our sales personnel, as well as through independent brokers, agents and consultants who assist in the production and servicing of business. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. We pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. We support our marketing and sales efforts with an advertising program that may include television, radio, billboards and print media, supplemented by market research and direct marketing efforts.

#### Pricing

For Commercial Insured plans, employer group contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. We use prospective rating methodologies in determining the premium rates charged to the majority of employer groups, and we also use retrospective rating methodologies for some groups. Premium rates for customers with more than approximately 125 employees generally take into consideration the individual plan sponsor’s historical and anticipated claim experience where permitted by law. Some states may prohibit the use of one or more of these rating methods for some customers, such as small employer groups, or all customers.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We typically cannot recover unanticipated increases in health care costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved prior to contract inception. Our future results could be adversely affected if the premium rates we request are not approved or are adjusted downward by state regulators.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, we may, in certain instances, recover the resulting deficit through contractual provisions or consider the deficit in setting future premium levels. Generally, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating may be used for Commercial Insured plans that cover more than approximately 300 lives.

We have Medicare Advantage and PDP contracts with CMS to provide HMO, PPO, PFFS and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays us a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. Our PDP contracts also provide a risk-sharing arrangement with CMS to limit our exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable under the Medicare arrangements are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Premiums paid to us for Medicare products are subject to federal government reviews and audits, which can result and have resulted in retroactive and prospective premium adjustments. In addition to payments received from CMS, most of our Medicare Advantage products and all of our PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial products, Medicare contracts generate higher per member per month revenues and medical costs.

Under our Insured Medicaid contracts with states, government agencies pay us fixed monthly rates per member that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. We also receive fees from our customers where we provide services under ASC Medicaid contracts. Our ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain guarantees with respect to certain medical, financial and operational metrics, as well as certain performance guarantees regarding reduction of the claim expenses incurred under state government contracts. Under these guarantees, we are financially at risk if the conditions of the arrangements are not met. Payments to us under each of these Medicaid contracts are subject to the annual appropriation process in the applicable state.

We offer HMO, consumer-directed and dental plans to federal employees under the Federal Employees Health Benefit Program. Premium rates for those plans are subject to federal government review and audit, which can result and have resulted in retroactive and prospective premium adjustments.

Our ASC plans are generally for a period of one year, but some last up to three years. Some of our ASC contracts include performance guarantees with respect to certain functions such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain performance guarantees that claim expenses to be incurred by plan sponsors will fall within a specified range. Under these guarantees, we are financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to us by the customer involved.

### Competition

The health care industry is highly competitive, primarily due to a large number of competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the market. New entrants into the marketplace as well as significant consolidation within the industry have contributed to the competitive environment.

We believe that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including both premium and member out-of-pocket costs), product design, financial stability, geographic scope of provider networks, providers available in such networks, and quality of member support and care management programs. We believe that we are competitive on each of these factors. Our ability to increase the number of persons

covered by our plans or to increase our revenues is affected by our ability to differentiate ourselves from our competitors on these factors. In addition, our ability to increase the number of persons enrolled in our Insured products is affected by the desire and ability of employers to self fund their health coverage. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

In addition to competitive pressures affecting our ability to obtain new customers or retain existing customers, our membership has been and may continue to be affected by reductions in workforce by existing customers due to soft economic conditions, especially in the geographies where our membership is concentrated.

Our Insured products compete with local and regional health care benefits plans, in addition to health care benefits and other plans sponsored by other large commercial health benefit insurance companies and Blue Cross/Blue Shield plans. Additional competitors include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit providers), integrated health care delivery organizations, health information technology companies and, for certain plans, programs sponsored by the federal or state governments.

Our ASC plans compete primarily with other large commercial health benefit insurance companies, Blue Cross/Blue Shield plans and third party administrators.

#### Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect Health Care business and our statements concerning future events is included in the "Outlook for 2010" and "Forward-Looking Information/Risk Factors" sections of the MD&A, beginning on pages 3 and 31 of the Annual Report, respectively, which are incorporated herein by reference.

#### Group Insurance

##### Principal Products

Group Insurance products consist primarily of the following:

- *Life Insurance Products* consist principally of group term life insurance coverage, the amounts of which may be fixed or linked to individual employee wage levels. We also offer voluntary spouse and dependent term life coverage, and group universal life and accidental death and dismemberment coverage. We offer life products on an Insured basis.
- *Disability Insurance Products* provide employee income replacement benefits for both short-term and long-term disability. We also offer disability products with additional case management features. Similar to Health Care products, we offer disability benefits on both an Insured and employer-funded basis. We also provide absence management services to employers, including short-term and long-term disability administration and leave management.
- *Long-Term Care Insurance Products* provide benefits to cover the cost of care in private home settings, adult day care, assisted living or nursing facilities. Long-term care benefits were offered primarily on an Insured basis. The product was available on both a service reimbursement and disability basis. We no longer solicit or accept new long-term care customers, and we are working with our customers on an orderly transition of this product to other carriers.

##### Principal Markets and Sales

We offer our Group Insurance products in 49 states as well as Washington, D.C., Guam, Puerto Rico, the United States Virgin Islands and Canada. Depending on the product, we market to a range of customers from small employer groups to large, multi-site and/or multi-state employer programs.

We market Group Insurance products and services primarily to employers that sponsor our products for the benefit of their employees and their employees' dependents. Frequently, employers offer employees a choice of benefits, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain

reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Group Insurance products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly.

Group Insurance products are sold through our sales personnel, as well as through independent brokers, agents and consultants who assist in the production and servicing of business. For large plan sponsors, independent consultants and brokers are frequently involved in employer plan selection decisions and sales. We pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. We support our marketing and sales efforts with an advertising program that may include television, radio, billboards and print media, supplemented by market research and direct marketing efforts.

#### Pricing

For Insured Group Insurance plans, employer group contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period. We use prospective and retrospective rating methodologies to determine the premium rates charged to employer groups. These are typically offered with rate guarantees that generally range from one to three years.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We cannot recover unanticipated increases in mortality or morbidity costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the experience is favorable (i.e., actual claim costs and other expenses are less than expected), we may issue a refund to the plan sponsor. If the experience is unfavorable, we consider the deficit in setting future premium levels, and in certain instances, we may recover the deficit through contractual provisions such as offsets against refund credits that develop for future policy periods. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating is most often used for Insured employer funded plans that cover more than 3,000 lives and pay more than \$500,000 in annual premiums.

#### Competition

For the group insurance industry, we believe that the significant factors that distinguish competing companies are cost, quality of service, financial strength of the insurer, comprehensiveness of coverage, and product array and design. We believe we are competitive on each of these factors. The group life and group disability markets remain highly competitive.

#### Reinsurance

We currently have several reinsurance agreements with nonaffiliated insurers that relate to both group life and long-term disability products. Most reinsurance arrangements are established on a case by case basis and a subset of our reinsurance agreements cover closed blocks of business and cancelled cases. We also have reinsurance that provides a limited degree of catastrophic risk protection for certain of our life products. We frequently evaluate reinsurance opportunities and refine our reinsurance and risk management strategies on a regular basis.

#### *Group Life Insurance In Force and Other Statistical Data*

The following table summarizes changes in group life insurance in force before deductions for reinsurance ceded to other companies for 2009, 2008 and 2007:

<b>(Dollars in Millions)</b>	<b>2009</b>		<b>2008</b>		<b>2007</b>	
In force, end of year	\$	<b>467,850</b>	\$	441,306	\$	461,952
Terminations (lapses and all other)	\$	<b>72,180</b>	\$	94,448	\$	67,793
Number of policies and contracts in force, end of year:						
Life Contracts (1)		<b>22,262</b>		22,180		21,963
Conversion Policies (2)		<b>18,788</b>		19,493		20,439

(1) Due to the diversity of coverages and size of covered groups, statistics are not provided for average size of policies in force.

(2) Reflects conversion privileges exercised by insureds under group life policies to replace those policies with individual life policies.

### Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect Group Insurance business and our statements concerning future events is included in the “Outlook for 2010” and “Forward-Looking Information/Risk Factors” sections of the MD&A, beginning on pages 3 and 31, respectively, of the Annual Report, which are incorporated herein by reference.

### Large Case Pensions

#### Principal Products

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. Contracts provide non-guaranteed, experience-rated and guaranteed investment options through general and separate account products. Large Case Pensions products that use separate accounts provide contract holders with a vehicle for investments under which the contract holders assume the investment risk. Large Case Pensions earns a management fee on these separate accounts.

In 1993, we discontinued our fully-guaranteed Large Case Pensions products. Information regarding these products is incorporated herein by reference to Note 20 of Notes to Consolidated Financial Statements beginning on page 82 in the Annual Report. We do not actively market Large Case Pensions products, but continue to accept deposits from existing customers and manage the run-off of our existing business.

### Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect Large Case Pensions business and our statements concerning future events is included in the “Outlook for 2010” and “Forward-Looking Information/Risk Factors” sections of the MD&A, beginning on pages 3 and 31, respectively, of the Annual Report, which are incorporated herein by reference.

### Other Matters

#### Access to Reports

Our reports to the United States Securities and Exchange Commission (the “SEC”), including our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports, if any, are available without charge on our website at [www.aetna.com](http://www.aetna.com) as soon as practicable after they are electronically filed with or furnished to the SEC. The information on our website is not incorporated by reference in this Form 10-K. Copies of these reports are also available, without charge, from Aetna’s Investor Relations Department, 151 Farmington Avenue, Hartford, CT 06156.

#### Regulation

Information regarding significant regulations affecting us is included in the “Regulatory Environment” and “Forward-Looking Information/Risk Factors” sections of the MD&A, beginning on pages 22 and 31, respectively, of the Annual Report, which are incorporated herein by reference.

#### Patents and Trademarks

We own the trademarks Aetna®, We Want You To Know® and CareEngine®, together with the corresponding Aetna design logo. The patent on our CareEngine® expires in 2021. We consider our CareEngine® and these trademarks and our other trademarks and trade names important in the operation of our business. However, our business, including that of each of our individual segments, is not dependent on any individual patent, trademark or trade name.

#### Ratings

Information regarding our ratings is included in the “Ratings” section of the MD&A, on page 15 of the Annual Report, which is incorporated herein by reference.

#### Miscellaneous

We had approximately 35,000 employees at December 31, 2009.

The United States federal government is a significant customer of both the Health Care segment and the Company. Premiums and fees and other revenue paid by the federal government accounted for approximately 22% of the Health Care segment's revenue and 21% of our consolidated revenue in 2009. Contracts with CMS for coverage of Medicare-eligible individuals accounted for 80% of our federal government premiums and fees and other revenue, with the balance coming from federal employee-related benefit programs. No other individual customer, in any of our segments, accounted for 10% or more of our consolidated revenues in 2009. Our segments are not dependent upon a single customer or a few customers, the loss of which would have a significant effect on the earnings of a segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on our earnings or the earnings of any of our segments. Refer to Note 19 of Notes to Consolidated Financial Statements, beginning on page 80 of the Annual Report, which is incorporated herein by reference, regarding segment information.

#### **Item 1A. Risk Factors**

The information contained in the "Forward-Looking Information/Risk Factors" section of the MD&A, which begins on page 31 of the Annual Report, is incorporated herein by reference.

#### **Item 1B. Unresolved Staff Comments**

None.

#### **Item 2. Properties**

Our principal office is a building complex located at 151 Farmington Avenue, Hartford, Connecticut that is approximately 1.7 million square feet in size. Our principal office is used by all of our business segments. We also own or lease other space in the greater Hartford area; Blue Bell, Pennsylvania; and various field locations in the United States and several foreign countries. Such properties are primarily used by our Health Care segment. We believe our properties are adequate and suitable for our business as presently conducted.

The foregoing does not include numerous investment properties that we hold in our general and separate accounts.

#### **Item 3. Legal Proceedings**

The information contained under Litigation and Regulatory Proceedings in Note 18 of Notes to Consolidated Financial Statements, which begins on page 78 of the Annual Report, is incorporated herein by reference.

#### **Item 4. Submission of Matters to a Vote of Security Holders**

None.

### **EXECUTIVE OFFICERS OF THE REGISTRANT**

Aetna's Chairman is elected by Aetna's Board of Directors (the "Board") and all of Aetna's other executive officers listed on page 12 are appointed by the Board, generally at its Annual Meeting, and such persons hold office until the next Annual Meeting of the Board or until their successors are elected or appointed. None of these officers has a family relationship with any other executive officer or Director. In addition, there exist no arrangements or understandings, other than those with Directors or executive officers acting solely in their capacities as such, pursuant to which these executive officers were appointed.

<b>Name of Executive Officer</b>	<b>Position*</b>	<b>Age *</b>
Ronald A. Williams	Chairman and Chief Executive Officer	60
Mark T. Bertolini	President	53
Joseph M. Zubretsky	Executive Vice President, Chief Financial Officer and Chief Enterprise Risk Officer	53
William J. Casazza	Senior Vice President and General Counsel	54
Margaret M. McCarthy	Chief Information Officer and Senior Vice President Innovation, Technology and Service Operations	56
Lonny Reisman, M.D.	Senior Vice President and Chief Medical Officer	54

\*As of February 26, 2010

### **Executive Officers' Business Experience During Past Five Years**

**Ronald A. Williams** became Chairman on October 1, 2006, has served as Chief Executive Officer since February 14, 2006, and served as President from May 27, 2002 to July 24, 2007. Mr. Williams is a director of American Express Company (financial services), chairman of the Council for Affordable Quality Healthcare, vice chairman of The Business Council, and is a trustee of The Conference Board and the Connecticut Science Center Board. He also serves on the Massachusetts Institute of Technology ("MIT") North American Executive Board and is a member of MIT's Alfred P. Sloan Management Society.

**Mark T. Bertolini** became President on July 24, 2007, having served as Executive Vice President and Head of Business Operations since May 3, 2007. Prior to that, he had served as Executive Vice President, Regional Businesses from February 1, 2006, and as Senior Vice President, Regional Businesses from September 2005 to February 1, 2006. He served as Senior Vice President, Specialty Group from April 2005 to September 2005 and as Senior Vice President, Specialty Products from February 2003 to April 2005.

**Joseph M. Zubretsky** became Executive Vice President and Chief Financial Officer on April 20, 2007 having served as Executive Vice President, Finance since February 28, 2007. Mr. Zubretsky has also served as the Company's Chief Enterprise Risk Officer since April 27, 2007. Prior to joining Aetna, Mr. Zubretsky served as Senior Executive Vice President for Finance, Investments and Corporate Development at UnumProvident Corporation, a position he assumed in March 2005. Prior to that, Mr. Zubretsky was Chairman and Chief Executive Officer of GAB Robins Group, a global insurance services company, as well as a partner specializing in insurance industry investments with Brera Capital Partners, a New York-based private equity firm, since 1999.

**William J. Casazza** became Senior Vice President and General Counsel on September 6, 2005. He served as Senior Vice President and Deputy General Counsel from July 6, 2004 to September 6, 2005. Mr. Casazza also served as Corporate Secretary from October 2000 to January 27, 2006.

**Margaret M. McCarthy** became Chief Information Officer and Senior Vice President Innovation, Technology and Service Operations on January 1, 2010. She served as Chief Information Officer and Senior Vice President of Procurement and Real Estate from January 30, 2008 to December 31, 2009. Prior to that, Ms. McCarthy was Senior Vice President and Chief Information Officer from June 3, 2005 to January 29, 2008 and Vice President for Business Solutions Delivery since 2003.

**Lonny Reisman, M.D.,** became Senior Vice President and Chief Medical Officer on November 12, 2008, having served as Chief Executive Officer and as a director of ActiveHealth Management Inc. since October, 1998. We acquired ActiveHealth Management in 2005.

## Part II

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

Our common shares ("common stock") are listed on the New York Stock Exchange, where they trade under the symbol AET. As of January 31, 2010, there were 9,984 record holders of our common stock.

On February 27, 2009, we announced that our Board authorized a share repurchase program for the repurchase of up to \$750 million of common stock. During the three months ended December 31, 2009, we repurchased approximately 3.7 million shares of common stock at a cost of approximately \$111 million under this program. At December 31, 2009, we had authorization to repurchase up to \$591 million of common stock remaining under the February 27, 2009 authorization.

The following table provides information about our monthly share repurchases, all of which were purchased as part of a publicly-announced program, for the three months ended December 31, 2009:

<b>Issuer Purchases of Equity Securities</b>				
(Millions, except per share amounts)	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs
October 1, 2009 - October 31, 2009	-	\$ -	-	\$ 702.2
November 1, 2009 - November 30, 2009	2.1	28.92	2.1	642.2
December 1, 2009 - December 31, 2009	1.6	31.67	1.6	591.2
<b>Total</b>	<b>3.7</b>	<b>\$ 30.12</b>	<b>3.7</b>	<b>N/A</b>

We declared, and subsequently paid, an annual cash dividend in the amount of \$.04 per share of common stock in each of 2009 and 2008. Information regarding restrictions on our present and future ability to pay dividends is included in the "Liquidity and Capital Resources" section of the MD&A and Note 16 of Notes to Consolidated Financial Statements, beginning on pages 13 and 76, respectively, of the Annual Report, which are incorporated herein by reference. Information regarding quarterly common stock prices is incorporated herein by reference to the Quarterly Data (unaudited) included on page 87 of the Annual Report.

### Item 6. Selected Financial Data

The information contained in Selected Financial Data on page 43 of the Annual Report is incorporated herein by reference.

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

The information contained in the MD&A, beginning on page 2 of the Annual Report, is incorporated herein by reference.

### Item 7A. Quantitative and Qualitative Disclosures About Market Risk

The information contained in the "Risk Management and Market-Sensitive Instruments" section of the MD&A, on page 13 of the Annual Report, is incorporated herein by reference.

### Item 8. Financial Statements and Supplementary Data

The information contained in Consolidated Financial Statements, Notes to Consolidated Financial Statements, Report of Independent Registered Public Accounting Firm and Quarterly Data (unaudited), beginning on page 44 of the Annual Report, is incorporated herein by reference.

## **Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure**

None.

### **Item 9A. Controls and Procedures**

#### **Disclosure Controls and Procedures**

We maintain disclosure controls and procedures, which are designed to ensure that information that we are required to disclose in the reports we file or submit under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

An evaluation of the effectiveness of our disclosure controls and procedures as of December 31, 2009 was conducted under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures as of December 31, 2009 were effective and designed to ensure that material information relating to Aetna Inc. and its consolidated subsidiaries would be made known to the Chief Executive Officer and Chief Financial Officer by others within those entities, particularly during the periods when periodic reports under the Exchange Act are being prepared. Refer to the Certifications by our Chief Executive Officer and Chief Financial Officer filed as Exhibits 31.1 and 31.2 to this Form 10-K.

#### **Management's Report on Internal Control Over Financial Reporting**

Management's Report on Internal Control Over Financial Reporting, on page 85 of the Annual Report, is incorporated herein by reference.

#### **Report of Independent Registered Public Accounting Firm**

The Report of Independent Registered Public Accounting Firm, on page 86 of the Annual Report, is incorporated herein by reference.

#### **Changes in Internal Control over Financial Reporting**

There has been no change in our internal control over financial reporting identified in connection with the evaluation of such control that occurred during our fourth fiscal quarter that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

### **Item 9B. Other Information**

None.

## **Part III**

### **Item 10. Directors, Executive Officers and Corporate Governance**

Information concerning the Executive Officers of Aetna Inc. is included in Part I pursuant to General Instruction G to Form 10-K.

Information concerning our Directors, our Directors' and certain of our executives' compliance with Section 16(a) of the Exchange Act, our Code of Conduct (our written code of ethics) and our audit committee and audit committee financial experts is incorporated herein by reference to the information under the captions "Nominees for Directorships," "Certain Transactions and Relationships," "Section 16(a) Beneficial Ownership Reporting Compliance," "Aetna's Code of Conduct" and "Board and Committee Membership; Committee Descriptions" in the Proxy Statement.

## **Item 11. Executive Compensation**

The information under the captions “Compensation Discussion and Analysis,” “Director Compensation Philosophy and Elements,” “Executive Compensation,” “Compensation Committee Interlocks and Insider Participation” and “Report of the Committee on Compensation and Organization” in the Proxy Statement is incorporated herein by reference.

## **Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters**

The information under the caption “Security Ownership of Certain Beneficial Owners, Directors, Nominees and Executive Officers” and “Equity Compensation Plans” in the Proxy Statement is incorporated herein by reference.

## **Item 13. Certain Relationships and Related Transactions, and Director Independence**

The information under the captions “Director Independence” and “Related Party Transaction Policy” in the Proxy Statement is incorporated herein by reference.

## **Item 14. Principal Accounting Fees and Services**

The information under the captions “Fees Incurred for 2009 and 2008 Services Performed by the Independent Registered Public Accounting Firm” and “Nonaudit Services and Other Relationships Between the Company and the Independent Registered Public Accounting Firm” in the Proxy Statement is incorporated herein by reference.

## **Part IV**

### **Item 15. Exhibits, Financial Statement Schedules**

The following documents are filed as part of this Form 10-K:

#### *Financial statements*

The Consolidated Financial Statements, Notes to Consolidated Financial Statements and Report of Independent Registered Public Accounting Firm, which begin on pages 44, 48 and 86, respectively, of the Annual Report, are incorporated herein by reference.

#### *Financial statement schedule*

The Condensed Financial Information of Aetna Inc. (Parent Company Only) is included in this Item 15. Refer to Index to Financial Statement Schedules on page 19.

#### *Exhibits\**

Exhibits to this Form 10-K are as follows:

### **3 Articles of Incorporation and By-Laws**

- 3.1 Amended and Restated Articles of Incorporation of Aetna Inc., incorporated herein by reference to Exhibit 99.1 to Aetna Inc.’s Form 8-K filed on May 2, 2007.
- 3.2 Amended and Restated By-Laws of Aetna Inc., incorporated herein by reference to Exhibit 99.2 to Aetna Inc.’s Form 8-K filed on May 2, 2007.

### **4 Instruments defining the rights of security holders, including indentures**

- 4.1 Form of Aetna Inc. Common Share certificate, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.’s Amendment No. 2 to Registration Statement on Form 10 filed on December 1, 2000.
- 4.2 Senior Indenture between Aetna Inc. and U. S. Bank National Association, successor in interest to State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.’s Form 10-Q filed on May 10, 2001.

4.3 Form of Subordinated Indenture between Aetna Inc. and U. S. Bank National Association, successor in interest to State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.2 to Aetna Inc.'s Registration Statement on Form S-3 filed on January 19, 2001.

**10 Material contracts**

- 10.1 Form of Distribution Agreement between Aetna's former parent company and Aetna Inc., incorporated herein by reference to Annex C to Aetna's former parent company's definitive proxy statement on Schedule 14A filed on October 18, 2000.
- 10.2 \$1,500,000,000 Amended and Restated Five-Year Credit Agreement dated as of March 27, 2008, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.'s Form 8-K filed on April 1, 2008.
- 10.3 Amended and Restated Aetna Inc. 2000 Stock Incentive Plan, incorporated by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-K filed on February 27, 2009. \*\*
- 10.4 Form of Aetna Inc. 2000 Stock Incentive Plan - Stock Appreciation Right Terms of Award, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on October 26, 2006. \*\*
- 10.5 Form of Aetna Inc. 2000 Stock Incentive Plan - Restricted Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on October 26, 2006. \*\*
- 10.6 Form of Aetna Inc. 2000 Stock Incentive Plan - Aetna Performance Unit Award Agreement, incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on October 26, 2006. \*\*
- 10.7 Form of Aetna Inc. 2000 Stock Incentive Plan - Aetna Performance Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.10 to Aetna Inc.'s Form 10-K filed on February 29, 2008. \*\*
- 10.8 Form of Aetna Inc. 2000 Stock Incentive Plan - Restricted Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q/A filed on August 1, 2008. \*\*
- 1 10.9 Form of Aetna Inc. 2000 Stock Incentive Plan - Restricted Stock Unit Terms Of Award (with non-compete provision), incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q/A filed on August 1, 2008. \*\*
- 10.10 Amended and Restated Aetna Inc. 2002 Stock Incentive Plan, incorporated by reference to Exhibit 10.11 to Aetna Inc.'s Form 10-K filed February 27, 2009. \*\*
- 10.11 Amended and Restated Aetna Inc. 2001 Annual Incentive Plan, incorporated by reference to Exhibit 10.12 to Aetna Inc.'s Form 10-K filed on February 27, 2009. \*\*
- 10.12 Aetna Inc. Non-Employee Director Compensation Plan as Amended through December 5, 2008, incorporated by reference to Exhibit 10.13 to Aetna Inc.'s Form 10-K filed on February 27, 2009. \*\*
- 10.13 Form of Aetna Inc. Non-Employee Director Compensation Plan - Restricted Stock Unit Agreement, incorporated herein by reference to Exhibit 10.4 to Aetna Inc.'s Form 10-Q filed on October 26, 2006. \*\*
- 10.14 1999 Director Charitable Award Program, as Amended and Restated on January 25, 2008, incorporated herein by referenced to Exhibit 10.15 to Aetna Inc.'s Form 10-K filed on February 29, 2008. \*\*
- 10.15 Amended and Restated Employment Agreement dated as of December 5, 2003 by and between Aetna Inc. and Ronald A. Williams, incorporated herein by reference to Exhibit 10.24 to Aetna Inc.'s Form 10-K filed on February 27, 2004. \*\*
- 1 10.16 Amendment to Employment Agreement dated as of January 27, 2006 between Aetna Inc. and Ronald A. Williams, incorporated herein by reference to Exhibit 10.14 to Aetna Inc.'s Form 10-K filed on March 1, 2006. \*\*
- 1 10.17 Amendment No. 2 to Employment Agreement dated as of December 31, 2008 between Aetna Inc. and Ronald A. Williams, incorporated by reference to Exhibit 10.18 to Aetna Inc.'s Form 10-K filed on February 27, 2009. \*\*



- 10.18 Amendment No. 3 to Employment Agreement dated as of December 11, 2009 between Aetna Inc. and Ronald A. Williams. \*\*
- 10.19 Incentive Stock Unit Agreement between Aetna Inc. and Ronald A. Williams dated as of February 14, 2006, pursuant to the Aetna Inc. 2000 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.15 to Aetna Inc.'s Form 10-K filed on March 1, 2006. \*\*
- 10.20 Employment Agreement dated as of July 24, 2007, between Aetna Inc. and Mark T. Bertolini, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on July 26, 2007. \*\*
- 10.21 Amendment No. 1 to Employment Agreement dated as of December 31, 2008 between Aetna Inc. and Mark T. Bertolini, incorporated by reference to Exhibit 10.21 to Aetna Inc.'s Form 10-K filed on February 27, 2009. \*\*
- 10.22 Amendment No. 2 to Employment Agreement dated as of December 22, 2009 between Aetna Inc. and Mark T. Bertolini. \*\*
- 10.23 Letter agreement dated January 25, 2007 between Aetna Inc. and Joseph M. Zubretsky, incorporated herein by reference to Exhibit 10.29 to Aetna Inc.'s Form 10-K filed on February 27, 2007. \*\*
- 10.24 Amendment No. 1 to Employment Agreement dated as of December 17, 2008 between Aetna Inc. and Joseph M. Zubretsky, incorporated by reference to Exhibit 10.23 to Aetna Inc.'s Form 10-K filed on February 27, 2009. \*\*
- 10.25 Letter agreement dated July 20, 2000 between Aetna Inc. and William J. Casazza, incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on April 24, 2008. \*\*
- 10.26 Amended and Restated Employment Agreement, dated as of December 21, 2004, between ActiveHealth Management, Inc. and Lonny Reisman, M.D., incorporated by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on April 29, 2009. \*\*
- 10.27 Employment Agreement Amendment, dated as of May 12, 2005, among Aetna Inc., ActiveHealth Management, Inc. and Lonny Reisman, M.D., incorporated by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on April 29, 2009. \*\*
- 10.28 Amendment No. 2 to Employment Agreement, dated as of December 31, 2008, between Aetna Inc. and Lonny Reisman, M.D., incorporated by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on April 29, 2009. \*\*
- 10.29 Description of certain arrangements not embodied in formal documents, as described under the headings "2009 Non-management Director Compensation" and "Additional Director Compensation Information" are incorporated herein by reference to the Proxy Statement. \*\*

**11 Statement re: computation of per share earnings**

- 11.1 Computation of per share earnings is incorporated herein by reference to Note 4 of Notes to Consolidated Financial Statements on page 55 of the Annual Report.

**12 Statement re: computation of ratios**

- 12.1 Computation of ratio of earnings to fixed charges.

**1 13 Annual report to security holders**

- 13.1 Management's Discussion and Analysis of Financial Condition and Results of Operations, Selected Financial Data, Consolidated Financial Statements, Notes to Consolidated Financial Statements, Management's Report on Internal Control Over Financial Reporting, Management's Responsibility for Financial Statements, Audit Committee Oversight, Report of Independent Registered Public Accounting Firm and Quarterly Data (unaudited) are incorporated herein by reference to the Annual Report and filed herewith in electronic format.

**14 Code of Ethics**  
14.1 Aetna Inc. Code of Conduct, as amended on December 4, 2009.

**21 Subsidiaries of the registrant**  
21.1 Subsidiaries of Aetna Inc.

**23 Consents of experts and counsel**  
23.1 Consent of Independent Registered Public Accounting Firm.

**24 Power of Attorney**  
24.1 Power of Attorney.

**31 Rule 13a – 14(a)/15d – 14(e) Certifications**  
31.1 Certification.

31.2 Certification.

**32 Section 1350 Certifications**  
32.1 Certification.

32.2 Certification.

**101 XBRL Documents**

101.INS XBRL Instance Document.

101.SCH XBRL Taxonomy Extension Schema.

101.CAL XBRL Taxonomy Extension Calculation Linkbase.

101.DEF XBRL Taxonomy Extension Definition Linkbase.

101.LAB XBRL Taxonomy Extension Label Linkbase.

101.PRE XBRL Taxonomy Extension Presentation Linkbase.

\* Copies of exhibits will be furnished without charge upon written request to the Office of the Corporate Secretary, Aetna Inc., 151 Farmington Avenue, Hartford, Connecticut 06156.

\*\* Management contract or compensatory plan or arrangement.

**Index to Financial Statement Schedule**

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## **Report of Independent Registered Public Accounting Firm**

The Board of Directors and Shareholders  
Aetna Inc.

Under the date of February 26, 2010, we reported on the consolidated balance sheets of Aetna Inc. and subsidiaries (the "Company") as of December 31, 2009 and 2008, and the related consolidated statements of income, shareholders' equity and cash flows for each of the years in the three-year period ended December 31, 2009, as contained in the Annual Report on Form 10-K for the year ended December 31, 2009. In connection with our audits of the aforementioned consolidated financial statements, we also audited the related financial statement schedule listed in the accompanying index. The financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statement schedule based on our audits.

In our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

As discussed in Notes 2 and 5 to the financial statements, effective April 1, 2009, the Company changed its method of accounting for other-than-temporary impairments of debt securities due to the adoption of new accounting guidance issued by the Financial Accounting Standards Board.

/s/ KPMG LLP

Hartford, Connecticut  
February 26, 2010

## Schedule I – Financial Information of Aetna Inc.

### Aetna Inc. (Parent Company Only) Statements of Income

<b>(Millions)</b>	<b>For the Years Ended December 31,</b>		
	<b>2009</b>	<b>2008</b>	<b>2007</b>
Net investment income	\$ 2.8	\$ 10.5	\$ 26.0
Other income	30.2	-	-
Net realized capital losses	(3.5)	(11.6)	(.9)
<b>Total revenue</b>	<b>29.5</b>	<b>(1.1)</b>	<b>25.1</b>
Operating expenses	95.8	69.9	112.7
Interest expense	243.5	236.0	180.3
<b>Total expenses</b>	<b>339.3</b>	<b>305.9</b>	<b>293.0</b>
Loss before income tax benefit and equity in earnings of affiliates, net	(309.8)	(307.0)	(267.9)
Income tax benefit	104.7	86.6	97.1
Equity in earnings of affiliates, net <sup>(1)</sup>	1,481.6	1,604.5	2,001.8
<b>Net income</b>	<b>\$ 1,276.5</b>	<b>\$ 1,384.1</b>	<b>\$ 1,831.0</b>

(1) Includes amortization of other acquired intangible assets after tax of \$63.2 million, \$70.3 million and \$63.4 million for the years ended December 31, 2009, 2008 and 2007, respectively.

Refer to accompanying Notes to Financial Statements.

**Aetna Inc. (Parent Company Only)**  
**Balance Sheets**

(Millions)	At December 31,	
	2009	2008
<b>Assets</b>		
Current assets:		
Cash and cash equivalents	\$ 75.3	\$ 33.8
Investments	43.7	63.4
Other receivables	142.5	99.3
Income taxes receivable	-	16.1
Deferred income taxes	70.4	63.0
Other current assets	13.0	19.2
<b>Total current assets</b>	<b>344.9</b>	<b>294.8</b>
Investment in affiliates (1)	14,285.1	12,643.2
Long-term investments	42.2	-
Deferred income taxes	578.7	539.7
Other long-term assets	26.0	27.5
<b>Total assets</b>	<b>\$ 15,276.9</b>	<b>\$ 13,505.2</b>
<b>Liabilities and shareholders' equity</b>		
Current liabilities:		
Short-term debt	\$ 480.8	\$ 215.7
Income tax payable	6.4	-
Accrued expenses and other current liabilities	341.4	262.3
<b>Total current liabilities</b>	<b>828.6</b>	<b>478.0</b>
Long-term debt	3,639.5	3,638.3
Employee benefit liabilities	1,269.3	1,169.6
Other long-term liabilities	35.7	32.9
<b>Total liabilities</b>	<b>5,773.1</b>	<b>5,318.8</b>
Shareholders' equity:		
Common stock (\$.01 par value; 2.7 billion shares authorized; 430.8 million and 456.3 million shares issued and outstanding in 2009 and 2008, respectively) and additional paid-in capital	470.1	351.2
Retained earnings	10,256.7	9,716.5
Accumulated other comprehensive loss	(1,223.0)	(1,881.3)
<b>Total shareholders' equity</b>	<b>9,503.8</b>	<b>8,186.4</b>
<b>Total liabilities and shareholders' equity</b>	<b>\$ 15,276.9</b>	<b>\$ 13,505.2</b>

(1) Includes goodwill and other acquired intangible assets of \$5.7 billion and \$5.8 billion at December 31, 2009 and 2008, respectively.

Refer to accompanying Notes to Financial Statements.

**Aetna Inc. (Parent Company Only)**  
**Statements of Shareholders' Equity**

(Millions)	Number of Common Shares Outstanding	Common Stock and Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income	Total Shareholders' Equity	Comprehensive Income (Loss)
<b>Balance at December 31, 2006</b>	516.0	\$ 366.2	\$ 9,404.6	\$ (625.7)	\$ 9,145.1	
Cumulative effect of new accounting standards (Note 2)	-	-	(1.0)	113.9	112.9	
Beginning balance at January 1, 2007, as adjusted	516.0	366.2	9,403.6	(511.8)	9,258.0	
Comprehensive income:						
Net income	-	-	1,831.0	-	1,831.0	\$ 1,831.0
Other comprehensive income:						
Net unrealized losses on securities	-	-	-	(13.2)	(13.2)	
Net foreign currency and derivative losses	-	-	-	(12.2)	(12.2)	
Pension and OPEB plans	-	-	-	248.8	248.8	
Other comprehensive income	-	-	-	223.4	223.4	223.4
Total comprehensive income						<u>\$ 2,054.4</u>
Common shares issued for benefit plans, including tax benefits	13.5	415.0	-	-	415.0	
Repurchases of common shares	(33.2)	(592.4)	(1,076.6)	-	(1,669.0)	
Dividends declared (\$.04 per share)	-	-	(20.0)	-	(20.0)	
<b>Balance at December 31, 2007</b>	496.3	188.8	10,138.0	(288.4)	10,038.4	
Comprehensive income:						
Net income	-	-	1,384.1	-	1,384.1	\$ 1,384.1
Other comprehensive loss:						
Net unrealized losses on securities	-	-	-	(282.6)	(282.6)	
Net foreign currency and derivative losses	-	-	-	(15.7)	(15.7)	
Pension and OPEB plans	-	-	-	(1,294.6)	(1,294.6)	
Other comprehensive loss	-	-	-	(1,592.9)	(1,592.9)	(1,592.9)
Total comprehensive loss						<u>\$ (208.8)</u>
Common shares issued for benefit plans, including tax benefits	2.9	162.9	-	-	162.9	
Repurchases of common shares	(42.9)	(.5)	(1,787.2)	-	(1,787.7)	
Dividends declared (\$.04 per share)	-	-	(18.4)	-	(18.4)	
<b>Balance at December 31, 2008</b>	456.3	351.2	9,716.5	(1,881.3)	8,186.4	
Cumulative effect of adopting new accounting standard at April 1, 2009 (Note 2)	-	-	53.7	(53.7)	-	
Comprehensive income:						
Net income	-	-	1,276.5	-	1,276.5	\$ 1,276.5
Other comprehensive income:						
Net unrealized gains on securities	-	-	-	619.0	619.0	
Net foreign currency and derivative gains	-	-	-	34.0	34.0	
Pension and OPEB plans	-	-	-	59.0	59.0	
Other comprehensive income	-	-	-	712.0	712.0	712.0
Total comprehensive income						<u>\$ 1,988.5</u>
Common shares issued for benefit plans, including tax benefits	3.4	119.2	-	-	119.2	
Repurchases of common shares	(28.9)	(.3)	(772.7)	-	(773.0)	
Dividends declared (\$.04 per share)	-	-	(17.3)	-	(17.3)	
<b>Balance at December 31, 2009</b>	430.8	\$ 470.1	\$ 10,256.7	\$ (1,223.0)	\$ 9,503.8	

Refer to accompanying Notes to Financial Statements.

**Aetna Inc. (Parent Company Only)**  
**Statements of Cash Flows**

<b>(Millions)</b>	<b>For the Years Ended December 31,</b>		
	<b>2009</b>	<b>2008</b>	<b>2007</b>
<b>Cash flows from operating activities:</b>			
Net income	\$ 1,276.5	\$ 1,384.1	\$ 1,831.0
Adjustments to reconcile net income to net cash used for operating activities:			
Equity earnings of affiliates (1)	(1,481.6)	(1,604.5)	(2,001.8)
Stock-based compensation expense	90.7	95.7	89.4
Net realized capital losses	3.5	11.6	.9
Net change in other assets and other liabilities	151.0	(150.0)	(119.3)
<b>Net cash provided by (used for) operating activities</b>	<b>40.1</b>	<b>(263.1)</b>	<b>(199.8)</b>
<b>Cash flows from investing activities:</b>			
Proceeds from sales and maturities of investments	20.9	78.0	-
Cost of investments	(1.0)	(1.3)	(14.5)
Dividends received from affiliates, net	444.1	1,355.2	842.4
<b>Net cash provided by investing activities</b>	<b>464.0</b>	<b>1,431.9</b>	<b>827.9</b>
<b>Cash flows from financing activities:</b>			
Proceeds from issuance of long-term debt, net of issuance costs	-	484.8	663.9
Net issuance of short-term debt	266.1	116.5	99.5
Common shares issued under benefit plans	14.8	29.7	170.8
Stock-based compensation tax benefits	5.1	27.8	153.2
Common shares repurchased	(773.0)	(1,787.7)	(1,695.6)
Collateral held on interest rate swaps	41.7	-	-
Dividends paid to shareholders	(17.3)	(18.4)	(20.0)
<b>Net cash used for financing activities</b>	<b>(462.6)</b>	<b>(1,147.3)</b>	<b>(628.2)</b>
Net increase (decrease) in cash and cash equivalents	41.5	21.5	(.1)
Cash and cash equivalents, beginning of period	33.8	12.3	12.4
<b>Cash and cash equivalents, end of period</b>	<b>\$ 75.3</b>	<b>\$ 33.8</b>	<b>\$ 12.3</b>
<b>Supplemental cash flow information:</b>			
Interest paid	\$ 244.4	\$ 227.1	\$ 177.3
Income taxes refunded	62.9	236.6	292.8

(1) Includes amortization of other acquired intangible assets after tax of \$63.2 million, \$70.3 million and \$63.4 million for the years ended December 31, 2009, 2008 and 2007, respectively.

Refer to accompanying Notes to Financial Statements.

**Aetna Inc. (Parent Company Only)**  
**Notes to Financial Statements**

**1. Organization**

The financial statements reflect financial information for Aetna Inc. (a Pennsylvania corporation) only (the “Parent Company”). The financial information presented herein includes the balance sheet of Aetna Inc. as of December 31, 2009 and 2008 and the related statements of income, shareholders’ equity and cash flows for the years ended December 31, 2009, 2008 and 2007. The accompanying financial statements should be read in conjunction with the consolidated financial statements and notes thereto in the Annual Report.

**2. Summary of Significant Accounting Policies**

Refer to Note 2 of Notes to Consolidated Financial Statements, beginning on page 48 of the Annual Report, for the summary of significant accounting policies.

**3. Dividends**

Cash dividends received from subsidiaries and included in net cash provided by (used for) operating entities in the Statements of Cash Flows were \$961 million, \$1.8 billion and \$1.5 billion in 2009, 2008 and 2007, respectively.

**4. Acquisitions and Dispositions**

Refer to Note 3 of Notes to Consolidated Financial Statements, on page 55 of the Annual Report, for a description of acquisitions and dispositions.

**5. Other Comprehensive Income (Loss)**

Refer to Note 9 of Notes to Consolidated Financial Statements, beginning on page 62 of the Annual Report, for a description of accumulated other comprehensive income (loss).

**6. Debt**

Refer to Note 14 of Notes to Consolidated Financial Statements, on page 75 of the Annual Report, for a description of debt.

## Signatures

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: February 26, 2010

Aetna Inc.

By: /s/ Rajan Parmeswar  
Rajan Parmeswar  
Vice President, Controller and Chief Accounting Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signer	Title	Date
<u>/s/ Ronald A. Williams</u> Ronald A. Williams	Chairman and Chief Executive Officer (Principal Executive Officer)	February 26, 2010
<u>/s/ Joseph M. Zubretsky</u> Joseph M. Zubretsky	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 26, 2010
<u>/s/ Rajan Parmeswar</u> Rajan Parmeswar	Vice President, Controller and Chief Accounting Officer (Principal Accounting Officer)	February 26, 2010
Frank M. Clark *	Director	
Betsy Z. Cohen *	Director	
Molly J. Coye, M.D. *	Director	
Roger N. Farah *	Director	
Barbara Hackman Franklin *	Director	
Jeffrey E. Garten *	Director	
Earl G. Graves *	Director	
Gerald Greenwald *	Director	
Ellen M. Hancock *	Director	
Richard J. Harrington *	Director	
Edward J. Ludwig *	Director	
Joseph P. Newhouse *	Director	

\* By: /s/ Rajan Parmeswar  
Rajan Parmeswar  
Attorney-in-fact  
February 26, 2010

## INDEX TO EXHIBITS

Exhibit Number	Description of Exhibit	Filing Method
<b>10</b>	<b>Material contracts</b>	
10.18	Amendment No. 3 to Employment Agreement dated as of December 11, 2009 between Aetna Inc. and Ronald A. Williams.	Electronic
10.22	Amendment No. 2 to Employment Agreement dated as of December 22, 2009 between Aetna Inc. and Mark T. Bertolini.	Electronic
<b>12</b>	<b>Statement re: computation of ratios</b>	
12.1	Computation of ratio of earnings to fixed charges.	Electronic
<b>13</b>	<b>Annual report to security holders</b>	
13.1	Management's Discussion and Analysis of Financial Condition and Results of Operations, Selected Financial Data, Consolidated Financial Statements, Notes to Consolidated Financial Statements, Management's Report on Internal Control Over Financial Reporting, Management's Responsibility for Financial Statements, Audit Committee Oversight, Report of Independent Registered Public Accounting Firm and Quarterly Data (unaudited) sections of the Annual Report.	Electronic
<b>14</b>	<b>Code of Ethics</b>	
14.1	Aetna Inc. Code of Conduct, as amended on December 4, 2009.	Electronic
<b>21</b>	<b>Subsidiaries of the registrant</b>	
21.1	Subsidiaries of Aetna Inc.	Electronic
<b>23</b>	<b>Consents of experts and counsel</b>	
23.1	Consent of Independent Registered Public Accounting Firm.	Electronic
<b>24</b>	<b>Power of Attorney</b>	
24.1	Power of Attorney.	Electronic
<b>31</b>	<b>Rule 13a – 14(a)/15d – 14(e) Certifications</b>	
31.1	Certification.	Electronic
31.2	Certification.	Electronic
<b>32</b>	<b>Section 1350 Certifications</b>	
32.1	Certification.	Electronic
32.2	Certification.	Electronic
<b>101</b>	<b>XBRL Documents</b>	
101.INS	XBRL Instance Document.	
101.SCH	XBRL Taxonomy Extension Schema.	
101.CAL	XBRL Taxonomy Extension Calculation Linkbase.	

101.DEF XBRL Taxonomy Extension Definition Linkbase.

101.LAB XBRL Taxonomy Extension Label Linkbase.

101.PRE XBRL Taxonomy Extension Presentation Linkbase.



**Amendment No. 3 to Employment Agreement**

Amendment Number 3 to the Amended and Restated Employment Agreement dated as of December 5, 2003 (the "Employment Agreement") as further amended on January 27, 2006 and December 31, 2008, by and between Aetna Inc. ("Aetna"), a Pennsylvania corporation, and Ronald A. Williams ("Executive").

**WHEREAS**, Aetna and Executive have previously entered into the Agreement;

**WHEREAS**, the Employment Agreement was amended on January 27, 2006 ("Amendment Number 1") and December 31, 2008 ("Amendment Number 2");

**WHEREAS**, Aetna and Executive wish to further amend the Employment Agreement to address certain changes to the interpretation of Section 162(m) of the Internal Revenue Code of 1986, as amended, described in IRS Revenue Ruling 2008-13;

**NOW, THEREFORE**, the Agreement is amended effective January 1, 2010, as follows:

1. Section 3.04(b) (ii) is amended to read in its entirety as follows: "The Pro-Rata Bonus Amount, provided that the minimum 162(m) performance criteria established under the Aetna Inc. Annual Incentive Plan (162(m)) or any such successor plan are satisfied (the performance target shall include a straight monthly proration for any performance period that is less than 12 months). For purposes of this Section 3.04(b) (ii), the performance period shall end on the later of (i) September 30th in the year of termination of employment or (ii) the end of the month prior to the month of termination of employment. The amount, if any, shall be paid on the latest of (x) 35 days following the end of the performance period (but not later than December 31st of the year of termination of employment), (y) 60 days following the Qualifying Event and (z) six months following termination of employment, to the extent required pursuant to Section 6.17(b) hereof.

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be executed this 11 day of December, 2009.

**Aetna Inc.**

/s/ Elease E. Wright\_\_\_\_\_

By: Elease E. Wright

Title: Sr. V.P. Human Resources

**Executive**

/s/ Ronald A. Williams

Ronald A. Williams

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**Amendment No. 2 to Employment Agreement**

Amendment Number 2 to the Employment Agreement dated as of July 24, 2007 (the "Employment Agreement") as further amended on December 31, 2008, by and between Aetna Inc. ("Aetna"), a Pennsylvania corporation, and Mark T. Bertolini ("Executive").

**WHEREAS**, Aetna and Executive have previously entered into the Employment Agreement;

**WHEREAS**, the Employment Agreement was amended on December 31, 2008 ("Amendment Number 1");

**WHEREAS**, Aetna and Executive wish to further amend the Employment Agreement to address certain changes to the interpretation of Section 162(m) of the Internal Revenue Code of 1986, as amended, described in IRS Revenue Ruling 2008-13;

**NOW, THEREFORE**, the Employment Agreement is amended effective January 1, 2010, as follows:

1. Section 3.03(b)(ii) is amended to read in its entirety as follows: "A pro-rata bonus amount for the year of Executive's termination of employment calculated as Executive's target bonus opportunity for the year of Executive's termination of employment multiplied by a fraction, the numerator of which is the number of days in the year through the date of Executive's termination of employment and the denominator of which is 365, provided that the minimum 162(m) performance criteria established under the Aetna Inc. Annual Incentive Plan (162(m)) or any such successor plan applicable to Executive with respect to such year are satisfied. In the event that Executive's termination of employment occurs prior to the determination of performance criteria applicable to the performance period for the year of Executive's termination of employment, the performance criteria applicable to Executive in respect of the pro-rata bonus shall be at least as favorable to Executive as the most favorable performance criteria applicable for that year to any award to a named executive officer of the Company, within the meaning of Section 402(a)(3) of Regulation S-K. Payment of this pro-rata bonus amount, if any, shall be made to Executive within 45 days following the completion of the performance period in which Executive's termination of employment occurs."

**IN WITNESS WHEREOF**, the undersigned has caused this Amendment to be executed this 22 day of December, 2009.

**Aetna Inc.**

/s/ Elease E. Wright  
By: Elease E. Wright  
Title: Sr. V.P. Human Resources

**Executive**

/s/ Mark T. Bertolini  
Mark T. Bertolini

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**Computation of Ratio of Earnings to Fixed Charges**

The computation of the ratio of earnings to fixed charges for the years ended December 31, 2009, 2008, 2007, 2006 and 2005 are as follows:

<b>(Millions)</b>	<b>Years Ended December 31,</b>				
	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>2006</b>	<b>2005</b>
Pretax income from continuing operations	<b>\$1,901.2</b>	\$2,174.2	\$2,796.4	\$2,586.6	\$2,453.3
Add back fixed charges	<b>302.9</b>	297.9	234.3	199.5	177.5
<b>Income as adjusted</b>	<b>\$2,204.1</b>	\$2,472.1	\$3,030.7	\$2,786.1	\$2,630.8
Fixed charges:					
Interest on indebtedness	<b>\$ 243.4</b>	\$ 236.4	\$ 180.6	\$ 148.3	\$ 122.8
Portion of rents representative of interest factor	<b>59.5</b>	61.5	53.7	51.2	54.7
<b>Total fixed charges</b>	<b>\$ 302.9</b>	\$ 297.9	\$ 234.3	\$ 199.5	\$ 177.5
<b>Ratio of earnings to fixed charges</b>	<b>7.28</b>	8.30	12.94	13.97	14.82



## **2009 Aetna Annual Report, Financial Report to Shareholders**

*Unless the context otherwise requires, references to the terms we, our, or, us, used throughout this 2009 Annual Report, Financial Report to Shareholders (the “Annual Report”) refer to Aetna Inc. (a Pennsylvania corporation) (“Aetna”) and its subsidiaries.*

For your reference, we provide the following index to the Annual Report:

<b>Page</b>	
<b>2 - 42</b>	<b>Management’s Discussion and Analysis of Financial Condition and Results of Operations (“MD&amp;A”)</b> The MD&A covers the years 2007 through 2009, as well as our financial condition at December 31, 2009 and 2008. The MD&A should be read in conjunction with the financial statements and notes thereto. The MD&A is comprised of the following:
<i>2</i>	<i>Overview – We begin our MD&amp;A with an overview of earnings and cash flows for the years 2007 through 2009, as well as our financial condition at December 31, 2009 and 2008.</i>
<i>4</i>	<i>Health Care – We provide a quantitative and qualitative discussion about the factors affecting Health Care revenues and cash flows.</i>
<i>8</i>	<i>Group Insurance – We provide a quantitative and qualitative discussion about the factors affecting Group Insurance revenues and cash flows.</i>
<i>9</i>	<i>Large Case Pensions – We provide a quantitative and qualitative discussion about the factors affecting Large Case Pensions revenues and cash flows, of discontinued products, in this section.</i>
<i>11</i>	<i>Investments – As an insurer, we have substantial investment portfolios that support our liabilities and capital. In this section, we discuss our investment portfolios and realized capital gains and losses and describe our evaluation of the risk of our marketable securities.</i>
<i>13</i>	<i>Liquidity and Capital Resources – In this section, we discuss our cash flows, financing resources, contractual obligations, and liquidity and cash flows.</i>
<i>16</i>	<i>Critical Accounting Estimates – In this section, we discuss the accounting estimates we consider critical in preparing our financial statements, consider them critical and the key assumptions used in making these estimates and the sensitivities of those assumptions to changes in the underlying assumptions.</i>
<i>22</i>	<i>Regulatory Environment – In this section, we provide a discussion of the regulatory environment in which we operate.</i>
<i>31</i>	<i>Forward-Looking Information/Risk Factors – We conclude our MD&amp;A with a discussion of certain risks and uncertainties that we believe may have a material adverse impact on our business, financial condition or results of operations.</i>
<b>43</b>	<b>Selected Financial Data</b> – We provide selected annual financial data for the most recent five years.
<b>44</b>	<b>Consolidated Financial Statements</b> – Includes our consolidated balance sheets at December 31, 2009 and 2008 and the consolidated statements of shareholders’ equity and cash flows for each of the years in the three-year period ended December 31, 2009. These financial statements are included in the accompanying Notes to Consolidated Financial Statements.
<b>48</b>	<b>Notes to Consolidated Financial Statements</b>
<b>85</b>	<b>Reports of Management and our Independent Registered Public Accounting Firm</b> – We include a report from management over financial reporting and financial statements, the oversight of our Audit Committee and KPMG LLP’s opinion on our internal control over financial reporting.
<b>87</b>	<b>Quarterly Data (unaudited)</b> – We provide selected quarterly financial data for each of the quarters in 2009 and 2008.
<b>87</b>	<b>Corporate Performance Graph</b> – We provide a graph comparing the cumulative total shareholder return on our common stock to the published indices from December 31, 2004 through December 31, 2009.

## Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A")

### OVERVIEW

We are one of the nation's leading diversified health care benefits companies, serving approximately 36.1 million people with information and resources to help them make better informed decisions about their health care. We offer a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and health care management services for Medicaid plans. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions.

### Summarized Results

(Millions)	2009	2008	2007
Revenue:			
Health Care	\$ 32,073.3	\$ 28,775.0	\$ 24,768.6
Group Insurance	2,143.0	1,710.7	2,139.5
Large Case Pensions	547.8	465.0	691.5
Total revenue	34,764.1	30,950.7	27,599.6
Net income	1,276.5	1,384.1	1,831.0
Operating earnings:(1)			
Health Care	1,412.7	1,802.3	1,698.0
Group Insurance	103.8	136.8	144.6
Large Case Pensions	32.2	38.8	35.8
Cash flows from operations	2,488.3	2,206.9	2,065.5

(1) Our discussion of operating results for our reportable business segments is based on operating earnings, which is a non-GAAP measure of net income (the term "GAAP" refers to U.S. generally accepted accounting principles). Refer to Segment Results and Use of Non-GAAP Measures in this MD&A on page 4 for a discussion of non-GAAP measures. Refer to pages 5, 8 and 9 for a reconciliation of operating earnings to net income for Health Care, Group Insurance and Large Case Pensions, respectively.

We analyze our results of operations based on operating earnings, which exclude net realized capital gains and losses as well as other items from net income. Refer to Net Realized Capital Gains and Losses on page 12 for additional information. Our operating earnings in 2009 were lower than 2008 due primarily to lower underwriting margins in our Health Care segment. Operating earnings in 2008 reflect lower net investment income compared to 2007, reflecting the difficult investment climate experienced primarily in the latter half of 2008. In both 2009 and 2008, total revenues grew, primarily from rising membership levels and premium rate increases.

In 2009, underwriting margins in our Health Care segment, which represent the amount of premiums in excess of health care costs, were lower than 2008, primarily due to significantly lower underwriting margins in our Commercial health care products in 2009. Our Commercial health care products experienced increased per member per month health care costs that significantly outpaced the increase in per member per month premiums, which resulted in a higher Commercial medical benefit ratio and a lower Commercial underwriting margin in 2009. Underwriting margins in our Health Care segment improved in 2008 when compared to 2007, reflecting membership growth and premium rate increases.

During 2009 and 2008, total revenue grew, driven primarily by growth in membership and premium rate increases in our Health Care segment. We experienced membership growth in 2009 and 2008 in both our administrative services contract ("ASC") (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) and Insured (where we assume all or a majority of the risk for medical and dental care costs) products. Our Health Care medical membership grew during 2009 and 2008, increasing by 1.2 million in 2009 and 848 thousand in 2008 (refer to Health Care – Membership on page 7). During 2008 we also had growth in our dental and pharmacy products. At December 31, 2009, we served approximately 18.9 million medical members, 14.1 million dental members and 11.0 million pharmacy members. Premium rate increases, together with the growth in membership, and in 2008, rate increases for our ASC products, contributed to the expansion of our total revenue, which increased approximately \$3.8 billion and \$3.4 billion in 2009 and 2008, respectively.

Net income for 2008 includes after-tax net realized capital losses of \$482 million, primarily reflecting other-than-temporary impairments (“OTTI”) of our debt securities. These losses resulted from declines in the market values in our investment portfolio as a result of then deteriorating global economic conditions and the application of the then-applicable accounting guidance for OTTI, which required us to assert our intention to hold to recovery. Effective April 1, 2009, the accounting guidance for OTTI was changed. OTTI is now recognized when we plan to sell a security in an unrealized loss position. Refer to our discussion of Net Realized Capital Gains and Losses on page 12 for additional information.

**During 2009 and 2008, we managed our cash flows in support of both new and ongoing initiatives.**

During 2009 and 2008, we generated substantial cash flows from our businesses, which we used to support our organic growth strategies, increase our investment holdings and repurchase our common stock.

In 2009 and 2008, we repurchased approximately 29 million and 43 million shares of common stock at a cost of approximately \$773 million and \$1.8 billion, respectively, under share repurchase programs authorized by Aetna’s Board of Directors (the “Board”).

In addition, we continue to invest in the development of our business by acquiring companies that support our strategies as well as continuing the introduction or enhancement of new products and services. In 2009, we completed the acquisition of Horizon Behavioral Services, LLC, a leading provider of employee assistance programs, for approximately \$70 million.

In 2008, we issued \$500 million of senior notes to secure long-term capital at favorable rates. Refer to Liquidity and Capital Resources beginning on page 13 and Note 14 of Notes to Consolidated Financial Statements on page 75 for additional information.

**TRICARE Managed Care Support Contract**

In July 2009, we were awarded the TRICARE managed care support contract for the North Region by the United States Department of Defense. Under this administrative services contract, which was to commence in 2010, we expected to support health care delivery to approximately 2.8 million eligible beneficiaries who are active duty service members, retirees, and family members based in 21 states of TRICARE’s North Region. The contract consists of five one-year option periods.

The contract award was protested by an unsuccessful bidder. The United States Government Accountability Office (the “GAO”) sustained the protest in November 2009. Based upon procurement protocol, the United States Department of Defense will review the recommendations issued by the GAO and determine how to proceed with the procurement. We cannot predict how the Department of Defense will implement the GAO’s recommendations, and we do not expect the contract to commence during 2010.

**Outlook for 2010**

We expect to face continued economic challenges in our business during 2010, resulting from continued macro-economic pressures and high unemployment rates and health care costs. We also expect heightened activity in the regulatory and public policy environments that could result in the need for increased investments to prepare for any health care reform and have other implications for our business.

Our goals for 2010 are to: deliver superior medical quality and total cost management; improve our expense structure through enhanced productivity; create customer value through innovation and technology; deliver a best-in-class customer experience; and enhance our diverse, high-performance culture and work force.

We project that our operating earnings will likely be lower in 2010 than 2009, as challenges outweigh our opportunities. We expect improvement in the Commercial underwriting margin through pricing actions and medical management to be offset by other challenges including:

- Pricing pressure on premium and fee yields as plan sponsors deal with budgetary concerns.
- Lower Medicare reimbursement.
- Increased operating expenses due in part to performance compensation.

Refer to Forward-Looking Information/Risk Factors beginning on page 31 for information regarding other important factors that may materially affect us.

## **Segment Results and Use of Non-GAAP Measures in this Document**

The discussion of our results of operations that follows is presented based on our reportable segments in accordance with the accounting guidance for segment reporting and consistent with our segment disclosure included in Note 19 of Notes to Consolidated Financial Statements beginning on page 80. Each segment's discussion of results is based on operating earnings, which is the measure reported to our Chief Executive Officer for purposes of assessing the segment's financial performance and making operating decisions, such as allocating resources to the segment. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment. It is added to our business segments to reconcile our consolidated results. The Corporate Financing segment includes interest expense for our outstanding debt and, beginning in 2009, the financing components of our pension plan and other post-retirement benefit plans ("OPEB") expense (the service cost and prior service cost components of this expense are allocated to our business segments). Prior periods have been reclassified to reflect this change.

Our discussion of the results of operations of each business segment is based on operating earnings, which exclude net realized capital gains and losses as well as other items, if any, from net income reported in accordance with GAAP. We believe excluding realized capital gains and losses from net income to arrive at operating earnings provides more meaningful information about our underlying business performance. Net realized capital gains and losses arise from various types of transactions, primarily in the course of managing a portfolio of assets that support the payment of liabilities; however, these transactions do not directly relate to the underwriting or servicing of products for our customers and are not directly related to the core performance of our business operations. We also may exclude other items that do not relate to the ordinary course of our business from net income to arrive at operating earnings. In each segment discussion in this MD&A, we present a table that reconciles operating earnings to net income reported in accordance with GAAP. Each table details the net realized capital gains and losses and any other items excluded from net income, and the footnotes to each table describe the nature of each other item and why we believe it is appropriate to exclude that item from net income.

## **HEALTH CARE**

Health Care consists of medical, pharmacy benefits management, dental, behavioral health and vision plans offered on both an Insured basis and an ASC basis. Medical products include point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit plans. Medical products also include health savings accounts and Aetna HealthFund®, consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account. We also offer Medicare and Medicaid products and services and specialty products, such as medical management and data analytics services, and stop loss insurance, as well as products that provide access to our provider network in select markets. We separately track premiums and health care costs for Medicare and Medicaid products. The grouping referred to as Commercial includes all medical, dental and other insured products, except Medicare and Medicaid.

## Operating Summary

(Millions)	2009	2008	2007
Premiums:			
Commercial	\$ 21,581.6	\$ 20,096.2	\$ 18,656.8
Medicare	5,735.8	4,816.1	2,598.3
Medicaid	926.4	595.0	245.0
Total premiums	28,243.8	25,507.3	21,500.1
Fees and other revenue	3,418.0	3,202.6	2,931.3
Net investment income	392.5	341.3	370.9
Net realized capital gains (losses)	19.0	(276.2)	(33.7)
Total revenue	32,073.3	28,775.0	24,768.6
Health care costs	24,061.2	20,785.5	17,294.8
Operating expenses:			
Selling expenses	1,158.7	1,055.2	966.6
General and administrative expenses	4,602.9	4,424.3	3,821.2
Total operating expenses	5,761.6	5,479.5	4,787.8
Amortization of other acquired intangible assets	90.3	101.3	90.7
Total benefits and expenses	29,913.1	26,366.3	22,173.3
Income before income taxes	2,160.2	2,408.7	2,595.3
Income taxes	744.9	875.1	919.2
Net income	\$ 1,415.3	\$ 1,533.6	\$ 1,676.1

The table presented below reconciles net income reported in accordance with GAAP to operating earnings (1):

(Millions)	2009	2008	2007
Net income	\$ 1,415.3	\$ 1,533.6	\$ 1,676.1
Net realized capital (gains) losses	(19.0)	213.1	21.9
Severance and facility charges	60.9	35.6	-
ESI settlement	(19.6)	-	-
Litigation-related insurance proceeds	(24.9)	-	-
Contribution for the establishment of an out-of-network pricing database	-	20.0	-
Operating earnings	\$ 1,412.7	\$ 1,802.3	\$ 1,698.0

- (1) In addition to net realized capital (gains) losses, the following other items are excluded from operating earnings because we believe they neither relate to the ordinary course of our business nor reflect our underlying business performance:
- In 2009 and 2008 we recorded severance and facility charges of \$60.9 million (\$93.7 million pretax) and \$35.6 million (\$54.7 million pretax), respectively. The 2009 severance and facility charge related to actions taken or committed to be taken by the end of the first quarter of 2010.
  - In 2009, we reached an agreement with Express Scripts, Inc. and one of its subsidiaries (collectively "ESI") to settle certain litigation in which we were the plaintiff. Under the applicable settlement, we received approximately \$19.6 million (\$30.2 million pretax), net of fees and expenses.
  - Following a Pennsylvania Supreme Court ruling in 2009, we received \$24.9 million (\$38.2 million pretax) from one of our liability insurers related to certain litigation we settled in 2003. We are continuing to litigate similar claims against certain of our other liability insurers.
  - As a result of our agreement with the New York Attorney General to discontinue the use of Ingenix databases at a future date, in 2008 we committed to contribute \$20.0 million to a non-profit organization to help create a new independent database for determining out-of-network reimbursement rates. We made that contribution in October, 2009.

### Significantly higher health care costs contributed to operating earnings decline in 2009

Operating earnings for 2009, when compared to 2008, were negatively impacted by significantly higher health care costs, particularly for Commercial products (refer to discussion of Commercial results on page 6) partially offset by growth in premiums and fees and other revenue, higher net investment income and continued operating expense efficiencies (total operating expenses divided by total revenue). Operating earnings for 2008 increased when compared to 2007. This increase reflects growth in premiums and fees and other revenue as well as higher underwriting margins and improved operating expense efficiencies. The growth in premiums and fees and other revenue in both 2009 and 2008 resulted from increases in membership levels as well as premium rate increases for renewing membership. Furthermore, growth in premiums and fees and other revenue in 2008 reflect our recent acquisitions.

Although we became more efficient, based on our operating expenses as a percentage of revenue, our total operating expenses increased in 2009 and 2008 over the prior years primarily due to the growth in our membership. Total operating expenses increased due to higher general and administrative expenses as a result of higher employee-related costs and other expenses associated with higher membership and higher selling expenses (reflecting an increase in commissionable premiums and premium taxes both from membership growth).

We calculate our medical benefit ratio (“MBR”) by dividing health care costs by premiums. Our MBRs by product for the years ended December 31, 2009, 2008 and 2007 were as follows:

	2009	2008	2007
Commercial	84.5%	80.3%	79.5%
Medicare	87.1%	85.6%	86.8%
Medicaid	88.6%	87.4%	88.4%
Total	85.2%	81.5%	80.4%

Refer to the following discussion of Commercial, Medicare and Medicaid results for an explanation of the changes in our MBR.

**The operating results of our Commercial products reflect significantly lower underwriting margins in 2009.**

Commercial premiums increased approximately \$1.5 billion in 2009 compared to 2008, and increased approximately \$1.4 billion in 2008 compared to 2007. The increases in 2009 and 2008 reflect premium rate increases on renewing business and higher membership levels.

Our Commercial MBRs were 84.5% for 2009, 80.3% for 2008 and 79.5% for 2007. The Commercial MBRs in 2009 and 2008 increased when compared to the prior year MBRs, reflecting a percentage increase in our per member health care costs that outpaced the percentage increase in per member premiums. Included in the 2009 Commercial MBR is approximately \$97 million of unfavorable development of prior period health care cost estimates. This development was related to unusually high paid claims activity for the first half of 2009, primarily related to claim activity in the second half of 2008. The increase in per member health care costs in 2009 was driven primarily by higher facility claim intensity, higher costs from H1N1 influenza, and higher costs from higher participation rates in health care continuation coverage afforded to individuals under the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”) (refer to our discussion of our Regulatory Environment beginning on page 22). The increase in per member health care costs in 2008 was attributed to general inflationary increases caused by higher costs related to physician services, laboratory services, emergency room and ancillary services as well as moderate increases in hospital inpatient and outpatient costs.

We had no significant development of prior period health care cost estimates that affected results of operations in 2008 or 2007. The calculation of Health Care Costs Payable is a critical accounting estimate (refer to Critical Accounting Estimates – Health Care Costs Payable beginning on page 16 for additional information).

**Medicare results reflects growth in 2009 and 2008**

Our Medicare Advantage contracts with the federal government are renewable for a one-year period on a calendar-year basis. We expanded our Medicare Advantage HMO and PPO offerings into select additional markets in 2009 and now offer Medicare Advantage HMO and PPO products in 246 counties in 22 states and Washington, D.C. We have been a national provider of Medicare Part D Prescription Drug Plan (“PDP”) since 2006. In anticipation of changes in the PFFS network requirements that will become effective in 2011, we decided to cease offering Medicare Advantage plans in certain geographic areas in 2010. We sold mainly individual PFFS plans in these geographic areas.

Medicare premiums increased approximately \$920 million in 2009, compared to 2008, and increased approximately \$2.2 billion in 2008 compared to 2007. The increase in 2009 and 2008 primarily reflects the introduction of our new private fee-for-service (“PFFS”) product, which was effective January 1, 2007, including the conversion of a large customer’s membership from a Commercial ASC plan to a Medicare Insured plan in 2008. The increase in 2009 was also due to increases in supplemental premiums across all of our Medicare Advantage products, rate increases from the Centers for Medicare & Medicaid Services (“CMS”) and true-ups for specified risk adjustments from CMS.

Our Medicare MBRs were 87.1% for 2009, 85.6% for 2008 and 86.8% for 2007. We had no significant development of prior period health care cost estimates that affected results of operations in 2009, 2008 or 2007. The increase in our Medicare MBR in 2009 reflects a percentage increase in our per member premiums that was outpaced by the percentage increase in per member health care costs. The decrease in our Medicare MBR in 2008 reflected a percentage increase in our per member premiums that outpaced the percentage increase in per member health care costs.

### Other Sources of Revenue

Fees and other revenue for 2009 increased \$215 million compared to 2008 reflecting growth in ASC membership as described in the table below, partially offset by lower fee yields and revised product and service mix. The \$271 million increase in 2008 compared to 2007, reflected revenue from our acquisitions of Schaller Anderson Incorporated and Goodhealth Worldwide (Bermuda) Limited as well as growth in ASC membership.

Net investment income for 2009 increased \$51 million compared to 2008 primarily reflecting higher average asset levels and higher yields on alternative investments. Net investment income for 2008 decreased \$30 million compared to 2007, primarily reflecting lower income from alternative investments.

Net realized capital gains (losses) for 2009 and 2007 were not significant. Net realized capital losses in 2008 were due primarily to OTTI of debt securities (refer to our discussion of Investments – Net Realized Capital Gains and Losses on page 12 for additional information) and net losses on the sale of debt securities.

### Membership

Health Care's membership at December 31, 2009 and 2008 was as follows:

(Thousands)	2009			2008		
	Insured	ASC	Total	Insured	ASC	Total
Medical:						
Commercial	5,614	11,821	17,435	5,595	10,893	16,488
Medicare	433	-	433	366	-	366
Medicaid	310	736	1,046	207	640	847
<b>Total Medical Membership</b>	<b>6,357</b>	<b>12,557</b>	<b>18,914</b>	6,168	11,533	17,701
Consumer-Directed Health Plans <sup>(1)</sup>			1,868			1,431
Dental:						
Commercial	4,998	7,304	12,302	5,012	7,494	12,506
Medicare and Medicaid	260	432	692	229	374	603
Network Access <sup>(2)</sup>	-	1,067	1,067	-	1,015	1,015
<b>Total Dental Membership</b>	<b>5,258</b>	<b>8,803</b>	<b>14,061</b>	5,241	8,883	14,124
Pharmacy:						
Commercial			9,728			9,846
Medicare PDP (stand-alone)			346			375
Medicare Advantage PDP			240			195
Medicaid			30			25
Total Pharmacy Benefit Management Services			10,344			10,441
Mail Order <sup>(3)</sup>			669			657
<b>Total Pharmacy Membership</b>			<b>11,013</b>			11,098

(1) Represents members in consumer-directed health plans included in Commercial medical membership above.

(2) Represents members in products that allow these members access to our dental provider network for a nominal fee.

(3) Represents members who purchased medications through our mail order pharmacy operations during the fourth quarter of 2009 and 2008, respectively, and are included in pharmacy membership above.

Total medical membership at December 31, 2009 increased compared to December 31, 2008. The increase in medical membership was primarily due to growth in Commercial membership, driven by growth within existing plan sponsors and new customers, net of lapses, and Medicaid membership attributable to a new Insured contract.

Total dental membership at December 31, 2009 decreased compared to 2008 primarily due to the loss of a large Government plan sponsor.

Total pharmacy membership decreased in 2009 compared to 2008 primarily due to lower cross-selling of our Commercial pharmacy benefit management services.

## GROUP INSURANCE

Group Insurance primarily includes group life insurance products offered on an Insured basis, including basic and supplemental group term life insurance, group universal life, supplemental or voluntary programs, and accidental death and dismemberment coverage. Group Insurance also includes (i) group disability products offered to employers on both an Insured and an ASC basis, which consist primarily of short-term and long-term disability insurance (and products which combine both), (ii) absence management services offered to employers, which include short-term and long-term disability administration and leave management, and (iii) long-term care products that were offered primarily on an Insured basis, which provide benefits covering the cost of care in private home settings, adult day care, assisted living or nursing facilities. We no longer solicit or accept new long-term care customers, and we are working with our customers on an orderly transition of this product to other carriers.

## Operating Summary

(Millions)	2009	2008	2007
Premiums:			
Life	\$ 1,093.0	\$ 1,062.7	\$ 1,201.4
Disability	559.4	534.6	478.8
Long-term care	67.8	86.3	93.8
Total premiums	1,720.2	1,683.6	1,774.0
Fees and other revenue	106.9	97.9	101.1
Net investment income	274.1	240.4	303.0
Net realized capital gains (losses)	41.8	(311.2)	(38.6)
Total revenue	2,143.0	1,710.7	2,139.5
Current and future benefits	1,575.2	1,468.8	1,619.2
Operating expenses:			
Selling expenses	93.2	94.4	94.3
General and administrative expenses	283.4	310.1	263.1
Total operating expenses	376.6	404.5	357.4
Amortization of other acquired intangible assets	6.9	6.9	6.9
Total benefits and expenses	1,958.7	1,880.2	1,983.5
Income (loss) before income taxes	184.3	(169.5)	156.0
Income taxes	38.7	(54.2)	36.5
Net income (loss)	\$ 145.6	\$ (115.3)	\$ 119.5

The table presented below reconciles net income to operating earnings reported in accordance with GAAP:

(Millions)	2009	2008	2007
Net income (loss)	\$ 145.6	\$ (115.3)	\$ 119.5
Net realized capital (gains) losses	(41.8)	224.7	25.1
Allowance on reinsurance recoverable (1)	-	27.4	-
Operating earnings	\$ 103.8	\$ 136.8	\$ 144.6

(1) As a result of the liquidation proceedings of Lehman Re Ltd. ("Lehman Re"), a subsidiary of Lehman Brothers Holdings Inc., we recorded an allowance against our reinsurance recoverable from Lehman Re of \$27.4 million (\$42.2 million pretax) in 2008. This reinsurance is on a closed block of paid-up group whole life insurance business.

Operating earnings for 2009 decreased \$33 million when compared to 2008, primarily reflecting lower disability underwriting margins primarily due to increased reserves in our disability business partially offset by higher net investment income. Operating earnings for 2008 decreased \$8 million compared to 2007, reflecting lower net investment income partially offset by a higher underwriting margin due to favorable disability and long-term care results. The variances in net investment income in 2009 and 2008 were primarily due to income from alternative investments in 2008.

Our group benefit ratios were 91.6% for 2009, 87.2% for 2008 and 91.3% for 2007. The increase in our group benefit ratio for 2009 compared to 2008 was primarily due to increased reserves for disability products caused by longer claim

duration rates reflecting recent experience and a lower reserve discount rate assumptions based upon projected investment returns. The decrease in our group benefit ratio in 2008 compared to 2007 was primarily due to favorable life and disability experience.

Net realized capital gains (losses) for 2009 and 2007 were not significant. Net realized capital losses for 2008 were due primarily to losses on OTTI of debt securities (refer to our discussion of Investments - Net Realized Capital Gains and Losses on page 12 for additional information).

## LARGE CASE PENSIONS

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. The Large Case Pensions segment includes certain discontinued products.

### Operating Summary

(Millions)	2009	2008	2007
Premiums	\$ 172.2	\$ 193.2	\$ 205.3
Net investment income	369.8	328.3	476.0
Other revenue	11.6	12.0	11.6
Net realized capital losses	(5.8)	(68.5)	(1.4)
Total revenue	547.8	465.0	691.5
Current and future benefits	502.9	469.9	628.9
General and administrative expenses	10.0	14.9	18.2
Reduction of reserve for anticipated future losses on discontinued products	-	(43.8)	(64.3)
Total benefits and expenses	512.9	441.0	582.8
Income before income taxes	34.9	24.0	108.7
Income taxes	8.5	1.2	32.0
Net income	\$ 26.4	\$ 22.8	\$ 76.7

The table presented below reconciles net income to operating earnings reported in accordance with GAAP:

(Millions)	2009	2008	2007
Net income	\$ 26.4	\$ 22.8	\$ 76.7
Net realized capital losses	5.8	44.5	.9
Reduction of reserve for anticipated future losses on discontinued products (1)	-	(28.5)	(41.8)
Operating earnings	\$ 32.2	\$ 38.8	\$ 35.8

(1) In 1993, we discontinued the sale of our fully-guaranteed large case pension products and established a reserve for anticipated future losses on these products, which we review quarterly. We reduced the reserve for anticipated future losses on discontinued products by \$28.5 million (\$43.8 million pretax) in 2008 and \$41.8 million (\$64.3 million pretax) in 2007. We believe excluding any changes to the reserve for anticipated future losses on discontinued products provides more meaningful information as to our continuing products and is consistent with the treatment of the results of operations of these discontinued products, which are credited or charged to the reserve and do not affect our results of operations.

### Discontinued Products in Large Case Pensions

Prior to 1993, we sold single-premium annuities (“SPAs”) and guaranteed investment contracts (“GICs”), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products, and now we refer to these products as discontinued products.

We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate future losses over their life (which is greater than 30 years); so we established a reserve for anticipated future losses at the time of discontinuance. We provide additional information on this reserve, including key assumptions and other important information, in Note 20 of Notes to Consolidated Financial Statements beginning on page 82. Please refer to this note for additional information.

The operating summary for Large Case Pensions above includes revenues and expenses related to our discontinued products, with the exception of net realized capital gains and losses, which are recorded as part of current and future

benefits. Since we established a reserve for future losses on discontinued products, as long as our expected future losses remain consistent with prior projections, the operating results of our discontinued products are applied against the reserve and do not impact operating earnings or net income for Large Case Pensions. However, if actual or expected future losses are greater than we currently estimate, we may have to increase the reserve, which could adversely impact net income. If actual or expected future losses are less than we currently estimate, we may have to decrease the reserve, which could favorably impact net income. In those cases, we disclose such adjustment separately in the operating summary.

The activity in the reserve for anticipated future losses on discontinued products in 2009, 2008 and 2007 was as follows:

<b>(Millions)</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
Reserve, beginning of period	\$ 790.4	\$ 1,052.3	\$ 1,061.1
Operating (loss) income	(34.8)	(93.4)	28.5
Cumulative effect of new accounting standard as of April 1, 2009 <sup>(1)</sup>	42.1	-	-
Net realized capital (losses) gains	(8.5)	(124.7)	27.0
Reserve reduction	-	(43.8)	(64.3)
<b>Reserve, end of period</b>	<b>\$ 789.2</b>	<b>\$ 790.4</b>	<b>\$ 1,052.3</b>

(1) The adoption of new accounting guidance for OTTI resulted in a cumulative effect adjustment. This adjustment represents OTTI securities held at April 1, 2009 that we do not intend to sell. Refer to Note 2 beginning on page 48 for additional information. This amount is not reflected in accumulated other comprehensive loss and retained earnings in our shareholders' equity since the results of discontinued products do not impact our results of operations.

During 2009, our discontinued products reflected an operating loss and net realized capital losses, both attributable to the unfavorable investment conditions that existed from the latter half of 2008 through the second quarter of 2009. Net realized capital losses in 2008 were due primarily to OTTI of debt securities (refer to Investments – Net Realized Capital Gains and Losses on page 12 for additional information) and derivative losses partially offset by net gains on the sale of equity securities.

Management reviews the adequacy of the discontinued products reserve quarterly and, as a result, the reserve at December 31, 2009 reflects management's best estimate of anticipated future losses. Specifically, we evaluated the operating losses and net realized capital losses in 2009 against our expectations of future cash flows assumed in estimating this reserve and do not believe an adjustment to this reserve is required at December 31, 2009. During the years ended December 31, 2008 and 2007, \$44 million (\$29 million after tax) and \$64 million (\$42 million after tax), respectively, were released from this reserve. The 2008 reserve reduction was primarily due to favorable mortality and retirement experience compared to assumptions we previously made in estimating the reserve. The 2007 reserve reduction was primarily due to favorable investment performance and favorable mortality and retirement experience compared to assumptions we previously made in estimating the reserve.

### Assets Managed by Large Case Pensions

At December 31, 2009 and 2008, Large Case Pensions assets under management consisted of the following:

<b>(Millions)</b>	<b>2009</b>	<b>2008</b>
Assets under management: <sup>(1)</sup>		
Fully guaranteed discontinued products	\$ 3,667.7	\$ 3,840.2
Experience-rated	4,879.9	4,226.8
Non-guaranteed	2,623.2	2,630.5
<b>Total assets under management</b>	<b>\$ 11,170.8</b>	<b>\$ 10,697.5</b>

(1) Excludes net unrealized capital gains (losses) of \$205.8 million and \$(111.2) million at December 31, 2009 and 2008, respectively.

Assets supporting experience-rated products (where the contract holder, not us, assumes investment and other risks subject to, among other things, certain minimum guarantees) may be subject to contract holder or participant withdrawals. For the years ended December 31, 2009, 2008 and 2007, experience-rated contract holder and participant-directed withdrawals were as follows:

(Millions)	2009	2008	2007
Scheduled contract maturities and benefit payments (1)	\$ 267.2	\$ 338.8	\$ 353.6
Contract holder withdrawals other than scheduled contract maturities and benefit payments (2)	10.6	31.1	39.4
Participant-directed withdrawals (2)	3.1	3.9	6.0

- (1) Includes payments made upon contract maturity and other amounts distributed in accordance with contract schedules.  
(2) Approximately \$537.0 million, \$524.3 million and \$534.9 million at December 31, 2009, 2008 and 2007, respectively, of experience-rated pension contracts allowed for unscheduled contract holder withdrawals, subject to timing restrictions and formula-based market value adjustments. Further, approximately \$95.9 million, \$93.2 million and \$118.7 million at December 31, 2009, 2008 and 2007, respectively, of experience-rated pension contracts supported by general account assets could be withdrawn or transferred to other plan investment options at the direction of plan participants, without market value adjustment, subject to plan, contractual and income tax provisions.

## INVESTMENTS

At December 31, 2009 and 2008, our investment portfolio consisted of the following:

(Millions)	2009		2008	
Debt and equity securities	\$	17,159.7	\$	13,993.3
Mortgage loans		1,594.0		1,679.9
Other investments		1,220.1		1,196.2
Total investments	\$	19,973.8	\$	16,869.4

The risks associated with investments supporting experience-rated pension and annuity products in our Large Case Pensions business are assumed by the contract holders and not by us (subject to, among other things, certain minimum guarantees). Anticipated future losses associated with investments supporting discontinued fully-guaranteed Large Case Pensions products are provided for in the reserve for anticipated future losses on discontinued products.

As a result of the foregoing, investment risks associated with our experience-rated and discontinued products generally do not impact our results of operations (refer to Note 2 of Notes to Consolidated Financial Statements beginning on page 48 for additional information). Our total investments supported the following products at December 31, 2009 and 2008:

(Millions)	2009		2008	
Supporting experience-rated products	\$	1,681.1	\$	1,582.8
Supporting discontinued products		3,681.8		3,635.1
Supporting remaining products		14,610.9		11,651.5
Total investments	\$	19,973.8	\$	16,869.4

### Debt and Equity Securities

The debt securities in our portfolio had an average quality rating of A+ at December 31, 2009 and 2008, with approximately \$4.9 billion at December 31, 2009 and \$4.3 billion at December 31, 2008 rated AAA. Total debt securities that were rated below investment grade (that is, having a quality rating below BBB-/Baa3) at December 31, 2009 and 2008 were \$1.3 billion and \$640 million, respectively (of which 15% and 18% at December 31, 2009 and 2008, respectively, supported our discontinued and experience-rated products).

At December 31, 2009 and 2008, we held approximately \$486 million and \$824 million, respectively, of municipal debt securities and \$34 million and \$64 million, respectively, of structured product debt securities that were guaranteed by third parties, collectively representing approximately 3% and 5%, respectively, of our total investments. These securities had an average credit rating of A+ at December 31, 2009 and AA- at December 31, 2008 with the guarantee. Without the guarantee, the average credit rating of the municipal debt securities was A+ on each date. The structured product debt securities are not rated by the rating agencies on a standalone basis. We do not have any significant concentration of investments with third party guarantors (either direct or indirect).

We classify our debt and equity securities as available for sale, carrying them at fair value on our balance sheet. Approximately 3% of our debt and equity securities at both December 31, 2009 and 2008 are valued using inputs that reflect our own assumptions (categorized as Level 3 inputs in accordance with GAAP). Refer to Note 10 of Notes to Consolidated Financial Statements beginning on page 63 for additional information on the methodologies and key assumptions we use to determine the fair value of investments.

At December 31, 2009 and 2008, our debt and equity securities had net unrealized gains (losses) of \$717 million and \$(500) million, respectively, of which \$207 million and \$(123) million, respectively, related to our experience-rated and discontinued products.

Refer to Note 8 of Notes to Consolidated Financial Statements beginning on page 58 for details of net unrealized capital gains and losses by major security type, as well as details on our debt securities with unrealized losses at December 31, 2009 and 2008. We regularly review our debt securities to determine if a decline in fair value below the carrying value is other than temporary. If we determine a decline in fair value is other than temporary, the carrying value of the security is written down. The amount of the credit-related impairment is included in our results of operations, and the non-credit component is included in other comprehensive income if we do not intend to sell the security. Accounting for OTTI of our debt securities is considered a critical accounting estimate. Refer to Critical Accounting Estimates - Other-Than-Temporary Impairment of Debt Securities on page 21 for additional information.

### **Net Realized Capital Gains and Losses**

Net realized capital gains (losses) were \$55 million in 2009, \$(656) million in 2008 and \$(74) million in 2007. Included in these amounts were \$76 million for 2009, \$523 million for 2008 and \$125 million for 2007 of yield-related OTTI losses.

The decrease in OTTI recognized in earnings in 2009 compared to 2008 was primarily related to a change in the accounting guidance for the recognition of OTTI of debt securities and an overall general improvement in the economic environment during 2009 compared to 2008. Prior to the adoption of new accounting guidance for OTTI of debt securities on April 1, 2009, both yield- and credit-related OTTI were recognized in earnings if we could not assert our intention to hold the security until recovery. In contrast, after April 1, 2009, only credit-related impairments are recognized in earnings unless we have the intention to sell the security in an unrealized loss position, in which case the yield-related OTTI is also recognized in earnings. Refer to Note 2 of Notes to Consolidated Financial Statements beginning on page 48 for additional information.

In 2009, yield-related OTTI losses were \$76 million, primarily related to U.S. Treasury and corporate securities that were temporarily in a loss position due to changes in interest rates and the widening of credit spreads relative to the interest rates on U.S. Treasury securities in the first half of 2009. Because we did not assert our intention to hold these securities, under applicable accounting guidance, we recorded a yield-related OTTI loss. In 2008, yield-related OTTI losses were \$523 million. These yield-related impairments were primarily due to the widening of credit spreads relative to the interest rates on U.S. Treasury securities in 2008 and the application of the then-applicable accounting guidance for OTTI which required us to assert our intention to hold to recovery, which we could not make. During 2008, significant declines in the U.S. housing market resulted in the credit and other capital markets experiencing volatility and limitations on the ability of companies to issue debt or equity securities. The lack of available credit, lack of confidence in the financial sector, increased volatility in the financial markets and reduced business activity resulted in credit spreads widening during 2008.

Included in net realized capital losses for 2008 were \$120 million of credit-related OTTI losses of which \$105 million related to investments in debt securities of Lehman Brothers Holdings Inc. and Washington Mutual, Inc. We had no other individually material realized capital losses on debt or equity securities that impacted our results of operations during 2009 or 2008.

### **Mortgage Loans**

Our mortgage loan portfolio (which is collateralized by commercial real estate) represented 8% and 10% of our total invested assets at December 31, 2009 and 2008, respectively. At December 31, 2009, 99% of our mortgage loans continued to be performing assets. In accordance with our accounting policies, there were no material impairment reserves on these loans at December 31, 2009 or 2008. Refer to Notes 2 and 8 of Notes to Consolidated Financial Statements beginning on pages 48 and 58, respectively, for additional information.

### **Risk Management and Market-Sensitive Instruments**

We manage interest rate risk by seeking to maintain a tight match between the durations of our assets and liabilities where appropriate. We manage credit risk by seeking to maintain high average quality ratings and diversified sector exposure within our debt securities portfolio. In connection with our investment and risk management objectives, we also use derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. Our use of these derivatives is generally limited to hedging purposes and has principally consisted of using interest rate swap agreements, warrants, forward contracts, futures contracts and credit default swaps. These instruments, viewed separately, subject us to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, we expect these instruments to reduce overall risk.

We regularly evaluate our risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. We also regularly evaluate the appropriateness of investments relative to our management-approved investment guidelines (and operate within those guidelines) and the business objectives of our portfolios.

On a quarterly basis, we review the impact of hypothetical net losses in our investment portfolio on our consolidated near-term financial position, results of operations and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. We determine the potential effect of interest rate risk on near-term net income, cash flow and fair value based on commonly-used models. The models project the impact of interest rate changes on a wide range of factors, including duration, put options and call options. We also estimate the impact on fair value based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which we believe represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate movements for our intermediate-term available-for-sale debt securities) and an immediate decrease of 25% in prices for domestic equity securities.

Based on our overall exposure to interest rate risk and equity price risk, we believe that these changes in market rates and prices would not materially affect our consolidated near-term financial position, results of operations or cash flows as of December 31, 2009.

### **LIQUIDITY AND CAPITAL RESOURCES**

#### **Cash Flows**

Generally, we meet our operating cash requirements by maintaining appropriate levels of liquidity in our investment portfolio and using overall cash flows from premiums, deposits and income received on investments. We monitor the duration of our portfolio of debt securities (which is highly marketable) and mortgage loans, and execute purchases and sales of these investments with the objective of having adequate funds available to satisfy our maturing liabilities. Overall cash flows are used primarily for claim and benefit payments, contract withdrawals, operating expenses and share repurchases.

Presented in the following table is a condensed statement of cash flows for the years ended December 31, 2009, 2008 and 2007. We present net cash flows used for operating activities of continuing operations and net cash flows provided by investing activities separately for our Large Case Pensions segment because, in accordance with applicable accounting guidance, changes in the insurance reserves for this segment (which are reported as cash used for operating activities) are funded from the sale of investments (which are reported as cash provided by investing activities). Refer to the Consolidated Statements of Cash Flows on page 47 for additional information.

(Millions)	2009	2008	2007
<b>Cash flows from operating activities</b>			
Health Care and Group Insurance (including Corporate Financing)	\$ 2,711.5	\$ 2,397.6	\$ 2,367.7
Large Case Pensions	(223.2)	(190.7)	(302.2)
<b>Net cash provided by operating activities of continuing operations</b>	<b>2,488.3</b>	<b>2,206.9</b>	<b>2,065.5</b>
<b>Cash flows from investing activities</b>			
Health Care and Group Insurance	(2,380.0)	(1,485.2)	(1,391.5)
Large Case Pensions	380.3	411.9	353.7
<b>Net cash used for investing activities</b>	<b>(1,999.7)</b>	<b>(1,073.3)</b>	<b>(1,037.8)</b>
<b>Net cash used for financing activities</b>	<b>(464.5)</b>	<b>(1,208.1)</b>	<b>(653.7)</b>
<b>Net increase (decrease) in cash and cash equivalents</b>	<b>\$ 24.1</b>	<b>\$ (74.5)</b>	<b>\$ 374.0</b>

### *Cash Flow Analysis*

Cash flows provided by operating activities for Health Care and Group Insurance were approximately \$2.7 billion in 2009 and \$2.4 billion in both 2008 and 2007. During 2009 and 2007, we spent \$70 million and \$613 million, respectively, on acquisitions we expect will enhance our existing product capabilities and future growth opportunities. There were no acquisitions in 2008. In addition, in each of the past three years we increased our investment holdings. This use of cash was reported as cash flows used in investing activities.

Cash flows used for financing activities primarily reflect share repurchases partially offset by our issuance of debt in 2008 and 2007. Refer to Short- and Long-Term Debt below for additional information. During the period 2007 through 2009, we repurchased common stock under various repurchase programs authorized by our Board. In 2009, 2008 and 2007, we repurchased approximately 29 million, 43 million and 33 million shares of common stock at a cost of \$773 million, \$1.8 billion and \$1.7 billion, respectively. At December 31, 2009, the capacity remaining under our Board-approved share repurchase program was approximately \$591 million.

On September 25, 2009, our Board declared an annual cash dividend of \$.04 per common share to shareholders of record at the close of business on November 13, 2009. The dividend was paid on November 30, 2009. Our Board reviews our common stock dividend annually. Among the factors considered by our Board in determining the amount of dividends are our results of operations and the capital requirements, growth and other characteristics of our businesses.

### *Short- and Long-Term Debt*

In September 2008 and December 2007, we issued \$500 million and \$700 million, respectively, of senior notes and used the proceeds to repay commercial paper borrowings.

We use short-term borrowings from time to time to address timing differences between cash receipts and disbursements. The maximum amount of commercial paper borrowings outstanding during 2009 was \$553 million.

Our committed short-term borrowing capacity consists of a \$1.5 billion revolving credit facility (the "Facility") which terminates in March 2013. The Facility also provides for the issuance of letters of credit at our request, up to \$200 million, which count as usage of the available commitments under the Facility. The Facility permits the aggregate commitments under the Facility to be expanded to a maximum of \$2.0 billion upon our agreement with one or more financial institutions. There were no amounts outstanding under the Facility at any time during 2009.

Our total debt to total capital ratio (total debt divided by the sum of shareholders' equity plus total debt) was approximately 30% and 32% at December 31, 2009 and 2008, respectively. We continually monitor existing and alternative financing sources to support our capital and liquidity needs, including, but not limited to, debt issuance, preferred or common stock issuance, and pledging or selling of assets.

Interest expense on our debt was \$243 million, \$236 million and \$181 million for 2009, 2008 and 2007, respectively. The increase in interest expense in 2009 and 2008 was due to higher overall average long-term debt levels as a result of our issuance of senior notes in September 2008 and December 2007.

Refer to Note 14 of Notes to Consolidated Financial Statements on page 75 for additional information on our short-term and long-term debt.

### Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to Aetna as a holding company, since Aetna is not an HMO or an insurance company. The additional regulations applicable to our HMO and insurance company subsidiaries are not expected to affect our ability to service our debt, meet our other financing obligations or pay dividends, or the ability of any of our subsidiaries to service other financing obligations, if any. Under regulatory requirements, at December 31, 2009, the amount of dividends that our insurance and HMO subsidiaries could pay to Aetna without prior approval by regulatory authorities was approximately \$1.2 billion in the aggregate.

We maintain capital levels in our operating subsidiaries at or above targeted and/or required capital levels and dividend amounts in excess of these levels to meet our liquidity requirements, including the payment of interest on debt and shareholder dividends. In addition, at our discretion, we use these funds for other purposes such as funding share repurchase programs, investments in new businesses and other purposes we consider necessary.

### Off-Balance Sheet Arrangements

We do not have guarantees or other off-balance sheet arrangements that we believe, based on historical experience and current business plans, are reasonably likely to have a material impact on our current or future results of operations, financial condition or cash flows. Refer to Notes 8 and 18 of Notes to Consolidated Financial Statements beginning on page 58 and 77, respectively, for additional detail of our variable interest entities and guarantee arrangements, respectively, at December 31, 2009.

### Ratings

As of February 25, 2010, the credit ratings of Aetna and Aetna Life Insurance Company (“ALIC”) from the respective nationally recognized statistical rating organizations (“Rating Agencies”) were as follows:

	A.M. Best	Fitch	Moody's Investors Service	Standard & Poor's
Aetna (senior debt) (1)	bbb+	A-	A3	A-
Aetna (commercial paper)	AMB-2	F1	P-2	A-2
ALIC (financial strength) (1)	A	AA-	Aa3	A+

(1) Aetna's senior debt and ALIC's financial strength have a stable outlook from A.M. Best and a negative outlook from Fitch and Standard & Poor's. Moody's Investors Service has placed Aetna's senior debt and ALIC's financial strength ratings under review for possible downgrade.

### Solvency Regulation

The National Association of Insurance Commissioners (the “NAIC”) utilizes risk-based capital (“RBC”) standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (“RBC Ratio”). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2009, the RBC Ratio of each of our primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2009, at that date, each of our active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own RBC standards when they determine a company's rating.

## Contractual Obligations

The following table summarizes certain estimated future obligations by period at December 31, 2009, under our various contractual obligations. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2009 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements). We believe that funds from future operating cash flows, together with cash, investments and other funds available under our credit agreements or from public or private financing sources, will be sufficient to meet our existing commitments as well as our liquidity needs associated with future operations, including strategic transactions.

(Millions)	2010	2011 - 2012	2013 - 2014	Thereafter	Total
Long-term debt obligations, including interest	\$ 239.1	\$ 1,273.3	\$ 355.5	\$ 5,158.2	\$ 7,026.1
Operating lease obligations	165.2	178.4	78.2	79.9	501.7
Purchase obligations	137.8	129.6	45.3	.8	313.5
Other liabilities reflected on our balance sheet:(1)					
Future policy benefits (2)	739.6	1,396.4	1,092.5	3,981.2	7,209.7
Unpaid claims (2)	559.5	438.1	302.9	712.0	2,012.5
Policyholders' funds (2)(3)	788.3	117.6	109.3	646.1	1,661.3
Other liabilities (4)	2,284.1	159.5	112.6	251.1	2,807.3
<b>Total</b>	<b>\$ 4,913.6</b>	<b>\$ 3,692.9</b>	<b>\$ 2,096.3</b>	<b>\$ 10,829.3</b>	<b>\$ 21,532.1</b>

- (1) Payments of other long-term liabilities exclude Separate Account liabilities of approximately \$6.3 billion because these liabilities are supported by assets that are legally segregated (i.e., Separate Account assets) and are not subject to claims that arise out of our business.
- (2) Payments of future policy benefits, unpaid claims and policyholders' funds include approximately \$774.8 million, \$48.1 million and \$186.1 million, respectively, of reserves for contracts subject to reinsurance. We expect the assuming reinsurance carrier to fund these obligations and have reflected these amounts as reinsurance recoverable assets on our consolidated balance sheet.
- (3) Customer funds associated with group life and health contracts of approximately \$350.6 million have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt and equity securities supporting experience-rated products of \$70.5 million have been excluded from the table above.
- (4) Other liabilities in the table above include general expense accruals and other related payables and exclude the following:
- Employee-related benefit obligations of \$1.37 billion including our pension, other postretirement and post-employment benefit obligations and certain deferred compensation arrangements. These liabilities do not necessarily represent future cash payments we will be required to make, or such payment patterns cannot be determined. However, other long-term liabilities include anticipated voluntary pension contributions to our tax-qualified defined pension plan of \$45.0 million in 2010 and expected benefit payments of approximately \$481.2 million over the next ten years for our nonqualified pension plan and our postretirement benefit plans, which we primarily fund when paid by the plans.
  - Deferred gains of \$72.7 million related to prior cash payments which will be recognized in our earnings in the future in accordance with GAAP.
  - Net unrealized capital gains of \$104.3 million supporting discontinued products.
  - Minority interests of \$77.1 million consisting of subsidiaries less than 100% owned by us. This amount does not represent future cash payments we will be required to make.
  - Income taxes payable of \$22.2 million related to uncertain tax positions.

## CRITICAL ACCOUNTING ESTIMATES

We prepare our consolidated financial statements in accordance with GAAP. The application of GAAP requires management to make estimates and assumptions that affect our consolidated financial statements and related notes. The accounting estimates described below are those we consider critical in preparing our consolidated financial statements. We use information available to us at the time the estimates are made; however, as described below, these estimates could change materially if different information or assumptions were used. Also, these estimates may not ultimately reflect the actual amounts of the final transactions that occur.

### Health Care Costs Payable

Health care costs payable include estimates of the ultimate cost of claims that have been incurred but not yet reported to us and of those which have been reported to us but not yet paid (collectively "IBNR"). At December 31, 2009 and 2008, our IBNR reserves represented approximately 88% and 86%, respectively, of total health care costs payable. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables and accruals for state assessments. We develop our IBNR estimates using actuarial principles and assumptions that consider

numerous factors. Of those factors, we consider the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate to be the most critical assumptions. In developing our estimate of health care costs payable, we consistently apply these actuarial principles and assumptions each period, with consideration to the variability of related factors.

We analyze historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." We estimate completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents our estimate of claims remaining to be paid as of the financial statement date and is included in our health care costs payable.

We use completion factors predominantly to estimate reserves for claims with claim incurred dates greater than three months prior to the financial statement date. The completion factors we use reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in membership and product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months prior to the financial statement date have less activity, we use a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. We place a greater emphasis on the assumed health care cost trend rate for the most recent dates of services as these months may be influenced by seasonal patterns and changes in membership and product mix.

Our health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including our ability to manage health care costs through underwriting criteria, product design, negotiation of favorable provider contracts and medical management programs. The aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs, direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and our health care cost trend rate.

For each reporting period, we use an extensive degree of judgment in the process of estimating our health care costs payable, and as a result, considerable variability and uncertainty is inherent in such estimates; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period we recognize our best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. We believe our estimate of health care costs payable is reasonable and adequate to cover our obligations at December 31, 2009; however, actual claim payments may differ from our estimates. A worsening (or improvement) of our health care cost trend rates or changes in completion factors from those that we assumed in estimating health care costs payable at December 31, 2009 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, we re-examine previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that our estimates of health care costs payable could develop either favorably, (that is, our actual health care costs for the period were less than we estimated) or unfavorably. The changes in our estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. As reported in the rollforward of our health care costs payable in Note 6 of our Consolidated Financial Statements on page 56, our prior year estimates of health care costs payable decreased by approximately \$66 million, \$163 million and \$177 million in 2009, 2008 and

2007, respectively. This reduction was offset by current year health care costs when we established our estimate of current period health care costs payable. Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for health care costs payable. When significant decreases (increases) in prior periods' health care cost estimates occur that we believe significantly impact our current period results of operations, we disclose that amount as favorable (unfavorable) development of prior period health care cost estimates. In 2009 we had approximately \$116 million of unfavorable development of prior year health care cost estimates that was driven by what we believe was unusually high paid claims activity in the first half of 2009 related to the second half of 2008. This unfavorable development of prior year health care cost estimates offset the amount of the 2009 reduction in our estimate of health care costs payable for prior years. We had no significant amount of favorable (unfavorable) development of prior year health care cost estimates that affected our results of operations in 2008.

During 2009 we observed essentially no change in our completion factors relative to those assumed at year end 2008. During 2008 we observed an increase in our completion factors as a result of a speedup in the provider claim submission and our processing times relative to those assumed at December 31, 2007. After considering the claims paid in 2009 and 2008 with dates of service prior to the fourth quarter of the previous year, we observed the assumed weighted average completion factors were approximately flat and 20 basis points higher, respectively, than previously estimated, resulting in a decrease of approximately \$7 million in 2009 and \$43 million in 2008 in health care costs payable that related to the prior year. We have considered the pattern of changes in our completion factors when determining the completion factors used in our estimates of IBNR at December 31, 2009. However, based on our historical claim experience, it is reasonably possible that our estimated completion factors may vary by plus or minus 50 basis points from our assumed rates, which could impact health care costs payable by approximately plus or minus \$29 million pretax.

Also during 2009 and 2008, we observed that our health care cost trend rates for claims with dates of service three months or less before the financial statement date were slightly lower than previously estimated. Specifically, after considering the claims paid in 2009 and 2008 with dates of service for the fourth quarter of the previous year, we observed health care cost trend rates that were approximately .9% and 3.7%, respectively, lower than previously estimated, resulting in a reduction of approximately \$59 million in 2009 and \$120 million in 2008 in health care costs payable that related to the prior year.

We consider historical health care cost trend rates together with our knowledge of recent events that may impact current trends when developing our estimates of current health care cost trend rates. When establishing our reserves at December 31, 2009, we increased our assumed health care cost trend rates for the most recent three months by 5.3% from health care cost trend rates recently observed. However, based on our historical claim experience, it is reasonably possible that our estimated health care cost trend rates may vary by plus or minus 3.5% from our assumed rates, which could impact health care costs payable by approximately plus or minus \$182 million pretax.

Health care costs payable as of December 31, 2009 and 2008 consisted of the following products:

<b>(Millions)</b>		<b>2009</b>		<b>2008</b>
Commercial	\$	2,295.0	\$	1,936.6
Medicare		492.0		390.9
Medicaid		108.3		65.7
<b>Total health care costs payable</b>	<b>\$</b>	<b>2,895.3</b>	<b>\$</b>	<b>2,393.2</b>

#### *Premium Deficiency Reserves*

We recognize a premium deficiency loss when it is probable that expected future health care costs will exceed our existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of expected losses for certain contracts. Any such reserves established would normally cover expected losses until the next policy renewal dates for the related policies. We did not have any material premium deficiency reserves for our Health Care business at December 31, 2009 or 2008.

#### **Other Insurance Liabilities**

We establish insurance liabilities other than health care costs payable for benefit claims related to our Group Insurance segment. We refer to these liabilities as other insurance liabilities. These liabilities relate to our life, disability and long-term care products.

### *Life and Disability*

The liabilities for our life and disability products reflect benefit claims that have been reported to us but not yet paid, estimates of claims that have been incurred but not yet reported to us, and future policy benefits earned under insurance contracts. We develop these reserves and the related benefit expenses using actuarial principles and assumptions that consider, among other things, discount, resolution and mortality rates (each discussed below). Completion factors are also evaluated when estimating our reserves for claims incurred but not yet reported for life products. We also consider the benefit payments from the U.S. Social Security Administration for which our disability members may be eligible and which may offset our liability for disability claims (this is known as the Social Security offset). Each period, we estimate these factors, to the extent relevant, based primarily on historical data, and use these estimates to determine the assumptions underlying our reserve calculations. Given the extensive degree of judgment and uncertainty used in developing these estimates, it is possible that our estimates could develop either favorably or unfavorably.

The discount rate is the interest rate at which future benefit cash flows are discounted to determine the present value of those cash flows. The discount rate we select is a critical estimate, because higher discount rates result in lower reserves. We determine the discount rate based on the current and estimated future yield of the asset portfolio supporting our life and disability reserves. If the discount rate we select in estimating our reserves is lower (higher) than our actual future portfolio returns, our reserves may be higher (lower) than necessary. Our discount rates for life and disability reserves at December 31, 2009 both decreased .5% when compared to the rates used at December 31, 2008. Our discount rates for life and disability reserves at December 31, 2008 increased by .17% and .04%, respectively, when compared to the rates used at December 31, 2007. The discount rates we selected for disability and life reserves at December 31, 2009 were lower than 2008 due to lower projected future yields on the investment portfolio supporting these reserves. The discount rates for 2008 were higher than the rates we selected in the previous year as a result of increasing investment yields on the portfolio of assets supporting these reserves. Based on our historical experience, it is reasonably possible that the assumed discount rates for our life and disability reserves may vary by plus or minus .25% from year to year. A .25% decrease in the discount rates selected for both our life and disability reserves would have increased current and future life and disability benefit costs by approximately \$17 million pretax for 2009.

For disability claims and a portion of our life claims, we must estimate the timing of benefit payments, which takes into consideration the maximum benefit period and the probabilities of recovery (i.e., recovery rate) or death (i.e., mortality rate) of the member. Benefit payments may also be affected by a change in employment status of a disabled member, for example, if the member returns to work on a part-time basis. Estimating the recovery and mortality rates of our members is complex. Our actuaries evaluate our current and historical claim patterns, the timing and amount of any Social Security offset (for disability only), as well as other factors including the relative ages of covered members and the duration of each member's disability when developing these assumptions. For disability reserves, if our actual recovery and mortality rates are lower (higher) than our estimates, our reserves will be lower (higher) than required to cover future disability benefit payments. For certain life reserves, if the actual recovery rates are lower (higher) than our estimates or the actual mortality rates are higher (lower) than our estimates, our reserves will be lower (higher) than required to cover future life benefit payments. We use standard industry tables and our historical claim experience to develop our estimated recovery and mortality rates. Claim reserves for our disability and life products are sensitive to these assumptions. Our historical experience has been that our recovery or mortality rates for our life and disability reserves vary by less than one percent during the course of a year. A one percent less (more) favorable assumption for our recovery or mortality rates would have increased (decreased) current and future life and disability benefit costs by approximately \$6 million pretax for 2009. When establishing our reserves at December 31, 2009, we have adjusted our estimates of these rates based on recent experience.

We estimate our reserve for claims incurred but not yet reported to us for life products largely based on completion factors. The completion factors we use are based on our historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. At December 31, 2009, we held approximately \$189 million in reserves for life claims incurred but not yet reported to us.

### *Long-term Care*

We establish a reserve for future policy benefits for our long-term care products at the time each policy is issued based on the present value of estimated future benefit payments less the present value of estimated future premiums. In establishing this reserve, we must evaluate assumptions about mortality, morbidity, lapse rates and the rate at which new claims are submitted to us. We estimate the future policy benefits reserve for long-term care products using these assumptions and actuarial principles. For long-duration insurance contracts, we use our original assumptions throughout the life of the policy and do not subsequently modify them unless we deem the reserves to be inadequate. A portion of our reserves for long-term care products also reflect our estimates relating to future payments to members currently receiving benefits. These reserves are estimated primarily using recovery and mortality rates, as described above.

### *Premium Deficiency Reserves*

We recognize a premium deficiency loss when it is probable that expected future policy benefit costs will exceed our existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of expected losses for certain contracts. Any such reserves established would normally cover expected losses until the next policy renewal dates for the related policies. We did not have any material premium deficiency reserves for our Group Insurance business at December 31, 2009 or 2008.

### *Large Case Pensions Discontinued Products Reserve*

We discontinued certain Large Case Pensions products in 1993 and established a reserve to cover losses expected during the run-off period. Since 1993, we have made several adjustments to reduce this reserve that have increased our net income. These adjustments occurred primarily because our investment experience as well as our mortality and retirement experience have been better than the experience we projected at the time we discontinued the products. There was no release of this reserve in 2009. In 2008 and 2007, \$44 million and \$64 million, respectively, of reserves were released for these reasons. There can be no assurance that adjustments to the discontinued products reserve will occur in the future or that they will increase net income. Future adjustments could positively or negatively impact our operating earnings.

### **Recoverability of Goodwill and Other Acquired Intangible Assets**

We have made acquisitions that included a significant amount of goodwill and other intangible assets. Goodwill is subject to an annual (or under certain circumstances more frequent) impairment test based on its estimated fair value. Other intangible assets that meet certain criteria continue to be amortized over their useful lives and are also subject to a periodic impairment test. For these impairment evaluations, we use an implied fair value approach, which uses a discounted cash flow analysis and other valuation methodologies. These impairment evaluations use many assumptions and estimates in determining an impairment loss, including certain assumptions and estimates related to future earnings. If we do not achieve our earnings objectives, the assumptions and estimates underlying these impairment evaluations could be adversely affected, which could result in an asset impairment charge that would negatively impact our operating results.

### **Measurement of Defined Benefit Pension and Other Postretirement Benefit Plans**

We sponsor defined benefit pension ("pension") and other postretirement benefit ("OPEB") plans for our employees and retirees. Major assumptions used in the accounting for these plans include the expected return on plan assets and the discount rate. We select our assumptions based on our information and market indicators, and we evaluate our assumptions at each annual measurement date (December 31). A change in any of our assumptions would have an effect on our pension and OPEB plan costs. A discussion of our assumptions used to determine the expected return on plan assets can be found in Note 11 of Notes to Consolidated Financial Statements beginning on page 67.

The discount rates we used in accounting for our pension and OPEB plans were calculated using a yield curve as of our annual measurement date. The yield curve consists of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds (that is, bonds with a rating of Aa or better from Moody's Investors Service or a rating of AA or better from Standard and Poor's). We project the benefits expected to be paid from each plan at each point in the future based on each participant's current service (but reflecting expected future pay increases). These projected benefit payments are then discounted to the measurement date using the corresponding rate from the yield curve. A lower discount rate increases the present value of benefit obligations and increases costs. In 2009, we decreased our assumed discount rate to 5.89% and 5.64% for our pension and OPEB plans, respectively, from 6.89% and 6.92%, respectively, at the previous measurement date in 2008. A one-percentage

point decrease in the assumed discount rate would increase our annual pension costs by approximately \$37 million after tax and would have a negligible effect on our annual OPEB costs.

At December 31, 2009, the pension and OPEB plans had aggregate actuarial losses of \$2.5 billion. These losses are primarily due to investment losses incurred in 2008. The accumulated actuarial loss is amortized over the remaining service life of pension plan participants (estimated at 9.4 years at December 31, 2009) and the expected life of OPEB plan participants (estimated at up to 15.8 years at December 31, 2009) to the extent the loss is outside of a corridor established in accordance with GAAP. The corridor is established based on the greater of 10% of the plan assets or 10% of the projected benefit obligation. At December 31, 2009, \$1.9 billion of the actuarial loss was outside of the corridor, resulting in amortization of approximately \$206 million after tax in our 2010 pension and OPEB expense.

Our expected return on plan assets and discount rate discussed above will not affect the cash contributions we are required to make to our pension and OPEB plans because we have met all minimum funding requirements. We will not have a minimum funding requirement for our pension or OPEB plans in 2010. However, we currently intend to make a voluntary pension contribution of approximately \$45 million in 2010.

Refer to Note 11 of Notes to Consolidated Financial Statements beginning on page 67 for additional information on our defined benefit pension and other postretirement benefit plans.

### **Other-Than-Temporary Impairment of Debt Securities**

We regularly review our debt securities to determine whether a decline in fair value below the carrying value is other than temporary. If a decline in fair value is considered other than temporary, the cost basis or carrying amount of the security is written down. The write-down is then bifurcated into its credit and non-credit related components. The credit-related component is included in our results of operations and the non-credit related component is included in other comprehensive loss if we do not intend to sell the security. We analyze all facts and circumstances we believe are relevant for each investment when performing this analysis, in accordance with applicable accounting guidance promulgated by the Financial Accounting Standards Board and the United States Securities and Exchange Commission.

Among the factors we consider in evaluating whether a decline is other than temporary are whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole and the prospects for realizing the carrying value of the security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, we determine whether we intend to sell the security or if it is more likely than not that we will be required to sell the security before recovery of its cost basis. If either case is true, we recognize an OTTI and the cost basis/carrying amount of the security is written down to fair value.

Securities in an unrealized loss position for which we believe we will not recover the amortized cost due to the quality of the security or the credit-worthiness of the issuer are categorized as credit-related OTTI.

The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our projections and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell securities that were not impaired in prior reporting periods.

### **Revenue Recognition (Allowance for Estimated Terminations and Uncollectable Accounts)**

Our revenue is principally derived from premiums and fees billed to customers in the Health Care and Group Insurance businesses. In Health Care, revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in our records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. In Group Insurance, premium for group life and disability products is recognized as revenue, net of allowances for uncollectable accounts, over the term of coverage. Amounts received before the period of coverage begins are recorded as unearned premiums.

Health Care billings may be subsequently adjusted to reflect changes in the number of covered employees due to terminations or other factors. These adjustments are known as retroactivity adjustments. We estimate the amount of

future retroactivity each period and adjust the recorded revenue accordingly. We also estimate the amount of uncollectable receivables each period and establish an allowance for uncollectable amounts. We base such estimates on historical trends, premiums billed, the amount of contract renewal activity during the period and other relevant information. As information regarding actual retroactivity and uncollectable amounts becomes known, we refine our estimates and record any required adjustments to revenues in the period they arise. A significant difference in the actual level of retroactivity or uncollectable amounts when compared to our estimated levels would have a significant effect on Health Care's results of operations.

## **NEW ACCOUNTING STANDARDS**

Refer to Note 2 of Notes to Consolidated Financial Statements, beginning on page 48, for a discussion of recently issued accounting standards.

## **REGULATORY ENVIRONMENT**

### **General**

Our operations are subject to comprehensive federal, state, local and international regulation in the jurisdictions in which we do business. The laws and rules governing our business and interpretations of those laws and rules continue to become more restrictive each year and are subject to frequent change. Further, we must obtain and maintain regulatory approvals to market many of our products. Supervisory agencies, including state health, insurance and managed care departments and state boards of pharmacy and CMS have broad authority to:

- Grant, suspend and revoke our licenses to transact business;
- Regulate many aspects of the products and services we offer;
- Assess fines, penalties and/or sanctions;
- Monitor our solvency and reserve adequacy; and/or
- Regulate our investment activities on the basis of quality, diversification and other quantitative criteria.

Our operations and accounts and other books and records are subject to examination at regular intervals by these agencies. In addition, our current and past business practices are subject to review by, and from time to time we receive subpoenas and other requests for information from, various state insurance and health care regulatory authorities and attorneys general, the Office of the Inspector General, and other state and federal authorities, including inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our business practices. These reviews, subpoenas and requests may result, and have resulted, in changes to or clarifications of our business practices, as well as fines, penalties or other sanctions.

The federal and state governments continue to enact and seriously consider many broad-based legislative and regulatory proposals that have or could materially impact various aspects of the health care system. For example:

- During 2009, the federal government became increasingly focused on broad-based health care reform, and both the U.S. House of Representatives and Senate passed extensive health reform measures in November and December of 2009, respectively. On February 22, 2010, President Obama published an alternative proposal for broad-based health care reform legislation. If enacted, this proposal, which is similar to the legislation passed by the U.S. Senate, would significantly affect our business and results of operations. Some of the proposed changes in this legislation include a provision for guaranteed issue of coverage in the individual and small group market with a weak mandate that requires coverage. It would also specify required benefit designs, limit rating and pricing practices, and impose minimum requirements for medical benefit ratios, create new ways in which health insurance is distributed (for example, state-based health insurance exchanges), encourage additional competition (including potential incentives for new market entrants) and expand eligibility for Medicaid programs. In addition, President Obama's proposal would create a new federal Health Insurance Rate Authority that would significantly increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately increase health plan premiums. Financing for these reforms was expected to come, in part, from material additional fees and taxes on us and other health insurers and health plans, as well as reductions in certain levels of reimbursement under Medicare. Given recent political developments in Washington, D.C., the fate of this legislation and the nature and extent of any other new health care reform is uncertain, though it is reasonably possible that federal health care reform in some form

could be enacted. We cannot predict whether federal health care reform will be enacted, and if it is, what provisions it will contain or what effect it will have on our business or results of operations, although it could have a material adverse effect. If enacted, health care reform would most likely require significant rule making, and we will continue to work with health care policy makers to ensure Americans have access to affordable insurance.

At the state level, forty-four states and the District of Columbia will hold a regular legislative session in 2010. We expect state legislatures to focus on the impact of federal health care reform legislation and state budget deficits in 2010. Proposals under consideration in U.S. Congress could significantly alter the federal structure that shapes the state regulation of health insurance. While the federal debate is ongoing and the outcome uncertain, if federal health care reform legislation is enacted, states may be required to significantly amend numerous existing statutes and regulations. Independent of federal efforts, we expect many states to consider legislation to extend coverage to the uninsured through health insurance exchanges, increase the limiting age for dependent eligibility, restrict health plan rescission of individual coverage, increase mandatory medical benefit ratios, implement rating reforms and enact an autism benefit mandate. We cannot predict whether health care reforms will be enacted at the state level, and if it is, what provisions it will contain in any state or what effect it will have on our business or results of operations.

- On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (“ARRA”) was enacted into law. Under ARRA, as amended, if an individual is involuntarily terminated from employment (for reasons other than gross misconduct) before March 1, 2010, the individual may elect COBRA coverage and, for a period of up to fifteen months, receive a subsidy from his or her employer equal to 65% of the otherwise applicable COBRA premium charged to the employee. The employer is entitled to apply the amount of premium assistance it pays as an offset against its payroll taxes. Congress may extend the end date of this subsidy. During 2009, the availability of this subsidy caused more people to elect COBRA coverage from us than we assumed, which caused unexpected increases in our medical costs. This subsidy may continue to cause unexpected increases in our medical costs.
- ARRA also expands and strengthens the privacy and security provisions of the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and imposes additional limits on the use and disclosure of Protected Health Information (“PHI”). Among other things, ARRA requires us and other covered entities to report any unauthorized release of, use of, or access to PHI to any impacted individuals and to the U.S. Department of Health and Human Services in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. Business associates (e.g., entities that provide services to health plans, such as electronic claims clearinghouses, print and fulfillment vendors, consultants, and us for the administrative services we provide to our ASC customers) must also comply with certain HIPAA provisions. In addition, ARRA establishes greater civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA’s provisions and requires the U.S. Department of Health and Human Services to issue regulations implementing its privacy and security enhancements. We will continue to assess the impact of these regulations on our business as they are issued.
- In 2008, the U.S. Congress reduced funding for Medicare Advantage plans beginning in 2010 and imposed new marketing requirements on Medicare Advantage and PDP plans beginning in 2009. The health reform legislation pending in Congress contemplates both a further reduction for Medicare Advantage plans beginning in 2011 and the introduction of a competitive bidding approach to service members of Medicare Advantage plans by 2015.

## Health Care Regulation

### General

The federal, state and foreign governments have adopted laws and regulations that govern our business activities in various ways. These laws and regulations restrict how we conduct our business and result in additional burdens and costs to us. Areas of governmental regulation include:

- Licensure
- Premium rates and rating methodologies
- Medical benefit ratios
- Underwriting rules and procedures
- Policy forms, including plan design and disclosures
- Benefit mandates
- Market conduct
- Utilization review activities
- Payment of claims, including timeliness and accuracy of payment
- Member rights and responsibilities
- Sales and marketing activities
- Quality assurance procedures
- Disclosure of medical and other information
- In-network and out-of-network provider rates of payment
- General assessments
- Provider contract forms
- Pharmacy and pharmacy benefit management operations
- Required participation in coverage arrangements for high-risk insureds, either directly or through an assessment or other risk-pooling mechanism
- Delegation of risk and other financial arrangements
- Producer licensing and compensation
- Financial condition (including reserves) and
- Corporate governance.

These laws and regulations are different in each jurisdiction.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. To establish a new insurance company or an HMO in a state, we generally would have to obtain such a certificate. The time necessary to obtain such a certificate varies from state to state. Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of our regulated subsidiaries to pay dividends. In addition, some of our business and related activities may be subject to PPO, managed care organization, utilization review or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, but may contain network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for our delivery of services, payment of claims, fraud prevention, protection of consumer health information and covered benefits and services. With the amendment of the Annual Financial Reporting Model Regulation by the NAIC to incorporate elements of the Sarbanes-Oxley Act of 2002, we expect states will continue to expand their regulation of the corporate governance and internal control activities of HMOs and insurance companies.

### Pricing and Underwriting Restrictions

Pricing and underwriting regulation by states limits our underwriting and rating practices and that of other health insurers, particularly for small employer groups and individuals. These laws and regulations vary by state. In general, they apply to certain business segments and limit our ability to set prices or renew business, or both based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict our ability to price for the risk we assume and/or reflect reasonable costs in our pricing, including by specifying minimum medical benefit ratios or requiring us to issue policies at specific prices to certain members. For example, on July 8, 2008, the state of New Jersey enacted legislation mandating a minimum medical benefit ratio of 80% for

individual and small group insured health business in that state beginning January 1, 2009. The health reform measures passed by the U.S. Senate and the House of Representatives also specify minimum medical benefit ratios, President Obama's February 22, 2010 health reform proposal would establish a new federal Health Insurance Rate Authority that would significantly increase federal oversight of health plan premium rates, and states may further restrict our ability to price for the risk we assume, any of which could adversely affect our ability to appropriately increase health plan premiums.

Many of these laws and regulations limit the differentials in rates insurers and other carriers may charge between new and renewal business, and/or between groups or individuals based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal rates, restrict the application of pre-existing condition exclusions and limit the ability of a carrier to terminate coverage of an employer group.

HIPAA generally requires insurers and other carriers that cover small employer groups in any market to accept for coverage any small employer group applying for a basic and standard plan of benefits. HIPAA also mandates guaranteed renewal of health care coverage for most employer groups, subject to certain defined exceptions, and provides for specified employer notice periods in connection with product and market withdrawals. The law further limits exclusions based on pre-existing conditions for individuals covered under group policies to the extent the individuals had prior creditable coverage within a specified time frame. HIPAA is structured as a "floor" requirement, allowing states latitude to enact more stringent rules governing each of these restrictions. For example, certain states have modified HIPAA's definition of a small group (2-50 employees) to include groups of one employee.

In addition, a number of states provide for a voluntary reinsurance mechanism to spread small group risk among participating insurers and other carriers. In a small number of states, participation in this pooling mechanism is mandatory for all small group carriers. In general, we have elected not to participate in voluntary pools, but even in the voluntary pool states, we may be subject to certain supplemental assessments related to the state's small group experience.

#### **HIPAA Administrative Simplification and Privacy; Gramm-Leach-Bliley Act**

The regulations under the administrative simplification provisions of HIPAA also impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors. The law authorizes the U.S. Department of Health and Human Services ("HHS") to issue standards for electronic transactions, as well as privacy and security of medical records and other individually identifiable health information ("Administrative Simplification").

Administrative Simplification requirements apply to self-funded group health plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically ("Covered Entities"). Regulations adopted to implement Administrative Simplification also require that business associates acting for or on behalf of these Covered Entities be contractually obligated to meet HIPAA standards. The Administrative Simplification regulations establish significant criminal penalties and civil sanctions for noncompliance.

Under Administrative Simplification, HHS has released rules mandating the use of standard formats in electronic health care transactions (for example, health care claims submission and payment, plan eligibility, precertification, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits). HHS also has published rules requiring the use of standardized code sets and unique identifiers for employers and providers. By 2013, the federal government will require that healthcare organizations, including health insurers, upgrade to updated and expanded standardized code sets used for describing health conditions. These new standardized code sets, known as ICD-10, will require substantial investments from health care organizations, including us. We estimate that our ICD-10 project costs will be \$30 million in 2010.

The HIPAA privacy regulations adopted by HHS established limits on the use and disclosure of medical records and other individually identifiable health information by Covered Entities. In addition, the HIPAA privacy regulations provide patients with new rights to understand and control how their health information is used. The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may apply to us and other Covered Entities, including laws that place stricter controls on the release of information relating to specific diseases or conditions, and complying with additional state requirements could require us to make additional investments beyond those we have

made to comply with the HIPAA regulations. HHS has also adopted security regulations designed to protect member health information from unauthorized use or disclosure.

In addition, states have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as Gramm-Leach-Bliley Act (“GLBA”)) which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to “opt out” of certain disclosures before the insurer shares such information with a non-affiliated third party. In addition to health insurance, the GLBA regulations apply to life and disability insurance. Like HIPAA, this law sets a “floor” standard, allowing states to adopt more stringent requirements governing privacy protection. GLBA also gives banks and other financial institutions the ability to affiliate with insurance companies, which may lead to new competitors in the insurance and health benefits businesses.

### **Legislative and Regulatory Initiatives**

In addition to broad-based federal health reform legislation, there has been a continuing trend of increased legislative activity concerning health reform and regulation at both the federal and state levels. For example, Massachusetts has enacted comprehensive reform, including an individual health coverage mandate and a health insurance exchange. However, in 2009, less than a dozen states considered major structural reforms, and only two of those states enacted such proposals into law. For example, Oregon adopted elements of a comprehensive reform proposal, many of which are elements contained in the federal health reform legislation. Utah adopted a voluntary health insurance exchange, as well as a new basic benefit plan that must be offered by all individual and small group carriers.

Other states are expected to consider these types of reforms as well as more modest reforms aimed at expanding Medicaid and SCHIP eligibility. These proposals include provisions affecting both public programs and privately-financed health insurance arrangements, and some of these proposals could have the longer-term effect of materially altering the current role of employers in providing health benefits. Broadly stated, these proposals attempt to increase the number of insured by expanding eligibility for Medicaid and other public programs and compelling individuals and/or employers to purchase health insurance coverage while expanding access to coverage through guaranteed issue requirements, and through new insurance exchanges and/or other mechanisms. At the same time, these proposals could change the underwriting and marketing practices of health plans, for example by placing restrictions on pricing and mandating minimum medical benefit ratios.

Legislation, regulation and initiatives relating to this continuing trend include among other things, the following:

- Amending or supplementing ERISA to impose greater requirements on the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, assessments for uninsured or high-risk pools, assessments for uncompensated care, or assessments to defray provider medical malpractice insurance costs.
- Reducing government funding of government-sponsored health programs in which we participate.
- Mandating minimum medical benefit ratios or otherwise restricting health plans’ profitability.
- Extending malpractice and other liability exposure for decisions made by health plans.
- Mandating coverage for certain conditions and/or specified procedures, drugs or devices (for example, treatment for autism and infertility and experimental pharmaceuticals).
- Mandating expanded employer and consumer disclosures and notices.
- Regulating e-connectivity.
- Mandating health insurance access and/or affordability.
- Mandating or regulating the disclosure of provider fee schedules and other data about our payments to providers.
- Mandating or regulating disclosure of provider outcome and/or efficiency information.
- Imposing substantial penalties for our failure to pay claims within specified time periods.
- Imposing payment levels for services rendered to our members by providers who do not have contracts with us.

- Exempting physicians from the antitrust laws that prohibit price fixing, group boycotts and other horizontal restraints on competition.
- Restricting health plan claim processing, review, payment and related procedures.
- Mandating internal and external grievance and appeal procedures (including expedited decision making and access to external claim review).
- Enabling the creation of new types of health plans or health carriers, which in some instances would not be subject to the regulations or restrictions that govern our operations.
- Allowing individuals and small groups to collectively purchase health care coverage without any other affiliations.
- Imposing requirements and restrictions on operations of pharmacy benefit managers, including restricting or eliminating the use of formularies for prescription drugs or the use of average wholesale price.
- Creating or expanding state-sponsored health benefit purchasing pools, in which we may be required to participate.
- Creating a single payer system where the government oversees or manages the provision of health care coverage.
- Imposing requirements and restrictions on consumer-driven health plans and/or health savings accounts.
- Restricting the ability of health plans to establish member financial responsibility.
- Regulating the individual coverage market by restricting or mandating premium levels, restricting our underwriting discretion or restricting our ability to rescind coverage based on a member's misrepresentations or omissions.
- Requiring employers to provide health care coverage for their employees.
- Assisting individuals in retaining access to employer-based coverage, for example, through government subsidies for terminated workers.
- Requiring individuals to purchase health care coverage.
- Allowing significantly expanded access to Medicaid, Medicare, the Federal Employees Health Benefit Plan or other government-based health insurance programs, or creating other government-run insurance programs that would compete with commercial health plans.

For example, on October 3, 2008, the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act 2008 (the "Mental Health Parity Act") was enacted into law as part of an end-of-session package that included the Emergency Economic Stabilization Act of 2008. The Mental Health Parity Act became effective for plan years beginning on or after October 3, 2009 and requires that financial requirements and treatment limitations applicable to mental health or substance abuse disorder benefits be no more restrictive than those imposed on medical/surgical benefits. The Mental Health Parity Act does not require plans to offer mental health or substance use disorder benefits. The regulations implementing the Mental Health Parity Act are more stringent than anticipated and will require us to revise our benefit offerings.

Some of the changes, if enacted, could provide us with business opportunities. However, it is uncertain whether we can counter the potential adverse effects of such potential legislation or regulation, including whether we can recoup, through higher premiums, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments or other increased costs.

We also may be adversely impacted by court and regulatory decisions that expand the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Among other issues, federal and state courts continue to consider cases addressing group life insurance payment practices and the pre-emptive effect of ERISA on state laws. In general, limitations to ERISA pre-emption have the effect of increasing our costs, liability exposures, or both. The legislative initiatives discussed above include proposals in the U.S. Congress to restrict the pre-emptive effect of ERISA and state legislative activity in several states that, should it result in enacted legislation that is not pre-empted by ERISA, could increase our liability exposure and could result in greater state regulation of our operations.

#### **The Employee Retirement Income Security Act of 1974 ("ERISA")**

The provision of services to certain employee benefit plans, including certain Health Care, Group Insurance and Large Case Pensions benefit plans, is subject to ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor (the "DOL"). ERISA regulates certain

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aspects of the relationships between us and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities may also be subject to regulation under ERISA.

DOL regulations under ERISA set standards for claim payment and member appeals along with associated notice and disclosure requirements. Certain final and proposed regulations would require additional disclosures to employers of certain types of indirect compensation we receive. We have invested significant resources to comply with these standards, which represent an additional regulatory burden for us.

ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the preemption continues to be reviewed by courts. For example, the United States Supreme Court may consider a lawsuit regarding a local mandate which allows the City of San Francisco to require that City employers must either provide health benefits to their employees or pay into a City fund. This lawsuit challenges the current application of ERISA preemption to employers in their administration of benefits.

Certain Large Case Pensions and Group Insurance products and services are also subject to potential issues raised by certain judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, we may have ERISA fiduciary duties with respect to certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those assets are subject to conflict of interest and other restrictions, and we must provide certain disclosures to policyholders annually. We must comply with these restrictions or face substantial penalties.

### **Federal Employees Health Benefits (“FEHB”) Program**

Our subsidiaries contract with the Office of Personnel Management (“OPM”) to provide managed health care services under the FEHB Program in their service area. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. The OPM conducts periodic audits of its contractors to, among other things, verify that the premiums established under its contracts are in compliance with the community rating and other requirements under FEHB Program. The OPM may seek premium refunds or institute other sanctions against health plans that participate in the program if the health plan is found to be non-compliant with the program requirements.

### **Medicare**

Our Medicare products are regulated by CMS. CMS regularly audits our performance to determine compliance with CMS contracts and regulations and the quality of services being provided to Medicare beneficiaries. The regulations and contractual requirements applicable to us and other participants in Medicare programs are complex and subject to change. Although we have invested significant resources to comply with these standards and believe our compliance efforts are adequate, our Medicare compliance efforts will continue to require significant resources. If we fail to comply with the standards, CMS may prohibit us from continuing to market and/or enroll members in one or more Medicare products.

As a result of funding and other reforms contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the “Medicare Act”):

- In each year from 2005 through and including 2009, we elected to expand our participation in the Medicare Advantage program in selected markets. However, we decided to cease offering Medicare Advantage plans in certain geographic areas in 2010. We sold mainly individual PFFS plans in these geographic areas and the decision was made in anticipation of the changes in the PFFS network requirements which will become effective in 2011. Our market reductions resulted in the non-renewal of approximately 48,000 Medicare Advantage members.
- In January 2006, we began offering PDP products in all 34 CMS designated regions; and
- In 2007, we began to offer PFFS plans in select markets for individuals and PFFS plans for employer groups that can cover retirees nationwide.
- In 2008, we began to offer a Medicare Advantage Special Needs Plan in select markets to individuals who are eligible for both Medicare and Medicaid benefits.
- In 2009, we elected to expand our Medicare PPO and HMO offerings in a number of geographic areas.

This expansion of the Medicare markets we serve and Medicare products we offer increases our exposure to changes in government policy with respect to and/or regulation of the Medicare programs in which we participate, including changes in the amounts payable to us under those programs. For example, on July 15, 2008, the U.S. Congress overrode the President's veto and passed a Medicare funding bill that reduces amounts payable to health plans that offer Medicare Advantage plans beginning in 2010, requires health plans that offer Medicare Advantage plans to have contracts with the providers their members utilize beginning in 2011, and imposed new marketing requirements for Medicare Advantage and Medicare Part D Prescription Drug plans beginning in 2009. In addition, the Obama administration and various congressional leaders have signaled their interest in reducing payments to private plans offering Medicare Advantage. Depending on the extent and phasing of these potential reductions, the number of individuals participating in Medicare Advantage and the industry-wide earnings from these plans may fall. However, although it is not possible to predict the longer term adequacy of payments we receive under these programs and although there are economic and political pressures to continue to reduce spending on these programs, we currently believe that the payments we receive and will receive in the near term are adequate to justify our continued participation in these programs.

Going forward, we expect the U.S. Congress to continue to closely scrutinize each component of the Medicare program (including PDP) and possibly seek to limit the private insurers' role. For example, the federal government may seek to negotiate drug prices for the PDP, a function we currently perform as a PDP sponsor. It is not possible to predict the outcome of this Congressional oversight or any legislative activity, either of which could adversely affect us.

### **Medicaid**

In 2007, we substantially increased our Medicaid product offerings through our acquisition of Schaller Anderson. As a result, we also increased our exposure to changes in government policy with respect to and/or regulation of the various Medicaid programs in which we participate, including the amounts payable to us under those programs. Medicaid premiums are paid by each state and differ from state to state. The federal government and the states in which we have Medicaid business are presently considering proposals and legislation that would implement certain Medicaid reforms or redesigns, including changes to reimbursement or payment levels or eligibility criteria. Future levels of Medicaid funding and premium rates may be affected by continuing government efforts to contain health care costs and may be further affected by state and federal budgetary constraints. In addition, our Medicaid contracts with states are subject to cancellation by the state after a short notice period without cause or in the event of insufficient state funding. Our Medicaid products are also regulated by CMS, which has the right to audit our performance to determine compliance with CMS contracts and regulations. In addition, our Medicaid products and State Children's Health Insurance Program contracts are subject to federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services and other aspects of these programs. The regulations and contractual requirements applicable to us and other participants in Medicaid programs are complex and subject to change. Although we have invested significant resources to comply with these standards and believe our compliance efforts are adequate, our Medicaid compliance efforts will continue to require significant resources. If we fail to comply with the standards, CMS may prohibit us from continuing to market and/or enroll members in one or more Medicaid products.

### **HMO and Insurance Holding Company Laws**

A number of states, including Pennsylvania and Connecticut, regulate affiliated groups of HMOs and insurers such as the Company under holding company statutes. These laws may require us and our subsidiaries to maintain certain levels of equity. Holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file reports with those states' insurance departments regarding capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, various notice or prior regulatory approval requirements apply to transactions between insurance companies, HMOs and their affiliates within an insurance holding company system, depending on the size and nature of the transactions. With the amendment of the Annual Financial Reporting Model Regulation by the National Association of Insurance Commissioners to incorporate elements of the Sarbanes-Oxley Act of 2002, we expect that the states in which our insurance and HMO subsidiaries are licensed will continue to expand the regulation of corporate governance and internal control activities of HMOs and insurance companies.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year.

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as a company's RBC declines and provides for four different levels of regulatory attention depending on the ratio of a company's total adjusted capital (defined as the total of its statutory capital, surplus and asset valuation reserve) to its risk-based capital. The level of regulatory oversight ranges from requiring the company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its RBC, to mandatory regulatory intervention requiring a company to be placed under regulatory control in a rehabilitation or liquidation proceeding. As of December 31, 2009, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC thresholds.

For information regarding restrictions on certain payments of dividends or other distributions by HMO and insurance company subsidiaries of our company, refer to Note 16 of Notes to Consolidated Financial Statements on page 76.

The holding company laws for the states of domicile of Aetna and certain of its subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as our parent company, Aetna Inc.) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

#### **Audits and Investigations; Fraud and Abuse Laws**

We typically have been and are currently involved in various governmental investigations, audits and reviews, the frequency and depth of which continue to increase. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys and other governmental authorities. Such government actions can result in changes to our business practices, assessment of damages, civil or criminal fines or penalties, or other sanctions, including the loss of licensure or exclusion from participation in government programs. For example, in January 2009, we agreed to discontinue the use of the Ingenix database at a future date. We currently use the Ingenix database for many plans to determine the level of reimbursement when our members utilize providers who do not have a contract with us. Refer to Litigation and Regulatory Proceedings in Note 18 of Notes to Consolidated Financial Statements beginning on page 77 for more information.

Federal and state governments have 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 members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicare and Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to us and other participants in these public-sector programs are complex and subject to change. Although we believe our compliance efforts are adequate, ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

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, is increasing as are the penalties being imposed for inappropriate practices. Products offering limited benefits, such as those we issue and sell through Strategic Resource Company, which we acquired in January 2005, in particular may attract increased regulatory scrutiny.

### **Guaranty Fund Assessments/Solvency Protection**

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. Assessments generally are based on a formula relating to our premiums in the state compared to the premiums of other insurers. While we historically have recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could jeopardize future recovery of these assessments. Some states have similar laws relating to HMOs. In addition, changes to regulations or their interpretation due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to the current economic downturn, could negatively impact our business in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approved dividends from regulated subsidiaries.

### **Regulation of Pharmacy Operations**

We own two mail-order pharmacy facilities and one specialty pharmacy facility. One mail order pharmacy is located in Missouri and the specialty pharmacy and our second mail order pharmacy are located in Florida. These facilities dispense pharmaceuticals throughout the U.S. The pharmacy practice is generally regulated at the state level by state boards of pharmacy. Our pharmacies also must register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. Each of our pharmacies is licensed in the state where it is located, as well as in the states that require registration or licensure with the state's board of pharmacy or similar regulatory body. Loss or suspension of any such licenses or registrations could have a material effect on our pharmacy business and/or operating results.

### **Regulation of Pharmacy Benefit Management Operation**

Our pharmacy benefit management ("PBM") operation is regulated directly and indirectly at the federal and state levels. These laws and regulations govern, and proposed legislation may govern, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers, drug utilization management practices, the level of duty a PBM owes its customers and registration or licensing of PBMs. Failure to comply with these laws or regulations could have a material effect on our PBM operation and/or operating results.

### **Life and Disability Insurance**

Our life insurance and disability operations are subject to extensive regulation. Changes in these regulations, such as expanding the definition of disability or changing claim determination, settlement and/or payment practices, could have a material impact on our life insurance and/or disability insurance operations and/or operating results.

### **International Regulation**

We continue to expand our Health Care operations that are conducted in foreign countries. These international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, depending on the jurisdiction, including anti-corruption laws; various privacy, insurance, tax, tariff and trade laws and regulations; and corporate, employment, intellectual property and investment laws and regulations. In addition, the expansion of our operations into foreign countries increases our exposure to certain U.S. laws, such as the Foreign Corrupt Practices Act of 1977.

### **Anti-Money Laundering Regulations**

Certain of our lines of business are subject to United States Department of the Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their affected products comply with the regulations.

## **FORWARD-LOOKING INFORMATION/RISK FACTORS**

The Private Securities Litigation Reform Act of 1995 (the "1995 Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We want to take advantage of these safe harbor provisions.

Certain information contained in this MD&A is forward-looking within the meaning of the 1995 Act or SEC rules. This information includes, but is not limited to: the Outlook for 2010 on page 3 and Risk Management and Market-Sensitive Instruments on page 13. In addition, throughout this MD&A, we use the following words, or variations or negatives of these words and similar expressions, when we intend to identify forward-looking statements:

- |               |            |             |           |             |
|---------------|------------|-------------|-----------|-------------|
| • Expects     | • Intends  | • Seeks     | • Will    | • Potential |
| • Projects    | • Plans    | • Estimates | • Should  | • Continue  |
| • Anticipates | • Believes | • May       | • Outlook | • View      |

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant uncertainties and other factors, many of which are outside our control, that could cause actual results to differ materially from those statements. You should not put undue reliance on forward-looking statements. We disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events or otherwise.

### **Risk Factors**

You should carefully consider each of the following risks and all of the other information set forth in this MD&A or elsewhere in our Annual Report or our Annual Report on Form 10-K. These risks and other factors may affect forward-looking statements, including those we make in this MD&A or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect our business. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events, this could have a material adverse effect on our business, financial condition or operating results. In that case, the trading price of our common stock could decline materially.

#### **The continuing public policy debate on health reform and the stressed economic environment, with high U.S. unemployment, present overarching risks to all aspects of our enterprise.**

There can be no assurance that the outcome of that debate or the impact of the economic environment will not adversely affect our business, financial condition or results of operations. See “Regulatory Environment – General” beginning on page 22 and “Adverse economic conditions in the U.S. and abroad can significantly and adversely affect our business and profitability, and we do not expect these conditions to improve in the near future” beginning on page 34.

#### **We are subject to potential changes in public policy that can adversely affect the markets for our products and our profitability.**

It is not possible to predict with certainty or eliminate the impact of fundamental public policy changes that could adversely affect us. Examples of these changes include policy changes that would fundamentally change the dynamics of our industry, such as the federal or one or more state governments assuming a larger role in the health care industry or managed care operations (including increased regulation of health plan premiums and/or increases in those premiums such as that proposed by President Obama on February 22, 2010) or fundamentally restructuring or reducing the funding available for Medicare or Medicaid programs. Legislative and regulatory proposals that would significantly reform the health care system are currently pending in many states and at the federal level, and could be enacted in 2010. Our business and operating results could be materially adversely affected by such changes even if we correctly predict their occurrence. For more information on these matters, refer to Regulatory Environment – Legislative and Regulatory Initiatives beginning on page 26.

**We must continue to differentiate our products and services from those of our competitors; we operate in an evolving industry that requires us to anticipate changes in customer preferences and to innovate and deliver products and services that demonstrate value to our customers, particularly in response to market changes from public policy.**

We operate in a highly competitive environment and in an industry that is subject to significant ongoing changes from market pressures brought about by customer demands, as well as business consolidations, strategic alliances, legislative and regulatory changes and marketing practices. In addition, our customers generally, and our larger customers particularly, are well informed and organized and can easily move between us and our competitors. These factors require us to differentiate our products and services by anticipating changes in customer preferences and innovating and delivering products and services that demonstrate value to our customers, particularly in response to market changes from public policy. Failure to anticipate changes in customer preferences or to innovate and deliver products and services that demonstrate value to our customers can affect our ability to retain or grow profitable membership which can adversely affect our operating results.

**Our ability to anticipate and detect medical cost trends and achieve appropriate pricing affects our profitability; and our business and profitability may continue to be adversely affected by prevailing economic conditions. There can be no assurance that future health care costs will not continue to exceed our projections.**

Adverse economic conditions and unanticipated increases in our health care costs can significantly and adversely affect our businesses and profitability in a number of ways. The current economic environment is challenging and less predictable than recently experienced, which has caused and may continue to cause unanticipated increases and volatility in our health care costs. Premium revenues from our Insured Health Care products comprised approximately 81% of our total consolidated revenues for the year ended December 31, 2009. We continue to be vigilant in our pricing and have generally increased our premium rates for Insured business that will be under contract in 2010. Our health care premiums are generally fixed for one-year periods. Accordingly, future cost increases in excess of health care or other benefit cost projections reflected in our pricing cannot be recovered in the contract year through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts of the increases in health care and other benefit costs that we expect to occur during the fixed premium period. Those forecasts typically are made several months before the fixed premium period begins and are dependent on our ability to anticipate and detect medical cost trends. For example, during the year ended December 31, 2009, medical costs were higher and more volatile than we predicted, which led to health care costs that were significantly higher than we projected. As a result of these increases and volatility, accurately detecting, forecasting, managing and reserving for our and our self-insured customers' medical cost trends and future health care costs have become more challenging. There can be no assurance regarding the accuracy of the health care or other benefit cost projections reflected in our pricing, and our health care and other benefit costs can be affected by external events over which we have no control. Relatively small differences between predicted and actual health care costs as a percentage of premium revenues can result in significant adverse changes in our results of operations. If the rate of increase in our health care or other benefit costs in 2010 were to exceed the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our operating results would be adversely affected.

**Our ability to manage health care costs affects our profitability.**

Our profitability depends in large part on our ability to appropriately manage future health care costs through underwriting criteria, product design, negotiation of favorable provider contracts and medical management programs. The aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising health care costs. Changes in health care practices, general economic conditions such as inflation and employment levels, new technologies, increases in the cost of prescription drugs, direct-to-consumer marketing by pharmaceutical companies, clusters of high cost cases, changes in the regulatory environment, health care provider or member fraud and numerous other factors affecting the cost of health care can be beyond any health plan's control and may adversely affect our ability to manage health care costs, which can adversely affect our operating results.

**We face risks from industry, public policy and economic forces that can change the fundamentals of the health and related benefits industry and adversely affect our business and operating results.**

Various factors particular to the health and related benefits industry may affect our business model. Those factors include, among others, the rapid evolution of the business model, particularly as that model moves to a direct sales to the consumer model, shifts in public policy, adverse changes in laws and regulations, consumerism, pricing actions by competitors, competitor and supplier consolidation and a declining number of commercially insured people. We also face the potential of competition from existing or new companies that have not historically been in the health or group

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insurance industries, such as health information technology companies. If we are unable to anticipate, detect and deploy meaningful responses to these external factors, our business and operating results may be adversely affected.

**Adverse economic conditions in the U.S. and abroad can significantly and adversely affect our businesses and profitability, and we do not expect these conditions to improve in the near future.**

Serious concerns over inflation, energy costs, geopolitical issues, the availability and cost of credit and other capital, the U.S. mortgage market, consumer spending, a declining U.S. real estate market, higher unemployment rates and other factors have contributed to a slow global economy and significantly diminished expectations for the global economy, particularly the U.S. economy, going forward. Our customers, medical providers and the other companies with which we do business are generally headquartered in the U.S.; however many of our largest customers are global companies with operations around the world. As a result, adverse economic conditions in the U.S. and abroad can significantly and adversely affect our businesses and profitability by:

- Leading to reductions in force by our customers, which would reduce both our revenues and the number of members we serve.
- Leading our customers and potential customers, particularly those with the most members, and state and local governments, to force us to compete more vigorously on factors such as price and service to retain or obtain their business.
- Leading our customers and potential customers to purchase fewer products and/or products that generate less profit for us than the ones they currently purchase or otherwise would have purchased.
- Leading our customers and potential customers, particularly smaller employers and individuals, to forego obtaining or renewing their health and other coverage with us.
- Causing unanticipated increases and volatility in utilization of medical and other covered services by our members and/or increases in medical unit costs, each of which would increase our costs and limit our ability to accurately detect, forecast, manage and reserve for our and our self-insured customers' medical cost trends and future health care costs.
- Increasing our medical unit costs as hospitals and other providers attempt to maintain revenue levels in their efforts to adjust to their own economic challenges.
- Causing, over time, inflation that could cause interest rates to increase and thereby increase our interest expense and reduce our operating results, as well as decrease the value of the debt securities we hold in our investment portfolio, which would reduce our operating results and/or financial position.
- Weakening the ability or perceived ability of the issuers and/or guarantors of the debt or other securities we hold in our investment portfolio to perform on their obligations to us, which could result in defaults in those securities or reduce the value of those securities and create net realized capital losses for us that reduce our operating results.
- Weakening the ability of our customers, medical providers and the other companies with which we do business to perform their obligations to us or causing them not to perform those obligations, either of which could reduce our operating results.

Furthermore, reductions in workforce by our customers in excess of, or at a faster rate than those we project could reduce both our revenue and membership below our projected levels and cause unanticipated increases in our health care costs. For example, our business associated with members who have elected to receive benefits under COBRA typically has an MBR that is significantly higher than our Commercial average. In addition, the operating results associated with our COBRA membership may be subject to a high degree of variability until we are able to gain more experience with the expected increase in COBRA membership resulting from the ARRA subsidy described in Regulatory Environment – General beginning on page 22. There can be no assurance that our health care costs, business and profitability will not be adversely affected by these economy-related conditions or other factors.

**We are subject to funding and other risks with respect to revenue received from our participation in Medicare and Medicaid programs and subject to retroactive adjustments to certain premiums.**

We continue to increase our focus on the non-Commercial part of our Health Care segment as part of our business diversification efforts. In government-funded health programs such as Medicare and Medicaid, our revenues are dependent on annual funding from the federal government and/or applicable state governments, and state governments have the right to cancel their contracts with us on short notice if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions at the federal or applicable state level and general political issues and priorities. For example, in 2008, the U.S. Congress reduced funding for Medicare Advantage plans beginning in 2010 and imposed new marketing requirements on Medicare Advantage and

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PDP plans beginning in 2009. The health reform legislation pending in Congress contemplates both a further reduction in funding for Medicare Advantage plans beginning in 2011 and the introduction of a competitive bidding approach to service members of Medicare Advantage plans by 2015. Our government customers also determine the premium levels and other aspects of these programs that affect the number of persons eligible or enrolled in these programs and our administrative and health care costs under these programs. In the past, determinations of this type have adversely affected our financial results from and willingness to participate in such programs, and similar conditions may exist in the future. For example, if a government customer reduces the premium levels or increases premiums by less than the increase in our costs and we cannot offset the impact of these actions with supplemental premiums and/or changes in benefit plans, then our business and operating results could be adversely affected. In addition, premiums for certain federal government employee groups, Medicare members and Medicaid beneficiaries are subject to retroactive adjustments by the federal and applicable state governments. Any such adjustments could materially adversely affect our business and operating results.

**Our business success and profitability depend in part on effective information technology systems and on continuing to develop and implement improvements in technology; we have several significant multiyear strategic information technology projects in process.**

Our businesses depend in large part on our information and other technology systems to adequately price our products and services, process claims and interact with providers, employer plan sponsors and members in an efficient and uninterrupted fashion, and we have many different information systems supporting our businesses. Our business strategy involves providing customers with easy to use products that leverage information to meet the needs of those customers. Our success therefore is dependent in large part on maintaining the effectiveness of existing technology systems and on continuing to develop, redesign and enhance technology systems that support our business processes in a cost and resource efficient manner, including through technology outsourcing, within the context of our existing business partnership relationships, a limited budget of human resources and capital. Certain of our technology systems (including software) are older, legacy systems that are less efficient and require an ongoing commitment of significant capital and human resources to maintain. We also need to develop new systems to meet current and expected standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and customer demands. For example, the federal government has mandated that by 2013 the health care industry, including health insurers, providers and laboratories, upgrade to an updated and expanded set of standardized diagnosis and procedure codes used for describing health conditions. Implementing this new set of standardized codes, known as ICD-10, will require a substantial investment of resources by us and the health care industry in general over the next several years, including significant information technology investments, changes in business processes and documentation and extensive employee education and training. If we and/or the health care industry fail to adequately implement ICD-10, we may suffer a significant loss in the resources invested and in productivity, and/or fluctuations in our cash flows. We also have several significant multiyear strategic information technology projects in process in addition to preparing for ICD-10. System development and other information technology projects are long-term in nature and may take longer and cost more than we expect to complete and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently manage and upgrade our technology portfolio, we could, among other things, have problems determining health care cost estimates and/or establishing appropriate pricing, meeting the needs of providers, employer plan sponsors and members, or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

**In order to remain competitive, we must further integrate our businesses and processes; significant acquisitions and/or our ability to manage multiple multi-year strategic projects could make this integration more challenging; we expect to continue to pursue acquisitions.**

Ineffective integration of our businesses and processes may adversely affect our ability to compete by, among other things, increasing our costs relative to competitors. This integration task may be made more complex by significant acquisitions, multi-year strategic projects, our existing business partnership relationships and a limited budget of human resources and capital. For example, as a result of our acquisition activities, we have acquired a number of information technology systems that we must effectively and efficiently consolidate with our own systems. Our strategy includes effectively investing our capital in appropriate acquisitions, strategic projects and current operations in addition to share repurchases. If we are unable to successfully integrate acquired businesses and other processes to realize anticipated economic and other benefits on a timely basis, it could result in substantial costs or delays or other operational or financial problems.

Our strategic projects include, among other things, addressing rising health care costs, achieving profitable membership growth, further improving the efficiency of our operations, managing certain significant technology projects, further improving relations with health care providers, negotiating contract changes with customers and providers, and implementing other business process improvements. The future performance of our businesses will depend in large part on our ability to design and implement these initiatives, some of which will occur over several years. If these initiatives result in increased health care costs or do not achieve their objectives, our operating results could be adversely affected.

We have completed a number of acquisitions over the last several years, and we expect to continue to pursue acquisitions as part of our growth strategy. In addition to integration risks, some additional risks we face with respect to acquisitions include:

- The acquired business may not perform as projected;
- We may assume liabilities that we do not anticipate, including those that were not disclosed to us;
- Acquisitions could disrupt our ongoing business, distract management, divert resources and make it difficult to maintain our current business standards, controls and procedures;
- We may finance future acquisitions by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- We may incur additional debt related to future acquisitions; and
- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies.

**Managing CEO succession and retention of key executive talent is critical to our success given the current environment.**

We would be adversely affected if we fail to adequately plan for succession of our CEO and senior management and retention of key executives particularly given the current environment. While we have succession plans in place and we have employment arrangements with certain key executives, these do not guarantee that the services of these executives will continue to be available to us.

**We operate in a highly competitive environment; loss of membership or failure to achieve profitable membership growth and diversify the geographic concentrations in our core Insured membership (including strategies to increase membership for targeted product types and customers, such as commercial or public sector business) could materially adversely affect our profitability.**

Competitive factors (including our customers' flexibility in moving between us and our competitors), the current economic environment and ongoing changes in the health benefits industry (including merger and acquisition activity in the industry) create pressure to contain premium price increases despite being faced with increasing health care costs. Our customer contracts are subject to negotiation as customers seek to contain their benefit costs, particularly in a slow economy. Customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, although such elections also may reduce our health care costs. Alternatively, our customers may purchase different types of products from us that are less profitable, or move to a competitor to obtain more favorable pricing. Our membership is also concentrated in certain geographic areas, and increased competition in those geographic areas could therefore have a disproportionate adverse effect on our operating results. Among other factors, we compete on the basis of overall cost, plan design, customer service, quality and sufficiency of medical provider networks and quality of medical management programs. In addition to competitive pressures affecting our ability to obtain new customers or retain existing customers, our membership can be affected by reductions in workforce by existing customers due to soft general economic conditions, especially in the geographies where our membership is concentrated. Failure to profitably grow and diversify our membership geographically or by product type may adversely affect our revenue and operating results.

**Our ability to manage general and administrative expenses affects our profitability.**

Our profitability depends in part on our ability to drive our general and administrative expenses to competitive levels through controlling salaries and related benefits and information technology and other general and administrative costs, while being able to attract and retain key employees, maintain robust management practices and controls, implement improvements in technology and achieve our strategic goals.

**Our business activities are highly regulated; new laws or regulations or changes in existing laws or regulations or their enforcement could also materially adversely affect our business and profitability.**

Our business is subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations change frequently and generally are designed to benefit and protect members and providers rather than our investors. The federal and many state governments have enacted and continue to consider legislative and regulatory changes related to health products and changes in the interpretation and/or enforcement of existing laws and regulations, and the likelihood of adverse changes is increasing due to state and federal budgetary pressures. We must monitor these changes and promptly implement any revisions to our business processes that these changes require. At this time, we are unable to predict the impact of future changes, although we anticipate that some of these measures, if enacted, could materially affect our health operations and/or operating results including:

- Reducing our ability to obtain adequate premium rates (including regulatory approval for and implementation of those rates),
- Restricting our ability to price for the risk we assume and/or reflect reasonable costs or profits in our pricing, including mandating minimum medical benefit ratios,
- Reducing our ability to manage health care costs,
- Increasing health care costs and operating expenses,
- Increasing our exposure to lawsuits and other adverse legal proceedings,
- Regulating levels and permitted lines of business,
- Restricting our ability to underwrite and operate our individual health business,
- Imposing new or increasing taxes and financial assessments, and/or
- Regulating business practices.

For example, decisions by health plans to rescind coverage and decline payment to treating providers after a member has received medical services have generated public attention, particularly in California. As a result, there has been both legislative and regulatory action in connection with this issue. On September 30, 2008, the state of California enacted legislation requiring health care service plans and health insurers that have rescinded an individual policy to reinstate coverage, on a guarantee issue basis, for the individual(s) whose information in the application for coverage and related communications did not lead to the rescission. In 2009, California enacted legislation that limits the time period in which health plans and health insurers can rescind an individual policy to two years. In addition, in 2009 Illinois issued a bulletin requiring a health carrier who is seeking to rescind an individual policy to provide the state with a complete copy of its underwriting guidelines so the state can determine whether the false information provided in the individual policy application materially affected the acceptance of the risk assumed by the health carrier.

In addition, our Medicare, Medicaid and specialty and mail order pharmacy products are more highly regulated than our Commercial products.

There continues to be a heightened review by federal and state regulators of the health care insurance industry's business and reporting practices, including utilization management, payment of providers with whom the payor does not have contracts and other claim payment practices, as well as heightened review of the general insurance industry's brokerage practices. As one of the largest national health and related benefits providers, we are regularly the subject of regulatory market conduct and other reviews, audits and investigations by state insurance and health and welfare departments and attorneys general, CMS, the Office of the Inspector General, the Office of Personnel Management, the U.S. Department of Justice and U.S. Attorneys. Several such reviews, audits and investigations currently are pending, some of which may be resolved during 2010. These regulatory reviews, audits and investigations could result in changes to or clarifications of our business practices, and also could result in significant or material fines, penalties, civil liabilities, criminal liabilities or other sanctions, including exclusion from participation in government programs. For example, in January 2009, Aetna and the New York Attorney General announced an agreement relating to an industry-wide investigation into certain payment practices with respect to out-of-network providers. As a result of that agreement, Aetna contributed \$20 million towards the establishment of an independent database system to provide fee information regarding out-of-network reimbursement rates. Our business also may be adversely impacted by judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA, or reduce the scope of ERISA pre-emption of state law claims.

For more information regarding these matters, refer to Regulatory Environment beginning on page 22 and Litigation and Regulatory Proceedings in Note 18 of Notes to Consolidated Financial Statements beginning on page 78.

**We would be adversely affected if our prevention, detection or control systems fail to detect and implement required changes to maintain regulatory compliance.**

Federal and state governments have made investigating and prosecuting health care and other insurance fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other participants are complex and subject to change. Although we believe our compliance efforts are adequate, ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

Similarly, failure of our prevention, detection or control systems related to regulatory compliance and/or compliance with our internal policies, including data systems security issues and/or unethical conduct by managers and/or employees, could adversely affect our reputation and also expose us to litigation and other proceedings, fines and/or penalties, any of which could adversely affect our business, operating results or financial condition.

**We face risks related to litigation and regulatory proceedings.**

We are growing by expanding into certain segments and subsegments of the health care marketplace. Some of the segments and subsegments we have targeted for growth include Medicare, Medicaid, individual, public sector and labor customers who are not subject to ERISA's limits on state law remedies. In addition, over the last several years we have entered product lines in which we previously did not participate, including Insured Medicaid, Medicaid plan management, international managing general underwriting, Medicare PDP, mail order pharmacy, specialty pharmacy and ActiveHealth. These products subject us to regulatory and other risks that are different from the risks of providing Commercial managed care and health insurance products and may increase the risks we face from litigation, regulatory reviews, audits and investigations and other adverse legal proceedings. For example, our Medicaid products are more highly regulated than our Commercial products, and we are dispensing medications at our mail order and specialty pharmacies directly to members. In addition to the risks of purported dispensing and other operational errors, failure to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our pharmacy subsidiaries to civil and criminal penalties.

In addition, we are party to a number of lawsuits, certain of which are purported to be class actions. The majority of these cases relate to the conduct of our health care operations and allege various violations of law. Many of these cases seek substantial damages (including non-economic or punitive damages and treble damages) and may also seek changes in our business practices. We may also be subject to additional litigation and other adverse legal proceedings in the future. Litigation and other adverse legal proceedings could materially adversely affect our business or operating results because of reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. For example, during 2009, Aetna and the New York Attorney General announced an agreement relating to an industry-wide investigation into certain payment practices with respect to out-of-network providers. Among other things, the agreement required Aetna to contribute \$20 million towards the establishment of an independent database system to provide fee information regarding out-of-network reimbursement rates. Refer to Litigation and Regulatory Proceedings in Note 18 of Notes to Consolidated Financial Statements beginning on page 78 for more information.

**Our products providing pharmacy benefit management services face regulatory and other risks and uncertainties associated with the PBM industry that may differ from the risks of our core business of providing managed care and health insurance products.**

The following are some of the PBM and pharmacy related risks that could have a material adverse effect on our business, financial condition or operating results:

- Federal and state anti-kickback and other laws that govern our PBM and mail order and specialty mail order pharmacies' relationship with pharmaceutical manufacturers, customers and consumers.
- Compliance requirements for PBM fiduciaries under ERISA, including compliance with fiduciary obligations under ERISA in connection with the development and implementation of items such as drug formularies and preferred drug listings.

- A number of federal and state legislative proposals are being considered that could adversely affect a variety of pharmacy benefit industry practices, including without limitation the receipt or required disclosure of rebates from pharmaceutical manufacturers, the regulation of the development and use of formularies, legislation imposing additional rights to access to drugs for individuals enrolled in health care benefits plans, and restrictions on the use of average wholesale prices.
- The application of federal, state and local laws and regulations to the operation of our mail order pharmacy and mail order specialty pharmacy products.
- The risks inherent in the dispensing, packaging and distribution of pharmaceuticals and other health care products, including claims related to purported dispensing errors.

The failure to adhere to the laws and regulations that apply to our PBM and/or pharmacies' products could expose our PBM and/or pharmacy subsidiaries to civil and criminal penalties and/or have a material adverse effect on our business, financial condition and operating results.

**Our reputation is one of our most important assets; negative public perception of the health benefits industry, or of the industry's or our practices, can adversely affect our profitability.**

The health benefits industry is subject to negative publicity, which can arise from, among other things, the public policy debate over health reform and/or from actual or perceived shortfalls regarding the industry's or our own business practices and/or products. The risk of negative publicity is particularly high as a result of current health care reform efforts being discussed by Congress and President Obama. This risk may be increased as we continue to offer new products, such as products with limited benefits, targeted at market segments, such as the uninsured, part time and hourly workers and those eligible for Medicaid, beyond those in which we traditionally have operated. Negative publicity of the health benefits industry in general or Aetna in particular can further increase our costs of doing business and adversely affect our profitability and our stock price by:

- Adversely affecting the Aetna brand particularly;
- Adversely affecting our ability to market and sell our products and/or services;
- Requiring us to change our products and/or services; and/or
- Increasing the regulatory and legislative requirements with which we must comply.

**We would be adversely affected if we fail to adequately protect member health related and other sensitive information.**

The use and disclosure of personal health and other sensitive information is regulated at the federal, state and international levels, and we collect, process and maintain large amounts of personal health and financial information and other sensitive data about our members in the ordinary course of our business. Our business therefore depends substantially on our members' and customers' willingness to entrust us with their health related and other sensitive information. Events that negatively affect that trust, including failing to keep sensitive information secure, whether as a result of our action or inaction or that of one of our vendors, could adversely affect our reputation and also expose us to litigation and other proceedings, fines and/or penalties, any of which could adversely affect our business, operating results or financial condition.

**We would be adversely affected if we do not effectively deploy our capital.**

Our operations generate significant capital, and we have the ability to raise additional capital. In deploying our capital to fund our investments in operations (including information technology and other strategic projects), share repurchases, potential acquisitions or other capital uses, our financial position and operating results could be adversely affected if we do not appropriately balance the risks and opportunities that are inherent in each method of deploying our capital. In addition, our cost of capital could increase if our debt ratings are downgraded.

**We must continue to provide quality service to our customers that meets their expectations.**

Our ability to attract and retain membership is dependent upon providing quality customer service operations (such as call center operations, claim processing, mail order pharmacy prescription delivery, specialty pharmacy prescription delivery and customer case installation) that meet or exceed our customers' expectations. Failure to provide service that meets our customers' expectations, including failures resulting from operational performance issues, can affect our ability to retain or grow profitable membership which can adversely affect our operating results.

**Our profitability may be adversely affected if we are unable to contract with providers on competitive terms and otherwise maintain favorable provider relationships.**

Our profitability is dependent in part upon our ability to contract competitively while maintaining favorable relationships with hospitals, physicians, pharmaceutical benefit service providers, pharmaceutical manufacturers and other health benefits providers. That ability is affected by the rates we pay providers for services rendered to our members, by our business practices and processes and by our provider payment and other provider relations practices, as well as factors not associated with us that impact these providers, such as merger and acquisition activity and other consolidations among providers. The breadth and quality of our networks of available providers is also an important factor when customers consider our products and services. Our contracts with providers generally may be terminated by either party without cause on short notice. The failure to maintain or to secure new cost-effective health care provider contracts may result in a loss in membership, higher health care costs, less desirable products for our customers and/or difficulty in meeting regulatory or accreditation requirements, any of which could adversely affect our operating results.

In addition, some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers about the amount of compensation that is due to these providers for services rendered to our members. In some states, the amount of compensation due to these non-participating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

For example, we are currently involved in litigation with non-participating providers, and during 2009, we recently settled a matter with the New York Attorney General that will change the source of information we use to determine the amount we pay non-participating providers. These matters are described in more detail in Litigation and Regulatory Proceedings in Note 18 of Notes to Consolidated Financial Statements beginning on page 78.

**We must demonstrate that our products and processes lead to access by our members to quality care by their providers, or delivery of care by us.**

Failure to demonstrate that our products and processes (such as disease management and patient safety programs, provider credentialing and other quality of care and information management initiatives) lead to access by our members to quality care by providers or delivery of quality care by us would adversely affect our ability to differentiate our product and/or service offerings from those of competitors and could adversely affect our operating results.

**We face a wide range of risks, and our success depends on our ability to identify, prioritize and appropriately manage our enterprise risk exposures.**

As a large company operating in a complex industry, we encounter a variety of risks. The risks we face include, among other matters, the range of industry, competitive, regulatory, financial, operational or external risks identified in this Risk Factors discussion. We continue to devote resources to further develop and integrate our enterprise-wide risk management processes. Failure to identify, prioritize and appropriately manage or mitigate these risks, including risk concentrations across different industries, segments and geographies, can adversely affect our profitability, our ability to retain or grow business, or, in the event of extreme circumstances, our financial condition or business operations.

**Sales of our products and services are dependent on our ability to attract, retain and provide support to a network of internal sales personnel and third party brokers, consultants and agents.**

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently also recommend and/or market health benefits products of our competitors, and we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract or retain sales personnel and third party brokers, consultants and agents or if we do not adequately provide support, training and education to this sales network regarding our product portfolio, which is complex, or if our sales strategy is not appropriately aligned across distribution channels.

**We hold reserves for expected claims, which are estimated, and these estimates involve an extensive degree of judgment; if actual claims exceed reserve estimates, our operating results could be materially adversely affected.** Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of claims that have been incurred by our members but not yet reported to us and claims that have been reported to us but not yet paid. We estimate health care costs payable periodically, and any resulting adjustments are reflected in current-period operating results within health care costs. Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience. A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. As a result, an extensive degree of judgment is used in this estimation process, considerable variability is inherent in such estimates, and the adequacy of the estimate is highly sensitive to changes in medical claims payment patterns and changes in medical cost trends. A worsening (or improvement) of medical cost trend or changes in claim payment patterns from those that were assumed in estimating health care costs payable at December 31, 2009 would cause these estimates to change in the near term, and such a change could be material. Furthermore, if we are not able to accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions may be limited, which would further exacerbate the extent of any negative impact on our results of operations. Refer to our discussion of Critical Accounting Estimates – Health Care Costs Payable beginning on page 16 for more information.

**Any requirement to restate financial results due to the inappropriate application of accounting principles or other matters could also have a material adverse effect on us and/or the trading price of our common stock.**

The appropriate application of accounting principles in accordance with GAAP is required to ensure the soundness and accuracy of our financial statements. An inappropriate application of these principles may lead to a restatement of our financial results and/or a deterioration in the soundness and accuracy of our reported financial results. If we experienced such a deterioration, users of our financial statements may lose confidence in our reported results, which could adversely affect the trading price of our common stock and/or our access to capital markets.

**We are dependent on our ability to manage, engage and retain a very large workforce.**

Our products and services and our operations require a large number of employees. Our business could be adversely affected if our retention, development, succession and other human resource management techniques are not aligned with our strategic objectives. The impact of the external environment or other factors on employee morale and engagement could also significantly impact the success of our company.

**Epidemics, pandemics, terrorist attack, natural disasters or other extreme events or the continued threat of these extreme events could materially increase health care utilization, pharmacy costs and/or life and disability claims and impact our business continuity, and we cannot predict with certainty whether any such events will occur.**

Extreme events, including terrorism, can affect the U.S. economy in general, our industry and us specifically. Such events could adversely affect our business and operating results, and in the event of extreme circumstances, our financial condition or viability. Other than obtaining insurance coverage for our facilities, there are few, if any, commercial options through which to transfer the exposure from terrorism away from us. In particular, in the event of bioterrorism attacks, epidemics or other extreme events, we could face significant health care (including behavioral health), life insurance and disability costs depending on the government's actions and the responsiveness of public health agencies and other insurers. In addition, our life insurance members and our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be exposed to these events. Our business could also be adversely affected if we do not maintain adequate procedures to ensure disaster recovery and business continuity during and after such events.

**Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our profitability and/or our financial position.**

The global capital markets, including credit markets, experienced extreme volatility, uncertainty and disruption during 2008 and 2009. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and is comprised particularly of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the financial markets, and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S.

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credit markets, and governments' monetary policy, particularly the easing of U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our profitability and/or our financial position by:

- Significantly reducing the value of the debt securities we hold in our investment portfolio, and creating net realized capital losses that reduces our operating results and/or net unrealized capital losses that reduce our shareholders' equity.
- Reducing interest rates on high quality short-term debt securities and thereby materially reducing our net investment income and operating results.
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our operating results and shareholders' equity.
- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results.
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit exposures, a failure to adequately do so could adversely affect our results of operations and our financial condition.

**We outsource and obtain certain information technology systems or other services from independent third parties, and also delegate selected functions to independent practice associations and specialty service providers; portions of our operations are subject to their performance.**

Although we take steps to monitor and regulate the performance of independent third parties who provide services to us or to whom we delegate selected functions, these arrangements may make our operations vulnerable if those third parties fail to satisfy their obligations to us, whether because of our failure to adequately monitor and regulate their performance, or changes in their own financial condition or other matters outside our control. In recent years, certain third parties to whom we delegated selected functions, such as independent practice associations and specialty services providers, have experienced financial difficulties, including bankruptcy, which may subject us to increased costs and potential health benefits provider network disruptions, and in some cases cause us to incur duplicative claims expense. In addition, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us. Certain legislative authorities have in recent years also discussed or proposed legislation that would restrict outsourcing and, if enacted, could materially increase our costs. We also could become overly dependent on key vendors, which could cause us to lose core competencies if not properly monitored.

**Our pension plan expenses are affected by general market conditions, interest rates and the accuracy of actuarial estimates of future benefit costs.**

We have pension plans that cover a large number of current employees and retirees. Unfavorable investment performance, interest rate changes or changes in estimates of benefit costs, if significant, could adversely affect our operating results or financial condition by significantly increasing our pension plan expense and obligations. For example, due to market driven unfavorable investment performance in 2008, our pension expense increased in 2009.

**We also face other risks that could adversely affect our business, results of operations or financial condition, which include:**

- Health benefits provider fraud that is not prevented or detected and impacts our medical cost trends or those of our self-insured customers. In addition, during an economic downturn, our businesses may see increased fraudulent claims volume, which may lead to additional costs because of an increase in disputed claims and litigation;
- A significant failure of internal control over financial reporting;
- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Financial loss from inadequate insurance coverage due to self insurance levels or unavailability of insurance and reinsurance coverage for credit or other reasons; and
- Failure to protect our proprietary information.

## Selected Financial Data

(Millions, except per common share data)	For the Years Ended December 31,				
	2009	2008	2007	2006	2005
Revenue	\$34,764.1	\$30,950.7	\$27,599.6	\$25,145.7	\$22,491.9
Income from continuing operations	1,276.5	1,384.1	1,831.0	1,685.6	1,573.3
Net income	1,276.5	1,384.1	1,831.0	1,701.7	1,573.3
Net realized capital gains (losses), net of tax	55.0	(482.3)	(47.9)	24.1	21.1
Assets	38,550.4	35,852.5	50,724.7	47,626.4	44,433.3
Short-term debt	480.8	215.7	130.7	45.0	-
Long-term debt	3,639.5	3,638.3	3,138.5	2,442.3	1,605.7
Shareholders' equity	9,503.8	8,186.4	10,038.4	9,145.1	10,188.7
<b>Per common share data:</b>					
Dividends declared	\$ .04	\$ .04	\$ .04	\$ .04	\$ .02
Income from continuing operations:					
Basic	2.89	2.91	3.60	3.09	2.72
Diluted	2.84	2.83	3.47	2.96	2.60
Net income:					
Basic	2.89	2.91	3.60	3.12	2.72
Diluted	2.84	2.83	3.47	2.99	2.60

See Notes to Consolidated Financial Statements and MD&A for significant events affecting the comparability of results as well as material uncertainties.

## Consolidated Statements of Income

(Millions, except per common share data)	For the Years Ended December 31,		
	2009	2008	2007
Revenue:			
Health care premiums	\$ 28,243.8	\$ 25,507.3	\$ 21,500.1
Other premiums	1,892.4	1,876.8	1,979.3
Fees and other revenue (1)	3,536.5	3,312.5	3,044.0
Net investment income	1,036.4	910.0	1,149.9
Net realized capital gains (losses)	55.0	(655.9)	(73.7)
<b>Total revenue</b>	<b>34,764.1</b>	<b>30,950.7</b>	<b>27,599.6</b>
Benefits and expenses:			
Health care costs (2)	24,061.2	20,785.5	17,294.8
Current and future benefits	2,078.1	1,938.7	2,248.1
Operating expenses:			
Selling expenses	1,251.9	1,149.6	1,060.9
General and administrative expenses	5,131.1	4,601.9	3,985.5
<b>Total operating expenses</b>	<b>6,383.0</b>	<b>5,751.5</b>	<b>5,046.4</b>
Interest expense	243.4	236.4	180.6
Amortization of other acquired intangible assets	97.2	108.2	97.6
Reduction of reserve for anticipated future losses on discontinued products	-	(43.8)	(64.3)
<b>Total benefits and expenses</b>	<b>32,862.9</b>	<b>28,776.5</b>	<b>24,803.2</b>
Income before income taxes	1,901.2	2,174.2	2,796.4
Income taxes	624.7	790.1	965.4
<b>Net income</b>	<b>\$ 1,276.5</b>	<b>\$ 1,384.1</b>	<b>\$ 1,831.0</b>
Earnings per common share:			
Basic	\$ 2.89	\$ 2.91	\$ 3.60
Diluted	\$ 2.84	\$ 2.83	\$ 3.47

(1) Fees and other revenue include administrative services contract member co-payments and plan sponsor reimbursements related to our mail order and specialty pharmacy operations of \$81 million, \$60 million and \$52 million (net of pharmaceutical and processing costs of \$1.6 billion, \$1.6 billion and \$1.4 billion) for 2009, 2008 and 2007, respectively.

(2) Health care costs have been reduced by fully insured member co-payments revenue related to our mail order and specialty pharmacy operations of \$122 million, \$111 million and \$102 million for 2009, 2008 and 2007, respectively.

Refer to accompanying Notes to Consolidated Financial Statements.

## Consolidated Balance Sheets

(Millions)	At December 31,	
	2009	2008
<b>Assets:</b>		
Current assets:		
Cash and cash equivalents	\$ 1,203.6	\$ 1,179.5
Investments	2,922.7	706.0
Premiums receivable, net	630.4	616.4
Other receivables, net	626.7	554.3
Accrued investment income	209.2	193.6
Collateral received under securities loan agreements	210.0	749.6
Income taxes receivable	89.5	164.9
Deferred income taxes	383.4	301.5
Other current assets	551.4	452.6
<b>Total current assets</b>	<b>6,826.9</b>	<b>4,918.4</b>
Long-term investments	17,051.1	16,163.4
Reinsurance recoverables	986.9	1,010.3
Goodwill	5,146.2	5,085.6
Other acquired intangible assets, net	590.7	667.4
Property and equipment, net	551.0	467.5
Deferred income taxes	333.4	778.7
Other long-term assets	781.1	841.3
Separate Accounts assets	6,283.1	5,919.9
<b>Total assets</b>	<b>\$38,550.4</b>	<b>\$35,852.5</b>
<b>Liabilities and shareholders' equity:</b>		
Current liabilities:		
Health care costs payable	\$ 2,895.3	\$ 2,393.2
Future policy benefits	739.6	759.7
Unpaid claims	559.5	559.8
Unearned premiums	306.4	238.6
Policyholders' funds	788.3	754.4
Collateral payable under securities loan agreements	210.0	749.6
Short-term debt	480.8	215.7
Accrued expenses and other current liabilities	2,484.3	1,883.8
<b>Total current liabilities</b>	<b>8,464.2</b>	<b>7,554.8</b>
Future policy benefits	6,470.1	6,765.4
Unpaid claims	1,453.0	1,271.2
Policyholders' funds	1,294.1	1,171.7
Long-term debt	3,639.5	3,638.3
Other long-term liabilities	1,442.6	1,344.8
Separate Accounts liabilities	6,283.1	5,919.9
<b>Total liabilities</b>	<b>29,046.6</b>	<b>27,666.1</b>
Commitments and contingencies (Note 18)		
Shareholders' equity:		
Common stock (\$.01 par value; 2.7 billion shares authorized; 430.8 million and 456.3 million shares issued and outstanding in 2009 and 2008, respectively) and additional paid-in capital	470.1	351.2
Retained earnings	10,256.7	9,716.5
Accumulated other comprehensive loss	(1,223.0)	(1,881.3)
<b>Total shareholders' equity</b>	<b>9,503.8</b>	<b>8,186.4</b>
<b>Total liabilities and shareholders' equity</b>	<b>\$38,550.4</b>	<b>\$35,852.5</b>

Refer to accompanying Notes to Consolidated Financial Statements.

## Consolidated Statements of Shareholders' Equity

(Millions)	Number of Common Shares Outstanding	Common Stock and Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income	Total Shareholders' Equity	Total Comprehensive Income (Loss)
<b>Balance at December 31, 2006</b>	516.0	\$ 366.2	\$ 9,404.6	\$ (625.7)	\$ 9,145.1	
Cumulative effect of new accounting standards (Note 2)	-	-	(1.0)	113.9	112.9	
Beginning balance at January 1, 2007, as adjusted	516.0	366.2	9,403.6	(511.8)	9,258.0	
Comprehensive income:						
Net income	-	-	1,831.0	-	1,831.0	\$ 1,831.0
Other comprehensive income (Note 9):						
Net unrealized losses on securities	-	-	-	(13.2)	(13.2)	
Net foreign currency and derivative losses	-	-	-	(12.2)	(12.2)	
Pension and OPEB plans	-	-	-	248.8	248.8	
Other comprehensive income	-	-	-	223.4	223.4	223.4
Total comprehensive income						\$ 2,054.4
Common shares issued for benefit plans, including tax benefits	13.5	415.0	-	-	415.0	
Repurchases of common shares	(33.2)	(592.4)	(1,076.6)	-	(1,669.0)	
Dividends declared (\$.04 per share)	-	-	(20.0)	-	(20.0)	
<b>Balance at December 31, 2007</b>	496.3	188.8	10,138.0	(288.4)	10,038.4	
Comprehensive income:						
Net income	-	-	1,384.1	-	1,384.1	\$ 1,384.1
Other comprehensive loss (Note 9):						
Net unrealized losses on securities	-	-	-	(282.6)	(282.6)	
Net foreign currency and derivative losses	-	-	-	(15.7)	(15.7)	
Pension and OPEB plans	-	-	-	(1,294.6)	(1,294.6)	
Other comprehensive loss	-	-	-	(1,592.9)	(1,592.9)	(1,592.9)
Total comprehensive loss						\$ (208.8)
Common shares issued for benefit plans, including tax benefits	2.9	162.9	-	-	162.9	
Repurchases of common shares	(42.9)	(.5)	(1,787.2)	-	(1,787.7)	
Dividends declared (\$.04 per share)	-	-	(18.4)	-	(18.4)	
<b>Balance at December 31, 2008</b>	456.3	351.2	9,716.5	(1,881.3)	8,186.4	
Cumulative effect of adopting new accounting standard at April 1, 2009 (Note 2)	-	-	53.7	(53.7)	-	
Comprehensive income:						
Net income	-	-	1,276.5	-	1,276.5	\$ 1,276.5
Other comprehensive income (Note 9):						
Net unrealized gains on securities	-	-	-	619.0	619.0	
Net foreign currency and derivative gains	-	-	-	34.0	34.0	
Pension and OPEB plans	-	-	-	59.0	59.0	
Other comprehensive income	-	-	-	712.0	712.0	712.0
Total comprehensive income						\$ 1,988.5
Common shares issued for benefit plans, including tax benefits	3.4	119.2	-	-	119.2	
Repurchases of common shares	(28.9)	(.3)	(772.7)	-	(773.0)	
Dividends declared (\$.04 per share)	-	-	(17.3)	-	(17.3)	
<b>Balance at December 31, 2009</b>	430.8	\$ 470.1	\$10,256.7	\$ (1,223.0)	\$ 9,503.8	

Refer to accompanying Notes to Consolidated Financial Statements.

## Consolidated Statements of Cash Flows

(Millions)	For the Years Ended December 31,		
	2009	2008	2007
Cash flows from operating activities:			
Net income	\$ 1,276.5	\$ 1,384.1	\$ 1,831.0
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized capital (gains) losses	(55.0)	655.9	73.7
Depreciation and amortization	416.0	378.3	321.5
Equity in earnings of affiliates, net	(15.7)	159.1	(88.3)
Stock-based compensation expense	90.7	95.7	89.4
(Accretion) amortization of net investment (discount) premium	(67.0)	(15.2)	3.6
Changes in assets and liabilities:			
Accrued investment income	(15.6)	(4.4)	(6.1)
Premiums due and other receivables	(53.7)	(106.2)	(91.7)
Income taxes	(14.4)	(137.5)	28.8
Other assets and other liabilities	570.4	(116.3)	(119.0)
Health care and insurance liabilities	357.6	(82.1)	23.8
Other, net	(1.5)	(4.5)	(1.2)
<b>Net cash provided by operating activities</b>	<b>2,488.3</b>	<b>2,206.9</b>	<b>2,065.5</b>
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	10,029.6	11,681.2	10,577.0
Cost of investments	(11,592.2)	(12,307.9)	(10,642.2)
Increase in property, equipment and software	(362.0)	(446.6)	(400.4)
Cash used for acquisitions, net of cash acquired	(75.1)	-	(572.2)
<b>Net cash used for investing activities</b>	<b>(1,999.7)</b>	<b>(1,073.3)</b>	<b>(1,037.8)</b>
Cash flows from financing activities:			
Proceeds from issuance of long-term debt, net of issuance costs	-	484.8	663.9
Net issuance of short-term debt	266.1	85.6	85.5
Deposits and interest credited for investment contracts	7.1	8.5	9.7
Withdrawals of investment contracts	(9.0)	(38.4)	(21.2)
Common shares issued under benefit plans	14.8	29.7	170.8
Stock-based compensation tax benefits	5.1	27.8	153.2
Common shares repurchased	(773.0)	(1,787.7)	(1,695.6)
Dividends paid to shareholders	(17.3)	(18.4)	(20.0)
Collateral received on interest rate swaps	41.7	-	-
<b>Net cash used for financing activities</b>	<b>(464.5)</b>	<b>(1,208.1)</b>	<b>(653.7)</b>
Net increase (decrease) in cash and cash equivalents	24.1	(74.5)	374.0
Cash and cash equivalents, beginning of period	1,179.5	1,254.0	880.0
<b>Cash and cash equivalents, end of period</b>	<b>\$ 1,203.6</b>	<b>\$ 1,179.5</b>	<b>\$ 1,254.0</b>

Refer to accompanying Notes to Consolidated Financial Statements.

## Notes to Consolidated Financial Statements

### 1. Organization

We conduct our operations in three business segments:

- **Health Care** consists of medical, pharmacy benefits management, dental and vision plans offered on both an Insured basis (where we assume all or a majority of the risk for medical and dental care costs) and an employer-funded basis (where the plan sponsor under an administrative services contract (“ASC”) assumes all or a majority of this risk). Medical products include point-of-service (“POS”), preferred provider organization (“PPO”), health maintenance organization (“HMO”) and indemnity benefit plans. Medical products also include health savings accounts (“HSAs”) and Aetna HealthFund®, consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). We also offer Medicare and Medicaid products and services and specialty products, such as medical management and data analytics services, behavioral health plans and stop loss insurance, as well as products that provide access to our provider network in select markets.
- **Group Insurance** primarily includes group life insurance products offered on an Insured basis, including basic and supplemental group term life, group universal life, supplemental or voluntary programs and accidental death and dismemberment coverage. Group Insurance also includes (i) group disability products offered to employers on both an Insured and an ASC basis which consist primarily of short-term and long-term disability insurance, (ii) absence management services offered to employers, which include short-term and long-term disability administration and leave management, and (iii) long-term care products that were offered primarily on an Insured basis, which provide benefits covering the cost of care in private home settings, adult day care, assisted living or nursing facilities. We no longer solicit or accept new long-term care customers, and we are working with our customers on an orderly transition of this product to other carriers.
- **Large Case Pensions** manages a variety of retirement products (including pension and annuity products) primarily for tax qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. Large Case Pensions also includes certain discontinued products (refer to Note 20 beginning on page 82 for additional information).

Our three business segments are distinct businesses that offer different products and services. Our Chief Executive Officer evaluates financial performance and makes resource allocation decisions at these segment levels. The accounting policies of the segments are the same as those described in the summary of significant accounting policies in Note 2, below. We evaluate the performance of these business segments based on operating earnings (net income or loss, excluding net realized capital gains and losses and certain other items) (refer to Note 19 beginning on page 80 for segment financial information).

### 2. Summary of Significant Accounting Policies

#### Principles of Consolidation

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles (“GAAP”) and include the accounts of Aetna and the subsidiaries that we control. All significant intercompany balances have been eliminated in consolidation. The Company has evaluated subsequent events from the balance sheet date through the date the financial statements were issued and determined there were no other items to disclose.

#### Reclassifications

Certain reclassifications were made to the 2008 financial information to conform to the 2009 presentation.

#### New Accounting Standards

##### *Recognition and Presentation of Other-Than-Temporary Impairments*

Effective April 1, 2009, we adopted new accounting guidance issued by the Financial Accounting Standards Board (“FASB”) for other-than-temporary impairments (“OTTI”) of debt securities. This guidance establishes new criteria for the recognition of OTTI on debt securities and also requires additional financial statement disclosure. The new criteria require OTTI to be recognized if either a credit-related loss is deemed to have occurred or we have the

intention to sell a security that is in an unrealized loss position. Refer to Notes 8 and 9 beginning on pages 58 and 62, respectively.

Upon adoption of this new guidance, we evaluated securities held at April 1, 2009 for which a previous OTTI was recognized, and identified those securities that we did not intend to sell. As a result of this analysis, we recorded a \$54 million (\$83 million pretax) cumulative effect adjustment that increased retained earnings and accumulated other comprehensive loss as of April 1, 2009.

#### *Fair Value Measurements – Assessing Fair Value in Market Conditions That Are Not Orderly*

In April 2009, the FASB released updates to the accounting guidance for measuring the fair value of assets and liabilities. These updates provide clarification as to how to determine the fair value of assets and liabilities in distressed economic conditions and also require greater disaggregation of debt and equity securities within our fair value measurements disclosures (refer to Note 10 beginning on page 63). This accounting guidance was effective on June 30, 2009 and did not impact our financial position or results of operations.

#### *Codification*

In June 2009, the FASB released *FASB Accounting Standards Codification*™ (“Codification”). Beginning in September 2009, all existing accounting standard documents were superseded, and Codification became the single source of authoritative GAAP. Codification did not result in any change in our significant accounting policies.

#### *Cumulative Effect of New Accounting Standards in 2007*

Effective January 1, 2007, we changed the measurement date of our defined benefit pension and other postretirement plans in accordance with a new accounting standard issued by the FASB. This change resulted in a cumulative effect adjustment to the opening balance of shareholders’ equity at January 1, 2007 comprised of a \$4 million increase to retained earnings and a \$114 million decrease to accumulated other comprehensive loss. In addition, we adopted new guidance on accounting for uncertainty in income taxes, which resulted in a cumulative effect adjustment to the opening balance of retained earnings at January 1, 2007 of \$5 million.

### **Future Application of Accounting Standards**

#### *Variable Interest Entities*

In June 2009, the FASB released revised accounting guidance for variable interest entities (“VIEs”). This accounting guidance removes the quantitative-based risks-and-rewards calculation previously used to assess whether a company must consolidate a VIE and, instead, requires a variable interest holder to qualitatively assess whether it has a controlling financial interest in the VIE. This accounting guidance became effective on January 1, 2010. We are currently assessing the impact of this new guidance on our financial position and results of operations.

#### **Use of Estimates**

The preparation of the accompanying consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the amounts reported in the accompanying consolidated financial statements and notes. We consider the following accounting estimates critical in the preparation of the accompanying consolidated financial statements: health care costs payable, other insurance liabilities, recoverability of goodwill and other acquired intangible assets, measurement of defined benefit pension and other postretirement benefit plans, other-than-temporary impairment of debt securities and revenue recognition. We use information available to us at the time estimates are made; however, these estimates could change materially if different information or assumptions were used. Additionally, these estimates may not ultimately reflect the actual amounts of the final transactions that occur.

### **Cash and Cash Equivalents**

Cash and cash equivalents include cash on hand and other debt securities with a maturity of three months or less when purchased. The carrying value of cash equivalents approximates fair value due to the short-term maturity of these investments.

### **Investments**

#### *Debt and Equity Securities*

Debt and equity securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt and equity securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless we intend to sell an investment within the next

twelve months, in which case it is classified as current. We have classified our debt and equity securities as available for sale and carry them at fair value. Refer to Note 10 beginning on page 63 for additional information on how we estimate the fair value of our debt and equity securities. The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments. We regularly review our debt and equity securities to determine whether a decline in fair value below the carrying value is other-than-temporary. When a debt or equity security is in an unrealized capital loss position, we monitor the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. Beginning April 1, 2009, we recognize an impairment on debt securities when we intend to sell a security that is in an unrealized loss position or if we determine a credit-related loss has occurred. Prior to April 1, 2009, we would recognize an impairment if we did not have the intention and ability to hold the security until it recovered its value (refer to New Accounting Standards beginning on page 48 for additional information). We do not accrue interest on debt securities when management believes the collection of interest is unlikely.

We lend certain debt and equity securities from our investment portfolio to other institutions for short periods of time. Borrowers must post cash collateral in the amount of 102% to 105% of the fair value of the loaned security. The fair value of the loaned securities is monitored on a daily basis, with additional collateral obtained or refunded as the fair value of the loaned securities fluctuates. The collateral is retained and invested by a lending agent according to our guidelines to generate additional income for us.

#### *Mortgage Loans*

We carry the value of our mortgage loan investments on our balance sheet at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default within 3 years) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. We apply our loan impairment policy individually to all loans in our portfolio. We record full or partial charge-offs of loans at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on an impaired loan is accrued to the extent we deem it collectable and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date of less than one year from the balance sheet date are reported in current assets on our balance sheets.

#### *Other Investments*

Other investments consist primarily of alternative investments (which are comprised of private equity and hedge fund limited partnerships), investment real estate and derivatives. We typically do not have a controlling ownership in our alternative investments and therefore we apply the equity method of accounting for these investments. We invest in real estate for the production of income. We carry the value of our investment real estate on our balance sheet at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any of our real estate investments is considered held-for-sale, we carry it at the lower of its carrying value or fair value less estimated selling costs. We generally estimate fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, we record the difference between the sales price and the carrying value as a realized capital gain or loss.

We make limited use of derivatives in order to manage interest rate, foreign exchange, price risk and credit exposure. The derivatives we use consist primarily of futures contracts, forward contracts, interest rate swaps, credit default swaps and warrants. Derivatives are reflected at fair value on our balance sheets.

When we enter into a derivative contract, if certain criteria are met, we may designate the derivative as one of the following: a hedge of the fair value of a recognized asset or liability or of an unrecognized firm commitment; a hedge of a forecasted transaction or of the variability of cash flows to be received or paid related to a recognized asset or liability; or a foreign currency fair value or cash flow hedge.

### **Net Investment Income and Realized Capital Gains and Losses**

Net investment income and realized capital gains and losses on investments supporting Health Care's and Group Insurance's liabilities and Large Case Pensions' products (other than experience-rated and discontinued products) are reflected in our results of operations. Realized capital gains and losses are determined on a specific identification basis. Unrealized capital gains and losses (other than experience-rated and discontinued products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive loss. We reflect purchases and sales of debt and equity securities and alternative investments on the trade date. We reflect purchases and sales of mortgage loans and investment real estate on the closing date.

Experience-rated products are products in the Large Case Pensions business where the contract holder, not us, assumes investment and other risks, subject to, among other things, minimum guarantees provided by us. The effect of investment performance is allocated to contract holders' accounts daily, based on the underlying investment's experience and, therefore, does not impact our results of operations (as long as minimum guarantees are not triggered). Realized and unrealized capital gains and losses on investments supporting experience-rated products in the Large Case Pensions business are reflected in policyholders' funds in our balance sheets. Net investment income supporting Large Case Pensions' experience-rated products is included in net investment income in our statements of income and is credited to contract holders in current and future benefits.

When we discontinued the sale of our fully-guaranteed Large Case Pensions products, we established a reserve for anticipated future losses from these products and segregated the related investments. These investments are managed as a separate portfolio. Net investment income and realized capital gains and losses on this separate portfolio are ultimately credited/charged to the reserve and, therefore, do not impact our results of operations. Unrealized capital gains or losses on this separate portfolio are reflected in other current liabilities in our balance sheets. Refer to Note 20 beginning on page 82 for additional information on our discontinued products.

### **Reinsurance**

We utilize reinsurance agreements primarily to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit us to recover a portion of our losses from reinsurers, although they do not discharge our primary liability as direct insurer of the risks reinsured. Failure of reinsurers to indemnify us could result in losses; however, we do not expect charges for unrecoverable reinsurance to have a material effect on our results of operations or financial position. We evaluate the financial position of our reinsurers and monitor concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of our reinsurers. At December 31, 2009, our reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations.

In the normal course of business, we enter into agreements with other insurance companies under which we assume reinsurance, primarily related to our group life and health products (refer to Note 17 beginning on page 76 for additional information). We do not transfer any portion of the financial risk associated with our HMO products to third parties, except in areas that we participate in state-mandated health insurance pools. We did not have material premiums ceded to or assumed from other insurance companies in the three years ended December 31, 2009.

### **Goodwill**

We evaluate goodwill for impairment (at the reporting unit level) annually, or more frequently if circumstances indicate a possible impairment, by comparing an estimate of the fair value of the applicable reporting unit to its carrying value, including goodwill. If the carrying value exceeds fair value, we compare the implied fair value of the applicable goodwill to its carrying amount to measure the amount of goodwill impairment, if any. Our reporting units with goodwill are our Health Care and Group Insurance segments. Impairments, if any, would be classified as an operating expense. After performing our analysis, we determined that there was no impairment of goodwill in each of the three years ended December 31, 2009.

Our annual impairment tests were based on an evaluation of future discounted cash flows. These evaluations utilized the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Collectively, these evaluations were our best estimates of projected future cash flows. Our discounted cash flow evaluations used a range of discount rates that corresponds to our weighted-average cost of capital. This discount rate range is consistent with that used for investment decisions and takes into account the specific and detailed operating plans and strategies of the Health Care and Group Insurance reporting units. Certain other key assumptions

utilized, including changes in membership, revenue, health care costs, operating expenses and effective tax rates, are based on estimates consistent with those utilized in our annual planning process that we believe are reasonable. If we do not achieve our earnings objectives, the assumptions and estimates underlying these goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment.

### **Property and Equipment and Other Acquired Intangible Assets**

We report property and equipment and other acquired intangible assets at historical cost, net of accumulated depreciation or amortization. At both December 31, 2009 and 2008, the historical cost of property and equipment was approximately \$1.1 billion, and the related accumulated depreciation was approximately \$543 million and \$615 million, respectively. We calculate depreciation and amortization primarily using the straight-line method over the estimated useful lives of the respective assets ranging from three to forty years.

We regularly evaluate whether events or changes in circumstances indicate that the carrying value of property and equipment or other acquired intangible assets may not be recoverable. If we determine that an asset may not be recoverable, we estimate the future undiscounted cash flows expected to result from future use of the asset and its eventual disposition. If the sum of the expected undiscounted future cash flows is less than the carrying value of the asset, we recognize an impairment loss for the amount by which the carrying value of the asset exceeds its fair value. There were no impairment losses recognized in the three years ended December 31, 2009.

### **Separate Accounts**

Separate Account assets and liabilities in the Large Case Pensions business represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Investment income and capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from our other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Account assets are not reflected in our statements of income or cash flows. Management fees charged to contract holders are included in fees and other revenue and recognized over the period earned.

### **Health Care and Other Insurance Liabilities**

#### *Health Care Costs Payable*

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs and other amounts due to health care providers pursuant to risk-sharing arrangements related to Health Care's POS, PPO, HMO, Indemnity, Medicare and Medicaid products. Unpaid health care claims include our estimate of payments we will make on claims reported to us but not yet paid and for health care services rendered to members but not yet reported to us as of the balance sheet date (collectively, "IBNR"). Also included in these estimates is the cost of services that will continue to be rendered after the balance sheet date if we are obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, medical cost trends, historical utilization of health care services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors. We reflect changes in these estimates in health care costs in our results of operations in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the member. Less than 6% of our health care costs related to capitated arrangements in each of the last three years. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the balance sheet date.

#### *Future policy benefits*

Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts in the Large Case Pensions business and long-duration group life and long-term care insurance contracts in the Group Insurance business. Reserves for limited payment contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 2.0% to 11.3% in both 2009 and 2008. We periodically review mortality assumptions against both industry standards and our experience. Reserves for long-duration group life and long-term care contracts represent

our estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. Assumed interest rates on such contracts ranged from 2.5% to 8.8% in both 2009 and 2008. Our estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions.

#### *Unpaid claims*

Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts in the Group Insurance business, including an estimate for IBNR as of the balance sheet date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon our estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. We develop our reserves for IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. We discount certain claim liabilities related to group long-term disability and premium waiver contracts. The discounted unpaid claim liabilities were \$1.8 billion and \$1.6 billion at December 31, 2009 and 2008, respectively. The undiscounted value of these unpaid claim liabilities was \$2.4 billion and \$2.5 billion at December 31, 2009 and 2008, respectively. The discount rates generally reflect our expected investment returns for the investments supporting these liabilities and ranged from 5.8% to 6.3% in 2009 and 6.0% to 6.4% in 2008. The discount rates for retrospectively-rated contracts are set at contractually specified levels. Our estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in our statements of income in the period they are determined.

#### *Policyholders' funds*

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts in the Large Case Pensions business and customer funds associated with group life and health contracts in the Health Care and Group Insurance businesses. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus credited interest thereon, net of experience-rated adjustments. In 2009, interest rates for pension and annuity investment contracts ranged from 3.5% to 10.5% and interest rates for group life and health contracts ranged from 0% to 4.2%. In 2008, interest rates for pension and annuity investment contracts ranged from 3.3% to 9.7% and interest rates for group life and health contracts ranged from .1% to 4.7%. Reserves for contracts subject to experience rating reflect our rights as well as the rights of policyholders and plan participants.

We review health care and insurance liabilities periodically. We reflect any necessary adjustments during the current period in results of operations. While the ultimate amount of claims and related expenses are dependent on future developments, it is management's opinion that the liabilities that have been established are adequate to cover such costs. The health care and insurance liabilities that are expected to be paid within one year from the balance sheet date are classified as current liabilities in our balance sheets.

#### *Premium Deficiency Reserves*

We evaluate our insurance contracts to determine if it is probable that a loss will be incurred. We recognize a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries on existing contracts. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. We did not have any material premium deficiency reserves at December 31, 2009 or 2008.

#### **Health Care Contract Acquisition Costs**

Health care products included in the Health Care segment are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to our prepaid health care and health indemnity contracts are expensed as incurred.

#### **Revenue Recognition**

Health care premiums are recognized as income in the month in which the enrollee is entitled to receive health care services. Health care premiums are reported net of an allowance for estimated terminations and uncollectable amounts. Other premium revenue for group life, long-term care and disability products is recognized as income, net of

allowances for termination and uncollectable accounts, over the term of the coverage. Other premium revenue for Large Case Pensions' limited payment pension and annuity contracts is recognized as revenue in the period received. Premiums related to unexpired contractual coverage periods are reported as unearned premiums in our balance sheets.

The balance of the allowance for estimated terminations and uncollectable accounts on premiums receivable was \$107 million and \$82 million at December 31, 2009 and 2008, respectively, and is reflected as a reduction of premiums receivable in our balance sheets. The balance of the allowance for uncollectable accounts on other receivables was \$55 million and \$61 million at December 31, 2009 and 2008, respectively, and is reflected as a reduction of other receivables in our balance sheets.

Some of our contracts allow for premiums to be adjusted to reflect actual experience. Such adjustments are reasonably estimable (based on actual experience of the customer emerging under the contract and the terms of the underlying contract) and are recognized as the experience emerges.

Fees and other revenue consists primarily of ASC fees which are received in exchange for performing certain claims processing and member services for health and disability members and are recognized as revenue over the period the service is provided. Some of our contracts include guarantees with respect to certain functions such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that claim expenses to be incurred by plan sponsors will fall within a certain range. With any of these guarantees, we are financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to us by the customer involved. We accrue for any such exposure upon occurrence.

In addition, fees and other revenue also include charges assessed against contract holders' funds for contract fees, participant fees and asset charges related to pension and annuity products in the Large Case Pensions business. Other amounts received on pension and annuity investment-type contracts are reflected as deposits and are not recorded as revenue. Some of our Large Case Pension contract holders have the contractual right to purchase annuities with life contingencies using the funds they maintain on deposit with us. Since these products are considered an insurance contract, when the contract holder makes this election, we treat the accumulated investment balance as a single premium and reflect it as both premiums and current and future benefits in our statements of income.

#### *Accounting for the Medicare Part D Prescription Drug Program ("PDP")*

We were selected by the Centers for Medicare & Medicaid Services ("CMS") to be a national provider of PDP in all 50 states to both individuals and employer groups in 2009, 2008 and 2007. Under these annual contracts, CMS pays us a portion of the premium, a portion of, or a capitated fee for, catastrophic drug costs and a portion of the health care costs for low-income Medicare beneficiaries and provides a risk sharing arrangement to limit our exposure to unexpected expenses.

We recognize premiums received from, or on behalf of, members or CMS and capitated fees as premium revenue ratably over the contract period. We expense the cost of covered prescription drugs as incurred. Costs associated with low-income Medicare beneficiaries (deductible, coinsurance, etc.) and the catastrophic drug costs paid in advance by CMS are recorded as a liability and offset health care costs when incurred. For individual PDP coverage, the risk sharing arrangement provides a risk corridor whereby the target amount (what we received in premiums from members and CMS based on our annual bid amount less administrative expenses) is compared to our actual drug costs incurred during the contract year. Based on the risk corridor provision and PDP activity to date, an estimated risk sharing receivable or payable is recorded on a quarterly basis as an adjustment to premium revenue. We perform a reconciliation of the final risk sharing, low-income subsidy and catastrophic amounts after the end of each contract year.

#### **Allocation of Operating Expenses**

We allocate to the business segments centrally incurred costs associated with specific internal goods or services provided to us, such as employee services, technology services and rent, based on a reasonable method for each specific cost (such as membership, usage, headcount, compensation or square footage occupied). Interest expense on third-party borrowings and, beginning on January 1, 2009, the financing components of our pension and other post-retirement benefit plan expense is not allocated to the reporting segments, since it is not used as a basis for measuring the operating performance of the segments. Such amounts are reflected in Corporate Financing in our segment

financial information. Segment results were restated for this change in expense allocation. Refer to Note 19 beginning on page 80 for additional information.

### Income Taxes

We are taxed at regular corporate rates after adjusting income reported for financial statement purposes for certain items. We recognize deferred income tax assets and liabilities for the differences between the financial and income tax reporting basis of assets and liabilities based on enacted tax rates and laws. Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. Deferred income tax expense or benefit primarily reflects the net change in deferred income tax assets and liabilities during the year.

Our current income tax provision reflects the tax results of revenues and expenses currently taxable or deductible. Penalties and interest on our tax positions are classified as a component of our income tax provision.

### 3. Acquisition

During 2009 we acquired Horizon Behavioral Services, LLC (“Horizon”), a leading provider of employee assistance programs, for approximately \$70 million in available cash. We believe this acquisition will enhance our existing product capabilities and future growth opportunities. We recorded goodwill related to this transaction of approximately \$57 million in 2009 (pending the final allocation of purchase price). Of this goodwill amount, \$36 million will be tax deductible. All of the goodwill related to this acquisition was assigned to our Health Care segment. Refer to Note 7 on page 57 for additional information.

### 4. Earnings Per Common Share

Basic earnings per share (“EPS”) is computed by dividing net income (i.e., the numerator) by the weighted average number of common shares outstanding (i.e., the denominator) during the reporting period. Diluted EPS is computed in a similar manner, except that the weighted average number of common shares outstanding is adjusted for the dilutive effects of stock options, stock appreciation rights (“SARs”) and other dilutive financial instruments, but only in the periods in which such effect is dilutive.

The computations of basic and diluted EPS for 2009, 2008 and 2007 were as follows:

<b>(Millions, except per common share data)</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
Net Income	\$ 1,276.5	\$ 1,384.1	\$ 1,831.0
Weighted average shares used to compute basic EPS	441.1	475.5	509.2
Dilutive effect of outstanding stock-based compensation awards <sup>(1)</sup>	8.4	12.8	17.8
Weighted average shares used to compute diluted EPS	449.5	488.3	527.0
Basic EPS	\$ 2.89	\$ 2.91	\$ 3.60
Diluted EPS	\$ 2.84	\$ 2.83	\$ 3.47

<sup>(1)</sup> Approximately 19.3 million, 9.7 million and 2.6 million SARs (with exercise prices ranging from \$25.94 to \$59.76, \$25.94 to \$59.76, and \$44.22 to \$59.76, respectively) were not included in the calculation of diluted EPS for 2009, 2008 and 2007, respectively, and approximately 6.2 million and 1.6 million stock options (with exercise prices ranging from \$33.38 to \$42.35) were not included in the calculation of diluted EPS for 2009 and 2008, respectively, as their exercise prices were greater than the average market price of Aetna common shares during such periods.

## 5. Operating Expenses

For 2009, 2008 and 2007, selling expenses (which include broker commissions, the variable component of our internal sales force compensation and premium taxes) and general and administrative expenses were as follows:

(Millions)	2009	2008	2007
Selling expenses	\$ 1,251.9	\$ 1,149.6	\$ 1,060.9
General and administrative expenses:			
Salaries and related benefits	2,971.8	2,619.8	2,343.6
Other general and administrative expenses (1)	2,159.3	1,982.1	1,641.9
Total general and administrative expenses (2)	5,131.1	4,601.9	3,985.5
Total operating expenses	\$ 6,383.0	\$ 5,751.5	\$ 5,046.4

- (1) Includes the following for 2009: litigation-related insurance proceeds of \$38.2 million. Includes the following charges for 2008: a \$20.0 million contribution for the establishment of an out-of-network pricing database and a \$42.2 million allowance on a reinsurance recoverable. Refer to the reconciliation of operating earnings to net income in Note 19 beginning on page 81 for additional information.
- (2) In 2009 and 2008, we recorded severance and facility charges of \$93.7 million and \$54.7 million, respectively. The 2009 severance and facility charges related to actions taken or committed to be taken by the end of the first quarter of 2010. These charges are reflected in total general and administrative expenses. Refer to the reconciliation of operating earnings to net income in Note 19 beginning on page 81 for additional information.

## 6. Health Care Costs Payable

The following table shows the components of the change in health care costs payable during 2009, 2008 and 2007:

(Millions)	2009	2008	2007
Health care costs payable, beginning of the period	\$ 2,393.2	\$ 2,177.4	\$ 1,927.5
Less: Reinsurance recoverables	2.0	2.9	3.7
Health care costs payable, beginning of the period - net	2,391.2	2,174.5	1,923.8
Acquisition of businesses	1.1	-	58.1
Add: Components of incurred health care costs			
Current year	24,127.2	20,948.5	17,472.0
Prior years	(66.0)	(163.0)	(177.2)
Total incurred health care costs	24,061.2	20,785.5	17,294.8
Less: Claims paid			
Current year	21,401.1	18,726.4	15,528.5
Prior years	2,159.0	1,842.4	1,573.7
Total claims paid	23,560.1	20,568.8	17,102.2
Health care costs payable, end of period - net	2,893.4	2,391.2	2,174.5
Add: Reinsurance recoverables	1.9	2.0	2.9
Health care costs payable, end of the period	\$ 2,895.3	\$ 2,393.2	\$ 2,177.4

Our prior year estimates of health care costs payable decreased by approximately \$66 million, \$163 million and \$177 million in 2009, 2008 and 2007, respectively, resulting from claims being settled for amounts less than originally estimated. This reduction was primarily the result of lower than expected health care cost trends as well as the actual claim submission time being faster than we assumed in establishing our health care costs payable in the prior year. This reduction was offset by current period health care costs when we established our estimate of current year health care costs payable. When significant decreases (increases) in prior period health care cost estimates occur that we believe significantly impact our current period results of operations, we disclose that amount as favorable (unfavorable) development of prior period health care cost estimates. In 2009, we had approximately \$116 million of unfavorable development of prior year health care cost estimates that was driven by what we believe was unusually high paid claims activity in the first half of 2009 related to the second half of 2008. This unfavorable development of prior year health care cost estimates offset the amount of the 2009 reduction in our estimate of health care costs payable for prior years. We had no significant amount of favorable (unfavorable) development of prior year health care cost estimates that affected our results of operations in 2008 and 2007.

## 7. Goodwill and Other Acquired Intangible Assets

As a result of recent acquisitions, in accordance with applicable accounting guidance, we allocated the amount paid to the fair value of the net assets acquired, with any excess amounts recorded as goodwill. The increase in goodwill in 2009 and 2008 was as follows:

(Millions)	2009		2008	
Balance, beginning of the period	\$	5,085.6	\$	5,081.0
Goodwill acquired:				
Horizon (1)		56.8		-
Schaller Anderson		3.8		1.0
Goodhealth		-		3.6
Balance, end of the period (2)	\$	5,146.2	\$	5,085.6

(1) Goodwill related to the acquisition of Horizon is considered preliminary, pending the final allocation of purchase price. (Refer to Note 3 on page 55 for additional information).

(2) Approximately \$5.0 billion and \$104 million of goodwill was assigned to the Health Care and Group Insurance segments, respectively, at both December 31, 2009 and 2008.

Other acquired intangible assets at December 31, 2009 and 2008 were comprised of the following:

(Millions)	Cost		Accumulated Amortization		Net Balance	Amortization Period (Years)	
<b>2009</b>							
Other acquired intangible assets:							
Provider networks	\$	703.2	\$	369.0	\$	334.2	12-25 (2)
Customer lists		399.9		205.7	194.2	4-10 (2)	
Technology		25.3		20.7	4.6	3-5	
Other		58.6 (1)		23.2	35.4	2-15	
Trademarks		22.3		-	22.3	Indefinite	
Total other acquired intangible assets	\$	1,209.3	\$	618.6	\$	590.7	
<b>2008</b>							
Other acquired intangible assets:							
Provider networks	\$	703.2	\$	340.2	\$	363.0	12-25
Customer lists		399.9		150.8	249.1	4-10	
Technology		25.3		14.7	10.6	3-5	
Other		38.1		15.7	22.4	2-15	
Trademarks		22.3		-	22.3	Indefinite	
Total other acquired intangible assets	\$	1,188.8	\$	521.4	\$	667.4	

(1) As a result of our acquisition of Horizon in 2009, we preliminarily assigned \$21 million to Other.

(2) The amortization period for our customer lists and provider networks includes an assumption of renewal or extension of these arrangements. At December 31, 2009, the period prior to the next renewal or extension for our provider networks ranges from 1 to 3 years and the weighted average period prior to the next renewal or extension for our customer lists is .7 years. Any costs related to the renewal or extension of these contracts is expensed as incurred.

We estimate annual pretax amortization for other acquired intangible assets over the next five years to be as follows:

(Millions)	
2010	\$ 95.1
2011	87.7
2012	76.2
2013	67.0
2014	47.9

## 8. Investments

Total investments at December 31, 2009 and 2008 were as follows:

(Millions)	2009			2008		
	Current	Long-term	Total	Current	Long-term	Total
Debt and equity securities available for sale	\$ 2,834.8	\$ 14,324.9	\$ 17,159.7	\$ 633.8	\$ 13,359.5	\$ 13,993.3
Mortgage loans	86.1	1,507.9	1,594.0	70.4	1,609.5	1,679.9
Other investments	1.8	1,218.3	1,220.1	1.8	1,194.4	1,196.2
<b>Total investments</b>	<b>\$ 2,922.7</b>	<b>\$ 17,051.1</b>	<b>\$ 19,973.8</b>	<b>\$ 706.0</b>	<b>\$ 16,163.4</b>	<b>\$ 16,869.4</b>

Debt and equity securities available for sale at December 31, 2009 and 2008 were as follows:

(Millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
<b>December 31, 2009</b>				
Debt securities:				
U.S. government securities	\$ 1,801.3	\$ 50.7	\$ (5.2)	\$ 1,846.8
States, municipalities and political subdivisions	2,022.2	80.7	(27.5)	2,075.4
U.S. corporate securities	6,741.9	497.1	(54.4)	7,184.6
Foreign securities	2,554.5	210.9	(20.9)	2,744.5
Residential mortgage-backed securities	1,375.8	49.4	(5.0) (1)	1,420.2
Commercial mortgage-backed securities	1,109.8	37.6	(104.0) (1)	1,043.4
Other asset-backed securities	419.6	25.0	(8.2) (1)	436.4
Redeemable preferred securities	381.9	27.8	(41.0)	368.7
<b>Total debt securities</b>	<b>16,407.0</b>	<b>979.2</b>	<b>(266.2)</b>	<b>17,120.0</b>
Equity securities	35.3	7.9	(3.5)	39.7
<b>Total debt and equity securities (2)</b>	<b>\$ 16,442.3</b>	<b>\$ 987.1</b>	<b>\$ (269.7)</b>	<b>\$ 17,159.7</b>
<b>December 31, 2008</b>				
Debt securities:				
U.S. government securities	\$ 890.7	\$ 115.3	\$ (.4)	\$ 1,005.6
States, municipalities and political subdivisions	1,942.8	23.3	(72.5)	1,893.6
U.S. corporate securities	6,343.8	228.2	(416.5)	6,155.5
Foreign securities	2,134.0	103.0	(124.9)	2,112.1
Residential mortgage-backed securities	1,210.2	39.3	(.4)	1,249.1
Commercial mortgage-backed securities	1,086.4	15.3	(239.3)	862.4
Other asset-backed securities	441.3	1.5	(59.3)	383.5
Redeemable preferred securities	400.4	6.6	(107.0)	300.0
<b>Total debt securities</b>	<b>14,449.6</b>	<b>532.5</b>	<b>(1,020.3)</b>	<b>13,961.8</b>
Equity securities	43.4	.2	(12.1)	31.5
<b>Total debt and equity securities (2)</b>	<b>\$ 14,493.0</b>	<b>\$ 532.7</b>	<b>\$ (1,032.4)</b>	<b>\$ 13,993.3</b>

(1) When we record a credit-related OTTI on a security, we recognize a loss in earnings equal to the difference between the security's amortized cost and the present value of its cash flows. If we do not intend to sell the security, the difference between the fair value and the present value of cash flows of the security is considered a non-credit-related impairment, which is reflected in other comprehensive loss rather than earnings. At December 31, 2009, we held securities for which we recognized a credit-related impairment in the past. Effective April 1, 2009 and for periods through December 31, 2009, we recognized \$61.7 million of non-credit-related impairments in other comprehensive loss (as of December 31, 2009, these securities had a net unrealized capital loss of \$17.2 million).

(2) Investment risks associated with our experience-rated and discontinued products generally do not impact our results of operations (refer to Note 20 beginning on page 82 for additional information on our accounting for discontinued products). At December 31, 2009, investments with a fair value of \$4.0 billion, gross unrealized gains of \$285.6 million and gross unrealized losses of \$78.2 million and, at December 31, 2008, investments with a fair value of \$3.7 billion, gross unrealized gains of \$211.3 million and gross unrealized losses of \$334.7 million were included in total debt and equity securities, but support our experience-rated and discontinued products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive loss.

The fair value of debt securities at December 31, 2009 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid.

(Millions)	Fair Value
Due to mature:	
Less than one year	\$ 692.6
One year through five years	3,405.5
After five years through ten years	4,987.4
Greater than ten years	5,134.5
Residential mortgage-backed securities	1,420.2
Commercial mortgage-backed securities	1,043.4
Other asset-backed securities	436.4
<b>Total</b>	<b>\$17,120.0</b>

### Unrealized Capital Losses and Net Realized Capital Gains (Losses)

When a debt or equity security is in an unrealized capital loss position, we monitor the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. As described in Note 2 beginning on page 48, effective April 1, 2009, we recognize an OTTI when we intend to sell a security that is in an unrealized loss position or if we determine a credit-related loss has occurred. Prior to April 1, 2009, we would recognize an OTTI on a security in an unrealized loss position if we did not have the intention and ability to hold the security until it recovered its value.

Summarized below are the debt and equity securities we held at December 31, 2009 and 2008 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

(Millions)	Less than 12 months		Greater than 12 months		Total (1)	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
<b>December 31, 2009</b>						
Debt securities:						
U.S. government securities	\$ 1,062.5	\$ 4.8	\$ 19.3	\$ .4	\$ 1,081.8	\$ 5.2
States, municipalities and political subdivisions	292.2	10.6	216.7	16.9	508.9	27.5
U.S. corporate securities	730.2	16.8	681.4	37.6	1,411.6	54.4
Foreign securities	418.1	9.0	110.4	11.9	528.5	20.9
Residential mortgage-backed securities	383.0	4.7	8.2	.3	391.2	5.0
Commercial mortgage-backed securities	129.7	3.1	401.6	100.9	531.3	104.0
Other asset-backed securities	46.6	7.5	16.7	.7	63.3	8.2
Redeemable preferred securities	49.1	8.8	198.5	32.2	247.6	41.0
Total debt securities	3,111.4	65.3	1,652.8	200.9	4,764.2	266.2
Equity securities	3.9	1.6	18.8	1.9	22.7	3.5
Total debt and equity securities (1)	\$ 3,115.3	\$ 66.9	\$ 1,671.6	\$ 202.8	\$ 4,786.9	\$ 269.7
<b>December 31, 2008</b>						
Debt securities:						
U.S. government securities	\$ 4.0	\$ -	\$ 24.4	\$ .4	\$ 28.4	\$ .4
States, municipalities and political subdivisions	786.9	42.9	175.6	29.6	962.5	72.5
U.S. corporate securities	2,010.4	167.9	1,238.6	248.6	3,249.0	416.5
Foreign securities	777.7	73.5	178.6	51.4	956.3	124.9
Residential mortgage-backed securities	9.0	-	24.3	.4	33.3	.4
Commercial mortgage-backed securities	336.3	59.9	403.6	179.4	739.9	239.3
Other asset-backed securities	271.3	34.8	76.2	24.5	347.5	59.3
Redeemable preferred securities	125.3	32.5	139.7	74.5	265.0	107.0
Total debt securities	4,320.9	411.5	2,261.0	608.8	6,581.9	1,020.3
Equity securities	24.5	9.5	.8	2.6	25.3	12.1
Total debt and equity securities(1)	\$ 4,345.4	\$ 421.0	\$ 2,261.8	\$ 611.4	\$ 6,607.2	\$ 1,032.4

(1) At December 31, 2009 and 2008, debt and equity securities in an unrealized loss position of \$78.2 million and \$334.7 million, respectively, and with related fair value of \$1.0 billion and \$1.8 billion, respectively, related to discontinued and experience-rated products.

We reviewed the securities in the tables above and concluded that these are performing assets generating investment income to support the needs of our business. In performing this review, we considered factors such as the quality of the investment security based on research performed by external rating agencies and our internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Unrealized losses at December 31, 2009 and 2008 were generally caused by the widening of credit spreads on these particular securities relative to the interest rates on U.S. Treasury securities. As of December 31, 2009, we did not have an intention to sell the securities that were in an unrealized loss position.

The maturity dates for debt securities in an unrealized loss position at December 31, 2009 were as follows:

(Millions)	Supporting discontinued and experience-rated products		Supporting remaining products		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Due to mature:						
Less than one year	\$ .8	\$ -	\$ 48.3	\$ 2.0	\$ 49.1	\$ 2.0
One year through five years	47.8	1.8	780.3	11.5	828.1	13.3
After five years through ten years	202.9	6.1	1,026.5	17.8	1,229.4	23.9
Greater than ten years	551.8	45.0	1,120.0	64.8	1,671.8	109.8
Residential mortgage-backed securities	-	-	391.2	5.0	391.2	5.0
Commercial mortgage-backed securities	182.3	21.6	349.0	82.4	531.3	104.0
Other asset-backed securities	17.0	.3	46.3	7.9	63.3	8.2
<b>Total</b>	<b>\$ 1,002.6</b>	<b>\$ 74.8</b>	<b>\$ 3,761.6</b>	<b>\$ 191.4</b>	<b>\$ 4,764.2</b>	<b>\$ 266.2</b>

Net realized capital gains (losses) for the years ended December 31, 2009, 2008 and 2007, excluding amounts related to experience-rated contract holders and discontinued products, were as follows:

(Millions)	2009	2008	2007
OTTI losses on securities	\$ (121.0)	\$ (643.6)	\$ (127.8)
Portion of OTTI losses recognized in other comprehensive income	26.5	-	-
Net OTTI losses on securities recognized in earnings	(94.5)	(643.6)	(127.8)
Net realized capital gains (losses), excluding OTTI losses on securities	149.5	(12.3)	54.1
Net realized capital gains (losses)	\$ 55.0	\$ (655.9)	\$ (73.7)

The decrease in net OTTI losses recognized in earnings in 2009 compared to 2008 was primarily driven by a significant change in the accounting guidance for the recognition of OTTI on debt securities and an overall general improvement in the economic environment in 2009 compared to 2008, which led to fewer securities in an unrealized loss position. Prior to the adoption of new accounting guidance for OTTI on debt securities on April 1, 2009, both yield and credit-related OTTI were recognized in earnings. In contrast, on and after April 1, 2009, only credit-related impairments are recognized in earnings unless we have the intention to sell the security in an unrealized loss position, in which case yield-related OTTI are also recognized in earnings.

In 2009, 2008 and 2007, yield-related OTTI losses were \$76 million, \$523 million and \$125 million, respectively. These yield-related impairments were generally caused by changes in interest rates in 2009 and the widening of credit spreads relative to the interest rates on U.S. Treasury securities in 2009 and 2008 and increases in interest rates in 2007. During 2008, significant declines in the U.S. housing market resulted in the credit and other capital markets experiencing volatility and limitations on the ability of companies to issue debt or equity securities. The lack of available credit, lack of confidence in the financial sector, increased volatility in the financial markets and reduced business activity resulted in credit spreads widening during 2008.

For the year ended December 31, 2008, credit-related impairments were \$120 million, which includes credit-related OTTI losses of \$105 million related to investments in debt securities of Lehman Brothers Holdings Inc. and Washington Mutual, Inc. There were no individually material credit impairments for 2009 or 2007.

Excluding amounts related to experience-rated and discontinued products, proceeds from the sale of debt securities and the related gross realized capital gains and losses for years ended December 31, 2009, 2008 and 2007 were as follows:

<u>(Millions)</u>		<u>2009</u>		<u>2008</u>		<u>2007</u>
Proceeds on sales	\$	9,485.7	\$	7,494.2	\$	8,370.6
Gross realized capital gains		205.0		120.6		80.0
Gross realized capital losses		71.6		136.8		28.1

### **Mortgage Loans**

Our mortgage loans are secured by commercial real estate. We had no material problem, restructured or potential problem loans included in mortgage loans at December 31, 2009 or 2008. At December 31, 2009, 99% of our mortgage loans continue to be performing assets. We had no material reserves on our mortgage loans at December 31, 2009 or 2008.

At December 31, 2009 scheduled mortgage loan principal repayments were as follows:

<u>(Millions)</u>	
2010	\$ 86.1
2011	105.8
2012	55.2
2013	277.2
2014	90.8
Thereafter	979.5

### **Variable Interest Entities**

We do not have any material relationships with VIEs which require consolidation, but we do have relationships with certain real estate and hedge fund partnerships that are considered VIEs. We record the amount of our investment in these partnerships as long-term investments on our balance sheets and recognize our share of partnership income or losses in earnings. Our maximum exposure to loss as a result of our investment in these partnerships is our investment balance at December 31, 2009 and December 31, 2008 of approximately \$125 million and \$103 million, respectively, and the risk of recapture of tax credits related to the real estate partnerships previously recognized, which we do not believe to be significant. We do not have a future obligation to fund losses or debt on behalf of these investments; however, we may voluntarily contribute funds. The real estate partnerships construct, own and manage low-income housing developments and had total assets of approximately \$5.1 billion and \$4.4 billion at December 31, 2009 and 2008, respectively. The hedge fund partnerships had total assets of approximately \$5.7 billion and \$7.2 billion at December 31, 2009 and 2008, respectively.

### **Credit Default Swaps**

We sell credit protection via credit default swap contracts to improve the return and diversification profile of our investment portfolio. Our contracts are limited to credit exposure on individual entities or investment-grade indices and have terms no longer than five years. We would have to pay under these contracts based on certain defined triggering events such as bankruptcy and failure to pay interest or principal on the underlying obligation. The fair value and maximum amount of future payments for these credit default swaps at December 31, 2009 were \$.1 million and \$18 million, respectively, and at December 31, 2008 were \$(1) million and \$46 million, respectively. At December 31, 2009, we were not required to make any payments to our counterparties for risks covered by these credit default swaps.

### **Non-controlling Interests**

Certain of our investment holdings are partially-owned by third parties. At December 31, 2009 and 2008, \$77 million and \$86 million, respectively, of our investment holdings were partially owned by third parties. The non-controlling entities' share of these investments was included in accrued expenses and other current liabilities. Net investment gains (losses) related to these interests were \$6 million and \$(17) million for years ended December 31, 2009 and 2008, respectively. These non-controlling interests did not have a material impact on our financial position or results of operations.

## Net Investment Income

Sources of net investment income for 2009, 2008 and 2007 were as follows:

(Millions)	2009	2008	2007
Debt securities	\$ 907.8	\$ 877.4	\$ 860.4
Mortgage loans	118.6	116.9	123.5
Other investments	38.6	(50.4)	205.4
Gross investment income	1,065.0	943.9	1,189.3
Less: Investment expenses	(28.6)	(33.9)	(39.4)
Net investment income <sup>(1)</sup>	\$ 1,036.4	\$ 910.0	\$ 1,149.9

(1) Investment risks associated with our experience-rated and discontinued products generally do not impact our results of operations (refer to Note 20 beginning on page 82 for additional information on our accounting for discontinued products). Net investment income includes \$347.8 million, \$296.1 million and \$446.4 million for 2009, 2008 and 2007, respectively, related to investments supporting our experience-rated and discontinued products.

The decrease in Other investment income in 2008 compared to 2007 was primarily due to losses from alternative investments, which did not recur in 2009.

## 9. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive loss in 2009:

(Millions)	Net Unrealized Gains (Losses)			Pension and OPEB Plans	Accumulated Other Comprehensive Income (Loss)
	Previously Impaired <sup>(1)</sup>	All Other	Foreign Currency and Derivatives		
<b>Balance at December 31, 2008</b>	\$ -	\$ (229.3)	\$ (8.7)	\$ (1,643.3)	\$ (1,881.3)
Cumulative effect of adopting a new accounting standard (\$83.0 pretax) <sup>(2)</sup>	(5.3)	(48.4)	-	-	(53.7)
Net unrealized gains (losses) (\$1,004.6 pretax)	106.3	592.4	34.4	(80.1)	653.0
Reclassification to earnings (\$110.5 pretax)	(.7)	(79.0)	(.4)	139.1	59.0
<b>Balance at December 31, 2009</b>	\$ 100.3	\$ 235.7	\$ 25.3	\$ (1,584.3)	\$ (1,223.0)

(1) Represents the non-credit-related component of OTTI on debt securities that we do not intend to sell as well as subsequent changes in fair value related to previously impaired debt securities.

(2) Effective April 1, 2009, we adopted new accounting guidance for other-than-temporary impairments of debt securities. Refer to Note 2 beginning on page 48 for additional information on the cumulative effect adjustment required.

Shareholders' equity included the following activity in accumulated other comprehensive loss in 2008 and 2007:

(Millions)	Net Unrealized Gains (Losses)			Accumulated Other Comprehensive Income (Loss)
	Securities	Foreign Currency and Derivatives	Pension and OPEB Plans	
<b>Balance at December 31, 2006</b>	\$ 66.5	\$ 19.2	\$ (711.4)	\$ (625.7)
Effect of changing measurement date of pension and OPEB plans pursuant to new accounting guidance	-	-	113.9 <sup>(1)</sup>	113.9
Balance at January 1, 2007, as adjusted	66.5	19.2	(597.5)	(511.8)
Net unrealized (losses) gains (\$250.0 pretax)	(64.3)	-	226.8	162.5
Net foreign currency and derivative losses (\$13.7 pretax)	-	(8.9)	-	(8.9)
Reclassification to earnings (\$107.4 pretax)	51.1	(3.3)	22.0	69.8
<b>Balance at December 31, 2007</b>	53.3	7.0	(348.7)	(288.4)
Net unrealized losses (\$3,158.9 pretax)	(756.7)	-	(1,296.6)	(2,053.3)
Net foreign currency and derivative losses (\$25.5 pretax)	-	(16.6)	-	(16.6)
Reclassification to earnings (\$647.7 pretax)	474.1	0.9	2.0	477.0
<b>Balance at December 31, 2008</b>	\$ (229.3)	\$ (8.7)	\$ (1,643.3)	\$ (1,881.3)

(1) We elected to adopt the measurement date provisions of new accounting guidance for defined benefit plans and other postretirement benefits in 2007. The transition provisions of this accounting guidance required us to recognize the effects of this change as an adjustment to the opening balance of accumulated other comprehensive loss on January 1, 2007.

The components of our pension and OPEB plans included the following activity in accumulated other comprehensive loss in 2009 and 2008:

(Millions)	Pension Plans		OPEB Plans		Total
	Unrecognized Net Actuarial Losses	Unrecognized Prior Service Costs	Unrecognized Net Actuarial Losses	Unrecognized Prior Service Costs	
<b>Balance at December 31, 2007</b>	\$ (348.7)	\$ 13.4	\$ (47.1)	\$ 33.7	\$ (348.7)
Unrealized net losses arising during the period (\$1,991.7 pretax)	(1,286.4)	-	(10.2)	-	(1,296.6)
Reclassification to earnings (\$3.1 pretax)	4.1	(1.4)	1.7	(2.4)	2.0
<b>Balance at December 31, 2008</b>	<b>(1,631.0)</b>	<b>12.0</b>	<b>(55.6)</b>	<b>31.3</b>	<b>(1,643.3)</b>
Unrealized net losses arising during the period (\$123.2 pretax)	(72.5)	-	(7.6)	-	(80.1)
Reclassification to earnings (\$214.0 pretax)	140.7	(1.4)	2.2	(2.4)	139.1
<b>Balance at December 31, 2009</b>	<b>\$ (1,562.8)</b>	<b>\$ 10.6</b>	<b>\$ (61.0)</b>	<b>\$ 28.9</b>	<b>\$ (1,584.3)</b>

## 10. Financial Instruments

The preparation of our consolidated financial statements in accordance with GAAP requires certain of our assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, we provide details on the fair value of financial assets and liabilities and how we determine those fair values. We present this information for those instruments that are reported at fair value for which the change in fair value impacts net income or other comprehensive income separately from other financial assets and liabilities.

### Financial Instruments Measured at Fair Value in our Balance Sheets

Certain of our financial instruments are measured at fair value in our balance sheet. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information (“inputs”) that qualifies a financial asset or liability for each level:

- o **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- o **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates, credit risks, etc.) and inputs that are derived from or corroborated by observable markets.
- o **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment’s financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be readily available.

The following is a description of the valuation methodologies used for our financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

**Debt Securities** - Where quoted prices are available in an active market, our debt securities are classified in Level 1 of the fair value hierarchy. Our Level 1 debt securities are comprised primarily of U.S. government securities. If Level 1 valuations are not available, the fair value is determined using models such as matrix pricing, which uses quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. We obtained one price for each of our Level 2 debt securities and did not adjust any of these prices at December 31, 2009.

We also value a certain amount of debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced by our internal staff. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. We obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of these quotes at December 31, 2009. The total fair value of our broker quoted securities was approximately \$364 million at December 31, 2009. Examples of these Level 3 debt securities include certain U.S. and foreign corporate securities and certain of our residential and commercial mortgage-backed securities as well as other asset-backed securities. For some of our private placement securities, our internal staff determine the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

**Equity Securities** - We currently have two classifications of equity securities: those that are publicly traded and those that are privately held. Our publicly-traded securities are classified as Level 1 because quoted prices are available for these securities in an active market. For privately-held equity securities, there is no active market; therefore, we classify these securities as Level 3 because we must price these securities through an internal analysis of each investment's financial statements and cash flow projections.

**Derivatives** - Our derivative instruments are valued using models that primarily use market observable inputs and therefore are classified as Level 2 because they are traded in markets where quoted market prices are not readily available.

Financial assets and liabilities with changes in fair value that are measured on a recurring basis in our balance sheets at December 31, 2009 and December 31, 2008 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total
<b>December 31, 2009</b>				
<b>Assets:</b>				
Debt securities:				
U.S. government securities	\$ 1,529.4	\$ 317.4	\$ -	\$ 1,846.8
States, municipalities and political subdivisions	-	2,062.7	12.7	2,075.4
U.S. corporate securities	-	7,056.5	128.1	7,184.6
Foreign securities	-	2,545.5	199.0	2,744.5
Residential mortgage-backed securities	-	1,420.2	-	1,420.2
Commercial mortgage-backed securities	-	971.6	71.8	1,043.4
Other asset-backed securities	-	425.4	11.0	436.4
Redeemable preferred securities	-	345.8	22.9	368.7
<b>Total debt securities</b>	<b>1,529.4</b>	<b>15,145.1</b>	<b>445.5</b>	<b>17,120.0</b>
Equity securities	1.7	-	38.0	39.7
Derivatives	-	44.0	-	44.0
<b>Total investments</b>	<b>\$ 1,531.1</b>	<b>\$ 15,189.1</b>	<b>\$ 483.5</b>	<b>\$ 17,203.7</b>
<b>December 31, 2008</b>				
<b>Assets:</b>				
Debt securities	\$ 669.9	\$ 12,836.2	\$ 455.7	\$ 13,961.8
Equity securities	2.2	-	29.3	31.5
Derivatives	-	1.8	-	1.8
<b>Total investments</b>	<b>\$ 672.1</b>	<b>\$ 12,838.0</b>	<b>\$ 485.0</b>	<b>\$ 13,995.1</b>
<b>Liabilities:</b>				
Derivatives	\$ -	\$ 4.0	\$ -	\$ 4.0

The changes in the balances of Level 3 financial assets for the years ended December 31, 2009 and 2008 were as follows:

(Millions)	2009				2008			
	U.S. Corporate Securities	Foreign Securities	Other	Total	Debt Securities	Equity Securities	Total	
Beginning balance	\$ 144.6	\$ 177.1	\$163.3	\$485.0	\$ 642.5	\$ 38.8	\$681.3	
Net realized and unrealized capital gains (losses):								
Included in earnings	3.6	11.7	12.3	27.6	(51.9)	-	(51.9)	
Included in other comprehensive income	.5	21.4	12.0	33.9	(30.2)	(1.0)	(31.2)	
Other (1)	7.2	5.7	17.4	30.3	(29.4)	10.4	(19.0)	
Purchases, sales and maturities	(24.2)	(17.6)	(44.0)	(85.8)	(48.5)	(34.6)	(83.1)	
Transfers (out of) into Level 3(2)	(3.6)	.7	(4.6)	(7.5)	(26.8)	15.7	(11.1)	
Ending Balance	\$ 128.1	\$ 199.0	\$156.4	\$483.5	\$ 455.7	\$ 29.3	\$485.0	
Amount of Level 3 net unrealized capital losses included in net income	\$ -	\$ (.1)	\$ (.7)	\$ (.8)	\$ (53.8)	\$ -	\$ (53.8)	

(1) Reflects realized and unrealized capital gains and losses on investments supporting our experience-rated and discontinued products, which do not impact our results of operations. Refer to Note 20 beginning on page 82 for additional information.

(2) For financial assets that are transferred (out of) into Level 3, we use the fair value of the assets at the (beginning) end of the reporting period.

### Financial Instruments Not Measured at Fair Value in our Balance Sheets

The following is a description of the valuation methodologies used for estimating the fair value of our financial assets and liabilities that are measured at adjusted cost or contract value.

**Mortgage loans** - Fair values are estimated by discounting expected mortgage loan cash flows at market rates that reflect the rates at which similar loans would be made to similar borrowers. These rates reflect management's assessment of the credit quality and the remaining duration of the loans. Our fair value estimates of mortgage loans of lower credit quality, including problem and restructured loans, are based on the estimated fair value of the underlying collateral.

#### Investment contract liabilities:

- *With a fixed maturity:* Fair value is estimated by discounting cash flows at interest rates currently being offered by, or available to, us for similar contracts.
- *Without a fixed maturity:* Fair value is estimated as the amount payable to the contract holder upon demand. However, we have the right under such contracts to delay payment of withdrawals that may ultimately result in paying an amount different than that determined to be payable on demand.

**Long-term debt:** Fair values are based on quoted market prices for the same or similar issued debt or, if no quoted market prices are available, on the current rates estimated to be available to us for debt of similar terms and remaining maturities.

The carrying value and estimated fair value of certain of our financial instruments at December 31, 2009 and 2008 were as follows:

(Millions)	2009		2008	
	Carrying Value	Estimated Fair Value	Carrying Value	Estimated Fair Value
Assets:				
Mortgage loans	\$ 1,594.0	\$ 1,506.5	\$ 1,679.9	\$ 1,622.9
Liabilities:				
Investment contract liabilities:				
With a fixed maturity	32.4	33.5	39.1	38.0
Without a fixed maturity	530.6	503.7	525.6	428.8
Long-term debt	3,639.5	3,865.9	3,638.3	3,372.2

### Separate Accounts Measured at Fair Value in our Balance Sheets

Separate Account assets in Large Case Pensions represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Account liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from our other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Account assets are not reflected in our statements of income, shareholders' equity or cash flows.

Separate Account assets include debt and equity securities and derivative instruments. The valuation methodologies used for these assets are similar to the methodologies described beginning on page 63. Separate Account assets also include investments in common/collective trusts and real estate that are carried at fair value. The following are descriptions of the valuation methodologies used to price these investments, including the general classification pursuant to the valuation hierarchy.

**Common/Collective Trusts** – Commingled trusts invest in other collective investment funds otherwise known as the underlying funds. The Separate Account's interests in the commingled trust funds are based on the fair values of the investments of the underlying funds and therefore are classified as Level 2. The underlying assets primarily consist of foreign equity securities. Investments in commingled trust funds are valued at their respective net asset value per share/unit on the valuation date.

**Real Estate** - The values of the underlying real estate investments are estimated using generally accepted valuation techniques and give consideration to the investment structure. An appraisal of the underlying real estate for each of these investments is performed annually. In the quarters in which an investment is not appraised or its valuation is not updated, fair value is based on available market information. The valuation of a real estate investment is adjusted only if there has been a significant change in economic circumstances related to the investment since acquisition or the most recent independent valuation and upon the appraiser's review and concurrence with the valuation. Further, these valuations have been prepared giving consideration to the income, cost and sales comparison approaches of estimating property value. These valuations do not necessarily represent the prices at which the real estate investments would sell, since market prices of real estate investments can only be determined by negotiation between a willing buyer and seller. Therefore, these investment values are classified as Level 3.

Separate Account financial assets at December 31, 2009 and 2008 were as follows:

(Millions)	2009				2008			
	Level 1	Level 2	Level 3	Total	Level 1	Level 2	Level 3	Total
Debt Securities	\$ 752.3	\$ 2,508.0	\$ 97.3	\$ 3,357.6	\$ 631.5	\$ 2,412.1	\$ 365.1	\$ 3,408.7
Equity Securities	1,215.1	.9	-	1,216.0	1,629.2	2.1	-	1,631.3
Derivatives	-	1.2	-	1.2	-	(.1)	-	(.1)
Common/Collective Trusts	-	1,152.6	-	1,152.6	-	-	-	-
Real Estate	-	-	71.4	71.4	-	-	86.7	86.7
<b>Total<sup>(1)</sup></b>	<b>\$ 1,967.4</b>	<b>\$ 3,662.7</b>	<b>\$ 168.7</b>	<b>\$ 5,798.8</b>	<b>\$ 2,260.7</b>	<b>\$ 2,414.1</b>	<b>\$ 451.8</b>	<b>\$ 5,126.6</b>

(1) Excludes \$484.3 million and \$793.3 million of cash and cash equivalents and other receivables at December 31, 2009 and 2008, respectively.

The changes in the balances of Level 3 Separate Account financial assets for 2009 and 2008 were as follows:

(Millions)	2009			2008		
	Debt Securities	Real Estate	Total	Debt Securities	Real Estate	Total
Beginning balance	\$ 365.1	\$ 86.7	\$ 451.8	\$ 291.2	\$ 12,541.8	\$ 12,833.0
Total losses accrued to contract holders	(116.7)	(15.2)	(131.9)	(16.4)	(45.6)	(62.0)
Purchases, sales and maturities	(114.8)	(.1)	(114.9)	105.2	(88.7)	16.5
Net transfers out of Level 3 <sup>(1)</sup>	(36.3)	-	(36.3)	(14.9)	-	(14.9)
Transfers of Separate Account assets <sup>(2)</sup>	-	-	-	-	(12,320.8)	(12,320.8)
<b>Ending Balance</b>	<b>\$ 97.3</b>	<b>\$ 71.4</b>	<b>\$ 168.7</b>	<b>\$ 365.1</b>	<b>\$ 86.7</b>	<b>\$ 451.8</b>

(1) For financial assets that are transferred into (out of) Level 3, we use the fair value of the assets at the end (beginning) of the reporting period.

(2) In 1996, we entered into a contract with UBS Realty Investors, LLC (formerly known as Allegis Realty Investors, LLC) under which mortgage loan and real estate separate account assets and corresponding liabilities transitioned out of our business.

## 11. Pension and Other Postretirement Plans

### Defined Benefit Retirement Plans

We sponsor various noncontributory defined benefit plans, including two pension plans and other postretirement benefit plans (“OPEB”) that provide certain health care and life insurance benefits for retired employees, including those of our former parent company.

For certain of our employees, we provide a noncontributory, defined benefit pension plan, the Aetna Pension Plan, which is a tax-qualified pension plan. All pension plan participants accrue future benefits under a cash balance formula.

We also sponsor a supplemental pension plan that, prior to January 1, 2007, had been used to provide benefits for wages above the Internal Revenue Code wage limits applicable to tax qualified pension plans (such as the Aetna Pension Plan). Effective January 1, 2007, no new benefits accrue under the supplemental pension plan, but interest will continue to be credited on outstanding supplemental cash balance accounts and the plan may continue to be used to credit special pension arrangements.

In addition, we currently provide certain medical and life insurance benefits for retired employees, including those of our former parent company. We provide subsidized health benefits to certain eligible employees who terminated employment prior to December 31, 2006. There is a cap on our portion of the cost of providing medical and dental benefits to our retirees. All current and future retirees and employees who terminate employment at age 45 or later with at least five years of service are eligible to participate in our group health plans at their own cost.

Our measurement date for determining benefit obligations and the fair value of plan assets of our pension and OPEB plans is December 31 (the end of our fiscal year).

The following table shows the changes in the benefit obligations during 2009 and 2008 for our pension and OPEB plans.

(Millions)	Pension Plans		OPEB Plans	
	2009	2008	2009	2008
Benefit obligation, beginning of year	\$ 4,742.8	\$ 4,906.2	\$ 329.6	\$ 332.1
Service cost	48.3	45.3	.2	.3
Interest cost	316.5	312.2	21.7	20.0
Actuarial loss (gain)	528.6	(232.6)	12.7	11.4
Benefits paid	(290.1)	(288.3)	(33.7)	(34.2)
Benefit obligation, end of year	\$ 5,346.1	\$ 4,742.8	\$ 330.5	\$ 329.6

The discount rates used to determine the benefit obligation of our pension and OPEB plans were calculated using a yield curve. The yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve. The weighted average discount rate for our pension plan was 5.89% and 6.89% for 2009 and 2008, respectively. The discount rate for our OPEB plan was 5.64% and 6.92% for 2009 and 2008, respectively. The discount rates differ for our pension and OPEB plans due to the nature of the projected benefit payments for each plan.

The following table reconciles the beginning and ending balances of the fair value of plan assets during 2009 and 2008 for the pension and OPEB plans:

(Millions)	Pension Plans		OPEB Plans	
	2009	2008	2009	2008
Fair value of plan assets, beginning of year	\$ 3,877.2	\$ 5,819.2	\$ 67.3	\$ 70.7
Actual return (loss) on plan assets	736.2	(1,727.1)	4.6	(.5)
Employer contributions	71.6	73.4	29.7	31.3
Benefits paid	(290.1)	(288.3)	(33.7)	(34.2)
Fair value of plan assets, end of year	\$ 4,394.9	\$ 3,877.2	\$ 67.9	\$ 67.3

The difference between the fair value of plan assets and the plan's benefit obligation is referred to as the plan's funded status. This funded status is an accounting-based calculation and is not indicative of our mandatory funding requirements, which are described on page 69. The funded status of our pension and OPEB plans at the measurement date for 2009 and 2008 were as follows:

(Millions)	Pension Plans		OPEB Plans	
	2009	2008	2009	2008
Benefit obligation	\$ (5,346.1)	\$ (4,742.8)	\$ (330.5)	\$ (329.6)
Fair value of plan assets	4,394.9	3,877.2	67.9	67.3
Funded status	\$ (951.2)	\$ (865.6)	\$ (262.6)	\$ (262.3)

A reconciliation of the funded status at the measurement date for 2009 and 2008 of our pension and OPEB plans to the net amounts recognized as assets or liabilities on our balance sheets at December 31, 2009 and 2008 were as follows:

(Millions)	Pension Plans		OPEB Plans	
	2009	2008	2009	2008
Funded status	\$ (951.2)	\$ (865.6)	\$ (262.6)	\$ (262.3)
Unrecognized prior service credit	(16.3)	(18.4)	(44.4)	(48.1)
Unrecognized net actuarial losses	2,404.2	2,509.2	93.9	85.5
Amount recognized in accumulated other comprehensive loss	(2,387.9)	(2,490.8)	(49.5)	(37.4)
Net amount of liabilities recognized at December 31	\$ (951.2)	\$ (865.6)	\$ (262.6)	\$ (262.3)

The liabilities recognized on our balance sheets at December 31, 2009 and 2008 for our pension and OPEB plans were comprised of the following:

(Millions)	Pension Plans		OPEB Plans	
	2009	2008	2009	2008
Accrued benefit liabilities reflected in other current liabilities	\$ (71.5)	\$ (71.4)	\$ (28.7)	\$ (31.1)
Accrued benefit liabilities reflected in other long-term liabilities	(879.7)	(794.2)	(233.9)	(231.2)
Net amount of liabilities recognized at December 31	\$ (951.2)	\$ (865.6)	\$ (262.6)	\$ (262.3)

At December 31, 2009, we had approximately \$2.4 billion and \$94 million of net actuarial losses for our pension and OPEB plans, respectively, and approximately \$16 million and \$44 million of prior service credits for our pension and OPEB plans, respectively, that have not been recognized as components of net periodic benefit costs. We expect to recognize approximately \$201 million and \$5 million in amortization of net actuarial losses for our pension and OPEB plans, respectively, and approximately \$2 million and \$4 million in accretion of prior service credits for our pension and OPEB plans, respectively, in 2010.

Components of the net periodic benefit cost (income) in 2009, 2008 and 2007 for the pension and OPEB plans were as follows:

(Millions)	Pension Plans			OPEB Plans		
	2009	2008	2007	2009	2008	2007
Service cost	\$ 48.3	\$ 45.3	\$ 44.4	\$ .2	\$ .3	\$ .3
Interest cost	316.5	312.2	299.1	21.7	20.0	21.7
Expected return on plan assets	(319.0)	(484.5)	(465.5)	(3.6)	(3.8)	(3.8)
(Accretion) amortization of prior service cost	(2.2)	(2.1)	4.8	(3.7)	(3.7)	(3.7)
Recognized net actuarial loss	216.5	6.3	27.6	3.4	2.6	5.3
Net periodic benefit cost (income)	\$ 260.1	\$ (122.8)	\$ (89.6)	\$ 18.0	\$ 15.4	\$ 19.8

The increase in pension benefit cost between 2008 and 2009 is primarily attributable to the approximately \$1.9 billion decline in the plan assets' fair value during 2008. This decline was due to the deteriorating economic conditions experienced during the latter half of 2008.

The weighted average assumptions used to determine net periodic benefit cost (income) in 2009, 2008 and 2007 for the pension and OPEB plans were as follows:

	Pension Plans			OPEB Plans		
	2009	2008	2007	2009	2008	2007
Discount rate	6.89%	6.57%	5.91%	6.92%	6.35%	5.82%
Expected long-term return on plan assets	8.50	8.50	8.50	5.50	5.50	5.50
Rate of increase in future compensation levels	4.51	4.51	4.51	-	-	-

We assume different health care cost trend rates for medical costs and prescription drug costs in estimating the expected costs of our OPEB plans. The assumed medical cost trend rate for 2010 is 9%, decreasing gradually to 5% by 2014. The assumed prescription drug cost trend rate for 2010 is 14%, decreasing gradually to 5% by 2019. These assumptions reflect our historical as well as expected future trends for retirees. In addition, the trend assumptions reflect factors specific to our retiree medical plan, such as plan design, cost-sharing provisions, benefits covered and the presence of subsidy caps.

Our current funding strategy is to fund an amount at least equal to the minimum funding requirement as determined under applicable regulatory requirements with consideration of factors such as the maximum tax deductibility of such amounts. We may elect to voluntarily contribute amounts to our tax-qualified pension plan. We do not have any regulatory contribution requirements for 2010; however, we intend to make a voluntary contribution of approximately \$45 million to the Aetna Pension Plan in 2010. Employer contributions related to the supplemental pension plan and OPEB plans represent payments to retirees for current benefits. We have no plans to return any pension or OPEB plan assets to the Company in 2010.

Expected benefit payments, which reflect future employee service, as appropriate, of the pension and OPEB plans to be paid for each of the next five years and in the aggregate for the next five years thereafter, at December 31, 2009 were as follows:

(Millions)	Pension Plans	OPEB Plans
2010	\$ 313.6	\$ 28.7
2011	315.5	28.4
2012	319.0	27.6
2013	324.0	26.9
2014	458.4	26.6
2015-2019	1,873.3	123.2

#### Assets of the Aetna Pension Plan

The assets of the Aetna Pension Plan ("Pension Assets") include debt and equity securities, common/collective trusts and real estate investments. The valuation methodologies used to price these assets are similar to the methodologies described beginning on pages 63 and 66, respectively. Pension assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodology used to price these additional investments, including the general classification pursuant to the valuation hierarchy.

**Other Assets** – Other assets consist of derivatives and private equity and hedge fund limited partnerships. Derivatives are either valued using models that primarily use market observable inputs and therefore are classified as Level 2 because they are traded in markets where quoted market prices are not readily available or are classified as Level 1 because they are traded in markets where quoted market prices are readily available. The fair value of private equity and hedge fund limited partnerships are estimated based on the net asset value of the investment fund provided by the general partner or manager of the investments, the financial statements of which generally are audited. Management considers observable market data, valuation procedures in place, contributions and withdrawal restrictions collectively in validating the appropriateness of using the net asset value as a fair value measurement. Therefore, these investments are classified as Level 3.

Pension Assets with changes in fair value measured on a recurring basis, asset allocation and the target asset allocation presented as a percentage of the total plan assets at December 31, 2009 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total	Actual Allocation	Target Allocation
Debt securities:						20-30%
U.S. government securities	\$ 100.6	\$ 6.7	\$ -	\$ 107.3	2.5%	
States, municipalities and political subdivisions	-	26.3	-	26.3	.6%	
U.S. corporate securities	-	656.6	-	656.6	15.3%	
Foreign securities	-	72.7	-	72.7	1.7%	
Residential mortgage-backed securities	-	266.1	-	266.1	6.2%	
Commercial mortgage-backed securities	-	15.7	-	15.7	.4%	
Other asset-backed securities	-	37.8	-	37.8	.9%	
Redeemable preferred securities	-	2.6	-	2.6	.1%	
Total debt securities	100.6	1,084.5	-	1,185.1	27.7%	
Equity securities and common/collective trusts:						50-60%
U.S. Domestic	1,141.1	-	-	1,141.1	26.7%	
International	814.3	-	-	814.3	19.1%	
Common/collective trusts	-	593.9	-	593.9	13.9%	
Domestic real estate	2.2	-	-	2.2	0.0%	
Total equity securities and common/collective trusts	1,957.6	593.9	-	2,551.5	59.7%	
Other investments:						10-20%
Real estate	-	-	353.0	353.0	8.3%	
Other assets	29.7	1.2	151.4	182.3	4.3%	
Total investments (1)	\$ 2,087.9	\$ 1,679.6	\$ 504.4	\$ 4,271.9	100.0%	

(1) Excludes \$123.0 million of cash and cash equivalents and other receivables.

The changes in the balances of Level 3 Pension Assets for the year ended December 31, 2009 were as follows:

	Real Estate	Other	Total
Beginning balance	\$ 425.0	\$ 138.7	\$ 563.7
Actual return on plan assets	(92.8)	9.4	(83.4)
Purchases, sales and settlements	20.8	4.5	25.3
Transfers into (out of) Level 3 (1)	-	(1.2)	(1.2)
Ending balance	\$ 353.0	\$ 151.4	\$ 504.4

(1) For financial assets that are transferred into (out of) Level 3, we use the fair value of the assets at the end (beginning) of the reporting period.

The asset allocation for the Aetna Pension Plan, presented as a percentage of total plan assets at December 31, 2008 was 55% for equity securities, 32% for debt securities, and 13% for real estate/other. The target allocation for the pension plan at December 31, 2008, was 55-75% for equity securities, 10-30% for debt securities and 5-25% for real estate/other.

The asset allocation of the OPEB plan at the measurement date and the target asset allocation at December 31, 2009 and 2008 presented as a percentage of total plan assets, were as follows:

(Millions)	2009	Target Allocation	2008	Target Allocation
Equity securities	8%	5-15%	7%	5-15%
Debt securities	87%	80-90%	87%	80-90%
Real estate/other	5%	0-10%	6%	2-10%

Our pension plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons, and by assessing the pension plan's liability characteristics, our financial condition and our future potential obligations from both the pension and general corporate perspectives. Complementary investment styles and techniques are utilized by multiple professional investment firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

Asset allocations and investment performance are formally reviewed quarterly by the plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually. More thorough analysis of assets and liabilities are also performed periodically.

We have several benefit plans for retired employees currently supported by the OPEB plan assets. OPEB plan assets are directly and indirectly invested in a diversified mix of traditional asset classes, primarily high-quality fixed income securities.

Our expected return on plan assets assumption is based on many factors, including forecasted capital market real returns over a long-term horizon, forecasted inflation rates, historical compounded asset returns and patterns and correlations on those returns. Expectations for modest increases in interest rates, normal inflation trends and average capital market real returns led us to an expected return on the Pension Assets assumption of 8.5% for both 2009 and 2008 and an expected return on OPEB plan assets assumption of 5.5% for both 2009 and 2008. We regularly review actual asset allocations and periodically rebalance our investments to the mid-point of our targeted allocation ranges when we consider it appropriate. At December 31, 2009, our actual asset allocations were consistent with our asset allocation assumptions. Investment returns can be volatile. Although our return on plan assets is a long-term assumption, shorter-term volatility in our annual pension costs can occur if investment returns differ from the assumed rate. For example, a one-percent deviation from our long-term 8.50% return assumption would impact our annual pension costs by approximately \$5 million after tax and would have a negligible effect on our annual OPEB costs.

#### **401(k) Plan**

Substantially all of our employees are eligible to participate in a defined contribution retirement savings plan under which designated contributions may be invested in our common stock or certain other investments. We provided for a match of up to 50% of the first 6% of eligible pay contributed to the plan for the years ended December 31, 2009, 2008 and 2007. The matching contributions are made in cash and invested according to each participant's investment elections. During 2009, 2008 and 2007, we made \$49 million, \$47 million and \$42 million, respectively, in matching contributions. The plan trustee held approximately 10 million shares of our common stock for plan participants at December 31, 2009. At December 31, 2009, approximately 34 million shares of our common stock were reserved for issuance under our 401(k) plan.

## **12. Stock-based Employee Incentive Plans**

Our stock-based employee compensation plans (collectively, the "Plans") provide for awards of stock options, SARs, restricted stock units ("RSUs"), performance stock units ("PSUs"), deferred contingent common stock and the ability for employees to purchase common stock at a discount. At December 31, 2009, approximately 83 million common shares were available for issuance under the Plans.

Executive, middle management and non-management employees may be granted stock options, SARs, RSUs and PSUs. Stock options are granted to purchase our common stock at or above the market price on the date of grant. SARs granted will be settled in stock, net of taxes, based on the appreciation of our stock price on the exercise date over the market price on the date of grant. SARs and stock options generally become 100% vested three years after the grant is made, with one-third vesting each year. Vested SARs and stock options may be exercised at any time during the 10 years after grant, except in certain circumstances, generally related to employment termination or retirement. At the end of the 10-year period, any unexercised SARs and stock options expire. For each RSU granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. The RSUs will generally become 100% vested three years after the grant is made, with one-third vesting each year. The PSUs granted in 2008 and 2009

will become vested on December 31, 2009 and December 31, 2010, respectively. The number of vested PSUs (which could be as high as 200% of the original number of units granted and as low as 0%) is dependent upon the degree to which we achieve performance goals as determined by the Board's Committee on Compensation and Organization. The value of each vested PSU is equal to one share of common stock, net of taxes. The PSUs granted in 2008 did not vest as the underlying performance metric was not achieved by December 31, 2009.

The fair value of RSUs and PSUs are based on the market price of our common stock on the date of grant. We estimate the fair value of stock options and SARs using a modified Black-Scholes option pricing model. SARs granted in 2009, 2008 and 2007 had a weighted average per share fair value of \$11.37, \$14.71, and \$15.10, respectively, using the assumptions noted in the following table:

	2009	2008	2007
Dividend yield	.1%	.1%	.1%
Expected volatility	39.8%	31.7%	31.7%
Risk-free interest rate	1.8%	2.5%	4.7%
Expected term	4.6 years	4.4 years	4.7 years

We use historical data to estimate the period of time that stock options or SARs are expected to be outstanding. Expected volatilities are based on a weighted average of the historical volatility of our stock price and implied volatility from traded options on our stock. The risk-free interest rate for periods within the expected life of the stock option or SAR is based on the benchmark five-year U.S. Treasury rate in effect on the date of grant. The dividend yield assumption is based on our historical dividends declared.

The stock option and SAR transactions in 2009, 2008 and 2007 were as follows:

(Millions, except exercise price and remaining life)	Number of Stock Options and SARs	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life	Aggregate Intrinsic Value
<b>2007</b>				
Outstanding, beginning of year	49.1	\$ 19.22	5.5	\$ 1,213.5
Granted	5.7	43.26	-	-
Exercised	(13.3)	12.55	-	494.1
Expired or forfeited	(1.0)	37.31	-	-
Outstanding, end of year	40.5	\$ 24.31	5.3	\$ 1,352.6
Exercisable, end of year	30.6	\$ 18.49	4.4	\$ 1,201.5
<b>2008</b>				
Outstanding, beginning of year	40.5	\$ 24.31	5.3	\$ 1,352.6
Granted	4.9	49.34	-	-
Exercised	(2.5)	14.13	-	75.5
Expired or forfeited	(1.0)	38.19	-	-
Outstanding, end of year	41.9	\$ 27.50	4.9	\$ 347.0
Exercisable, end of year	33.4	\$ 22.48	4.0	\$ 345.9
<b>2009</b>				
Outstanding, beginning of year	41.9	\$ 27.50	4.9	\$ 347.0
Granted	5.6	32.00	-	-
Exercised	(2.5)	10.01	-	46.9
Expired or forfeited	(.9)	36.34	-	-
Outstanding, end of year	44.1	\$ 28.88	4.7	\$ 356.6
Exercisable, end of year	34.6	\$ 26.16	3.7	\$ 355.0

During 2009, 2008 and 2007, the following activity occurred under the Plans:

(Millions)	2009	2008	2007
Cash received from stock option exercises	\$ 14.9	\$ 29.7	\$ 163.1
Intrinsic value (the excess of market price on the date of exercise over the exercise price)	46.9	75.5	494.1
Tax benefits realized for the tax deductions from stock options and SARs exercised	16.4	26.4	172.9
Fair value of stock options, SARs and stock units vested	98.7	86.5	18.0

We settle stock options with newly-issued common stock and generally utilize the proceeds to repurchase common stock in the open market in the same period.

The following is a summary of information regarding stock options and SARs outstanding and exercisable at December 31, 2009 (number of stock options and SARs and aggregate intrinsic values in millions):

Range of Exercise Prices	Outstanding			Exercisable			
	Number Outstanding	Weighted Average Remaining Contractual Life (Years)	Weighted Average Exercise Price	Aggregate Intrinsic Value	Number Exercisable	Weighted Average Exercise Price	Aggregate Intrinsic Value
\$ 0.00-\$10.00	5.9	1.5	\$ 8.38	\$ 136.0	5.9	\$ 8.38	\$ 136.0
10.00-20.00	12.7	3.0	14.55	218.0	12.7	14.55	218.1
20.00-30.00	.3	8.6	23.37	2.6	.1	22.25	.9
30.00-40.00	11.6	6.2	32.93	-	6.5	33.57	-
40.00-50.00	5.0	6.7	43.21	-	3.5	43.17	-
50.00-60.00	8.6	6.1	50.46	-	5.9	50.35	-
\$ 0.00-\$60.00	44.1	4.7	\$ 28.88	\$ 356.6	34.6	\$ 26.16	\$ 355.0

RSU and PSU transactions in 2009, 2008 and 2007 were as follows (number of units in millions):

	2009		2008		2007	
	RSUs and PSUs	Weighted Average Grant Date Fair Value	RSUs and PSUs	Weighted Average Grant Date Fair Value	RSUs	Weighted Average Grant Date Fair Value
RSUs and PSUs at beginning of year (1)	2.4	\$ 42.98	1.4	\$ 46.15	.8	\$ 49.52
Granted	1.8	30.27	1.5	39.81	.8	43.15
Vested	(1.1)	45.11	(.4)	44.78	(.1)	47.70
Forfeited	- (2)	38.56	(.1)	45.74	(.1)	46.36
RSUs and PSUs at end of year	3.1	\$ 34.60	2.4	\$ 42.98	1.4	\$ 46.15

(1) There were no PSU transactions prior to February, 2008.

(2) Rounds to zero.

In 2009, 2008 and 2007 we recorded pretax share-based compensation expense of \$91 million, \$96 million and \$89 million, respectively, in general and administrative expenses. We also recorded related tax benefits of \$32 million, \$34 million and \$32 million in 2009, 2008 and 2007, respectively. At December 31, 2009, \$95 million of total unrecognized compensation costs related to stock options, SARs, RSUs and PSUs is expected to be recognized over a weighted-average period of 1.7 years.

### 13. Income Taxes

The components of our income tax provision in 2009, 2008 and 2007 were as follows:

(Millions)	2009		2008		2007	
Current taxes:						
Federal	\$	657.4	\$	744.6	\$	742.1
State		61.2		25.5		63.8
Total current taxes		718.6		770.1		805.9
Deferred taxes (benefits):						
Federal		(81.1)		19.4		161.0
State		(12.8)		.6		(1.5)
Total deferred income taxes		(93.9)		20.0		159.5
Total income taxes	\$	624.7	\$	790.1	\$	965.4

Income taxes were different from the amount computed by applying the federal income tax rate to income before income taxes as follows:

(Millions)	2009		2008		2007	
Income before income taxes	\$	1,901.2	\$	2,174.2	\$	2,796.4
Tax rate		35%		35%		35%
Application of the tax rate		665.4		761.0		978.7
Tax effect of:						
Valuation allowance		(19.4)		56.0		-
Other, net		(21.3)		(26.9)		(13.3)
Income taxes	\$	624.7	\$	790.1	\$	965.4

The significant components of our net deferred tax assets at December 31, 2009 and 2008 were as follows:

(Millions)	2009		2008	
Deferred tax assets:				
Reserve for anticipated future losses on discontinued products		\$ 194.4	\$	262.7
Employee and postretirement benefits		626.1		601.6
Investments, net		283.2		422.2
Deferred policy acquisition costs		51.4		56.5
Unrealized losses on investment securities		-		128.2
Insurance reserves		157.5		27.2
Other		126.6		102.0
Gross deferred tax assets		1,439.2		1,600.4
Less: Valuation allowance		47.0		66.1
Deferred tax assets, net of valuation allowance		1,392.2		1,534.3
Deferred tax liabilities:				
Unrealized gains on investment securities		194.9		-
Goodwill and other acquired intangible assets		256.8		244.0
Depreciation and amortization		223.7		210.1
Total gross deferred tax liabilities		675.4		454.1
Net deferred tax assets (1)		\$ 716.8	\$	1,080.2

(1) Includes \$383.4 million and \$301.5 million classified as current assets at December 31, 2009 and 2008, respectively, and \$333.4 million and \$778.7 million classified as noncurrent assets at December 31, 2009 and 2008, respectively.

Valuation allowances are provided when we estimate that it is more likely than not that deferred tax assets will not be realized. A valuation allowance has been established on certain federal and state net operating losses, as well as on a portion of realized capital losses. We base our estimates of the future realization of deferred tax assets on historic and anticipated taxable income. However, the amount of the deferred tax asset considered realizable could be adjusted in the future if we revise our estimates of anticipated taxable income.

Beginning with the 2007 tax year, we entered into the Compliance Assurance Process (the “CAP”) with the IRS. Under the CAP, the IRS undertakes audit procedures during the tax year and as the return is prepared for filing. The IRS has concluded its CAP audit of the 2008 tax return as well as all the prior years. We expect the IRS will conclude its CAP audit of the 2009 tax year in 2010.

We are also subject to audits by state taxing authorities for tax years from 1998 through 2008. We believe we carry appropriate reserves for any exposure to state tax issues.

We paid net income taxes of \$634 million, \$906 million and \$783 million in 2009, 2008 and 2007, respectively.

At December 31, 2009 and 2008, we did not have material uncertain tax positions reflected in our consolidated balance sheet. As such, we do not believe uncertain tax positions will materially affect our financial position, results of operations or our effective tax rates in future periods.

#### 14. Debt

The carrying value of our long-term debt at December 31, 2009 and 2008 was as follows:

(Millions)		2009		2008
Senior notes, 5.75%, due 2011	\$	449.9	\$	449.8
Senior notes, 7.875%, due 2011		449.5		449.2
Senior notes, 6.0%, due 2016		747.1		746.7
Senior notes, 6.5%, due 2018		498.8		498.6
Senior notes, 6.625%, due 2036		798.6		798.6
Senior notes, 6.75%, due 2037		695.6		695.4
<b>Total long-term debt</b>	<b>\$</b>	<b>3,639.5</b>	<b>\$</b>	<b>3,638.3</b>

In September 2008, we issued \$500 million of 6.5% senior notes due 2018 (the “2008 Senior Notes”) and used the proceeds to repay commercial paper borrowings. This debt issuance was partially hedged with forward starting swaps prior to issuance. At the time of the debt issuance, the swaps were terminated and the amount paid was recorded as an other comprehensive loss and is being amortized as an increase of interest expense over the life of the relevant senior notes.

At December 31, 2009 and December 31, 2008, we had approximately \$481 million and \$216 million, respectively, of commercial paper outstanding with a weighted average interest rate of .38% and 5.36%, respectively.

We paid \$244 million, \$228 million and \$178 million in interest in 2009, 2008, and 2007, respectively.

At December 31, 2009 we had an unsecured \$1.5 billion revolving credit agreement (the “Facility”) with several financial institutions which terminates in March 2013. The Facility provides for the issuance of up to \$200 million of letters of credit at our request, which count as usage of the available commitments under the Facility. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the Facility to a maximum of \$2.0 billion. Various interest rate options are available under the Facility. Any revolving borrowings mature on the termination date of the Facility. We pay facility fees on the Facility ranging from .045% to .175% per annum, depending upon our long-term senior unsecured debt rating. The facility fee was .06% at December 31, 2009. The Facility contains a financial covenant that requires us to maintain a ratio of total debt to consolidated capitalization as of the end of each fiscal quarter ending on or after December 31, 2007 at or below .5 to 1.0. For this purpose, consolidated capitalization equals the sum of shareholders’ equity, excluding any overfunded or underfunded status of our pension and OPEB plans and any net unrealized capital gains and losses, and total debt (as defined in the Facility). We met this requirement at December 31, 2009. There were no amounts outstanding under the Facility at December 31, 2009.

During 2009, we entered into four interest rate swaps each with a notional value of \$100 million. We entered into these swaps to hedge interest rate exposure in anticipation of future issuance of long-term debt. At December 31, 2009, the interest rate swaps had an aggregate fair value of \$42.2 million, which were reflected in other comprehensive income for the year ended December 31, 2009.

## 15. Capital Stock

From time to time, the Board authorizes us to repurchase our common stock. Our activity under Board authorized share repurchase programs in 2009, 2008 and 2007 was as follows:

(Millions)	Purchase Not to Exceed	Shares Purchased					
		2009		2008		2007	
		Shares	Cost	Shares	Cost	Shares	Cost
<b>Authorization date:</b>							
February 27, 2009	\$ 750.0	5.3	\$ 158.8	-	\$ -	-	\$ -
June 27, 2008	750.0	23.6	614.2	5.8	135.8	-	-
February 29, 2008	750.0	-	-	17.4	750.0	-	-
September 28, 2007	1,250.0	-	-	19.7	901.9	6.1	348.1
April 27, 2007	750.0	-	-	-	-	15.0	750.0
September 29, 2006	750.0	-	-	-	-	12.1	570.9
<b>Total repurchases</b>	N/A	<b>28.9</b>	<b>\$ 773.0</b>	<b>42.9</b>	<b>\$ 1,787.7</b>	<b>33.2</b>	<b>\$ 1,669.0</b>
Repurchase authorization remaining at December 31,		N/A	\$ 591.2	N/A	\$ 614.2	N/A	\$ 901.9

On September 25, 2009, the Board declared an annual cash dividend of \$.04 per common share to shareholders of record at the close of business on November 13, 2009. The \$17.3 million dividend was paid on November 30, 2009.

In addition to the capital stock disclosed on our balance sheets, we have authorized 8 million shares of Class A voting preferred stock, \$.01 par value per share. At December 31, 2009, there were also 270 million undesignated shares that the Board has the power to divide into such classes and series, with such voting rights, designations, preferences, limitations and special rights as the Board determines.

## 16. Dividend Restrictions and Statutory Surplus

Our business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require such companies to maintain certain levels of equity, and restrict the amount of dividends and other distributions that may be paid to their parent corporations. The additional regulations applicable to our HMO and insurance company subsidiaries are not expected to affect our ability to service our debt or to pay dividends.

Under regulatory requirements, the amount of dividends that may be paid to Aetna by our insurance and HMO subsidiaries without prior approval by regulatory authorities as calculated at December 31, 2009 is approximately \$1.2 billion in the aggregate. There are no such restrictions on distributions from Aetna to its shareholders.

The combined statutory net income for the years ended and combined statutory capital and surplus at December 31, 2009, 2008 and 2007 for our insurance and HMO subsidiaries, were as follows:

(Millions)		2009		2008		2007
Statutory net income	\$	1,308.8	\$	1,815.8	\$	1,901.9
Statutory capital and surplus		6,777.1		5,665.6		5,316.0

## 17. Reinsurance

Effective October 1, 1998, we reinsured certain policyholder liabilities and obligations related to individual life insurance (in conjunction with our former parent company's sale of this business). These transactions were in the form of indemnity reinsurance arrangements, whereby the assuming companies contractually assumed certain policyholder liabilities and obligations, although we remain directly obligated to policyholders. The liability related

to our obligation is recorded in future policy benefits and policyholders' funds on our balance sheets. Assets related to and supporting these policies were transferred to the assuming companies, and we recorded a reinsurance recoverable.

Effective November 1, 1999, we reinsured certain policyholder liabilities and obligations related to paid-up group whole life insurance. In 2008, we recorded an allowance against our reinsurance recoverable from Lehman Re Ltd. ("Lehman Re") of \$42 million pretax in operating expenses. The reinsurance recoverable results from the 1999 transaction as described above. In September 2008, we took possession of assets supporting the reinsurance recoverable, which previously were held as collateral in a trust. In September 2008, Lehman Re commenced proceedings in Bermuda to liquidate itself. We intend to pursue our claims in Lehman Re's liquidation proceedings. We believe our reinsurance recoverables supporting all of these reinsurance obligations are adequate at December 31, 2009.

There is not a material difference between premiums on a written basis versus an earned basis. Reinsurance recoveries were approximately \$56 million, \$63 million and \$62 million in 2009, 2008 and 2007, respectively. Reinsurance recoverables related to these obligations were approximately \$1.0 billion at both December 31, 2009 and 2008 and \$1.1 billion at December 31, 2007. At December 31, 2009, reinsurance recoverables with a carrying value of approximately \$969 million were associated with three reinsurers.

Effective October 1, 2008, we entered into an agreement with Hannover Life Reassurance Company of America to reinsure fifty percent of our group term life and group accidental death and dismemberment insurance policies. We entered into this contract in order to reduce the risk on catastrophic loss which in turn reduces our statutory capital and surplus requirements. This contract does not qualify for reinsurance accounting under GAAP, and consequently it is accounted for using deposit accounting.

## **18. Commitments and Contingent Liabilities**

### **Guarantees**

We have the following guarantee arrangements at December 31, 2009.

- **ASC Claim Funding Accounts** - We have arrangements with certain banks for the processing of claim payments for our ASC customers. The banks maintain accounts to fund claims of our ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, we guarantee that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is \$250 million. We could limit our exposure to this guarantee by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- **Indemnification Agreements** - In connection with certain acquisitions and dispositions of assets and/or businesses, we have incurred certain customary indemnification obligations to the applicable seller or purchaser, respectively. In general, we have agreed to indemnify the other party for certain losses relating to the assets or business that we purchased or sold. Certain portions of our indemnification obligations are capped at the applicable purchase price, while other arrangements are not subject to such a limit. At December 31, 2009, we do not believe that our future obligations under any of these agreements will be material to us.
- **Separate Account assets** - Certain Separate Account assets associated with the Large Case Pensions business represent funds maintained as a contractual requirement to fund specific pension annuities that we have guaranteed. Contractual obligations in these Separate Accounts were \$4.0 billion and \$4.5 billion at December 31, 2009 and 2008, respectively. Refer to Note 2 beginning on page 48 for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Account balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Accounts' investment strategy. If contract holders do not maintain the required level of Separate Account assets to meet the annuity guarantees, we would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2009 exceeded the value of the guaranteed benefit obligation. As a result, we were not required to maintain any additional liability for our related guarantees at December 31, 2009.

## **Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools**

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. Our assessments generally are based on a formula relating to our premiums in the state compared to the premiums of other insurers. Certain states allow recoverability of assessments as offsets to premium taxes. While we have historically recovered more than half of guaranty fund assessments through statutorily-permitted premium tax offsets, significant increases in assessments could jeopardize future recovery of these assessments. Some states have similar laws relating to HMOs. HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

## **Litigation and Regulatory Proceedings**

### *Out-of-Network Benefit Proceedings*

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract (“out-of-network providers”). Other major health insurers are also the subject of similar litigation or have settled similar litigation. Among other things, these lawsuits charge that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors (“Ingenix”).

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), the Racketeer Influenced and Corrupt Organizations Act and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys’ fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by a health plan member and by out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the “MDL Panel”) has consolidated these class action cases in federal district court in New Jersey under the caption *In re: Aetna UCR Litigation*, MDL No. 2020 (“MDL 2020”). A purported member class action lawsuit which makes the same allegations as the other consolidated member class action lawsuits is pending in federal court in California. In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. Discovery has commenced in MDL 2020, and the court has not set a trial date. We intend to vigorously defend ourselves against the claims brought in these cases.

On January 15, 2009, Aetna and the New York Attorney General announced an agreement relating to an industry-wide investigation into certain payment practices with respect to out-of-network providers. In October 2009, pursuant to the agreement, we contributed \$20 million towards the establishment of an independent database system to provide fee information regarding out-of-network reimbursement rates. When the new database is operational, we will cease using databases owned by Ingenix and will use the new database for a period of at least five years in connection with out-of-network reimbursements in those benefit plans that employ a reasonable and customary standard for out-of-network reimbursements. During 2009, we also agreed to pay approximately \$7.5 million in claims and administrative penalties in connection with our out-of-network benefit payment practices as a result of agreements with state attorneys general and a state insurance department.

We also have received subpoenas and/or requests for documents and other information from attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment practices.

It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment practices.

#### *Securities Class Action Litigation*

Two purported class action lawsuits were pending in the United States District Court for the Eastern District of Pennsylvania (the "Pennsylvania Federal Court") against Aetna and certain of its current or former officers and/or directors. On October 24, 2007, the Southeastern Pennsylvania Transportation Authority filed suit on behalf of all purchasers of Aetna common stock between October 27, 2005 and April 27, 2006. The second lawsuit was filed on November 27, 2007, by the Plumbers and Pipefitters Local 51 Pension Fund on behalf of all purchasers of our common stock between July 28, 2005 and July 27, 2006. On June 3, 2008, plaintiffs in these two lawsuits filed a consolidated complaint in the Pennsylvania Federal Court on behalf of all purchasers of our common stock between October 27, 2005 and July 27, 2006. The consolidated complaint (the "Securities Class Action Litigation") supersedes and replaces the two previous complaints. The plaintiffs allege that Aetna and four of its current or former officers and/or directors, John W. Rowe, M.D., Ronald A. Williams, Alan M. Bennett and Craig R. Callen (collectively, the "Defendants"), violated federal securities laws. The plaintiffs allege misrepresentations and omissions regarding, among other things, our medical benefit ratios and health plan pricing practices, as well as insider trading by Dr. Rowe and Messrs. Bennett and Callen. The plaintiffs seek compensatory damages plus interest and attorneys' fees, among other remedies. On June 9, 2009, the Pennsylvania Federal Court granted Aetna's motion to dismiss the consolidated complaint. On July 7, 2009, the plaintiffs filed a notice of appeal of the Pennsylvania Federal Court's order dismissing the consolidated complaint. On February 11, 2010, the Third Circuit Court of Appeals conducted oral arguments on the plaintiff's appeal. The Defendants intend to vigorously defend themselves against the claims brought in the Securities Class Action Litigation.

#### *Other Litigation and Regulatory Proceedings*

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including employment litigation and claims of bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay medical and/or group insurance claims (including post-payment audit and collection practices), rescission of insurance coverage, improper disclosure of personal information, patent infringement and other intellectual property litigation and other litigation in our Health Care and Group Insurance businesses. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

In addition, our current and past business practices are subject to audit and review by, and from time to time we receive subpoenas and other requests for information from, various state insurance and health care regulatory authorities and attorneys general, the Office of the Inspector General, and other state and federal authorities. These reviews, subpoenas, and other requests include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our business practices, including our overall claims processing and payment practices, our business practices with respect to our small business customers (such as rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, in connection with their consideration of health care reform legislation, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." There also continues to be heightened review by regulatory authorities of and increased litigation regarding the health care benefits industry's business and reporting practices, including utilization management, complaint and grievance processing, information privacy, provider network structure (including the use of performance-based networks), delegated arrangements, rescission of insurance coverage, limited benefit health products, pharmacy benefit management practices and claim payment practices (including payments to out-of-network providers). As a leading national health care benefits company, we regularly are the subject of such reviews. These reviews may result, and have resulted, in changes to or clarifications of our business practices, as well as fines, penalties or other sanctions.

We are unable to predict at this time the ultimate outcome of the matters described above, and it is reasonably possible that their outcome could be material to us.

## Other Obligations

We have operating leases for office space and certain computer and other equipment. Rental expenses for these items were \$170 million, \$176 million and \$153 million in 2009, 2008 and 2007, respectively. The future net minimum payments under non-cancelable leases for 2010 through 2014 are estimated to be \$165 million, \$109 million, \$70 million, \$43 million and \$36 million, respectively.

We also have funding obligations relating to equity limited partnership investments and commercial mortgage loans. The funding requirements for equity limited partnership investments and commercial mortgage loans for 2010 through 2014 are estimated to be \$66 million, \$41 million, \$41 million, \$24 million and \$16 million, respectively.

## 19. Segment Information

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment. It is added to our business segments in order to reconcile to our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and, beginning on January 1, 2009, the financing components of our pension and other post-retirement benefit plan expense (the service cost components of this expense are allocated to our business segments). Prior periods have been reclassified to reflect this change.

Summarized financial information of our segment operations in 2009, 2008 and 2007 were as follows:

(Millions)	Health Care	Group Insurance	Large Case Pensions	Corporate Financing	Total Company
<b>2009</b>					
Revenue from external customers (1)	\$ 31,661.8	\$ 1,827.1	\$ 183.8	\$ -	\$ 33,672.7
Net investment income	392.5	274.1	369.8	-	1,036.4
Interest expense	-	-	-	243.4	243.4
Depreciation and amortization expense	409.1	6.9	-	-	416.0
Income taxes (benefits)	744.9	38.7	8.5	(167.4)	624.7
Operating earnings (loss) (2)	1,412.7	103.8	32.2	(310.8)	1,237.9
Segment assets	20,734.7	4,967.4	12,848.3	-	38,550.4
<b>2008</b>					
Revenue from external customers (1)	\$ 28,709.9	\$ 1,781.5	\$ 205.2	\$ -	\$ 30,696.6
Net investment income	341.3	240.4	328.3	-	910.0
Interest expense	-	-	-	236.4	236.4
Depreciation and amortization expense	371.4	6.9	-	-	378.3
Income taxes (benefits)	875.1	(54.2)	1.2	(32.0)	790.1
Operating earnings (loss) (2)	1,802.3	136.8	38.8	(57.0)	1,920.9
Segment assets	18,754.5	4,435.0	12,663.0	-	35,852.5
<b>2007</b>					
Revenue from external customers (1)	\$ 24,431.4	\$ 1,875.1	\$ 216.9	\$ -	\$ 26,523.4
Net investment income	370.9	303.0	476.0	-	1,149.9
Interest expense	-	-	-	180.6	180.6
Depreciation and amortization expense	314.6	6.9	-	-	321.5
Income taxes (benefits)	919.2	36.5	32.0	(22.3)	965.4
Operating earnings (loss) (2)	1,698.0	144.6	35.8	(41.3)	1,837.1
Segment assets	18,223.4	5,469.7	27,031.6	-	50,724.7

(1) Revenue from the United States federal government was ten percent or more of our total revenue from external customers in 2009, 2008 and 2007. We earned \$7.2 billion, \$6.2 billion and \$3.8 billion of revenue from this customer in 2009, 2008 and 2007, respectively, in the Health Care and Group Insurance segments.

(2) Operating earnings (loss) excludes net realized capital gains or losses and the other items described in the reconciliation on page 81.

A reconciliation of operating earnings<sup>(1)</sup> to net income in 2009, 2008 and 2007 was as follows:

(Millions)	2009	2008	2007
Operating earnings	\$ 1,237.9	\$ 1,920.9	\$ 1,837.1
Net realized capital gains (losses), net of tax	55.0	(482.3)	(47.9)
Severance and facility charges	(60.9)	(35.6)	-
ESI settlement	19.6	-	-
Litigation-related insurance proceeds	24.9	-	-
Contribution for the establishment of an out-of-network pricing database	-	(20.0)	-
Allowance on reinsurance recoverable	-	(27.4)	-
Reduction of reserve for anticipated future losses on discontinued products	-	28.5	41.8
<b>Net income</b>	<b>\$ 1,276.5</b>	<b>\$ 1,384.1</b>	<b>\$ 1,831.0</b>

(1) In addition to net realized capital gains (losses), the following other items are excluded from operating earnings because we believe they neither relate to the ordinary course of our business nor reflect our underlying business performance:

In 2009 and 2008, we recorded severance and facility charges of \$60.9 million (\$93.7 million pretax) and \$35.6 million (\$54.7 million pretax), respectively. The 2009 severance and facility charge related to actions taken or committed to be taken by the end of first quarter of 2010.

In 2009, we reached an agreement with Express Scripts, Inc. and one of its subsidiaries (collectively "ESI") to settle certain litigation in which we were the plaintiff. Under the applicable settlement, we received approximately \$19.6 million (\$30.2 million pretax), net of fees and expenses.

Following a Pennsylvania Supreme Court ruling in June 2009, we received \$24.9 million (\$38.2 million pretax) from one of our liability insurers related to certain litigation we settled in 2003. We are continuing to litigate similar claims against certain of our other liability insurers.

As a result of our agreement with the New York Attorney General to discontinue the use of Ingenix databases at a future date, in 2008 we committed to contribute \$20.0 million to a non-profit organization to help create a new independent database for determining out-of-network reimbursement rates. We made that contribution in October, 2009.

As a result of the liquidation proceedings of Lehman Re Ltd. ("Lehman Re"), a subsidiary of Lehman Brothers Holdings Inc., we recorded an allowance against our reinsurance recoverable from Lehman Re of \$27.4 million (\$42.2 million pretax) in 2008. This reinsurance is on a closed block of paid-up group whole life insurance business.

In 1993, we discontinued the sale of our fully guaranteed large case pension products and established a reserve for anticipated future losses on these products, which we review quarterly. Changes in this reserve are recognized when deemed appropriate. We reduced the reserve for anticipated future losses on discontinued products by \$28.5 million (\$43.8 million pretax) in 2008 and \$41.8 million (\$64.3 million pretax) in 2007.

Revenues from external customers by product in 2009, 2008 and 2007 were as follows:

(Millions)	2009	2008	2007
Health care premiums	\$ 28,243.8	\$ 25,507.3	\$ 21,500.1
Health care fees and other revenue	3,418.0	3,202.6	2,931.3
Group life	1,095.6	1,065.2	1,204.2
Group disability	663.7	630.0	577.1
Group long-term care	67.8	86.3	93.8
Large case pensions	183.8	205.2	216.9
<b>Total revenue from external customers (1)</b>	<b>\$ 33,672.7</b>	<b>\$ 30,696.6</b>	<b>\$ 26,523.4</b>

(1) All within the United States, except approximately \$240 million, \$145 million and \$7 million in 2009, 2008 and 2007, respectively, which were derived from foreign customers.

The following is a reconciliation of reportable segment revenues to total revenues included in our statements of income in 2009, 2008 and 2007:

(Millions)	2009	2008	2007
Revenue from external customers	\$ 33,672.7	\$ 30,696.6	\$ 26,523.4
Net investment income	1,036.4	910.0	1,149.9
Net realized capital gains (losses)	55.0	(655.9)	(73.7)
<b>Total revenue</b>	<b>\$ 34,764.1</b>	<b>\$ 30,950.7</b>	<b>\$ 27,599.6</b>

Long-lived assets, principally within the U.S., were \$551 million and \$467 million at December 31, 2009 and 2008, respectively.

## 20. Discontinued Products

Prior to 1993, we sold single-premium annuities (“SPAs”) and guaranteed investment contracts (“GICs”), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products, and now we refer to these products as discontinued products.

We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate losses over their life (which is greater than 30 years); so we established a reserve for anticipated future losses at the time of discontinuance. This reserve represents the present value (at the risk-free rate of return at the time of discontinuance, consistent with the duration of the liabilities) of the difference between the expected cash flows from the assets supporting these products and the cash flows expected to be required to meet the obligations of the outstanding contracts. Because we projected anticipated cash shortfalls in our discontinued products, at the time of discontinuance we established a receivable from Large Case Pensions’ continuing products (which is eliminated in consolidation).

Key assumptions in setting this reserve include future investment results, payments to retirees, mortality and retirement rates and the cost of asset management and customer service. In 1997, we began the use of a bond default assumption to reflect historical default experience. In 1995, we modified the mortality tables used in order to reflect a more up-to-date 1994 Uninsured Pensioner’s Mortality table. Other than these changes, since 1993 there have been no significant changes to the assumptions underlying the reserve.

We review the adequacy of this reserve quarterly based on actual experience. As long as our expectation of future losses remains consistent with prior projections, the results of the discontinued products are applied to the reserve and do not affect net income. However, if actual or expected future losses are greater than we currently estimate, we may have to increase the reserve, which could adversely impact net income. If actual or expected future losses are less than we currently estimate, we may have to decrease the reserve, which could favorably impact net income. The reserve for anticipated future losses is included in future policy benefits on our balance sheet.

As a result of this review, the reserve at December 31, 2009 reflects management’s best estimate of anticipated future losses. In the years ended December 31, 2008 and 2007, \$44 million (\$29 million after tax) and \$64 million (\$42 million after tax) of the reserve, respectively, was released due to favorable mortality and retirement experience compared to assumptions we previously made in estimating the reserve. The 2007 reserve reduction was also due to favorable investment performance.

The activity in the reserve for anticipated future losses on discontinued products in 2009, 2008 and 2007 was as follows (pretax):

<b>(Millions)</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>
Reserve, beginning of period	\$ 790.4	\$ 1,052.3	\$ 1,061.1
Operating (loss) income	(34.8)	(93.4)	28.5
Cumulative effect of new accounting standard as of April 1, 2009 <sup>(1)</sup>	42.1	-	-
Net realized capital (losses) gains	(8.5)	(124.7)	27.0
Reserve reduction	-	(43.8)	(64.3)
<b>Reserve, end of period</b>	<b>\$ 789.2</b>	<b>\$ 790.4</b>	<b>\$ 1,052.3</b>

<sup>(1)</sup> The adoption of new accounting guidance for other-than-temporary impairments of debt securities resulted in a cumulative effect adjustment at April 1, 2009. Refer to Note 2 beginning on page 48 for additional information. This amount is not reflected in accumulated other comprehensive loss and retained earnings in our shareholders’ equity since the results of discontinued products do not impact our results of operations.

During the year ended December 31, 2009, our discontinued products reflected an operating loss and net realized capital losses, both attributable to the unfavorable investment conditions that existed from the latter half of 2008 through the second quarter of 2009. We have evaluated the operating losses and net realized capital losses in 2009 against our expectations of future cash flows assumed in estimating the reserve and do not believe an adjustment to the reserve is required at December 31, 2009.

The anticipated run-off of the discontinued products reserve balance at December 31, 2009 (assuming that assets are held until maturity and that the reserve run-off is proportional to the liability run-off) is as follows:

<b>(Millions)</b>		
2010		\$ 38.7
2011		38.4
2012		37.9
2013		37.2
2014		36.4
Thereafter		<b>600.6</b>

Assets and liabilities supporting discontinued products at December 31, 2009 and 2008 were as follows: (1)

<b>(Millions)</b>	<b>2009</b>		<b>2008</b>	
<b>Assets:</b>				
Debt and equity securities available-for-sale	\$	2,507.7	\$	2,382.4
Mortgage loans		543.9		585.8
Other investments		630.2		666.9
<b>Total investments</b>		<b>3,681.8</b>		<b>3,635.1</b>
Other assets		118.6		133.4
Collateral received under securities loan agreements		33.4		150.7
Current and deferred income taxes		51.5		82.2
Receivable from continuing products (2)		463.4		436.0
<b>Total assets</b>	<b>\$</b>	<b>4,348.7</b>	<b>\$</b>	<b>4,437.4</b>
<b>Liabilities:</b>				
Future policy benefits	\$	3,301.0	\$	3,446.4
Policyholders' funds		12.1		16.7
Reserve for anticipated future losses on discontinued products		789.2		790.4
Collateral payable under securities loan agreements		33.4		150.7
Other liabilities(3)		213.0		33.2
<b>Total liabilities</b>	<b>\$</b>	<b>4,348.7</b>	<b>\$</b>	<b>4,437.4</b>

(1) Assets supporting the discontinued products are distinguished from assets supporting continuing products.

(2) The receivable from continuing products is eliminated in consolidation.

(3) Net unrealized capital gains and losses on debt securities available for sale are included in other liabilities and are not reflected in consolidated shareholders' equity.

The discontinued products investment portfolio has changed since inception. Mortgage loans have decreased from \$5.4 billion (37% of the investment portfolio) at December 31, 1993 to \$544 million (15% of the investment portfolio) at December 31, 2009. This was a result of maturities, prepayments and the securitization and sale of commercial mortgages. Also, real estate decreased from \$5 billion (4% of the investment portfolio) at December 31, 1993 to \$62 million (2% of the investment portfolio) at December 31, 2009, primarily as a result of sales. The resulting proceeds were primarily reinvested in debt and equity securities. Over time, the then existing mortgage loan and real estate portfolios and the reinvested proceeds have resulted in greater investment returns than we originally assumed in 1993.

At December 31, 2009, the expected run-off of the SPA and GIC liabilities, including future interest, were as follows:

<b>(Millions)</b>	
2010	\$ 450.6
2011	435.0
2012	418.6
2013	406.5
2014	383.5
Thereafter	<b>5,156.5</b>

The expected run-off of the SPA and GIC liabilities can vary from actual due to several factors, including, among other things, contract holders redeeming their contracts prior to contract maturity or additional amounts received from existing contracts. The liability expected at December 31, 1993 and actual liability balances at December 31, 2009, 2008 and 2007 for the GIC and SPA liabilities were as follows:

(Millions)	Expected		Actual	
	GIC	SPA	GIC	SPA
2007	\$ 26.4	\$ 3,414.7	\$ 21.0	\$ 3,614.5
2008	20.4	3,261.2	16.7	3,446.4
2009	<b>19.1</b>	<b>3,103.9</b>	<b>12.1</b>	<b>3,301.0</b>

The GIC balances were lower than expected in each period because several contract holders redeemed their contracts prior to contract maturity. The SPA balances in each period were higher than expected because of additional amounts received under existing contracts.

Distributions on SPA and GIC liabilities in 2009, 2008 and 2007 were as follows:

(Millions)	2009	2008	2007
Scheduled contract maturities, settlements and benefit payments	\$ 447.1	\$ 454.3	\$ 468.0
Participant-directed withdrawals	.2	.1	.3

Cash required to fund these distributions was provided by earnings and scheduled payments on, and sales of, invested assets.

### **Management's Report on Internal Control Over Financial Reporting**

Management is responsible for establishing and maintaining adequate internal control over financial reporting ("ICOFR") for the Company. ICOFR is defined as a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Our ICOFR process includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on our consolidated financial statements.

Because of its inherent limitations, ICOFR may not prevent or detect misstatements. Further, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with policies or procedures may deteriorate.

Under the supervision and with the participation of management, including our Chief Executive and Chief Financial Officers, management assessed the effectiveness of our ICOFR at December 31, 2009. In making this assessment, management used the framework set forth by the Committee of Sponsoring Organizations of the Treadway Commission in "*Internal Control – Integrated Framework*." Based on this assessment, management concluded that our ICOFR was effective at December 31, 2009. Our ICOFR as well as our consolidated financial statements have been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included on page 86.

### **Management's Responsibility for Financial Statements**

Management is responsible for our consolidated financial statements, which have been prepared in accordance with GAAP. Management believes the consolidated financial statements, and other financial information included in this report, fairly present in all material respects our financial position, results of operations and cash flows as of and for the periods presented in this report.

The financial statements are the product of a number of processes that include the gathering of financial data developed from the records of our day-to-day business transactions. Informed judgments and estimates are used for those transactions not yet complete or for which the ultimate effects cannot be measured precisely. We emphasize the selection and training of personnel who are qualified to perform these functions. In addition, our personnel are subject to rigorous standards of ethical conduct that are widely communicated throughout the organization.

The Audit Committee of Aetna's Board of Directors engages KPMG LLP, an independent registered public accounting firm, to audit our consolidated financial statements and express their opinion thereon. Members of that firm also have the right of full access to each member of management in conducting their audits. The report of KPMG LLP on their audit of our consolidated financial statements appears on page 86.

### **Audit Committee Oversight**

The Audit Committee of Aetna's Board of Directors is comprised solely of independent directors. The Audit Committee meets regularly with management, our internal auditors and KPMG LLP to oversee and monitor the work of each and to inquire of each as to their assessment of the performance of the others in their work relating to our consolidated financial statements and ICOFR. Both KPMG LLP and our internal auditors have, at all times, the right of full access to the Audit Committee, without management present, to discuss any matter they believe should be brought to the attention of the Audit Committee.

## Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders  
Aetna Inc.:

We have audited the accompanying consolidated balance sheets of Aetna Inc. and subsidiaries (the "Company") as of December 31, 2009 and 2008, and the related consolidated statements of income, shareholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2009. We also have audited the Company's internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on these financial statements and an opinion on the Company's internal control over financial reporting based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the consolidated financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2009 and 2008, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2009, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control - Integrated Framework* issued by COSO.

As discussed in Notes 2, 8 and 9 to the consolidated financial statements, effective April 1, 2009, the Company changed its method of accounting for other-than-temporary impairments of debt securities due to the adoption of new accounting guidance issued by the Financial Accounting Standards Board.

/s/ KPMG LLP

February 26, 2010

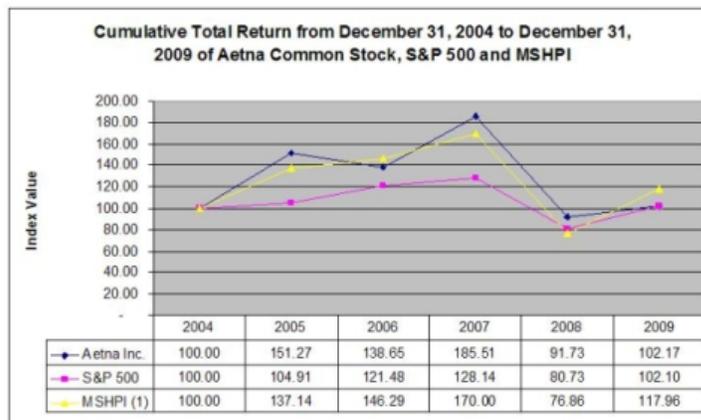
## Quarterly Data (Unaudited)

(Millions, except per share and common stock data)	First	Second	Third	Fourth
<b>2009</b>				
Total revenue	\$ 8,614.7	\$ 8,670.8	\$ 8,722.4	\$ 8,756.2
Income before income taxes	\$ 668.9	\$ 515.4	\$ 478.3	\$ 238.6
Income taxes	(231.1)	(168.8)	(152.1)	(72.7)
Net income	\$ 437.8	\$ 346.6	\$ 326.2	\$ 165.9
Net income per share - basic (1)	\$ .97	\$ .78	\$ .75	\$ .38
Net income per share - diluted (1)	.95	.77	.73	.38
Dividends declared per share	\$ -	\$ -	\$ .04	\$ -
Common stock prices, high	34.52	27.72	31.16	34.04
Common stock prices, low	18.99	21.88	24.05	25.22
<b>2008</b>				
Total revenue	\$ 7,738.7	\$ 7,828.1	\$ 7,624.6	\$ 7,759.3
Income before income taxes	\$ 660.5	\$ 735.9	\$ 422.7	\$ 355.1
Income taxes	(228.9)	(255.4)	(145.4)	(160.4)
Net income	\$ 431.6	\$ 480.5	\$ 277.3	\$ 194.7
Net income per share - basic (1)	\$ .87	\$ 1.00	\$ .59	\$ .42
Net income per share - diluted (1)	.85	.97	.58	.42
Dividends declared per share	\$ -	\$ -	\$ .04	\$ -
Common stock prices, high	59.19	47.49	44.11	37.43
Common stock prices, low	42.09	39.59	34.41	17.68

(1) Calculation of net income per share is based on weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

## Corporate Performance Graph

The following graph compares the cumulative total shareholder return on our common stock (assuming reinvestment of dividends) with the cumulative total return on the published Standard & Poor's 500 Stock Index ("S&P 500") and the cumulative total return on the published Morgan Stanley Healthcare Payors Index ("MSHPI") from December 31, 2004 through December 31, 2009. The graph assumes a \$100 investment in shares of our common stock on December 31, 2004.



(1) At December 31, 2009, the companies included in the MSHPI were: Aetna Inc., Amerigroup Corporation, Centene Corporation, CIGNA Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Molina Healthcare, Inc., UnitedHealth Group Incorporated, Wellcare Health Plans Inc. and Wellpoint, Inc.

Shareholder returns over the period shown on the corporate performance graph should not be considered indicative of future shareholder returns.



Message from Ron Williams

Aetna's success as an industry leader will be built on our ability to fulfill our commitments and to abide by a consistent set of values and standards. The Code of Conduct expresses the standards of integrity and business practice that support Aetna's own unique set of values, known as The Aetna Way. The Code also helps guide us in complying with the laws, regulations and ethical standards that govern our business practices.

I expect every Aetna employee, officer and director to understand and follow our Code of Conduct for several reasons. First, it's what our customers expect from us. Second, we have made a commitment to live by our values. And finally, if we follow these guidelines in all aspects of our business, we will be operating with the highest principles of fair and ethical business practices.

The Code of Conduct cannot cover every situation. When choices and decisions must be made, it will require sound judgment. When in doubt, ask for help and use The Aetna Way and our Ethical Decision-Making Framework as guides to make the right choices and take the right actions in conducting Aetna business. If you ever have reason to believe that a legal or ethical violation has occurred, you must report it to your manager, compliance contact, the Law Department or by using the Aetna AlertLine®. Our policies forbid any form of retaliation against you for fulfilling this obligation.

Compliance with the Code of Conduct, other company policies, and the laws and regulations applicable to our businesses must be a priority for each of us. Our officers, directors and senior managers have the added responsibility of promoting the principles in this Code -- but I expect all of us to foster a culture in which ethical conduct is recognized and valued. Anything less is unacceptable.

/s/ Ron Williams

**Ronald A. Williams**  
Chairman and Chief Executive Officer

## Introduction

**All employees, officers and directors of Aetna must perform their Aetna responsibilities in compliance with this Code of Conduct, applicable laws and company policies. If you become aware of a compliance violation related to any of these, or a business conduct or integrity problem, you must report it right away. If you are ever in doubt about the right thing to do in conducting Aetna business, ask for help.**

For over 150 years, Aetna has had a reputation for integrity and reliability. Central to this reputation is the way in which we conduct business. Aetna employees, officers and directors are expected to perform their Aetna duties in line with the standards of ethics and business practices embodied within this Code of Conduct. The Code of Conduct guides our day-to-day actions and provides us with a set of unifying principles that help us maintain our high standards of business conduct and integrity.

### **Required Business Conduct and Integrity training and acknowledgment**

To help you understand our Code of Conduct and our expected standards of business conduct and integrity, every new employee, officer and director must take Business Conduct and Integrity training. Also, you must read this Code. When you are done, you must complete an acknowledgment form (available on our intranet site or from Aetna Compliance) to:

- Confirm that you have read and do understand the Code, that you are complying with the Code and other key Aetna policies, and that you will continue to comply.
- Disclose possible conflicts of interest and raise concerns you may have about possible conflicts or Code violations.

Every year you are affiliated with Aetna, you must complete:

- Business Conduct and Integrity training, and
- Your acknowledgment form, including updating your disclosure of possible conflicts of interest or other issues as needed.

We know that things change. If you have a new situation that may cause a real or apparent conflict of interest, discuss it with your manager or compliance officer right away. If you are a director, discuss it with the Corporate Secretary or General Counsel. Also, you may need to update your disclosure on your acknowledgment form.

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### **Raising concerns and seeking advice**

If you are aware of any compliance violation or business conduct and integrity problem, or if you suspect one, you must report it right away. Ask for help if you don't know what to do. We have resources, including our Ethical Decision-Making Framework, that can help you and Aetna:

- Do the right thing
- Work in a way that preserves our reputation

If you are a director, you can raise issues and get guidance from Aetna's Corporate Secretary or General Counsel. If you are an employee or officer, turn to your manager. His or her business experience may help you make the right choice. For workplace and employment issues, someone in human resources may be the right person to answer your questions. It is always wise to see your compliance officer or internal legal counsel to raise concerns or get help with issues related to business conduct, integrity or compliance.

You can also ask for help or report a violation or problem by calling the Aetna AlertLine® toll free at 1-888-891-8910 in the U.S.\* It is open around the clock, every day of the year and you can call anonymously. Or, you can write to Corporate Compliance at P.O. Box 370205, West Hartford, CT 06137-0205 USA. Our contracted providers and suppliers can use these same avenues to report possible violations or business conduct and integrity concerns.

The Audit Committee of our Board of Directors or the Chairman of the Audit Committee, in consultation with the Chief Compliance Officer, Corporate Secretary or General Counsel, will review any complaints or concerns about our accounting, internal accounting controls or auditing matters.

\*Outside of the U.S., dial the AT&T Direct access code for the country you are calling from followed by 888-891-8910. AT&T Direct access codes can be found at <http://www.usa.att.com/traveler/index.jsp> or by contacting your local operator.

### **Confidentiality and non-retaliation policy**

We will do our best to guard your privacy to the extent possible if you report a violation, raise a concern or are involved in a complaint or investigation.

Aetna prohibits retaliating against someone because he or she in good faith:

- Makes a complaint or reports a violation
- Cooperates or helps with an investigation
- Gives information about a breach of federal or state law or Aetna policy

This is true whether the person raises the concern to, or cooperates with, Aetna or any law enforcement or other government agency. If a violation is found, appropriate corrective actions will be taken, including disciplining those involved, as warranted. For more information on discipline, see the Disciplinary action section of this Introduction.

If you report concerns about fraud, waste or abuse related to potential false or fraudulent claims for payment from the government, you may also have the right to employment protections under the federal False Claims Act and similar state or other applicable local laws. See your compliance officer or internal legal counsel for more information on:

- These laws and protections
- Aetna policies and procedures for detecting and preventing fraud, waste and abuse in government health care programs

**Code administration and waiver**

You can see the Code of Conduct on our public website at <http://www.aetna.com/governance/code.html>. Any changes to this Code will be put on our public website within four business days after the change is made.

- Any waiver or administration of this Code for our directors can only be implemented by the Aetna Board of Directors or the Board's Nominating and Corporate Governance Committee
- Any waiver of this Code for executive officers can only be given by the Aetna Board of Directors or by the Board's Audit Committee
- Any waiver of this Code for other officers or employees can only be granted by the Chairman
- Any waiver of this Code for directors, executive officers, the Chief Financial Officer, the Corporate Controller, or people with similar functions will be put on our public website within four business days after the waiver is granted

**Disciplinary action**

If you are an employee or officer, you may be disciplined, including loss of your Aetna job, if you:

- Do not follow this Code or other Aetna policies
- Break any laws or regulations that apply to Aetna
- Tell an employee to break the Code, an Aetna policy, a law or a regulation
- Do not share information or provide false information about a violation of the Code, a law or a regulation
- Retaliate against another employee who reports a suspected violation of the Code, a law or a regulation, or who cooperates or helps with an investigation of a possible violation

If you manage a person who commits a violation of the Code of Conduct or a law or regulation, and the Company finds that you neglected indications of such a violation, you may be disciplined, including loss of your Aetna job, depending on the circumstances and nature of the case. See the Workplace Policies section in AccessHR for more information.

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## **Statement 1: Conflicts of interest**

**Employees, officers and directors must avoid real or apparent conflicts of interest. You must act in a way that protects Aetna's reputation.**

### **Employee and officer affiliations and interests**

You may not have ownership interests or participate in outside activities that create a conflict of interest or interfere with your ability to do your job. You must report to your manager and compliance officer for review and approval any of the following types of proposed or existing affiliations or ownership interests involving you or a family member or close friend who lives in your home:

- A position (as employee, officer, director, consultant or agent) with any business, nonprofit organization or government entity that is an Aetna competitor, customer, provider or supplier, or for other reasons may lead to a conflict of interest
- The acquisition of a significant ownership interest in any business. A “significant ownership interest” is one-tenth of one percent or more of any business, including a partnership

You must not be an officer, director or advisor of, or hold a similar position with, a for-profit business without first getting approval from the Chairman or someone appointed by the Chairman, in consultation with Compliance. Contact your compliance officer if you need the Chairman's approval.

It may not always be clear when you have a conflict of interest. For example, a conflict of interest may arise if you or a member of your household has any affiliation with or ownership interest in a competitor, customer, provider, supplier or any company that does business with Aetna or works with a nonprofit or political organization with interests that intersect with Aetna's businesses or with our position on a public policy. Your compliance officer can help if you have questions. Be sure to report possible conflicts to your manager and compliance officer. For guidance on when to report family or personal relationships with other Aetna employees, see Statement 7.

**Q: My wife is an employee benefits manager for an Aetna customer. I am a customer service representative at Aetna. Is this a conflict of interest?**

**A:** It could be. You must report the relationship to your manager and compliance officer. To avoid the appearance of a conflict, you should not be involved in matters related to your wife's company. You should take care not to disclose or discuss any member or other confidential information with your wife.

**Q: I am a new employee. I own a consulting business that has worked with Aetna for years. I was hired by Aetna to do similar work. Can my consulting company still work with Aetna if my sister runs the business?**

**A:** As long as you own the consulting business, it should not continue to work with Aetna while you are an employee here. Even if your sister runs the company, there is an overlap in the business interests of your company and your work for Aetna. You should disclose your ownership of this business and its relationship with Aetna on the online Business Conduct and Integrity acknowledgement form.

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**Q: I am a claims processor. I have a job offer to help a health care provider keep records on weekends. Is this a conflict of interest?**

**A:** Since you process claims for Aetna and your weekend work may include submitting claims or handling claim files, there is a good chance of a real or apparent conflict of interest. You must report the job offer to your manager and compliance officer to see if it will be OK to accept it.

**Director affiliations and interests**

A director may have a conflict of interest if:

- You take an action or have an interest that makes it hard to perform your duties for Aetna objectively and effectively
- You or a family member receives improper personal benefits because of your Aetna Board position

To avoid director conflicts of interest, Aetna does not allow:

- Outside directors to have a direct economic relationship with Aetna unless it is approved by the Aetna Board of Directors
- Aetna loans to directors or their family members
- Aetna guarantees of obligations of directors or their family members

The Nominating and Corporate Governance Committee of the Board must review the following situations for possible conflicts:

- Any proposed affiliation with a for-profit organization
- Any proposed transaction involving Aetna or an Aetna subsidiary where a director has a direct economic or beneficial interest

Conflicts of interest are not always clear. Directors should report possible conflicts to, and are encouraged generally to consult with, the Corporate Secretary or General Counsel. They will consult with the Chairman of the Board, the Nominating and Corporate Governance Committee, or other members of the Board of Directors, as appropriate.

**Disclosure to customers**

Working with brokers and other producers may lead to situations that could create real or apparent conflicts of interest. We believe it is best for our customers, producers and Aetna when our customers understand our financial arrangements with producers. You must follow Aetna's rules for disclosing relationships with producers. Refer to the Policy on Producer Compensation and ask your compliance officer or internal legal counsel if you have questions.

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### **Giving or accepting gifts**

It is important that gifts or promotional items exchanged in the normal course of business be appropriate. You should generally neither give nor receive expensive gifts or other benefits. Never accept or give gifts of cash or cash equivalents (such as gift certificates). You may accept or give occasional, inexpensive gifts or promotional items (such as t-shirts, mugs, and other logo items) if doing so is legal and the gift is neither intended nor likely to be perceived by others as an attempt to influence business decisions. Any gifts given must be accurately disclosed in the appropriate expense report. It could be unlawful to offer any gift, travel expense, entertainment or meal, regardless of the cost, to a person who works for a federal, state or local government entity. See Statement 6 of this Code for more detail.

If you are offered or receive an expensive or inappropriate gift, politely refuse by explaining Aetna's policy on accepting gifts. Ask your compliance officer for help if you are unsure about a gift offered to you.

#### **Q: A supplier sent me a gift basket with fruit and cookies to celebrate the end of a project. May I keep it?**

**A:** This type of gift is generally acceptable as long as it does not contain expensive or inappropriate items or cash equivalents, and it is shared with others in your office, if possible.

#### **Q: A supplier offered me tickets to a Super Bowl game. May I accept the tickets?**

**A:** No. Whether the tickets were offered for your personal use or whether they were offered in conjunction with a meeting to discuss Aetna business, this type of offer is expensive and may be viewed by others as an attempt to influence your business decisions. Consult with your compliance officer to determine whether it would be OK for you to pay the supplier the fair market value for the tickets.

### **Travel, entertainment and honorarium**

Aetna pays for your business travel costs as permitted by Aetna's Travel and Entertainment Reimbursement Policy. These costs generally should not be paid for by others. You may accept meals or entertainment included for all attendees during conferences and similar meetings. You may also occasionally accept meals or entertainment offered in conjunction with meetings to discuss Aetna business. Do not accept such offers if they are lavish or expensive or if they are likely to be perceived by others as an attempt to influence your business decisions. Consult with your compliance officer if you have questions.

Aetna will pay for business related entertainment provided to others if permitted by law and Aetna's Travel and Expense Reimbursement Policy. It could be unlawful to offer any travel expense, entertainment or meal, regardless of the cost, to a person who works for a federal, state or local government entity. See Statement 6 of this Code for more detail.

You may not be paid (often referred to as an "honorarium") by others for participating in activities, professional forums or surveys that are related to Aetna or our business interests. If you are on a professional committee or make a platform speech, you generally may accept the event sponsor's offer to pay reasonable travel costs as long as other committee members or speakers who are not Aetna employees are treated equally.

#### **Q: A supplier has offered to pay for my airfare and hotel costs for an upcoming conference. The same offer has been made to other attendees, but I will not be a speaker at the conference. May I accept this offer?**

**A:** Since you are not speaking at the conference, Aetna should pay for your hotel and travel costs.

**Q: I have been offered an honorarium of \$1,500 to speak at an upcoming conference. The conference sponsor also offered to pay for my travel and hotel expenses. The same offers have been made to all the speakers. May I accept these offers?**

**A:** You may accept the offer of travel and hotel expenses, but you may not accept the honorarium. However, you may suggest that the conference sponsor donate the money in the sponsor's name to a charitable organization like those supported by the Aetna Foundation.

**Discounts and preferential treatment**

You must not accept a discount or preferential treatment that you know is offered to you because of your position at Aetna, except for discounts that are offered to all Aetna employees. If you use an Aetna supplier or contractor for personal purposes, you must pay full market value for the services and materials.

**Q: I was offered a discount on catering services for my family party by a company that I use to arrange Aetna events. May I accept the discount?**

**A:** Yes, but only if the discount is approved by Aetna and available to all Aetna employees. Other “personal” discounts that are offered to you because of your position with Aetna are considered gifts and must be turned down. Talk to your manager or compliance officer if you need help on a specific case.

**Loans and guarantees of obligations**

Loans to, or guarantees of obligations of, executive officers and their families are prohibited. Loans to, or guarantees of obligations of, other officers and employees may create conflicts of interest. They must be reviewed and approved in advance by the Chairman or someone appointed by the Chairman.

**Your Aetna contacts:**

For employees and officers: your manager, compliance officer or internal legal counsel

For directors: the Corporate Secretary or General Counsel

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## **Statement 2: Record keeping and use of Aetna property and resources**

### **All record keeping and use of Aetna property must be legal and proper.**

We are required to submit many documents and reports to the Securities and Exchange Commission and other regulators. These materials and any other Aetna public communications must include disclosure that is full, fair, accurate, timely and easy to understand.

You generally must use Aetna property and resources only for Aetna business. This includes the information in our computing and communications systems, such as e-mail, Internet and business applications. Some departments may permit incidental personal use of Aetna computers or other office equipment. If you are unclear on your department policy, you should ask your manager. See Statement 4 for guidance on protecting information; see below for additional guidelines on use of Aetna resources.

If you suspect improper record keeping, or if you think Aetna property or resources are being misused, contact your:

- Manager,
- Compliance officer,
- Internal legal counsel,
- Controller, or
- Investigative Services

### **Q: Can I use my Aetna computer or phone to plan a vacation?**

**A:** Some areas do not allow the personal use of Aetna computers or phones. But many areas allow incidental personal use as long as it is not excessive, inappropriate or abusive. You must not use

Aetna computers or office equipment for inappropriate things like gambling or accessing inappropriate websites or chat rooms. Ask your manager if you are not clear on your department policy.

### **Record keeping and accounting controls**

You must keep books, records and accounts in a way that shows a fair and accurate accounting of all business transactions and use of assets. You must show them in reasonable detail.

Falsifying an Aetna company record is not allowed. Off-balance sheet transactions, arrangements and obligations must not be executed, and unrecorded funds or assets must not be maintained unless permitted by applicable law or regulation. If permitted, such transactions, arrangements, obligations and accounts, if material, must be disclosed in appropriate reports to the Securities and Exchange Commission.

Officers and managers must build and keep an internal accounting system with controls that:

- Prevent unauthorized, unrecorded or inaccurately recorded transactions
- Let financial statements be prepared that are based on generally accepted accounting principles

Managers must make sure that third parties who create or update Aetna records follow the same rules, where appropriate.

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## **Corporate opportunities and resources**

You must not:

- Take for yourself a business opportunity that you discover using Aetna property, information or your Aetna position
- Use Aetna property, information, resources or Aetna position for your own personal gain
- Compete with Aetna
- Take or keep Aetna property, resources or confidential information once you leave or are no longer affiliated with Aetna

**Q: My department allows incidental personal use of Aetna computers and the Internet. Does that mean I can use Aetna e-mail to communicate with customers of my personal real estate business?**

**A:** No, Aetna property and resources should not be used for personal gain such as your personal real estate business.

## **Bribes and other illegal payments**

You must not make or approve:

- Bribes
- Payment for illegal activity
- Use of Aetna property or resources in a way that creates a conflict of interest or is against the law. See Statement 1 for guidance on giving gifts

## **Foreign payments**

You must comply with the U.S. Foreign Corrupt Practices Act. It makes it illegal for U.S. companies to win, retain or direct business by offering, paying or approving payments to foreign government workers, political parties and their officials, and political candidates. In many cases, the Act also applies to foreign subsidiaries of U.S. companies.

## **Payments for goods or services**

Payments you make on Aetna's behalf to a supplier, consultant, broker or other party must be made for identifiable goods and services only and must be appropriate in relation to the goods or services provided.

## **Monitoring**

Aetna may monitor or inspect information systems, e-mail, Internet use, personal computer files, or anything kept in Aetna furniture or on company property.

Aetna may do this at any time for any company purpose including to stop or find improper record keeping; improper use of Aetna property or resources; or violations of the law, Code of Conduct, or other company policies.

## **Your Aetna contacts:**

For employees and officers: your manager, compliance officer, internal legal counsel, controller, or Investigative Services  
For directors: the Corporate Secretary or General Counsel

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### **Statement 3: Fraud, dishonesty and criminal conduct**

**Aetna's reputation and continued success depend on all of us doing business honestly and in compliance with applicable laws, regulations and ethics rules. Fraud, dishonesty and criminal conduct by anyone doing work for, or business with, Aetna is not allowed.**

Conduct that is not allowed includes:

- Stealing employee or Aetna property
- Misusing an Aetna computer, telephone, mail or other resource
- Making false records or reports, including signing another person's name or altering an Aetna document without your manager's approval

Follow these guidelines if you see or suspect fraud, dishonesty or criminal conduct:

- Immediately report the situation to Investigative Services, internal legal counsel, or your compliance officer.
- Do not talk about it with anyone except those authorized to investigate the matter.
- Do not discipline an employee or officer until you:
  - talk to Investigative Services, and
  - are cleared to do so by your compliance officer or internal legal counsel, in consultation with Employee Relations.
- Do not promise for any reason not to report the conduct to law enforcement.
- Do not try to talk anyone out of reporting real or suspected illegal activity or improper conduct to any law enforcement or government agency.
- Do not destroy, change, falsify or hide evidence of any activity that violates this Code of Conduct. You must not even attempt to do this.
- Do not retaliate against anyone because he or she in good faith:
  - reports a possible violation of law, regulation or Aetna policy
  - helps Aetna or a government agency investigate a possible violation, or
  - files or participates in a proceeding to address a possible violation
- You must cooperate and be truthful during all Aetna investigations.
- If law enforcement or another government agency contacts you about a possible violation, immediately report the contact to Investigative Services, internal legal counsel or your compliance officer.

#### **Your Aetna contacts:**

For employees and officers: Investigative Services, internal legal counsel or your compliance officer

For directors: the Corporate Secretary or General Counsel

#### **Statement 4: Protecting member and other confidential information**

**You must keep member information safe from access, use or disclosure that is not appropriate. You must treat confidential information about Aetna, our employees and those who do business with us the same way.**

Aetna values the trust that is placed in us by:

- Members,
- Plan sponsors,
- Doctors and other providers,
- Brokers,
- Consultants,
- Suppliers,
- Shareholders,
- and others who do business with us.

To keep that trust, we must keep safe all member information and all other confidential information. We must also comply with the federal, state and local privacy and security laws that apply to Aetna. Each of us must treat this information with care to protect it from unapproved or inappropriate access, use or disclosure. You must follow Aetna's privacy and information security rules including the guidelines set out below. If you do not do this, you could face discipline that may include the loss of your job.

#### **Member information:**

- A member's name, address, date of birth, I.D., gender, Social Security number and other nonpublic personal information
- Financial, health or other information about the member that is not public. Health information is information that identifies the member and relates to the member's medical history

#### **Proprietary information:**

- Nonpublic information that is created or used in support of Aetna business or the business of another company. This information is owned by Aetna or the other company.

#### **Nonpublic information:**

- Information that is not known by or available to the public. Examples include information about:
  - members, employees, customers, suppliers, providers and competitors
  - Aetna business strategies or processes
  - pending contracts
  - unannounced products and initiatives
  - research results
  - unannounced financial results or projections

To learn more about confidential information, contact your business area's privacy and security manager or your compliance officer.

## **Member Information**

To keep member information safe, you must:

- Not access, use, view or send member information within Aetna unless you are authorized and there is a valid and approved business reason
- Not make member information known to anyone outside Aetna unless it is approved by your manager in consultation with internal legal counsel or your compliance officer. Approval cannot be given unless there is a real business need for the disclosure and it is allowed under Aetna policy and the law.
- Encrypt any member information that you send through e-mail that may go outside Aetna. You must comply with all Aetna information security safeguards.

### **Q: I am approved to use Aetna's claim systems. Can I use my system access to update or view information for my family or friends?**

**A:** No. In your Aetna role, you should not handle or be involved in any matters related to information about you or anyone you know. You should make sure there is not even the appearance of anything improper. If you are assigned to a claim or other matter about a family member or friend, you should ask that the matter be assigned to another worker. You should report the relationship to your manager and compliance officer.

## **Other confidential information**

Among Aetna's most important assets is our proprietary and other confidential information. This includes confidential information about Aetna, our business interests, employees, customers, plan sponsors, providers or suppliers. If used for the benefit of an Aetna competitor, the information could harm or limit our ability to meet our business goals.

To protect this information, you must:

- Not access, view, or use confidential information unless you are authorized and there is a valid business reason to do so
- Not send confidential information inside Aetna unless there is a business need to do so
- Not send confidential information to anyone outside Aetna without prior approval from your manager. Your manager must consult with internal legal counsel or your compliance officer before giving approval.
- Encrypt any confidential information that you send through e-mail that may go outside Aetna. You must comply with all Aetna information security measures.

## **Information security and records retention**

You must protect and keep private any document under your control that includes member information or any other confidential information. This means using encryption when you send or store documents electronically, and locking up paper documents when they are not in use. You must follow all security procedures that are listed in our Information Security Policy and Standards. When we no longer need to keep this information, you must dispose of it in a way that makes certain it is kept safe and private until properly destroyed. For more information, see Aetna's Records Retention and Management Policy.

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**When your Aetna job or affiliation ends**

You must not take or keep member information or other confidential information once your Aetna job or affiliation ends. You must return any such information that you have, and you must not use or disclose this information for any reason anywhere else, such as at a different employer or company. Aetna can inspect any materials you have when you leave Aetna to prevent unauthorized removal of information. If you have signed an agreement with Aetna requiring continued cooperation, confidentiality, or non-solicitation of employees, you must honor those obligations after leaving Aetna.

**Your Aetna contacts:**

For employees and officers: your manager, internal legal counsel, compliance officer or privacy and security manager  
For directors: the Corporate Secretary or General Counsel

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## **Statement 5: Business and trade practices**

**You are expected to obey all laws and regulations that apply to Aetna's business and to follow all company policies. You must be honest and act with integrity in all of your Aetna business dealings.**

Our businesses must comply with many federal, state and local laws, regulations and rules. How well we comply is often tested through state market conduct exams and other regulatory requests for information.

Also, our products and services are primarily contractual promises. As we strive to outperform our competition, we will do so honestly, fairly and with integrity. We will deal fairly with our customers, providers, suppliers and others with whom we do business.

Here are some key guidelines that you must follow in conducting Aetna business:

- You must not break any law or regulation, including unfair trade or insurance practices laws.
- You should consult with internal legal counsel on any matter relating to actual or potential noncompliance with any law or regulation or any of Aetna's contractual commitments.
- You must not be part of any conduct or sales practice that is intended to mislead, manipulate, or take unfair advantage of anyone, or misrepresent Aetna products, services, contract terms or policies to a customer, member, provider, supplier or regulator. If you do so by mistake, talk to your manager, internal legal counsel or compliance officer. Then, correct it as soon as you can.
- You must neither make, approve nor accept bribes, kickbacks or illegal payments.
- Do not agree with representatives of a competing company, or with others, to be part of these or any other practices that may illegally restrain competition:
  - fixing prices
  - allocating or dividing markets or customers
  - boycotting or refusing to deal with competitors, customers or suppliers
- You must know and follow our Records Retention and Management Policy. Never destroy, change or falsify a document that could be relevant to an anticipated or pending lawsuit or investigation. Meet with and follow the direction of internal legal counsel on these issues.
- Do not get confidential information from others in a way that is not proper.
- You must not accept, keep or use trade secret information that was improperly obtained by another person.
- Do not ask or permit a past or present employee of another company to improperly disclose confidential information about that company.
- Do not discuss or share sensitive competitive information (for example, relating to pricing or market share) with representatives of other companies or industry and trade associations. You may do so only if your manager, in consultation with internal legal counsel or your compliance officer, has given you approval to do so.
- Do not take part in industry or trade associations unless your manager, after talking with internal legal counsel or your compliance officer, approves it.

### **Your Aetna contacts:**

For employees and officers: your compliance officer or internal legal counsel

For directors: the Corporate Secretary or General Counsel

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## **Statement 6: Government contracts**

### **You must help Aetna be a responsible and reputable government contractor.**

Aetna takes seriously winning and keeping government contracts. We work hard to properly administer the contracts we earn. We must conduct these activities in a way that fully complies with all the laws, regulations and ethics rules that apply. Our work must meet our own high standards of business conduct and integrity. The same holds true for any of our subcontractors involved in supporting a government contract.

### **All government contracts**

You must follow all federal, state and local laws that apply to government contracting and procurement.

- You must not offer, promise or give a gift of any value to a federal, state or local government employee or elected or appointed official that might influence or reward them for their official acts or decisions. Do not pay for their travel or lodging costs. Do not pay for their meals, refreshments, entertainment or give them gifts unless you know that it is not against any laws or ethics rules. If you are not sure, ask the public official if accepting your offer is allowed under the laws, regulations or ethics rules that apply to them. Or, if there is time, talk to internal legal counsel or Government Relations before you make the offer.
- You must not use any Aetna resources from any source to lobby for or influence the awarding of any government business to Aetna without specific approval to do so from Government Relations. See Statement 9 for additional rules on contacts with government representatives.
- Some government contracts ask you to certify that when you pursued the contract you did nothing that is prohibited by procurement laws or regulations. Do not sign certificates or disclosures from a government body that are related to lobbying, lobbying costs, political contributions or election matters. These requests must go to the Federal Government Relations team for review and signoff. If you are requested to sign a certificate or disclosure related to conflicts of interest, you must contact internal legal counsel or your compliance officer.

You must also follow all employment laws that apply to federal, state and local contractors. These include:

- The Equal Employment Opportunity law
- State or local human rights laws
- Laws that say you may not discriminate against protected classes of people

See Statement 7 for additional information on these laws.

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## **Federal government contracts**

Aetna must follow special rules when we contract with the U.S. federal government, including:

- Employees and officers, and our subcontractors and providers as appropriate, must follow the laws, rules, regulations and requirements of contractor conduct in the Federal Employees Health Benefits Program (FEHBP), Medicaid and Medicare and other government programs. This includes our Medicare Advantage and Medicare Part D programs. If you are an employee or officer and you do not follow these rules, you may be disciplined, including possible loss of your Aetna job. If you are a subcontractor or a provider and you do not follow these rules, you may lose your contract with Aetna.
- You must follow the rules on recruiting and hiring current or former federal workers. Your internal legal counsel must give approval before you talk to such individuals about working at Aetna.
- You must let internal legal counsel or a compliance officer know right away if you have been debarred, excluded or suspended from working with any government sponsored program. This includes Medicare and Medicaid. If you are a director, you must let the Corporate Secretary or General Counsel know. You must also tell them if you know of any other reason why you might not be permitted to perform work related directly or indirectly to a government sponsored program, or if you know of anyone who works or is affiliated with us who is in this situation.
- You must not give or accept “kickbacks” or “rebates” (that is, anything of value) in connection with a government contract.
- You must not use money paid to Aetna from a federal government contract (referred to as “appropriated funds”) for lobbying activity that is focused on influencing federal officials and personnel in connection with the awarding of any federal contract, loan or other business. This same ban on appropriated funds is often adopted by state and local governments with respect to state or local government business.
- You must follow all laws and regulations that apply in the countries where Aetna does business. Do not make any payment that is in violation of the U.S. Foreign Corrupt Practices Act. Statement 2 has more information on our duties under this Act.
- If your job includes working with federal contracts, you must follow the federal privacy laws and regulations that apply to the federal agency that maintains the contract.
- Be accurate and complete when you represent, certify, negotiate or work with a federal government contract. You must give the federal government cost, pricing and other required data that is current, complete and accurate. You and Aetna may be liable for false, incomplete or misleading:
  - proposals, quotes and rates,
  - reconciliations,
  - certifications, or
  - other documents and statements

## **State and local government contracts**

State and local laws and ethics rules on contractor conduct for Medicaid, children's health programs, and state or local health plans are often like the federal rules above; however, they vary by locality. See your internal legal counsel with questions on how state or local rules may apply.

## **Your Aetna contacts:**

For employees and officers: your internal legal counsel, compliance officer, or Federal Government Relations  
For directors: the Corporate Secretary or General Counsel

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## **Statement 7: Employment practices and work environment**

**We strive for a workplace that is inclusive and safe for our employees and business partners. Our policies and programs are designed to promote fairness and respect for all individuals, and to foster a workplace where diversity and inclusion are valued. We do not tolerate discrimination, harassment or retaliation. Behaviors that put our employees or business partners at risk are not allowed.**

### **Equal employment opportunity**

We are proud to be an Equal Opportunity and Affirmative Action employer. It is our goal to have a work force that reasonably reflects the diversity of qualified talent that is available in relevant labor markets.

We base employment decisions, including selection, development and compensation decisions, on an individual's qualifications, skills and performance. We do not base these decisions on personal characteristics or status, such as race, color, sex, pregnancy, national origin, citizenship, religion, age, disability, veteran status, sexual orientation, gender identity, marital status, and/or genetic information.

### **Harassment-free workplace**

We strive to have a workplace that is free from harassment. We do not tolerate inappropriate behavior or harassment by, or of, our employees or business partners, including when it is based on the characteristics or statuses described above. Under our anti-harassment policy, harassment is any behavior that:

- Unreasonably interferes with a person's job performance, or
- Creates a workplace that is intimidating, hostile or offensive

Employees, officers and directors must:

- Treat everyone with respect, and
- Refrain from unwelcome or potentially offensive verbal or physical behavior, including slurs, name calling, jokes, touching and other potentially harassing or intimidating actions

Managers must:

- Administer Aetna policies and programs in a way that is appropriate, consistent and does not discriminate,
- Monitor the workplace and take steps to prevent and address inappropriate behavior,
- Support our equal opportunity and affirmative action policies and programs, and
- Make reasonable accommodations for workers with disabilities in keeping with the laws that apply

Aetna has the discretion to decide what behavior is not acceptable in our workplace. We will discipline those who act in an unacceptable way.

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### **Personal relationships**

We want to avoid even the appearance of favoritism in the workplace. People with close personal relationships must not be in supervisory/subordinate reporting relationships or other positions of authority that can influence employment decisions about one another. For example, you must not be in the reporting line of, or have in your reporting line, an employee who is a relative or with whom you have a close personal relationship (e.g., someone you are dating or with whom you have a close friendship).

If you find yourself in this situation, you must disclose it by calling the HR Contact Center or your compliance officer. HR or Compliance will work with your management to see if a change in reporting relationships is needed.

### **Violent behavior, alcohol and drugs**

We want a workplace that protects the health and safety of our employees and business partners. That is why Aetna prohibits intimidating behavior, threats and acts of violence in our workplace. It is also why we require a workplace that is free from drugs and alcohol. You must come to work free from the negative effects of drugs or alcohol and able to perform all your job duties.

Our Alcohol and Drug policy does not allow you to abuse or to unlawfully make, distribute, dispense, possess, use, transfer, solicit, purchase or sell:

- Alcoholic beverages
- Controlled substances
- Illegal or prescription drugs

This Alcohol and Drug policy applies while you are on company property and while you are doing company business anywhere.

To help you comply with our Alcohol and Drug policy, we have an Employee Work/Life Assistance (EWLA) program. It offers assessment, counseling and referrals for alcohol and drug-related problems.

### **Raising concerns and Aetna's non-retaliation policy**

If you believe that you have experienced or witnessed inappropriate behavior, you must report it to:

- Your manager,
- A senior manager,
- The HR Contact Center, or
- Anonymously through the AlertLine®

Aetna prohibits retaliating against anyone because he or she in good faith:

- Makes a complaint about or reports a violation of any of these policies, or
- Cooperates in the investigation of such a complaint.

Anyone who violates any of Aetna's employment or other policies may be disciplined, up to and including termination of employment.

For more information on our employment policies, practices and expected behaviors, see the Workplace Policies section in AccessHR.

### **Your Aetna contacts:**

For employees and officers: Your manager, compliance officer, internal legal counsel, or, from the U.S., the HR Contact Center (1-800-AETNA-HR)

For directors: the Corporate Secretary or General Counsel

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## **Statement 8: Securities transactions**

### **You must not trade securities if you have material nonpublic information about those securities.**

You must follow all insider trading and securities laws and all Aetna policies on securities transactions and handling confidential information. Insider trading is unethical and illegal. It will be dealt with firmly by Aetna. You and Aetna could face civil and criminal penalties for insider trading.

Follow the rules below when you enter into any transaction regarding Aetna securities including:

- Common stock
- Stock options
- Preferred stock
- Debt instruments
- Transfers, that you control, of accumulated values to and from any Aetna common stock account in any Aetna benefit plan, including the 401(k)

In some cases, insider trading rules apply to the purchase or sale of securities of other companies, including those securities that trade in foreign markets.

The rules apply to members of your family and any person living in your home. You must use discretion when you talk about work with friends, family and other employees.

### **What is “material nonpublic” information?**

“Material” information is information that a reasonable investor would think is important when making a decision about buying, holding or selling a company's securities. Information that affects the price of our stock is typically “material.” Here are some examples:

- Financial results or expected results for the quarter or the year
- Possible mergers or acquisitions
- Major changes in customer relationships
- Getting or losing an important contract
- New product news
- Changes in senior management
- Major lawsuit developments

Whether or not information is “material” may depend on the circumstances. Contact internal legal counsel for guidance.

Information is considered “nonpublic” until:

- It is made publicly available by Aetna
- The public and the financial markets have had time to read and understand it

Examples of public information include press releases and public filings with the Securities Exchange Commission.

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**Protect yourself and Aetna. Follow these rules.**

- Do not trade Aetna securities if you have material nonpublic information that relates to Aetna's:
  - operations,
  - activities,
  - plans, or
  - financial results

In some cases, some employees or directors can trade Aetna securities based on a pre-arranged contract, instruction or plan that complies with the law. Entering into such a pre-arranged contract, instruction or plan, or any changes to it, must be approved by the Chairman or someone appointed by the Chairman, in consultation with internal legal counsel.

- You should limit your transactions to times when it is reasonable to think that all material information is made public. Let two business days pass between the time the information is made public through news services and the time you place your order to buy or sell. This gives the market time to absorb the information.
- Do not trade securities of another company if you have material nonpublic information about that company, and the trade would violate Securities and Exchange Commission rules. Do not trade securities of another company if the trade for other reasons is not legal or creates a conflict of interest.
- Do not share material nonpublic information that you have about Aetna or any other company with anyone who is:
  - inside Aetna, unless they need the information to do their job
  - outside Aetna, unless your manager has worked with internal legal counsel to approve sharing it

Information you have because of your position at Aetna belongs to Aetna, and you must not take or share it for anyone's benefit. Giving a tip based on this information is unethical and illegal, even if you do not profit from it.

- You may not buy or sell “put” or “call” options or other derivatives on Aetna stock. You may not sell Aetna stock short.
- When you buy or sell Aetna securities, you must tell the broker about your relationship with Aetna.

**Your Aetna contacts:**

For employees and officers: your internal legal counsel or compliance officer

For directors: the Corporate Secretary or General Counsel

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## **Statement 9: Interacting with the media, the government or an outside party or organization**

**You may not speak for Aetna unless you have received approval from senior management or the Board of Directors to do so. Your own views must be kept separate from Aetna views. Aetna resources may not be used to hire a lobbyist or to make a political donation unless you have received prior approval from Government Relations.**

Because companies are watched closely by the public, any public statement that may be linked to Aetna must be given with care. When communicating publicly, if your Aetna affiliation is known, you must take care to keep your own views separate from Aetna views. To protect you and Aetna, contacts with outside parties (including the media and government) must be in keeping with the laws that apply and these rules.

### **Company communications**

- You must not speak publicly for Aetna unless you have received approval from senior management or the Board of Directors to do so. If you send or make communications (like e-mails, mailings, speeches or presentations) that go outside of Aetna and are addressed to more than one person, they must be reviewed by the Quality Communications Center (QCC) in consultation with internal legal counsel, if needed. This includes anything you might send to:
    - members,
    - those thinking about joining an Aetna plan,
    - plan sponsors, or
    - doctors and other providers
  - To make sure that we set the right tone and message, media requests must go to the Communications department. They will review the request and answer for Aetna. Contact the head of:
    - Communications,
    - Corporate Communications, or
    - Business Communications.
  - Requests from financial analysts or shareholders must go to the:
    - Chief Financial Officer, or
    - Head of Investor Relations
  - If a supplier asks you for a quote for a press release, or asks you for Aetna's approval or support of a product or service, send the request to the Communications department. They will review the request with the right business lead and compliance officer.
-

### **Personal communications**

- Do not use Aetna letterhead or titles when you write about issues that are not related to Aetna. An example is a letter to the editor. There are times when you can use letterhead for civic, public service or charity events, but only if you get approval from your manager and compliance officer.
- You must take care not to lead others to believe that Aetna supports your opinions. Do not link Aetna to your own opinions when you speak, write or take part in personal activities, unless you have received approval from your manager to do so. This includes using the Internet.
- Our key managers, and employees who regularly interact with the media on Aetna's behalf, must not disagree in public with Aetna's official positions. This is because it may be hard for the media to separate the personal views of these employees from our official company positions.

### **Political activity and contributions**

- You must not use Aetna resources to support any state or local candidate, ballot initiative, referendum or other question, or political activity, unless you get prior written approval from Government Relations. This is true no matter where the Aetna resources come from (for example, core, segment or region resources, or reimbursement of personal contributions such as money spent going to a political event).
- You must not use Aetna resources to make any political contribution related to a federal election (whether to a candidate, political party or political action committee) since it is against the law. In some cases, Aetna resources may be used to support some federal political activity. You must contact Government Relations to obtain written approval and if you have questions.
- Aetna is permitted by law to use its resources to support the administration of the Aetna political action committee (Aetna PAC). But, we are not permitted to contribute Aetna resources to the Aetna PAC for election contribution purposes.
- Any use of Aetna resources for any political activity must be processed through Government Relations, no matter what the source of the resources (core, segment or region resources).

### **Contacts with government representatives**

- You must work with your internal legal counsel or with Government Relations on issues that involve federal, state and local government. Promptly contact internal legal counsel, Regional Compliance or Government Relations if any part of the government, including a state insurance department, reaches out to you on an unexpected situation or matter. See Statement 6 for additional guidance related to government contracts.
- Only senior managers and those chosen by Aetna for government relations or legal work can formulate and express Aetna's views on legislation, regulations or government action. Other employees may communicate Aetna's views only with specific guidance from Government Relations.
- Only people from Government Relations or the Law Department may hire lobbyists to help Aetna.

### **Your Aetna contacts:**

For employees and officers: your manager, the Communications team, your compliance officer, internal legal counsel or  
Government Relations

For directors: the Corporate Secretary or General Counsel

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## **Statement 10: Intellectual property**

**Intellectual property is valuable to Aetna. You must protect it from improper use or disclosure. This is true whether it is owned by Aetna or licensed from others.**

You must handle all intellectual property that is under your control at Aetna in the right way. This includes all names, patents, logos, trademarks, service marks, registered marks and copyrights. See the Aetna Intellectual Property Guide for more information, and follow these rules to help you protect intellectual property.

### **Aetna's intellectual property**

- Before you use a new service mark or trademark, be sure internal legal counsel approves it. If the mark is approved, follow the guidelines for use in the Aetna Intellectual Property Guide.
- When created by Aetna, put copyright notices on all audiovisuals, Internet materials, computer programs, screen displays and other items meant for outside use or for broad internal use. Internal legal counsel will give you the right form of copyright notice.
- Do not share Aetna's trade secrets. Do not let anyone outside of Aetna use our marks or copyrighted works without getting approval from senior management, and getting a signed confidentiality or license agreement that is approved by internal legal counsel.
- Tell internal legal counsel right away if you know of any unauthorized or improper use or disclosure of an Aetna name, logo, service mark, trademark, trade secret, confidential document, patent or copyright.

### **Intellectual property of others**

- Unless you have written approval from the owner, do not use another party's name, logo, trademark, service mark or copyrighted material.
  - Treat all computer programs, documents and materials the same way you would treat Aetna trade secrets or confidential material. Note that it is illegal to copy computer software or related documentation without the approval of the software product's owner. Making a back-up copy is often permissible under the terms of software product license agreements, but you should check each license agreement for specific permissions. Do not remove copyright notices from software or its documentation.
  - Aetna has a photocopy agreement with the Copyright Clearance Center. This allows us to make copies of many hard copy publications, but only when you use the copies inside Aetna and follow certain conditions. Contact internal legal counsel for approval of photocopying.
  - Do not copy full-length or edited videos. You must get any required written approvals before you put all or part of a movie, newscast or TV show in an Aetna production. Contact internal legal counsel for assistance.
  - You must get approval from the person who owns any Internet material before you can use it in any Aetna material or presentation. This includes music, clip art, text, graphics, logos and other website elements. You must assume that all material on Internet websites is copyright protected even if no copyright symbol (designated by ©) is shown.
  - Aetna has a contracted right to play certain music at company events. See internal legal counsel to see if your use is allowed. Do not combine music with video or computer presentations without getting the written approval that internal legal counsel thinks is needed.
-

**Q: I found an article on the Internet that I want to share with my coworkers. Can I copy and paste it to a document? Can I e-mail it?**

**A:** No. You cannot copy and send the article unless you have written permission from the owner. As an alternative, you can send an e-mail with a link to the page where the article appears.

**Your Aetna contacts:**

For employees and officers: your compliance officer or internal legal counsel

For directors: the Corporate Secretary or General Counsel

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## **Our Ethical Decision-Making Framework**

### **Our working definition of ethics**

At times there may be competing interests and tensions among our various constituencies (members, providers, customers, business partners and employees). Yet, common to all is the desire to build trusting, value-added relationships. Therefore, we must be guided by The Aetna Way in conducting Aetna's business. This means that we:

- Are clear, open, and honest:
  - Make what you know accessible to others
  - Deliver bad news early and personally
  - Raise concerns and problems
- Keep our promises:
  - Hold yourself and others accountable for targets and deadlines
  - Do what you say you will do
  - Take responsibility for correcting your mistakes and do all you can to correct them
- Are fair in our dealings with others:
  - Express differences of opinion with respect for others
  - Assume positive intent
  - Strive for a win-win outcome with customers, clients, employees, colleagues, providers, suppliers
- Uphold our legal obligations:
  - Federal, state and local laws and regulations (for example, market conduct, HIPAA privacy and security)
  - Contractual obligations

When the right course of action is not clear, we use a six-question framework to help guide us to an ethical decision that is in keeping with Aetna's commitment to the highest standards of business conduct and integrity.

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### **Our ethical decision-making framework**

We recognize the complexity and breadth of our business and the importance of protecting Aetna's reputation. When faced with business decisions that have ethical implications, we involve the right people in considering the following questions:<sup>1</sup>

**1. Should I be troubled by this? Is this consistent with Aetna's commitment to integrity?**

- Is it really an issue? Am I genuinely perplexed, or am I afraid to do what is right?

**2. Who will be affected by my decisions? How will they be affected?**

- What other parties may be affected by my decisions? Another department, members, customers, providers? What will be the impact if I act, or decide not to act? Consider the Golden Rule (Treat others as you would like to be treated).

**3. What is my responsibility to act? What will happen if I don't act?**

- Have I caused the problem, or has someone else? How far should I go in resolving the issue? How serious a problem is it? If it is not my problem, will someone else take action if I don't?

**4. What are the ethical considerations?**

- Is it a question of legal obligations, fairness, promise keeping, honesty, doing good, or avoiding harm?

**5. Who needs to be involved in making this decision?**

- Should I consult with my manager, Compliance Officer, internal legal counsel, the HR Contact Center? If I am afraid to raise this issue, should I anonymously call AlertLine@?

**6. Am I being true to myself and The Aetna Way?**

**How would my actions appear to customers or the public?**

- What kind of person or company would do what I am contemplating? Have I made the right decision for the right reason? Would I be proud to share my decision with my family? With coworkers? With regulators or public officials? How would I feel if it were reported on the front page of the newspaper?

<sup>1</sup> Copyright 1990. Michael Rion, all rights reserved. Adapted with permission.

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**Subsidiaries of Aetna Inc.**

Listed below are subsidiaries of Aetna Inc. at December 31, 2009 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below would not, in the aggregate, constitute a “significant subsidiary” of Aetna Inc., as that term is defined in Rule 1-02(w) of Regulation S-X.

- Aetna Health Holdings, LLC (Delaware)
  - o Aetna Health of California Inc. (California)
  - o Aetna Health Inc. (Colorado)
  - o Aetna Health Inc. (Connecticut)
  - o Aetna Health Inc. (Delaware)
  - o Aetna Health Inc. (Florida)
  - o Aetna Health Inc. (Georgia)
  - o Aetna Health Inc. (Maine)
  - o Aetna Health Inc. (Michigan)
  - o Aetna Health Inc. (New Jersey)
  - o Aetna Health Inc. (New York)
  - o Aetna Health Inc. (Washington)
  - o Aetna Health of the Carolinas Inc. (North Carolina)
  - o Aetna Health Inc. (Pennsylvania)
  - o Aetna Health Inc. (Texas)
  - o AET Health Care Plan, Inc. (Texas)
  - o Aetna Family Plans of Georgia Inc. (Georgia)
  - o Aetna Dental of California Inc. (California)
  - o Aetna Dental Inc. (New Jersey)
  - o Aetna Dental Inc. (Texas)
  - o Aetna Rx Home Delivery, LLC (Delaware)
  - o Aetna Health Management, LLC (Delaware)
  - o Aetna Ireland, LLC (Delaware)
  - o Chickering Claims Administrators, Inc. (Massachusetts)
  - o Aetna Specialty Pharmacy, LLC (Delaware)
  - o AET Health Care Plan of California, Inc. (California)
  - o Cofinity, Inc. (Delaware)
  - o @Credentials Inc. (Delaware)
  - o Strategic Resource Company (South Carolina)
  - o Aetna Better Health Inc. (Pennsylvania)
  - o Aetna Better Health Inc. (Connecticut)
  - o Aetna Student Health Agency Inc. (Massachusetts)
  - o Delaware Physicians Care, Incorporated (Delaware)
  - o Missouri Care, Incorporated (Missouri)
  - o SABH of Arizona, Incorporated (Arizona)
  - o Schaller Anderson Medical Administrators, Incorporated (Delaware)
  - o Schaller Anderson of Arizona, L.L.C. (Arizona)
- Aetna Life Insurance Company (Connecticut)
  - o AHP Holdings, Inc. (Connecticut)
    - Aetna Insurance Company of Connecticut (Connecticut)
    - AE Fourteen, Incorporated (Connecticut)
    - Aetna Life Assignment Company (Connecticut)
    - Aetna /Area Corporation (Connecticut)
  - o PE Holdings, LLC (Connecticut)
  - o Tanker Six, LLC (Delaware)
  - o Azalea Mall, L.L.C. (Delaware)
  - o BPC Equity, Inc. (Delaware)
  - o Canal Place, LLC (Delaware)
  - o Aetna Ventures, LLC (Delaware)

- o Aetna Government Health Plans, LLC (Delaware)
  - o Broadspire National Services, Inc. (Florida)
- Aetna Financial Holdings, LLC (Delaware)
  - o Aetna Behavioral Health of Delaware, LLC (Delaware)
  - o Aetna Asset Advisors, LLC (Delaware)
  - o U.S. Healthcare Properties, Inc. (Pennsylvania)
  - o Aetna Capital Management, LLC (Delaware)
    - Aetna Partners Diversified Fund, LLC (Delaware)
    - Aetna Partners Diversified Fund (Cayman), Limited (Cayman)
  - o Aetna Workers' Comp Access, LLC (Delaware)
  - o Aetna Behavioral Health, LLC (Delaware)
  - o Managed Care Coordinators, Inc. (Delaware)
  - o Aetna Integrated Informatics, Inc. (Pennsylvania)
  - o Horizon Behavioral Services, LLC
    - Employee Assistance Services, LLC (KY)
    - Health and Human Resource Center, Inc. (CA)
    - Resources for Living, LLC (TX)
    - The Vasquez Group Inc. (IL)
    - Work and Family Benefits, Inc. (NJ)
- Aetna Health and Life Insurance Company (Connecticut)
- Aetna Health Insurance Company (Pennsylvania)
- Aetna Health Insurance Company of New York (New York)
- Aetna Risk Indemnity Company Limited (Bermuda)
- Aetna International Inc. (Connecticut)
  - o Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
  - o Aetna Global Benefits (UK) Limited (England & Wales)
  - o Aetna Health Services (UK) Limited (England & Wales)
  - o Aetna Global Benefits (Bermuda) Limited (Bermuda)
    - Goodhealth Worldwide (Global) Limited (Bermuda)
    - Aetna Global Benefits (Europe) Limited (England & Wales)
    - Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
    - Goodhealth Worldwide (Asia) Limited (Hong Kong)
    - GWL (UK) Limited (England & Wales)
    - Aetna Global Benefits Limited (DIFC, UAE)
    - Aetna Health Services (Middle East) FZ-LLC (DOZ-UAE)
  - o Aetna Health Insurance Company of Europe Limited (Ireland)
  - o Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
  - o Aetna Global Benefits Administrators Inc. (Florida)
- AUSHC Holdings, Inc. (Connecticut)
  - o PHPSNE Parent Corporation (Delaware)
- Active Health Management, Inc. (Delaware)
  - o Health Data & Management Solutions, Inc. (Delaware)
  - o AGV Aktive Gesundheitsversorgung GmbH (Germany)
- Health Re, Incorporated (Vermont)
- ASI Wings, L.L.C. (Delaware)
- Luettgens Limited (Connecticut)



**Consent of Independent Registered Public Accounting Firm**

The Board of Directors  
Aetna Inc.:

We consent to the incorporation by reference in the registration statement (No. 333-155961) on Form S-3 and the registration statements (No. 333-52124, 52122, 52120, 73052, 87722, 87726, 124619, 124620, 136176, 136177) on Form S-8 of Aetna Inc. of our reports dated February 26, 2010 with respect to the consolidated balance sheets of Aetna Inc. and subsidiaries (the “Company”) as of December 31, 2009 and 2008 and the related consolidated statements of income, shareholders’ equity and cash flows for each of the years in the three-year period ended December 31, 2009 and the related financial statement schedule, and the effectiveness of internal control over financial reporting as of December 31, 2009, which reports appear in the December 31, 2009 Annual Report on Form 10-K of Aetna Inc.

Our report with respect to the consolidated financial statements, the related financial statement schedule, and the effectiveness of internal control over financial reporting refers to change in accounting for other-than-temporary impairments of debt securities.

**/s/ KPMG LLP**

Hartford, Connecticut  
February 26, 2010

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**Power of Attorney**

We, the undersigned Directors of Aetna Inc. (the "Company"), hereby severally constitute and appoint Joseph M. Zubretsky and Rajan Parmeswar and both of them individually, our true and lawful attorneys-in-fact, with full power to them and each of them to sign for us, and in our names and in the capacities indicated below, the Company's 2009 Annual Report on Form 10-K and any and all amendments thereto to be filed with the Securities and Exchange Commission under the Securities Exchange Act of 1934, hereby ratifying and confirming our signatures as they may be signed by any of our said attorneys to such Form 10-K and to any and all amendments thereto.

This Power of Attorney shall not revoke any powers of attorney previously executed by the undersigned. This Power of Attorney shall not be revoked by any subsequent power of attorney that the undersigned may execute, unless such subsequent power of attorney specifically provides that it revokes this Power of Attorney by referring to the date of the undersigned's execution of this Power of Attorney. For the avoidance of doubt, whenever two or more powers of attorney granting the powers specified herein are valid, the agents appointed on each shall act separately unless otherwise specified.

NOTE: Individuals executing this document in the State of New York should note the New York statutory disclosures included below and have a notary public complete the acknowledgements following.

Dated: February 26, 2010

/s/ Frank M. Clark  
 Frank M. Clark  
 Chicago, IL

/s/ Earl G. Graves  
 Earl G. Graves  
 New York, NY

/s/ Betsy Z. Cohen  
 Betsy Z. Cohen  
 New York, NY

/s/ Gerald Greenwald  
 Gerald Greenwald  
 New York, NY

/s/ Molly J. Coye, M.D.  
 Molly J. Coye, M.D.  
 New York, NY

/s/ Ellen M. Hancock  
 Ellen M. Hancock  
 New York, NY

/s/ Roger N. Farah  
 Roger N. Farah  
 New York, NY

/s/ Richard J. Harrington  
 Richard J. Harrington  
 New York, NY

/s/ Barbara Hackman Franklin  
 Barbara H. Franklin  
 New York, NY

/s/ Edward J. Ludwig  
 Edward J. Ludwig  
 New York, NY

/s/ Jeffrey E. Garten  
 Jeffrey E. Garten  
 New York, NY

/s/ Joseph P. Newhouse  
 Joseph P. Newhouse  
 New York, NY

## **STATUTORY DISCLOSURES AND ACKNOWLEDGEMENTS FOR INDIVIDUALS EXECUTING POWERS OF ATTORNEY IN THE STATE OF NEW YORK**

The statutory disclosures entitled “CAUTION TO THE PRINCIPAL” and “IMPORTANT INFORMATION FOR THE AGENT” are included below solely for the purpose of ensuring compliance with Section 5-1501B of the New York General Obligations Law governing the execution of a power of attorney by an individual, if applicable, and, except for ensuring the validity of this power of attorney, shall not form part of, or in any way affect the interpretation of, this Power of Attorney or the Form 10-K. For the sake of clarity, notwithstanding anything to the contrary herein, this Power of Attorney DOES NOT grant the attorneys-in-fact authority to spend the principal’s money or sell or dispose of the principal’s property during the principal’s lifetime.

**CAUTION TO THE PRINCIPAL:** Your Power of Attorney is an important document. As the “principal,” you give the person whom you choose (your “agent”) authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. “Important Information for the Agent” at the end of this document describes your agent’s responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney by executing this Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a “Health Care Proxy” to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, [www.senate.state.ny.us](http://www.senate.state.ny.us) or [www.assembly.state.ny.us](http://www.assembly.state.ny.us).

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

### **IMPORTANT INFORMATION FOR THE AGENT:**

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

- (1) act according to any instructions from the principal, or, where there are no instructions, in the principal’s best interest;
- (2) avoid conflicts that would impair your ability to act in the principal’s best interest;
- (3) keep the principal’s property separate and distinct from any assets you own or control, unless otherwise permitted by law;
- (4) keep a record of all receipts, payments, and transactions conducted for the principal; and
- (5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal’s name and signing your own name as “agent” in either of the following manner: (Principal’s Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal’s Name).

You may not use the principal’s assets to benefit yourself or give major gifts to yourself or anyone else unless the principal has specifically granted you that authority in this Power of Attorney or in a Statutory Major Gifts Rider attached to this Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal’s best interest. You may resign by giving



**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Roger N. Farah, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*Notary Public* (Signature of

**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Barbara Hackman Franklin, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her capacity, and that by her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*Notary Public* (Signature of



**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Jeffrey E. Garten, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*(Signature of  
Notary Public)*

**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Earl G. Graves, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*(Signature of  
Notary Public)*



**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Gerald Greenwald, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*(Signature of  
Notary Public)*

**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Ellen M. Hancock, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her capacity, and that by her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*(Signature of  
Notary Public)*



**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Richard J. Harrington, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*(Signature of  
Notary Public)*

**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Edward J. Ludwig, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*(Signature of  
Notary Public)*

**ACKNOWLEDGMENT OF PRINCIPAL:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared, Joseph P. Newhouse, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lynch /s/ Melany A.

*(Signature of  
Notary Public)*

**Acceptance of Authority Granted by Individuals Executing Powers of Attorney in New York**

The undersigned does hereby accept its appointment as attorney-in-fact by each of the individuals who executed the within instrument in the State of New York.

/s/ Joseph M. Zubretsky  
Joseph M. Zubretsky  
Executive Vice President and  
Chief Financial Officer, Aetna Inc.

**Date:** February 26, 2010

The undersigned does hereby accept its appointment as attorney-in-fact by each of the individuals who executed the within instrument in the State of New York.

/s/ Rajan Parmeswar  
Rajan Parmeswar  
Vice President, Controller and  
Chief Accounting Officer, Aetna Inc.

**Date:** February 26, 2010

---

**ACKNOWLEDGMENT OF AGENT:**

STATE OF NEW YORK  
YORK

COUNTY OF NEW

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared Joseph M. Zubretsky, Executive Vice President and Chief Financial Officer of Aetna Inc., personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument for the purposes therein contained.

Lynch /s/ Melany A.

*(Signature of  
Notary Public)*

**ACKNOWLEDGMENT OF AGENT:**

STATE OF CONNECTICUT  
HARTFORD

COUNTY OF

ss.:

On the 26th day of February in the year 2010 before me, the undersigned, a Notary Public in and for said State, personally appeared Rajan Parmeswar, Vice President, Contoller and Chief Accounting Officer of Aetna Inc., personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument for the purposes therein contained.

MacInnis /s/ Allison S.

*(Signature of  
Notary Public)*



---

**Certification**

I, Ronald A. Williams, certify that:

1. I have reviewed this annual report on Form 10-K of Aetna Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
  - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 26, 2010

/s/ Ronald A. Williams

Ronald A. Williams  
Chairman and Chief Executive Officer

---



**Certification**

I, Joseph M. Zubretsky, certify that:

1. I have reviewed this annual report on Form 10-K of Aetna Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
  - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 26, 2010

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Executive Vice President and Chief Financial Officer

---



**Certification**

The certification set forth below is being submitted to the Securities and Exchange Commission in connection with the Annual Report on Form 10-K of Aetna Inc. for the period ended December 31, 2009 (the "Report") solely for the purpose of complying with Rule 13a-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Ronald A. Williams, Chairman and Chief Executive Officer of Aetna Inc., certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Aetna Inc.

Date: February 26, 2010

/s/ Ronald A. Williams

Ronald A. Williams  
Chairman and Chief Executive Officer

**Certification**

The certification set forth below is being submitted to the Securities and Exchange Commission in connection with the Annual Report on Form 10-K of Aetna Inc. for the period ended December 31, 2009 (the "Report") solely for the purpose of complying with Rule 13a-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Joseph M. Zubretsky, Executive Vice President and Chief Financial Officer of Aetna Inc., certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Aetna Inc.

Date: February 26, 2010

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Executive Vice President and Chief Financial Officer

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# AETNA INC /PA/ (AET)

## 10-K

Annual report pursuant to section 13 and 15(d)

Filed on 02/25/2011

Filed Period 12/31/2010



THOMSON REUTERS

Westlaw<sup>®</sup> BUSINESS

UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549

FORM 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2010

or

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from \_\_\_\_\_ to \_\_\_\_\_

Commission file number 1-16095

**Aetna Inc.**

(Exact name of registrant as specified in its charter)

**Pennsylvania**

(State or other jurisdiction of incorporation or organization)

**23-2229683**

(I.R.S. Employer Identification No.)

**151 Farmington Avenue, Hartford, CT**

(Address of principal executive offices)

**06156**

(Zip Code)

Registrant's telephone number, including area code

**(860) 273-0123**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class

**Common Shares, \$.01 par value**

Name of each exchange on which registered

**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:

**None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.  Yes  No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.  Yes  No

Indicate by check mark 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.  Yes  No

Indicate by check mark 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 (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).  Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) 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.

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

Large accelerated filer  Accelerated filer  Non-accelerated filer  Smaller reporting company

(Do not check if smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act)  Yes  No

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2010) was \$10.7 billion.

There were 384.5 million shares of the registrant's voting common stock with a par value of \$.01 per share outstanding at January 31, 2011.

**DOCUMENTS INCORPORATED BY REFERENCE**

The 2010 Annual Report, Financial Report to Shareholders (the "Annual Report") is incorporated by reference in Parts I, II and IV to the extent described therein. The definitive proxy statement related to Aetna Inc.'s 2011 Annual Meeting of Shareholders, to be filed on or about April 11, 2011 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

**Aetna Inc.**  
**Annual Report on Form 10-K**  
**For the Year Ended December 31, 2010**

*Unless the context otherwise requires, references to the terms “we,” “our” or “us” used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) (“Aetna”) and its subsidiaries (collectively, the “Company”).*

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## Part I

### Item 1. Business

**We are one of the nation's leading diversified health care benefits companies**, serving approximately 35.3 million people with information and resources to help them make better informed decisions about their health care. We offer a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and Medicaid health care management services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

We are strategically positioned for future success with the goal of participating in the shaping of more effective health care systems by empowering people to live healthier lives. Our operational, financial and strategically-important accomplishments in the last year include:

- Our long-term pharmacy benefit management subcontract with CVS Caremark Corporation ("CVS Caremark"), which commenced operations on January 1, 2011,
- The acquisition of Medicity Inc. ("Medicity"), a leading health information exchange company to bolster our health care information technology strategy in January 2011,
- The expansion of our Medicaid footprint by launching operations in Florida and expanding within Pennsylvania, and winning a fully-insured Aged Blind and Disabled contract in Illinois,
- The win by our ActiveHealth Management business of a contract to cover approximately 500,000 state employees and their beneficiaries in North Carolina, which includes facilitating the roll-out of a Patient Centered Medical Home model of care statewide,
- Achieving our short-term goal of a high single digit pretax operating margin, and
- Issuing \$750 million of debt, generating approximately \$1.4 billion of cash flow from operations, and launching the industry's first collateralized reinsurance transaction that was financed by health insurance linked debt securities.

We believe these achievements strategically position us for future success with the goal of participating in the shaping of more effective health care systems.

**The health care benefits industry continues to experience significant change.** In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, "Health Care Reform") was enacted legislating broad-based changes to the U.S. health care benefit system. The political environment remains uncertain, and there are pending efforts to repeal, and/or decline to fund implementation of various aspects of Health Care Reform and pending legal challenges to the constitutionality of Health Care Reform. For additional information on federal and state health care reform, refer to the "Overview," "Regulatory Environment" and "Forward-Looking Information/Risk Factors" sections of the Management's Discussion and Analysis of Financial Condition and Results of Operations (the "MD&A"), beginning on pages 2, 23 and 35 of the Annual Report, respectively, which are incorporated herein by reference.

In addition, employers, consumers and the federal and state governments continue to increase their focus on health care costs and providing health insurance to the uninsured; and they continue to drive changes in the structure of health insurance and related benefits products and services. Product features continue to evolve that are directed at containing rising health care costs, addressing affordability problems, enhancing access to quality health care services and giving members greater control and responsibility in directing their benefit dollars. For employer-based health coverage, employers are continuing to require covered employee members to assume a greater portion of the cost of their health care and/or coverage. These economic factors and greater consumer awareness are leading to increased popularity of products that offer flexibility in design features such as deductibles and co-payments, health savings accounts, consumer access to a broader network of health care providers and quality-based physician networks. The industry is also subject to other forces including adverse economic conditions in the U.S. and abroad, federal and state legislative and regulatory reforms, advances in pharmaceutical and medical technology and industry consolidation. All of these factors can affect the competitiveness of product and service

offerings, the range of industry competitors and the bases of competition. We believe that these factors will exist for some time and will drive a continuing evolution in the health care benefits industry.

**We continue to invest in our company through the development of new products, strategic acquisitions and new business alliances.** We place significant emphasis on developing and maintaining our product and service offerings to serve existing and new customer markets and have done so through organic growth, acquisitions and new business alliances.

Over the last five years, this focus has led to the introduction of new products, such as *Aetna One*<sup>®</sup>, our suite of integrated products such as disease management and prevention, wellness and health promotion, and health, disability and absence assessments designed to help improve member health and productivity and lower medical and other benefit cost trend over time; our Personal Health Record, which provides members with online access to personal information to help them make better informed decisions about their health care; Aetna Health Connection<sup>SM</sup>, our integrated disease management program and Aetna Vision Preferred<sup>SM</sup>, which will provide members with access to one of the largest vision networks in the U.S. starting in 2011. We also continue to develop and enhance our existing products, such as our Aexcel<sup>SM</sup> physician networks, which are comprised of specialist providers who have demonstrated effectiveness in the delivery of care based on measures of clinical performance and efficiency. We are also continuing to expand our initiative to improve the transparency of our products and pricing by utilizing our Aetna Navigator online tool to give our members access to physician-specific cost, clinical quality and efficiency information.

During 2010 and 2009, we acquired companies that support our strategy. In December 2010, we entered into an agreement to acquire Medicity. We completed this acquisition in January 2011. A leading innovator in provider solutions, Medicity offers a broad range of products and services that enable health systems, hospitals, physician practices and health information exchanges to securely access and exchange health care information, improving the quality and efficiency of patient care and reducing unnecessary health care costs. Additionally, in 2009, we acquired Horizon Behavioral Services, LLC (“Horizon”), a leading provider of employee assistance programs to mid-sized and large employers. More details on these acquisitions are included in Note 3 of Notes to Consolidated Financial Statements on page 64 of the Annual Report, which is incorporated herein by reference.

In July 2010, we entered into a Pharmacy Benefit Management Subcontract Agreement (the “PBM Agreement”) with CVS Caremark that we believe will further enhance value and service for our customers and members. CVS Caremark began providing services under the PBM Agreement on January 1, 2011. Under the PBM Agreement, we continue to maintain and manage our pharmacy benefit management (“PBM”) organization and retain and operate our mail order and specialty pharmacies. CVS Caremark provides the administration of selected functions for our retail pharmacy network contracting and claims administration; mail order pharmacy and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. We expect the PBM Agreement to allow us to preserve and enhance our integrated value proposition, integrate medical, clinical and pharmacy programs and data to improve quality of care while lowering costs, and enhance the affordability of our Health Care products through improved retail, mail order and specialty pharmacy drug pricing. Additional information on the PBM Agreement is included in the Overview section of the MD&A, on page 2 of the Annual Report.

**Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions.** We derive our revenues primarily from insurance premiums, administrative service fees, net investment income and other revenue. Refer to the MD&A and Note 19 of Notes to Consolidated Financial Statements beginning on pages 2 and 95, respectively, of the Annual Report, which are incorporated herein by reference, regarding revenue, profit and total asset information for each of our business segments and revenue and asset information about geographic areas. The following is a description of each of our business segments.

## **Health Care**

### **Products and Services**

Health Care products consist of medical, pharmacy benefits management, dental, behavioral health and vision plans offered on both an insured basis and an employer-funded, or administrative, basis. Medical products include point of service (“POS”), preferred provider organization (“PPO”), health maintenance organization (“HMO”) and indemnity benefit (“Indemnity”) plans. Medical products also include health savings accounts (“HSAs”) and Aetna HealthFund®, consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account. We also offer Medicare and Medicaid products and services, as well as specialty products, such as medical management and data analytics services, medical stop loss insurance and products that provide access to our provider networks in select markets. We refer to insurance products as “Insured” and administrative products as “ASC.”

Our principal products and services are targeted specifically to large multi-site national, mid-sized and small employers. We also serve individual insureds, expatriates and, in certain markets, Medicare and Medicaid beneficiaries. Medicare and Medicaid products and services are categorized separately from the Health Care products and services we sell to employers, other groups and individuals, which we refer to as Commercial.

The primary Commercial products we offer are POS, PPO, HMO and Indemnity plans. We also offer other Commercial products and services including:

#### *ActiveHealth Management*

Through the use of our patented CareEngine® system, our ActiveHealth Management business provides evidence-based medical management and data analytics products and services to a broad range of customers, including health plans, employers and others. In 2010, ActiveHealth Management won a contract to cover approximately 500,000 state employees and their beneficiaries in North Carolina, which includes facilitating the roll-out of a Patient Centered Medical Home model of care statewide.

#### *Behavioral Health*

Our behavioral health products provide members who experience mental health illness with integrated behavioral health benefit administration, access to a network of providers and innovative wellness programs. On November 1, 2009, we acquired Horizon. Horizon provides customized behavioral health solutions to employees in all 50 states.

#### *Personal Health Record*

Our Personal Health Record provides members with online access to personal information, including individual personalized messages and alerts, detailed health history based on available claims data and voluntarily submitted information, and integrated information and resources to help members make informed decisions about their health care.

#### *Pharmacy*

We offer pharmacy benefit management and specialty and mail order pharmacy services to our members. Our pharmacy fulfillment services are delivered by Aetna Specialty Pharmacy (“ASP”) and Aetna Rx Home Delivery®. ASP compounds and dispenses specialty medications and offers certain support services associated with specialty medications. Specialty medications are generally injectable or infused medications that may not be readily available at local pharmacies. Aetna Rx Home Delivery® provides mail order prescription drug services. Beginning on January 1, 2011, CVS Caremark began to perform the administration of selected functions for our retail pharmacy network contracting and claims administration; mail order and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services for us. Additional information on this arrangement is included in the “Overview” section of the MD&A, on page 2 of the Annual Report.

#### *Dental*

We offer managed dental plans on an Insured and ASC basis. We are one of the nation’s largest providers of dental coverage, based on membership at December 31, 2010.

*Provider Network Rental (“Cofinity”)*

Through our Cofinity products, we provide access to a regional health care provider network to other insurance companies, third party administrators, health plans and employers. It has operations in Michigan, Colorado and other states.

*Stop Loss*

We offer medical stop loss insurance coverage for certain employers. Under this product, we assume the costs associated with large individual claims and/or aggregate loss experience within the employer’s plan above a pre-set annual threshold.

*Aetna Visions<sup>SM</sup>Preferred*

Effective January 1, 2011, we offer vision benefits that provide members with access to one of the largest vision networks in the U.S. The vision program can be customized with a wide range of benefit levels and copayments. We are collaborating with EyeMed Vision Care LLC, a national vision benefits company, to offer this product to our customers.

*Other Commercial Products and Services*

We offer a variety of other health care coverage products either as supplements to health products or as stand-alone products, such as indemnity programs, which may be offered on an Insured or an ASC basis. We also offer, directly or in cooperation with third parties, our Aetna Health Connections<sup>SM</sup> disease management program which addresses over 35 chronic conditions, including asthma, diabetes, congestive heart failure and lower back pain.

We also offer comprehensive health care benefits and health management solutions worldwide through several different arrangements and offerings that include medical, dental, vision, life, disability and emergency assistance to expatriates, foreign nationals and other constituents. Our health management business collaborates with health care systems, government entities and plan sponsors around the world to design and build locally-applied health management solutions to improve health, quality and cost outcomes.

The recent acquisition of Medicity allows us to further the adoption of electronic health records and contribute to initiatives that foster administrative simplicity in health care, a key issue for consumers, patients and providers. Using Medicity in concert with ActiveHealth Management’s clinical decision support tools, we are developing a suite of solutions designed to facilitate delivery system reforms.

In addition to Commercial health products, in select markets we also offer HMO, PPO, private fee-for-service (“PFFS”) Medicare plans and prescription drug coverage for Medicare beneficiaries and participate in Medicaid and subsidized State Children’s Health Insurance Programs (“SCHIP”). SCHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. Our Medicare and Medicaid products include:

*Medicare*

Through annual contracts with the Centers for Medicare & Medicaid Services (“CMS”), we offer HMO, PPO and PFFS plans for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over standard Medicare fee-for-service coverage, including reduced cost-sharing for preventive care, vision and other services. We offered network-based HMO and/or PPO plans in 237 counties in 22 states and Washington, D.C. in 2010; and are expanding to 374 counties in 33 states and Washington, D.C. in 2011. In 2010, we offered non-network PFFS plans nationally for employer groups and in selected markets for individuals. As a result of changes in the PFFS requirements that became effective in 2011, we ceased offering our remaining PFFS products in 2011.

We are a national provider of the Medicare Part D Prescription Drug Program (“PDP”) in all 50 states and Washington, D.C. to both individuals and employer groups. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or copayment.

For certain qualifying employer groups, we offer our Medicare PPO products nationally. When combined with our PDP product, these national PPO plans form an integrated national fully-insured Medicare product for employers that provides medical and pharmacy benefits.

#### *Medicaid and SCHIP*

We offer health care management services to individuals eligible for Medicaid and SCHIP under multi-year contracts which are subject to annual appropriations. We offered these services on an Insured or ASC basis in nine states and targeted medical management services in five states in 2010, and expanded our offerings in Florida and within Pennsylvania. We were also awarded a new Aged Blind and Disabled contract in Illinois that is expected to commence during 2011.

#### *Provider Networks*

We contract with physicians, hospitals and other health care providers for services to our customers. The health care providers who participate in our networks are independent contractors and are neither our employees nor our agents, except for providers who work in our mail-order and specialty pharmacy facilities.

We use a variety of techniques designed to help encourage appropriate utilization of health care resources and maintain affordability of quality coverage. In addition to contracts with health care providers for negotiated rates of reimbursement, these techniques include the development and implementation of guidelines for the appropriate utilization of health care resources and the provision of data to providers to enable them to improve health care quality.

At December 31, 2010, we had an extensive nationwide provider network with approximately one million participating health care providers, including over 561,000 primary care and specialist physicians and over 5,000 hospitals.

#### *Primary Care Physicians*

We compensate primary care physicians (“PCPs”) participating in our networks on both a fee-for-service and capitated basis, with capitation generally limited to HMO products in certain geographic areas and representing approximately five percent of health care costs in each of the last three years. In a fee-for-service arrangement, physicians are paid for health care services provided to the member based upon a set fee for the services provided. Under a capitation arrangement, physicians receive a monthly fixed fee for each member, regardless of the health care services provided to the member.

#### *Specialist Physicians*

Specialist physicians participating in our networks are generally reimbursed at contracted rates per visit or per procedure.

#### *Hospitals*

We typically enter into contracts with hospitals that provide for per-day and/or per-case rates, often with fixed rates for ambulatory, surgery and emergency room services. We also have hospital contracts that provide for reimbursement based on a percentage of the charges billed by the hospital.

Our medical plans generally require notification of elective hospital admissions, and we monitor the length of hospital stays. Physicians who participate in our networks generally admit their patients in network-based products to participating hospitals using referral procedures that direct the hospital to contact our patient management unit in order to confirm the patient’s membership status and facilitate the patient management process. This unit also assists members and providers with related activities, including, if necessary, the subsequent transition to the home environment and home care. Case management assistance for complex cases is provided by a special case unit.

#### *Other Providers*

Laboratory, imaging, urgent care and other freestanding health facility providers are generally paid under fee-for-service arrangements, except for certain laboratory services.

### Quality Assessment

We seek Health Plan accreditation for our HMO plans from the National Committee for Quality Assurance (the “NCQA”), a national organization established to review the quality and medical management systems of health care plans. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance. At December 31, 2010, all of our Commercial HMO members participated in HMOs that had received accreditation by the NCQA.

Aetna Life Insurance Company (“ALIC”), a wholly-owned subsidiary of Aetna, has received nationwide NCQA PPO Health Plan accreditation, through December 20, 2013.

We also seek accreditation and certification for other products from NCQA and URAC, another national organization founded to establish standards for the health care industry. Purchasers and consumers look to URAC’s and NCQA’s accreditation and certification as an indication that a health care organization has the necessary structures and processes to promote high-quality care and preserve patient rights. In addition, regulators in over 74% of the states recognize NCQA’s accreditation and certification standards.

Our provider selection and credentialing/recredentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal requirements. In addition, we are certified under the NCQA Credentials Verification Organization (“CVO”) certification program for all certification options through January 27, 2013. Our URAC CVO accreditation is valid through October 1, 2012.

Our quality assessment programs for contracted providers who participate in our networks begin with the initial review of health care practitioners. Practitioners’ licenses and education are verified, and their work history is collected by us or in some cases by the practitioner’s affiliated group or organization. We generally require participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

We also offer quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

### Principal Markets and Sales

Our medical membership is dispersed throughout the U.S., and we serve a limited number of members in certain countries outside the U.S. Refer to Note 19 of Notes to Consolidated Financial Statements, beginning on page 95 of the Annual Report, which is incorporated herein by reference, for additional information on our foreign customers. We offer a broad range of traditional and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, we market to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by geographic region and funding arrangement at December 31, 2010, 2009 and 2008:

(Thousands)	2010			2009			2008		
	Insured	ASC	Total	Insured	ASC	Total	Insured	ASC	Total
Northeast	1,839	2,709	4,548	1,952	2,669	4,621	1,870	2,511	4,381
Southeast	1,125	2,902	4,027	1,302	2,826	4,128	1,300	2,611	3,911
Mid-America	1,306	4,522	5,828	1,426	4,423	5,849	1,412	3,965	5,377
West	1,286	2,356	3,642	1,391	2,521	3,912	1,328	2,311	3,639
Other	285	138	423	286	118	404	258	135	393
Total medical membership	5,841	12,627	18,468	6,357	12,557	18,914	6,168	11,533	17,701

Additional information on Health Care’s membership is included in the “Membership” section of the MD&A, on page 9 of the Annual Report, which is incorporated herein by reference.

We market both Insured and ASC products and services primarily to employers that sponsor our products (also called “plan sponsors”) for the benefit of their employees and their employees’ dependents. Frequently, larger

employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly. We also sell Insured plans directly to individual consumers in a number of states.

We offer Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and SCHIP members are enrolled on an individual basis.

Health Care products are sold through our sales personnel, as well as through independent brokers, agents and consultants who assist in the production and servicing of business. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, we may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. In certain cases, our customer pays the broker for services rendered, and we may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. We support our marketing and sales efforts with an advertising program that may include television, radio, billboards and print media, supplemented by market research and direct marketing efforts.

#### Pricing

For Commercial Insured plans, employer group contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. We use prospective rating methodologies in determining the premium rates charged to the majority of employer groups, and we also use retrospective rating methodologies for a limited number of groups. Premium rates for customers with more than approximately 125 employees generally take into consideration the individual plan sponsor's historical and anticipated claim experience where permitted by law. Some states may prohibit the use of one or more of these rating methods for some customers, such as small employer groups, or all customers.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We typically cannot recover unanticipated increases in health care costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Our future results could be adversely affected if the premium rates we request are not approved, are adjusted downward or are delayed by state or federal regulators.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, in certain instances, we may recover the resulting deficit through contractual provisions or consider the deficit in setting future premium levels. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating may be used for Commercial Insured plans that cover more than approximately 300 lives.

We have Medicare Advantage and PDP contracts with CMS to provide HMO, PPO, PFFS and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays us a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. Our PDP contracts also provide a risk-sharing arrangement with CMS to limit our exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to us under the Medicare arrangements are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Premiums paid to us for Medicare products are subject to federal government reviews and audits, which can result, and have resulted in retroactive and prospective premium adjustments. In addition to payments received from CMS, most of our Medicare Advantage products and all of our PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental

premiums are adjusted based on the member's income and asset levels. Compared to Commercial products, Medicare contracts generate higher per member per month revenues and health care costs.

Under our Insured Medicaid contracts, state government agencies pay us fixed monthly rates per member that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. We also receive fees from our customers where we provide services under ASC Medicaid contracts. Our ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain guarantees, including financial guarantees, with respect to certain medical, financial and operational metrics. Under these guarantees, we are financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to us by the state involved. Payments to us under each of these Medicaid contracts are subject to the annual appropriation process in the applicable state.

We offer HMO, consumer-directed and dental plans to federal employees under the Federal Employees Health Benefit Program. Premium rates for those plans are subject to federal government review and audit, which can result, and have resulted in retroactive and prospective premium adjustments.

Our ASC plans are generally for a period of one year, but some last up to three years. Some of our ASC contracts include performance guarantees with respect to certain functions such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's claim experience will fall within a specified range. Under these guarantees, we are financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to us by the customer involved.

#### Competition

The health care benefits industry is highly competitive, primarily due to a large number of competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the market. New entrants into the marketplace, as well as significant consolidation within the industry, have contributed to the competitive environment.

We believe that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including both premium and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. We believe that we are competitive on each of these factors. Our ability to increase the number of persons covered by our plans or to increase our revenues is affected by our ability to differentiate ourselves from our competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Our Insured products compete with local and regional health care benefits plans, in addition to health care benefits and other plans sponsored by other large commercial health care benefit insurance companies and Blue Cross/Blue Shield plans. Additional competitors include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management providers), integrated health care delivery organizations, health information technology ("HIT") companies and, for certain plans, programs sponsored by the federal or state governments. Our ability to increase the number of persons enrolled in our Insured product also is affected by the desire and ability of employers to self-fund their health coverage.

Our ASC plans compete primarily with other large commercial health care benefit companies, Blue Cross/Blue Shield plans and third party administrators.

Our international products compete with local, global and U.S.-based health plans and commercial health care benefit insurance companies, many of whom have greater scale, a longer operating history and better brand recognition in one or more geographies.

The HIT product space is evolving rapidly. We compete for HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in HIT. Many of our competitors have a longer operating and research and development history in, and greater financial and other resources devoted to, information technology products.

In addition to competitive pressures affecting our ability to obtain new customers or retain existing customers, our membership has been and may continue to be affected by reductions in workforce by existing customers due to unfavorable general economic conditions, especially in the U.S. and industries where our membership is concentrated.

#### Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect our Health Care business and our statements concerning future events is included in the "Outlook for 2011" and "Forward-Looking Information/Risk Factors" sections of the MD&A, beginning on pages 5 and 35 of the Annual Report, respectively, which are incorporated herein by reference.

#### Group Insurance

##### Principal Products

Group Insurance products consist primarily of the following:

- *Life Insurance Products* consist principally of group term life insurance, the amounts of which may be fixed or linked to individual employee wage levels. We also offer voluntary spouse and dependent term life insurance, and group universal life and accidental death and dismemberment insurance. We offer life insurance products on an Insured basis.
- *Disability Insurance Products* provide employee income replacement benefits for both short-term and long-term disability. We also offer disability products with additional case management features. Similar to Health Care products, we offer disability benefits on both an Insured and employer-funded basis. We also provide absence management services to employers, including short-term and long-term disability administration and leave management.
- *Long-Term Care Insurance Products* provide benefits to cover the cost of care in private home settings, adult day care, assisted living or nursing facilities. Long-term care benefits were offered primarily on an Insured basis. The product was available on both a service reimbursement and disability basis. We no longer solicit or accept new long-term care customers.

##### Principal Markets and Sales

We offer our Group Insurance products in 49 states as well as Washington, D.C., Guam, Puerto Rico, the U.S. Virgin Islands and Canada. Depending on the product, we market to a range of customers from small employer groups to large, multi-site and/or multi-state employer programs.

We market Group Insurance products and services primarily to employers that sponsor our products for the benefit of their employees and their employees' dependents. Frequently, employers offer employees a choice of benefits, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to us and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Group Insurance products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, we bill the covered individual directly.

Group Insurance products are sold through our sales personnel, as well as through independent brokers, agents and consultants who assist in the production and servicing of business. For large plan sponsors, independent consultants and brokers are frequently involved in employer plan selection decisions and sales. We pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with us. We support our marketing and sales efforts with an advertising program that may include television, radio, billboards and print media, supplemented by market research and direct marketing efforts.

### Pricing

For Insured Group Insurance plans, employer group contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period. We use prospective and retrospective rating methodologies to determine the premium rates charged to employer groups. These are typically offered with rate guarantees that generally range from one to three years.

Under prospective rating, a fixed premium rate is determined at the beginning of the policy period. We cannot recover unanticipated increases in mortality or morbidity costs in the current policy period; however, we may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods.

Under retrospective rating, we determine a premium rate at the beginning of the policy period. After the policy period has ended, the actual claim and cost experience is reviewed. If the actual claim costs and other expenses are less than expected, we may issue a refund to the plan sponsor based on this favorable experience. If the experience is unfavorable, we consider the deficit in setting future premium levels, and in certain instances, we may recover the deficit through contractual provisions such as offsets against refund credits that develop for future policy periods. However, we may not recover the deficit if a plan sponsor elects to terminate coverage. Retrospective rating is most often used for Insured employer-funded plans that cover more than approximately 3,000 lives.

### Competition

For the group insurance industry, we believe that the significant factors that distinguish competing companies are cost, quality of service, financial strength of the insurer, comprehensiveness of coverage, and product array and design. We believe we are reasonably competitive on each of these factors; however, many of our competitors have greater scale, financial and other resources, financial strength and brand recognition and lower expenses. The group life and group disability markets remain highly competitive.

### Reinsurance

We currently have several reinsurance agreements with nonaffiliated insurers that relate to both group life and long-term disability products. Most reinsurance arrangements are established on a case-by-case basis and a subset of our reinsurance agreements cover closed blocks of business and cancelled cases. We also have reinsurance that provides a limited degree of catastrophic risk protection for certain of our life products. We frequently evaluate reinsurance opportunities and refine our reinsurance and risk management strategies on a regular basis.

### Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect our Group Insurance business and our statements concerning future events is included in the "Outlook for 2011" and "Forward-Looking Information/Risk Factors" sections of the MD&A, beginning on pages 5 and 35, respectively, of the Annual Report, which are incorporated herein by reference.

### Large Case Pensions

#### Principal Products

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax-qualified pension plans. Contracts provide non-guaranteed, experience-rated and guaranteed investment options through general and separate account products. Large Case Pensions products that use separate accounts provide contract holders with a vehicle for investments under which the contract holders assume the investment risk. Large Case Pensions earns a management fee on these separate accounts.

In 1993, we discontinued our fully-guaranteed Large Case Pensions products. Information regarding these products is incorporated herein by reference to Note 20 of Notes to Consolidated Financial Statements beginning on page 97 in the Annual Report. We do not actively market Large Case Pensions products, but continue to accept deposits from existing customers and manage the run-off of our existing business.

#### Factors Affecting Forward-Looking Information

Information regarding certain important factors that may materially affect our Large Case Pensions business and our statements concerning future events is included in the “Outlook for 2011” and “Forward-Looking Information/Risk Factors” sections of the MD&A, beginning on pages 5 and 35, respectively, of the Annual Report, which are incorporated herein by reference.

#### Other Matters

##### Access to Reports

Our reports to the U.S. Securities and Exchange Commission (the “SEC”), including our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and any amendments to those reports are available without charge on our website at [www.aetna.com](http://www.aetna.com) as soon as practicable after they are electronically filed with or furnished to the SEC. The information on our website is not incorporated by reference in this Form 10-K. Copies of these reports are also available, without charge, from Aetna’s Investor Relations Department, 151 Farmington Avenue, Hartford, CT 06156.

##### Regulation

Information regarding significant regulations affecting us is included in the “Regulatory Environment” and “Forward-Looking Information/Risk Factors” sections of the MD&A, beginning on pages 23 and 35, respectively, of the Annual Report, which are incorporated herein by reference.

##### Patents and Trademarks

We own the trademarks Aetna®, We Want You To Know®, Medicity® and CareEngine®, together with the corresponding Aetna design logo. The patent on our CareEngine® expires in 2021. We consider our CareEngine® and these trademarks and our other trademarks and trade names important in the operation of our business. However, our business, including that of each of our individual segments, is not dependent on any individual patent, trademark or trade name.

##### Miscellaneous

We had approximately 34,000 employees at December 31, 2010.

The U.S. federal government is a significant customer of both the Health Care segment and the Company. Premiums and fees and other revenue paid by the federal government accounted for approximately 24% of the Health Care segment’s revenue and 22% of our consolidated revenue in 2010. Contracts with CMS for coverage of Medicare-eligible individuals accounted for 79% of our federal government premiums and fees and other revenue, with the balance coming from federal employee-related benefit programs. No other individual customer, in any of our segments, accounted for 10% or more of our consolidated revenues in 2010. Our segments are not dependent upon a single customer or a few customers, the loss of which would have a significant effect on the earnings of a segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on our earnings or the earnings of any of our segments. Refer to Note 19 of Notes to Consolidated Financial Statements, beginning on page 95 of the Annual Report, which is incorporated herein by reference, regarding segment information.

#### Item 1A. Risk Factors

The information contained in the “Forward-Looking Information/Risk Factors” section of the MD&A, which begins on page 35 of the Annual Report, is incorporated herein by reference.

#### Item 1B. Unresolved Staff Comments

None.

## Item 2. Properties

Our principal office is a building complex that is approximately 1.7 million square feet in size and is located at 151 Farmington Avenue, Hartford, Connecticut. Our principal office is used by all of our business segments. We also own or lease other space in the greater Hartford area, Blue Bell, Pennsylvania and various field locations in the U.S. and several foreign countries. Such properties are primarily used by our Health Care segment. We believe our properties are adequate and suitable for our business as presently conducted.

## Item 3. Legal Proceedings

The information contained under "Litigation and Regulatory Proceedings" in Note 18 of Notes to Consolidated Financial Statements, which begins on page 91 of the Annual Report, is incorporated herein by reference.

## Item 4. Removed and Reserved

### EXECUTIVE OFFICERS OF THE REGISTRANT

Aetna's Chairman is elected by Aetna's Board of Directors (our "Board"). All of Aetna's other executive officers listed below are appointed by our Board, generally at its Annual Meeting, and such persons hold office until the next Annual Meeting of our Board or until their successors are elected or appointed. None of these officers has a family relationship with any other executive officer or Director. In addition, there are no arrangements or understandings, other than those with Directors or executive officers acting solely in their capacities as such, pursuant to which these executive officers were appointed.

<u>Name of Executive Officer</u>	<u>Position*</u>	<u>Age *</u>
Ronald A. Williams	Chairman	61
Mark T. Bertolini	Chief Executive Officer and President	54
Joseph M. Zubretsky	Senior Executive Vice President and Chief Financial Officer and Chief Enterprise Risk Officer	54
William J. Casazza	Senior Vice President and General Counsel	55
Margaret M. McCarthy	Executive Vice President, Operations and Technology	57
Lonny Reisman, M.D.	Senior Vice President and Chief Medical Officer	55

\*As of February 25, 2011

### Executive Officers' Business Experience During Past Five Years

**Ronald A. Williams** serves as Aetna's Chairman, having held that position since October 1, 2006. Mr. Williams served as Chief Executive Officer from February 14, 2006 to November 29, 2010, and served as President from May 27, 2002 to July 24, 2007. Mr. Williams will retire from Aetna and our Board in April 2011. Mr. Williams is a director of American Express Company (financial services) and The Boeing Company (leading manufacturer of commercial airplanes) and is a trustee of The Conference Board and the Connecticut Science Center Board. He also serves on the Massachusetts Institute of Technology ("MIT") North American Executive Board. He served as chairman of the Council for Affordable Quality Healthcare from 2007 to 2010, and served as vice chairman of The Business Council from 2008 to 2010.

**Mark T. Bertolini** became Chief Executive Officer on November 29, 2010 and continues to serve as President, having held that position since July 24, 2007. Mr. Bertolini is expected to become Aetna's Chairman upon Mr. Williams' retirement in April 2011. Mr. Bertolini was elected to our Board on November 29, 2010. Prior to becoming President, Mr. Bertolini served as Executive Vice President and Head of Business Operations from May 3, 2006 to July 24, 2007. Before that, Mr. Bertolini served as Executive Vice President, Regional Businesses from February 1, 2006, and as Senior Vice President, Regional Businesses from September 2005 to February 1, 2006.

**Joseph M. Zubretsky** became Senior Executive Vice President and Chief Financial Officer on November 29, 2010, having served as Executive Vice President and Chief Financial Officer since April 20, 2007, and Executive Vice President, Finance since February 28, 2007. Mr. Zubretsky has also served as the Company's Chief Enterprise Risk Officer since April 27, 2007. Prior to joining Aetna, Mr. Zubretsky served as Senior Executive Vice President for Finance, Investments and Corporate Development at UnumProvident Corporation, a position he assumed in March 2005.

**William J. Casazza** became Senior Vice President and General Counsel on September 6, 2005. Mr. Casazza also served as Corporate Secretary from October 2000 to January 27, 2006.

**Margaret M. McCarthy** became Executive Vice President, Operations and Technology on November 29, 2010, having served as Chief Information Officer and Senior Vice President Innovation, Technology and Service Operations since January 1, 2010. She also served as Chief Information Officer and Senior Vice President of Procurement and Real Estate from January 30, 2008 to December 31, 2009. Before that, Ms. McCarthy was Senior Vice President and Chief Information Officer from June 3, 2005 to January 29, 2008.

**Lonny Reisman, M.D.**, became Senior Vice President and Chief Medical Officer on November 12, 2008, having served as Chief Executive Officer and as a director of ActiveHealth Management, Inc. since October, 1998.

## Part II

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

Our common shares ("common stock") are listed on the New York Stock Exchange, where they trade under the symbol AET. As of January 31, 2011, there were 9,062 record holders of our common stock.

On July 30, 2010 and December 3, 2010, our Board authorized two share repurchase programs for the repurchase of up to \$1 billion and \$750 million, respectively, of our common stock. During the three months ended December 31, 2010, we repurchased approximately 20 million shares of our common stock at a cost of approximately \$599 million under these programs. At December 31, 2010, we had remaining authorization to repurchase approximately \$735 million of common stock under the December 3, 2010 authorization.

The following table provides information about our monthly share repurchases, all of which were purchased as part of a publicly-announced program, for the three months ended December 31, 2010:

<b>Issuer Purchases of Equity Securities</b>				
<b>(Millions, except per share amounts)</b>	<b>Total Number of Shares Purchased</b>	<b>Average Price Paid Per Share</b>	<b>Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs</b>	<b>Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs</b>
October 1, 2010 - October 31, 2010	-	\$ -	-	\$ 583.8
November 1, 2010 - November 30, 2010	9.5	30.77	9.5	291.4
December 1, 2010 - December 31, 2010	10.0	30.49	10.0	735.2
<b>Total</b>	<b>19.5</b>	<b>\$ 30.63</b>	<b>19.5</b>	<b>N/A</b>

On February 3, 2011, our Board moves us to a quarterly dividend payment cycle and declared a cash dividend of \$.15 per common share that will be paid on April 29, 2011 to shareholders of record at the close of business on April 14, 2011. Declaration and payment of future dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change. We declared, and subsequently paid, an annual cash dividend in the amount of \$.04 per share of common stock in each of 2010 and 2009. Information regarding restrictions on our present and future ability to pay dividends is included in the "Liquidity and Capital Resources" section of the MD&A and Note 16 of Notes to Consolidated Financial Statements, beginning on pages 15 and 90, respectively, of the Annual Report, which are incorporated herein by reference. Information regarding quarterly common stock prices is incorporated herein by reference to the "Quarterly Data (unaudited)" included on page 102 of the Annual Report.

**Item 6. Selected Financial Data**

The information contained in “Selected Financial Data” on page 52 of the Annual Report is incorporated herein by reference.

**Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations**

The information contained in the MD&A, beginning on page 2 of the Annual Report, is incorporated herein by reference.

**Item 7A. Quantitative and Qualitative Disclosures About Market Risk**

The information contained in the “Risk Management and Market-Sensitive Instruments” section of the MD&A, on page 14 of the Annual Report, is incorporated herein by reference.

**Item 8. Financial Statements and Supplementary Data**

The information contained in Consolidated Financial Statements, Notes to Consolidated Financial Statements, Report of Independent Registered Public Accounting Firm and “Quarterly Data (unaudited)”, beginning on page 53 of the Annual Report, is incorporated herein by reference.

**Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure**

None.

**Item 9A. Controls and Procedures****Disclosure Controls and Procedures**

We maintain disclosure controls and procedures, which are designed to ensure that information that we are required to disclose in the reports we file or submit under the Securities Exchange Act of 1934, as amended (the “Exchange Act”), is recorded, processed, summarized and reported within the time periods specified in the SEC’s rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

An evaluation of the effectiveness of our disclosure controls and procedures as of December 31, 2010 was conducted under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures as of December 31, 2010 were designed to ensure that material information relating to Aetna Inc. and its consolidated subsidiaries would be made known to the Chief Executive Officer and Chief Financial Officer by others within those entities, particularly during the periods when periodic reports under the Exchange Act are being prepared and were effective. Refer to the Certifications by our Chief Executive Officer and Chief Financial Officer filed as Exhibits 31.1 and 31.2 to this Form 10-K.

**Management’s Report on Internal Control Over Financial Reporting**

Management’s Report on Internal Control Over Financial Reporting, on page 100 of the Annual Report, is incorporated herein by reference.

**Report of Independent Registered Public Accounting Firm**

The Report of Independent Registered Public Accounting Firm, on page 101 of the Annual Report, is incorporated herein by reference.

**Changes in Internal Control over Financial Reporting**

There has been no change in our internal control over financial reporting identified in connection with the evaluation of such control that occurred during our fourth fiscal quarter that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

**Item 9B. Other Information**

None.

**Part III****Item 10. Directors, Executive Officers and Corporate Governance**

Information concerning the Executive Officers of Aetna Inc. is included in Part I pursuant to General Instruction G to Form 10-K.

Information concerning our Directors, our Directors' and certain of our executives' compliance with Section 16(a) of the Exchange Act, our Code of Conduct (our written code of ethics) and our audit committee and audit committee financial experts is incorporated herein by reference to the information under the captions "Nominees for Directorships," "Certain Transactions and Relationships," "Section 16(a) Beneficial Ownership Reporting Compliance," "Aetna's Code of Conduct" and "Board and Committee Membership; Committee Descriptions" in the Proxy Statement.

**Item 11. Executive Compensation**

The information under the captions "Compensation Discussion and Analysis," "Director Compensation Philosophy and Elements," "Executive Compensation," "Compensation Committee Interlocks and Insider Participation" and "Report of the Committee on Compensation and Organization" in the Proxy Statement is incorporated herein by reference.

**Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters**

The information under the caption "Security Ownership of Certain Beneficial Owners, Directors, Nominees and Executive Officers" and "Equity Compensation Plans" in the Proxy Statement is incorporated herein by reference.

**Item 13. Certain Relationships and Related Transactions, and Director Independence**

The information under the captions "Director Independence" and "Related Party Transaction Policy" in the Proxy Statement is incorporated herein by reference.

**Item 14. Principal Accounting Fees and Services**

The information under the captions "Fees Incurred for 2010 and 2009 Services Performed by the Independent Registered Public Accounting Firm" and "Nonaudit Services and Other Relationships Between the Company and the Independent Registered Public Accounting Firm" in the Proxy Statement is incorporated herein by reference.

## Part IV

### Item 15. Exhibits, Financial Statement Schedules

The following documents are filed as part of this Form 10-K:

#### *Financial statements*

The “Consolidated Financial Statements, Notes to Consolidated Financial Statements and Report of Independent Registered Public Accounting Firm, which begin on pages 53, 57 and 101, respectively, of the Annual Report, are incorporated herein by reference.

#### *Financial statement schedule*

The “Condensed Financial Information of Aetna Inc. (Parent Company Only)” is included in this Item 15. Refer to Index to Financial Statement Schedules on page 20.

#### *Exhibits\**

Exhibits to this Form 10-K are as follows:

#### **3 Articles of Incorporation and By-Laws**

- 3.1 Amended and Restated Articles of Incorporation of Aetna Inc., incorporated herein by reference to Exhibit 99.1 to Aetna Inc.’s Form 8-K filed on May 2, 2007.
- 3.2 Amended and Restated By-Laws of Aetna Inc., incorporated herein by reference to Exhibit 99.2 to Aetna Inc.’s Form 8-K filed on May 2, 2007.

#### **4 Instruments defining the rights of security holders, including indentures**

- 4.1 Form of Aetna Inc. Common Share certificate, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.’s Amendment No. 2 to Registration Statement on Form 10 filed on December 1, 2000.
- 4.2 Senior Indenture between Aetna Inc. and U.S. Bank National Association, successor in interest to State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.1 to Aetna Inc.’s Form 10-Q filed on May 10, 2001. (SEC file number 001-16095).
- 4.3 Form of Subordinated Indenture between Aetna Inc. and U.S. Bank National Association, successor in interest to State Street Bank and Trust Company, incorporated herein by reference to Exhibit 4.2 to Aetna Inc.’s Registration Statement on Form S-3 filed on January 19, 2001.

#### **10 Material contracts**

- 10.1 \$1,500,000,000 Amended and Restated Five-Year Credit Agreement dated as of March 27, 2008, incorporated herein by reference to Exhibit 99.1 to Aetna Inc.’s Form 8-K filed on April 1, 2008.
- 10.2 Amended and Restated Aetna Inc. 2000 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.4 to Aetna Inc.’s Form 10-K filed on February 27, 2009. \*\*
- 10.3 Form of Aetna Inc. 2000 Stock Incentive Plan - Stock Appreciation Right Terms of Award, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.’s Form 10-Q filed on October 26, 2006. \*\*
- 10.4 Form of Aetna Inc. 2000 Stock Incentive Plan - Restricted Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.2 to Aetna Inc.’s Form 10-Q filed on October 26, 2006. \*\*
- 10.5 Form of Aetna Inc. 2000 Stock Incentive Plan - Aetna Performance Unit Award Agreement, incorporated herein by reference to Exhibit 10.3 to Aetna Inc.’s Form 10-Q filed on October 26, 2006. \*\*
- 10.6 Form of Aetna Inc. 2000 Stock Incentive Plan - Aetna Performance Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.10 to Aetna Inc.’s Form 10-K filed on February 29, 2008. \*\*
- 10.7 Form of Aetna Inc. 2000 Stock Incentive Plan - Restricted Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.’s Form 10-Q/A filed on August 1, 2008. \*\*

- 10.8 Form of Aetna Inc. 2000 Stock Incentive Plan – Restricted Stock Unit Terms of Award (with non-compete provision), incorporated herein by reference to Exhibit 10.2 to Aetna Inc.’s Form 10-Q/A filed on August 1, 2008. \*\*
- 10.9 Form of Aetna Inc. 2000 Stock Incentive Plan – Market Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.’s Form 10-Q filed on April 29, 2010. \*\*
- 10.10 Form of Aetna Inc. 2000 Stock Incentive Plan – Performance Stock Unit Terms of Award, incorporated herein by reference to Exhibit 10.2 to Aetna Inc.’s Form 10-Q filed on April 29, 2010. \*\*
- 10.11 Form of Aetna Inc. 2000 Stock Incentive Plan – Restricted Stock Unit Terms of Award (2010, with retirement vesting), incorporated herein by reference to Exhibit 10.3 to Aetna Inc.’s Form 10-Q filed on April 29, 2010. \*\*
- 10.12 Form of Aetna Inc. 2000 Stock Incentive Plan – Restricted Stock Unit Terms of Award (2010, without retirement vesting), incorporated herein by reference to Exhibit 10.4 to Aetna Inc.’s Form 10-Q filed on April 29, 2010. \*\*
- 10.13 Amended and Restated Aetna Inc. 2002 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.11 to Aetna Inc.’s Form 10-K filed February 27, 2009. \*\*
- 10.14 Aetna Inc. 2010 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.’s Form 10-Q filed on July 28, 2010. \*\*
- 10.15 Amended and Restated Aetna Inc. 2001 Annual Incentive Plan, incorporated herein by reference to Exhibit 10.5 to Aetna Inc.’s Form 10-Q filed on April 29, 2010. \*\*
- 10.16 Aetna Inc. 2010 Non-Employee Director Compensation Plan, incorporated herein by reference to Annex C to Aetna Inc.’s definitive proxy statement on Schedule 14A filed on April 12, 2010. \*\*
- 10.17 Aetna Inc. Non-Employee Director Compensation Plan as Amended through December 5, 2008, incorporated herein by reference to Exhibit 10.13 to Aetna Inc.’s Form 10-K filed on February 27, 2009. \*\*
- 10.18 Form of Aetna Inc. Non-Employee Director Compensation Plan - Restricted Stock Unit Agreement, incorporated herein by reference to Exhibit 10.4 to Aetna Inc.’s Form 10-Q filed on October 26, 2006. \*\*
- 10.19 1999 Director Charitable Award Program, as Amended and Restated on January 25, 2008, incorporated herein by referenced to Exhibit 10.15 to Aetna Inc.’s Form 10-K filed on February 29, 2008. \*\*
- 10.20 Amended and Restated Employment Agreement dated as of December 5, 2003 by and between Aetna Inc. and Ronald A. Williams, incorporated herein by reference to Exhibit 10.24 to Aetna Inc.’s Form 10-K filed on February 27, 2004 (SEC file number 001-16095). \*\*
- 10.21 Amendment to Employment Agreement dated as of January 27, 2006 between Aetna Inc. and Ronald A. Williams, incorporated herein by reference to Exhibit 10.14 to Aetna Inc.’s Form 10-K filed on March 1, 2006. \*\*
- 10.22 Amendment No. 2 to Employment Agreement dated as of December 31, 2008 between Aetna Inc. and Ronald A. Williams, incorporated herein by reference to Exhibit 10.18 to Aetna Inc.’s Form 10-K filed on February 27, 2009. \*\*
- 10.23 Amendment No. 3 to Employment Agreement dated as of December 11, 2009 between Aetna Inc. and Ronald A. Williams, incorporated herein by reference to exhibit 10.18 to Aetna Inc.’s Form 10-K filed on February 26, 2010. \*\*
- 10.24 Amendment No. 4 to Employment Agreement dated as of October 19, 2010 between Aetna Inc. and Ronald A. Williams, incorporated herein by reference to Exhibit 10.1 to Aetna Inc.’s Form 10-Q filed on November 3, 2010. \*\*

- 10.25 Incentive Stock Unit Agreement between Aetna Inc. and Ronald A. Williams dated as of February 14, 2006, pursuant to the Aetna Inc. 2000 Stock Incentive Plan, incorporated herein by reference to Exhibit 10.15 to Aetna Inc.'s Form 10-K filed on March 1, 2006. \*\*
- 10.26 Consulting Agreement dated as of October 19, 2010 between Aetna Inc. and Ronald A. Williams, incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on November 3, 2010. \*\*
- 10.27 Amended and Restated Employment Agreement dated October 19, 2010 between Aetna Inc. and Mark T. Bertolini, incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on November 3, 2010. \*\*
- 10.28 Letter agreement dated January 25, 2007 between Aetna Inc. and Joseph M. Zubretsky, incorporated herein by reference to Exhibit 10.29 to Aetna Inc.'s Form 10-K filed on February 27, 2007. \*\*
- 10.29 Amendment No. 1 to Employment Agreement dated as of December 17, 2008 between Aetna Inc. and Joseph M. Zubretsky, incorporated herein by reference to Exhibit 10.23 to Aetna Inc.'s Form 10-K filed on February 27, 2009. \*\*
- 10.30 Letter agreement dated July 20, 2000 between Aetna Inc. and William J. Casazza, incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on April 24, 2008. \*\*
- 10.31 Amended and Restated Employment Agreement, dated as of December 21, 2004, between ActiveHealth Management, Inc. and Lonny Reisman, M.D., incorporated herein by reference to Exhibit 10.1 to Aetna Inc.'s Form 10-Q filed on April 29, 2009. \*\*
- 10.32 Employment Agreement Amendment, dated as of May 12, 2005, among Aetna Inc., ActiveHealth Management, Inc. and Lonny Reisman, M.D., incorporated herein by reference to Exhibit 10.2 to Aetna Inc.'s Form 10-Q filed on April 29, 2009. \*\*
- 10.33 Amendment No. 2 to Employment Agreement, dated as of December 31, 2008, between Aetna Inc. and Lonny Reisman, M.D., incorporated herein by reference to Exhibit 10.3 to Aetna Inc.'s Form 10-Q filed on April 29, 2009. \*\*
- 10.34 Description of certain arrangements not embodied in formal documents, as described under the headings "2010 Nonmanagement Director Compensation" and "Additional Director Compensation Information" are incorporated herein by reference to the Proxy Statement. \*\*
  
- 11** **Statement re: computation of per share earnings**
- 11.1 "Computation of per share earnings" is incorporated herein by reference to Note 4 of Notes to Consolidated Financial Statements on page 64 of the Annual Report.
  
- 12** **Statement re: computation of ratios**
- 12.1 Computation of ratio of earnings to fixed charges.
  
- 13** **Annual report to security holders**
- 13.1 Management's Discussion and Analysis of Financial Condition and Results of Operations, Selected Financial Data, Consolidated Financial Statements, Notes to Consolidated Financial Statements, Management's Report on Internal Control Over Financial Reporting, Management's Responsibility for Financial Statements, Audit Committee Oversight, Report of Independent Registered Public Accounting Firm and Quarterly Data (unaudited) are incorporated herein by reference to the Annual Report and filed herewith in electronic format.
  
- 21** **Subsidiaries of the registrant**
- 21.1 Subsidiaries of Aetna Inc.
  
- 23** **Consents of experts and counsel**
- 23.1 Consent of Independent Registered Public Accounting Firm.

**24 Power of Attorney**

24.1 Power of Attorney

**31 Rule 13a – 14(a)/15d – 14(e) Certifications**

31.1 Certification.

31.2 Certification.

**32 Section 1350 Certifications**

32.1 Certification.

32.2 Certification.

**101 XBRL Documents**

101.INS XBRL Instance Document.

101.SCH XBRL Taxonomy Extension Schema.

101.CAL XBRL Taxonomy Extension Calculation Linkbase.

101.DEF XBRL Taxonomy Extension Definition Linkbase.

101.LAB XBRL Taxonomy Extension Label Linkbase.

101.PRE XBRL Taxonomy Extension Presentation Linkbase.

\* Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Copies of exhibits will be furnished without charge upon written request to the Office of the Corporate Secretary, Aetna Inc., 151 Farmington Avenue, Hartford, Connecticut 06156.

\*\* Management contract or compensatory plan or arrangement.

**Index to Financial Statement Schedule**

	<u>Page</u>
<b>Report of Independent Registered Public Accounting Firm</b>	<b>21</b>
<b>Schedule I: Financial Information of Aetna Inc. (Parent Company Only):</b>	
Statements of Income	22
Balance Sheets	23
Statements of Shareholders' Equity	24
Statements of Cash Flows	25
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## **Report of Independent Registered Public Accounting Firm**

The Board of Directors and Shareholders  
Aetna Inc.:

Under the date of February 25, 2011, we reported on the consolidated balance sheets of Aetna Inc. and subsidiaries (the “Company”) as of December 31, 2010 and 2009, and the related consolidated statements of income, shareholders’ equity and cash flows for each of the years in the three-year period ended December 31, 2010, as contained in the Annual Report on Form 10-K for the year ended December 31, 2010. In connection with our audits of the aforementioned consolidated financial statements, we also audited the related financial statement schedule listed in the accompanying index. The financial statement schedule is the responsibility of the Company’s management. Our responsibility is to express an opinion on the financial statement schedule based on our audits.

In our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ KPMG LLP

Hartford, Connecticut  
February 25, 2011

**Schedule I – Financial Information of Aetna Inc.**

**Aetna Inc. (Parent Company Only)  
Statements of Income**

<b>(Millions)</b>	<b>For the Years Ended December 31,</b>		
	<b>2010</b>	<b>2009</b>	<b>2008</b>
Net investment income	\$ 1.5	\$ 2.8	\$ 10.5
Other income	-	30.2	-
Net realized capital gains (losses)	3.0	(3.5)	(11.6)
Total revenue	4.5	29.5	(1.1)
Operating expenses	(27.8)	95.8	69.9
Interest expense	254.6	243.5	236.0
Total expenses	226.8	339.3	305.9
Loss before income tax benefit and equity in earnings of affiliates, net	(222.3)	(309.8)	(307.0)
Income tax benefit	66.6	104.7	86.6
Equity in earnings of affiliates, net (1)	1,922.5	1,481.6	1,604.5
Net income	\$ 1,766.8	\$ 1,276.5	\$ 1,384.1

(1) Includes amortization of other acquired intangible assets after tax of \$61.9 million, \$63.2 million and \$70.3 million for the years ended December 31, 2010, 2009 and 2008, respectively.

Refer to accompanying Notes to Financial Statements.

**Aetna Inc. (Parent Company Only)**  
**Balance Sheets**

<b>(Millions)</b>	<b>At December 31,</b>	
	<b>2010</b>	<b>2009</b>
Assets		
Current assets:		
Cash and cash equivalents	\$ 479.5	\$ 75.3
Investments	90.0	43.7
Other receivables	73.1	142.5
Income taxes receivable	24.6	-
Deferred income taxes	50.8	70.4
Other current assets	14.3	13.0
<b>Total current assets</b>	<b>732.3</b>	<b>344.9</b>
Investment in affiliates (1)	14,293.3	14,285.1
Long-term investments	-	42.2
Deferred income taxes	471.4	578.7
Other long-term assets	28.1	26.0
<b>Total assets</b>	<b>\$ 15,525.1</b>	<b>\$ 15,276.9</b>
Liabilities and shareholders' equity		
Current liabilities:		
Short-term debt	\$ -	\$ 480.8
Income tax payable	-	6.4
Current portion of long-term debt	899.9	-
Accrued expenses and other current liabilities	316.2	341.4
<b>Total current liabilities</b>	<b>1,216.1</b>	<b>828.6</b>
Long-term debt, less current portion	3,482.6	3,639.5
Employee benefit liabilities	897.1	1,269.3
Other long-term liabilities	38.5	35.7
<b>Total liabilities</b>	<b>5,634.3</b>	<b>5,773.1</b>
Shareholders' equity:		
Common stock (\$.01 par value; 2.7 billion shares authorized; 384.4 million and 430.8 million shares issued and outstanding in 2010 and 2009, respectively) and additional paid-in capital	651.5	470.1
Retained earnings	10,401.9	10,256.7
Accumulated other comprehensive loss	(1,162.6)	(1,223.0)
<b>Total shareholders' equity</b>	<b>9,890.8</b>	<b>9,503.8</b>
<b>Total liabilities and shareholders' equity</b>	<b>\$ 15,525.1</b>	<b>\$ 15,276.9</b>

(1) Includes goodwill and other acquired intangible assets of \$5.6 billion and \$5.7 billion at December 31, 2010 and 2009, respectively.

Refer to accompanying Notes to Financial Statements.

**Aetna Inc. (Parent Company Only)**  
**Statements of Shareholders' Equity**

(Millions)	Number of Common Shares Outstanding	Common Stock and Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income	Total Shareholders' Equity	Comprehensive Income (Loss)
<b>Balance at December 31, 2007</b>	496.3	\$ 188.8	\$ 10,138.0	\$ (288.4)	\$ 10,038.4	
Comprehensive income:						
Net income	-	-	1,384.1	-	1,384.1	\$ 1,384.1
Other comprehensive loss:						
Net unrealized loss on securities	-	-	-	(282.6)	(282.6)	
Net foreign currency and derivative losses	-	-	-	(15.7)	(15.7)	
Pension and OPEB plans	-	-	-	(1,294.6)	(1,294.6)	
Other comprehensive loss	-	-	-	(1,592.9)	(1,592.9)	(1,592.9)
Total comprehensive loss						<u>\$ (208.8)</u>
Common shares issued for benefit plans, including tax benefit	2.9	162.9	-	-	162.9	
Repurchases of common shares	(42.9)	(.5)	(1,787.2)	-	(1,787.7)	
Dividends declared (\$.04 per share)	-	-	(18.4)	-	(18.4)	
<b>Balance at December 31, 2008</b>	456.3	351.2	9,716.5	(1,881.3)	8,186.4	
Cumulative effect of adopting new accounting standard at April 1, 2009 (Note 2)	-	-	53.7	(53.7)	-	
Comprehensive income:						
Net income	-	-	1,276.5	-	1,276.5	\$ 1,276.5
Other comprehensive income:						
Net unrealized gain on securities	-	-	-	619.0	619.0	
Net foreign currency and derivative gains	-	-	-	34.0	34.0	
Pension and OPEB plans	-	-	-	59.0	59.0	
Other comprehensive income	-	-	-	712.0	712.0	712.0
Total comprehensive income						<u>\$ 1,988.5</u>
Common shares issued for benefit plans, including tax benefit	3.4	119.2	-	-	119.2	
Repurchases of common shares	(28.9)	(.3)	(772.7)	-	(773.0)	
Dividends declared (\$.04 per share)	-	-	(17.3)	-	(17.3)	
<b>Balance at December 31, 2009</b>	430.8	470.1	10,256.7	(1,223.0)	9,503.8	
Comprehensive income:						
Net income	-	-	1,766.8	-	1,766.8	\$ 1,766.8
Other comprehensive income:						
Net unrealized gain on securities	-	-	-	114.3	114.3	
Net foreign currency and derivative losses	-	-	-	(52.6)	(52.6)	
Pension and OPEB plans	-	-	-	(1.3)	(1.3)	
Other comprehensive income	-	-	-	60.4	60.4	60.4
Total comprehensive income						<u>\$ 1,827.2</u>
Common shares issued for benefit plans, including tax benefit	6.0	181.9	-	-	181.9	
Repurchases of common shares	(52.4)	(.5)	(1,605.5)	-	(1,606.0)	
Dividends declared (\$.04 per share)	-	-	(16.1)	-	(16.1)	
<b>Balance at December 31, 2010</b>	384.4	\$ 651.5	\$ 10,401.9	\$ (1,162.6)	\$ 9,890.8	

Refer to accompanying Notes to Financial Statements.

**Aetna Inc. (Parent Company Only)**  
**Statements of Cash Flows**

<b>(Millions)</b>	<b>For the Years Ended December 31,</b>		
	<b>2010</b>	<b>2009</b>	<b>2008</b>
Cash flows from operating activities:			
Net income	\$ 1,766.8	\$ 1,276.5	\$ 1,384.1
Adjustments to reconcile net income to net cash used for operating activities:			
Equity earnings of affiliates (1)	(1,922.5)	(1,481.6)	(1,604.5)
Stock-based compensation expense	110.4	90.7	95.7
Net realized capital (gains) losses	(3.0)	3.5	11.6
Net change in other assets and other liabilities	(165.9)	151.0	(150.0)
<b>Net cash (used for) provided by operating activities</b>	<b>(214.2)</b>	<b>40.1</b>	<b>(263.1)</b>
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	1.1	20.9	78.0
Cost of investments	(42.2)	(1.0)	(1.3)
Dividends received from affiliates, net	2,040.6	444.1	1,355.2
<b>Net cash provided by investing activities</b>	<b>1,999.5</b>	<b>464.0</b>	<b>1,431.9</b>
Cash flows from financing activities:			
Proceeds from issuance of long-term debt, net of issuance costs	697.8	-	484.8
Net (repayment) issuance of short-term debt	(480.8)	266.1	116.5
Common shares issued under benefit plans	43.2	14.8	29.7
Stock-based compensation tax benefits	22.5	5.1	27.8
Common shares repurchased	(1,606.0)	(773.0)	(1,787.7)
Collateral held on interest rate swaps	(41.7)	41.7	-
Dividends paid to shareholders	(16.1)	(17.3)	(18.4)
<b>Net cash used for financing activities</b>	<b>(1,381.1)</b>	<b>(462.6)</b>	<b>(1,147.3)</b>
Net increase in cash and cash equivalents	404.2	41.5	21.5
Cash and cash equivalents, beginning of period	75.3	33.8	12.3
<b>Cash and cash equivalents, end of period</b>	<b>\$ 479.5</b>	<b>\$ 75.3</b>	<b>\$ 33.8</b>
Supplemental cash flow information:			
Interest paid	\$ 242.9	\$ 244.4	\$ 227.1
Income taxes refunded	198.5	62.9	236.6

(1) Includes amortization of other acquired intangible assets after tax of \$61.9 million, \$63.2 million and \$70.3 million for the years ended December 31, 2010, 2009 and 2008, respectively.

Refer to accompanying Notes to Financial Statements.

**Aetna Inc. (Parent Company Only)**  
**Notes to Financial Statements**

**1. Organization**

The financial statements reflect financial information for Aetna Inc. (a Pennsylvania corporation) only (the "Parent Company"). The financial information presented herein includes the balance sheet of Aetna Inc. as of December 31, 2010 and 2009 and the related statements of income, shareholders' equity and cash flows for the years ended December 31, 2010, 2009 and 2008. The accompanying financial statements should be read in conjunction with the consolidated financial statements and notes thereto in the Annual Report.

**2. Summary of Significant Accounting Policies**

Refer to Note 2 of Notes to Consolidated Financial Statements, beginning on page 57 of the Annual Report, for the summary of significant accounting policies.

**3. Dividends**

Cash dividends received from subsidiaries and included in net cash provided by investing activities in the Statements of Cash Flows were \$2.1 billion, \$961 million and \$1.8 billion in 2010, 2009 and 2008, respectively.

**4. Acquisitions and Dispositions**

Refer to Note 3 of Notes to Consolidated Financial Statements, on page 64 of the Annual Report, for a description of acquisitions and dispositions.

**5. Other Comprehensive Income (Loss)**

Refer to Note 9 of Notes to Consolidated Financial Statements, beginning on page 72 of the Annual Report, for a description of accumulated other comprehensive income (loss).

**6. Debt**

Refer to Note 14 of Notes to Consolidated Financial Statements, on page 89 of the Annual Report, for a description of debt.

## Signatures

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: February 25, 2011

Aetna Inc.

By: /s/ Rajan Parmeswar

Rajan Parmeswar  
Vice President, Controller and Chief Accounting Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signer	Title	Date
<u>/s/ Ronald A. Williams</u> Ronald A. Williams	Chairman and Director	February 25, 2011
<u>/s/ Mark T. Bertolini</u> Mark T. Bertolini	Chief Executive Officer, President and Director (Principal Executive Officer)	February 25, 2011
<u>/s/ Joseph M. Zubretsky</u> Joseph M. Zubretsky	Senior Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 25, 2011
<u>/s/ Rajan Parmeswar</u> Rajan Parmeswar	Vice President, Controller and Chief Accounting Officer (Principal Accounting Officer)	February 25, 2011
Frank M. Clark *	Director	
Betsy Z. Cohen *	Director	
Molly J. Coye, M.D. *	Director	
Roger N. Farah *	Director	
Barbara Hackman Franklin *	Director	
Jeffrey E. Garten *	Director	
Earl G. Graves *	Director	
Gerald Greenwald *	Director	
Ellen M. Hancock *	Director	
Richard J. Harrington *	Director	
Edward J. Ludwig *	Director	
Joseph P. Newhouse *	Director	

\* By: /s/ Rajan Parmeswar

Rajan Parmeswar  
Attorney-in-fact  
February 25, 2011

## INDEX TO EXHIBITS

Exhibit Number	Description of Exhibit	Filing Method
<b>12</b>	<b>Statement re: computation of ratios</b>	
12.1	Computation of ratio of earnings to fixed charges.	Electronic
<b>13</b>	<b>Annual report to security holders</b>	
13.1	Management's Discussion and Analysis of Financial Condition and Results of Operations, Selected Financial Data, Consolidated Financial Statements, Notes to Consolidated Financial Statements, Management's Report on Internal Control Over Financial Reporting, Management's Responsibility for Financial Statements, Audit Committee Oversight, Report of Independent Registered Public Accounting Firm and Quarterly Data (unaudited) sections of the Annual Report.	Electronic
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101.CAL	XBRL Taxonomy Extension Calculation Linkbase.	
101.DEF	XBRL Taxonomy Extension Definition Linkbase.	
101.LAB	XBRL Taxonomy Extension Label Linkbase.	
101.PRE	XBRL Taxonomy Extension Presentation Linkbase.	



### Computation of Ratio of Earnings to Fixed Charges

The computation of the ratio of earnings to fixed charges for the years 2006 through 2010 are as follows:

(Millions)	Years Ended December 31,				
	2010	2009	2008	2007	2006
Income from continuing operations before income taxes	\$ 2,644.2	\$ 1,901.2	\$ 2,174.2	\$ 2,796.4	\$ 2,586.6
Add back fixed charges	307.7	302.9	297.9	234.3	199.5
Income as adjusted ("earnings")	\$ 2,951.9	\$ 2,204.1	\$ 2,472.1	\$ 3,030.7	\$ 2,786.1
Fixed charges:					
Interest expense	\$ 254.6	\$ 243.4	\$ 236.4	\$ 180.6	\$ 148.3
Portion of rents representative of interest factor	53.1	59.5	61.5	53.7	51.2
Total fixed charges	\$ 307.7	\$ 302.9	\$ 297.9	\$ 234.3	\$ 199.5
Ratio of earnings to fixed charges	9.59	7.28	8.30	12.94	13.97



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**2010 Aetna Annual Report, Financial Report to Shareholders**


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Unless the context otherwise requires, references to the terms *we*, *our*, or *us*, used throughout this 2010 Annual Report, Financial Report to Shareholders (the "Annual Report") refer to Aetna Inc. (a Pennsylvania corporation) ("Aetna") and its subsidiaries.

For your reference, we provide the following index to the Annual Report:

**Page**

<b>2-51</b>	<b>Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&amp;A")</b> The MD&A provides a review of our 2010, as well as our financial condition at December 31, 2010 and 2009. The MD&A should be read in conjunction with our consolidated financial statements comprised of the following:
<b>2</b>	<b>Overview</b> – We begin our MD&A with an overview of earnings, cash flows, and significant developments for the last three years.
<b>6</b>	<b>Health Care</b> – We discuss the factors affecting Health Care revenues and operating earnings in this section.
<b>9</b>	<b>Group Insurance</b> – We discuss the factors affecting Group Insurance revenues and operating earnings in this section.
<b>10</b>	<b>Large Case Pensions</b> – We discuss the factors affecting Large Case Pensions operating earnings, including the results of our discussions with the Pension Benefit Guaranty Corporation.
<b>12</b>	<b>Investments</b> – As an insurer, we have a significant investment portfolio to support our liabilities and capital. In this section, we discuss our investment strategy and describe our evaluation of the risk of our market-sensitive instruments.
<b>15</b>	<b>Liquidity and Capital Resources</b> – In this section, we discuss our cash flows, financing resources, contractual obligations and other commitments.
<b>18</b>	<b>Critical Accounting Estimates</b> – In this section, we discuss the accounting estimates we consider critical in preparing our financial statements.
<b>23</b>	<b>Regulatory Environment</b> – In this section, we discuss the regulatory environment in which we operate.
<b>35</b>	<b>Forward-Looking Information/Risk Factors</b> – We conclude our MD&A with a discussion of certain risks and uncertainties that, if they occur, could have a material adverse impact on our business, cash flows, financial condition or operating results.
<b>52</b>	<b>Selected Financial Data</b> – We provide selected annual financial data for the most recent five years.
<b>53</b>	<b>Consolidated Financial Statements</b> – We include our consolidated balance sheets at December 31, 2010 and 2009 and the related consolidated cash flows for each of the years 2008 through 2010.
<b>57</b>	<b>Notes to Consolidated Financial Statements</b>
<b>100</b>	<b>Reports of Management and our Independent Registered Public Accounting Firm</b> – We include a report on our responsibilities for the preparation of our financial statements, the oversight of our Audit Committee and KPMG LLP's opinion on our consolidated financial statements and internal control over financial reporting.
<b>102</b>	<b>Quarterly Data (unaudited)</b> – We provide selected quarterly financial data for each of the last eight quarters.
<b>102</b>	<b>Corporate Performance Graph</b> – We provide a graph comparing the cumulative total shareholder return on our common stock to the cumulative total shareholder return on the Standard & Poor's 500 Index from 2005 through 2010.

## Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A")

### OVERVIEW

We are one of the nation's leading diversified health care benefits companies, serving approximately 35.3 million people with information and resources to help them make better informed decisions about their health care. We offer a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and Medicaid health care management services. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions.

### Summarized Results

(Millions)	2010	2009	2008
Revenue:			
Health Care	\$ 31,604.0	\$ 32,073.3	\$ 28,775.0
Group Insurance	2,118.6	2,143.0	1,710.7
Large Case Pensions	523.4	547.8	465.0
Total revenue	34,246.0	34,764.1	30,950.7
Net income	1,766.8	1,276.5	1,384.1
Operating earnings: (1)			
Health Care	1,650.1	1,412.7	1,802.3
Group Insurance	128.0	103.8	136.8
Large Case Pensions	27.8	32.2	38.8
Cash flows from operations	1,412.1	2,488.3	2,206.9

(1) Our discussion of operating results for our reportable business segments is based on operating earnings, which is a non-GAAP measure of net income (the term "GAAP" refers to U.S. generally-accepted accounting principles). Refer to Segment Results and Use of Non-GAAP Measures in this Document on page 6 for a discussion of non-GAAP measures. Refer to pages 7, 10 and 11 for a reconciliation of operating earnings to net income for Health Care, Group Insurance and Large Case Pensions, respectively.

We analyze our operating results based on operating earnings, which excludes net realized capital gains and losses as well as other items from net income. Operating earnings for the past three years were primarily generated from our Health Care segment. This segment produced higher operating earnings in 2010 than 2009, but lower than 2008. Operating earnings in 2010 were higher than 2009 primarily due to higher Commercial underwriting margins (calculated as premiums less health care costs) in our Health Care segment. Our operating earnings in 2009 were lower than 2008 due primarily to lower underwriting margins in our Health Care segment.

In 2010, underwriting margins in the Health Care segment were higher than 2009 primarily due to higher Commercial underwriting margins, driven by management actions to appropriately price the business, members' lower utilization and favorable development of prior-period health care cost estimates, partially offset by the effect of lower Commercial Insured membership in 2010. Underwriting margins in 2009 were lower than 2008, primarily due to significantly lower Commercial underwriting margins in 2009 as well as unfavorable development of prior-period health care costs estimates from 2008. In 2009, our Commercial Health Care products experienced increased per member health care costs that significantly outpaced the increase in per member per month premiums, which resulted in a higher Commercial medical benefit ratio and a lower Commercial underwriting margin.

During 2010 total revenue declined compared to 2009 primarily as a result of lower Commercial Insured membership as well as a decline due to the mix of business partially offset by premium rate increases. In 2009, total revenue grew compared to 2008, driven primarily by growth in membership as well as the impact of premium rate increases in our Health Care segment.

In 2010, our Health Care segment experienced lower medical Insured membership (where we assume all or a majority of the risk for medical and dental care costs) and slightly higher medical membership in our administrative services contract ("ASC") products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs). During 2010, membership for our dental and pharmacy products also decreased. At December 31, 2010, we

served approximately 18.5 million medical members (consisting of approximately 32% Insured members and 68% ASC members), 13.7 million dental members and 9.4 million pharmacy benefit management services members. At December 31, 2009, we served approximately 18.9 million medical members (consisting of approximately 34% Insured members and 66% ASC members), 14.1 million dental members and 10.3 million pharmacy benefit management services members. Refer to “Health Care – Membership” on page 9 for further information.

**During the past three years our cash flows supported both new and ongoing initiatives.**

We generated substantial cash flows from our businesses in the past three years, which we used to support our growth strategies, repurchase our common stock and contribute to our pension plan.

We invest in the development of our business by acquiring companies that support our strategy. During 2010, we entered into an agreement to acquire Medicity Inc. (“Medicity”), a health information exchange technology company, for approximately \$500 million. This transaction closed in January 2011. In 2009, we completed the acquisition of Horizon Behavioral Services, LLC, a leading provider of employee assistance programs, for approximately \$70 million.

In 2010, 2009 and 2008, we repurchased approximately 52 million, 29 million and 43 million shares of our common stock at a cost of approximately \$1.6 billion, \$773 million and \$1.8 billion, respectively, under share repurchase programs authorized by Aetna’s Board of Directors (our “Board”).

We have contributed to our tax-qualified defined benefit pension plan (the “Aetna Pension Plan”) in each of the past three years. During 2010, 2009 and 2008, we made voluntary cash contributions of \$505 million, \$45 million and \$45 million, respectively. As a result of our 2010 contribution, we expect to have no required contribution in 2011, although we expect to voluntarily contribute \$60 million to the Aetna Pension Plan in 2011.

We issued \$750 million and \$500 million of senior notes in 2010 and 2008, respectively. The 2010 senior notes were issued in anticipation of the 2011 scheduled maturity of certain of our senior notes, and the 2008 senior notes were issued to secure long-term capital at favorable rates.

**Management Update**

In October 2010, we announced the following changes:

- Ronald A. Williams, Aetna’s Chairman, will retire from Aetna and our Board in April 2011. Mr. Williams had been our Chief Executive Officer since February 14, 2006 and has been our Chairman since October 1, 2006. Following his retirement, Mr. Williams has agreed to provide consulting services to Aetna and the Aetna Foundation, Inc., the independent and philanthropic arm of Aetna.
- Mark T. Bertolini, who has been President since 2007, was named Aetna’s Chief Executive Officer and elected to our Board, effective November 29, 2010. Mr. Bertolini is expected to become Aetna’s Chairman upon Mr. Williams’ retirement in 2011.
- Joseph M. Zubretsky was appointed Senior Executive Vice President and Chief Financial Officer, effective November 29, 2010.
- Margaret M. McCarthy was appointed Executive Vice President, Operations and Technology, effective November 29, 2010.

**Medicare Update**

Effective April 21, 2010, the Centers for Medicare & Medicaid Services (“CMS”) imposed intermediate sanctions on us, suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone Prescription Drug Plan (“PDP”) contracts. The sanctions relate to our compliance with certain Medicare Part D requirements. The suspension does not affect our current Medicare enrollees who stay in their existing plans. CMS has granted us a limited waiver of these sanctions to allow us to continue to enroll eligible members into existing, contracted group Aetna Medicare Advantage Plans and Standalone PDPs through March 31, 2011. As a result of the sanctions, our 2011 Medicare membership was adversely affected because we did not participate in the 2010 open enrollment for individual 2011 Medicare plans, which occurred between November 15, 2010 and December 31, 2010.

We are cooperating fully with CMS on its review and are working to resolve the issues CMS has raised as soon as possible. If the CMS sanctions remain in effect or we fail to obtain extensions of the limited waiver through the end of those sanctions, our Medicare membership and operating results could be adversely affected.

#### **Pharmacy Benefit Management Subcontract Agreement with CVS Caremark Corporation**

In July 2010, we entered into a Pharmacy Benefit Management Subcontract Agreement with CVS Caremark Corporation ("CVS Caremark") (the "PBM Agreement") that we believe will further enhance value and service for our customers and members. CVS Caremark began providing services under the PBM Agreement on January 1, 2011. Under the PBM Agreement, we continue to maintain and manage our pharmacy benefit management ("PBM") organization and retain and operate our mail order and specialty pharmacies. CVS Caremark provides the administration of selected functions for our retail pharmacy network contracting and claims administration; mail order pharmacy and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. We expect the PBM Agreement to allow us to preserve and enhance our integrated value proposition, integrate medical, clinical and pharmacy programs and data to improve quality of care while lowering costs, and enhance the affordability of our Health Care products through improved retail, mail order and specialty pharmacy drug pricing. We incurred transaction costs associated with the PBM Agreement in 2010 and expect to continue to incur integration costs during 2011. Those integration costs included and are expected to include costs associated with transferring employees to CVS Caremark, rationalizing locations and systems integration.

#### **Health Care Reform Legislation**

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, "Health Care Reform") which makes broad-based changes to the U.S. health care system which could significantly affect the U.S. economy and will significantly impact our business operations and financial results, including our pricing and medical benefit ratios. Health Care Reform presents us with new business opportunities, but also with new financial and other challenges. It is reasonably possible that Health Care Reform, in the aggregate, could have a material adverse effect on our business operations and financial results.

Components of the legislation will be phased in over the next seven years. We are and will continue to be required to dedicate material resources and incur material expenses during that time to implement and comply with Health Care Reform as well as state-level health care reform. While the federal government has begun to issue regulations implementing Health Care Reform, many significant parts of the legislation, including minimum medical loss ratios ("MLRs"), require further guidance and clarification both at the federal level and in the form of regulations and actions by state legislatures to implement the law. As a result, many of the impacts of Health Care Reform will not be known for several years. Pending efforts in the U.S. Congress to repeal, amend or restrict funding for various aspects of Health Care Reform and the pending litigation challenging the constitutionality of Health Care Reform create additional uncertainty about the ultimate impact of the legislation.

The expansion of health care coverage contemplated by Health Care Reform will be funded in part by material additional fees and taxes on us and other health insurers, health plans and other market participants and individuals beginning in 2014, as well as reductions to the reimbursements we and other health plans are paid by the federal government for our Medicare members, among other sources. While not all-inclusive, we are evaluating the impact of the following key provisions of Health Care Reform (assuming it is implemented in its current form) to determine the impact that they will have on our business operations and financial results:

- Requirements that began in September 2010 for health plans to submit and justify rates, provide dependent coverage up to age 26, eliminate certain lifetime and annual maximum limits on the dollar value of coverage, eliminate payments by members for covered preventive services, provide required reimbursements for emergency services, eliminate prohibited policy rescissions and implement new claim appeal procedures. Regulations issued to date, among other things: permit specified lifetime and minimum annual coverage limits, which will be phased out by 2014; effectively guarantee issuance of insurance coverage for enrollees under age 19 beginning in 2010; clarify the rules applicable to grandfathered status; clarify regulations regarding appeals; delay application of anti-discrimination requirements; and provide implementation guidance across a range of topics.
- Closure of the gap in coverage for Medicare Part D prescription drug coverage (the so-called "donut hole") which began to close in 2010 and will incrementally close until the coverage gap is eliminated in 2020.

- Required minimum MLRs, as defined by interim final regulations, for insured plans of 85% for the large group market and 80% for the individual and small group markets beginning January 1, 2011, with rebates issued to employers and/or members for the amount under the minimum beginning in 2012.
- Enhanced rate review and disclosure processes on the part of states or the U.S. Department of Health and Human Services (“HHS”) for premium increases above a specified threshold. HHS has filed a Notice of Proposed Rulemaking outlining its expectations of state review as well as circumstances under which HHS would intervene in the review process. The final rules are expected to be issued in 2011.
- Freezing 2011 Medicare Advantage payment rates for payments to us based on 2010 levels, with additional reductions over a multi-year period beginning in 2012 based on regionally-adjusted benchmarks and the linking of Medicare Advantage payments to a plan’s CMS quality rating or “star rating.”
- Non-deductibility of employee compensation in excess of \$500,000 beginning in 2013. Additionally, there will be material annual taxes and assessments on health insurance providers beginning in 2014.
- Multiple insurance reforms beginning in 2014, including rating limits and benefit requirements, guaranteed issue and renewability of coverage in the individual and small group markets, elimination of pre-existing conditions exclusions for all re-enrollees, elimination of annual limits on the dollar value of coverage, and a prohibition on eligibility waiting periods beyond 90 days.
- Establishment of state-based health insurance exchanges (the “Exchanges”) for the individual and small group markets by 2014.
- Expansion of state-based Medicaid coverage beginning in 2014.
- Establishment of individual and employer mandates for insurance coverage, federal assistance to purchase health coverage for individuals, and detailed public reporting and disclosure requirements for health care plans, each beginning in 2014.
- A 40% excise tax on employer-sponsored health benefits above a certain threshold beginning in 2018.

The law also specifies required benefit designs, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal oversight of health plans, including regulations and processes that could delay or limit our ability to appropriately increase our health plan premiums. This in turn could adversely affect our ability to continue to participate in certain product lines and/or geographies we serve today. Health Care Reform will require us to phase out many of our current limited benefit product offerings no later than 2014, and the application of minimum MLR standards to both our limited benefit and student health products may have an adverse effect on our ability to sell these products in the future. For additional information on health care reform, refer to "Regulatory Environment" beginning on page 23 and "Forward-Looking Information/Risk Factors" beginning on page 35.

#### **Outlook for 2011**

We expect to face continued external challenges in our business during 2011, including the difficult economic environment, the implementation of Health Care Reform (including minimum MLR rebates and increased governmental premium rate review) and a continued low interest rate environment for our investments. At the same time, our business faces a lower medical membership base in 2011 than we had in 2010, and we project that medical cost trends will increase from their 2010 levels to more normal levels in 2011. We are seeking to offset these factors by pricing our products and services appropriately, managing our expenses, making strategic investments designed to diversify our revenue streams and position us for the future and effectively managing our capital.

Our primary business goals for 2011 are: execution and operational excellence; diversifying our growth opportunities; simplifying our products and services; and delivering excellent customer service to create a more positive experience for our members.

Refer to "Forward-Looking Information/Risk Factors" beginning on page 35 for information regarding other important factors that may materially affect us.

## Segment Results and Use of Non-GAAP Measures in this Document

The following discussion of operating results is presented based on our reportable segments in accordance with the accounting guidance for segment reporting and consistent with our segment disclosure included in Note 19 of Notes to Consolidated Financial Statements beginning on page 95. Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments to reconcile our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and the financing components of our pension and other postretirement benefit plans ("OPEB") expense (the service cost and prior service cost components of this expense are allocated to our business segments).

Our discussion of our operating results is based on operating earnings, which is the measure reported to our Chief Executive Officer for purposes of assessing financial performance and making operating decisions, such as allocating resources to each segment. Operating earnings exclude net realized capital gains or losses as well as other items, if any, from net income reported in accordance with GAAP. We believe excluding realized capital gains or losses from net income to arrive at operating earnings provides more meaningful information about our underlying business performance. Net realized capital gains and losses arise from various types of transactions, primarily in the course of managing a portfolio of assets that support the payment of liabilities; however, these transactions do not directly relate to the underwriting or servicing of products for our customers and are not directly related to the core performance of our business operations. We also may exclude other items that do not relate to the ordinary course of our business from net income to arrive at operating earnings. In each segment discussion in this MD&A, we provide a table that reconciles operating earnings to net income. Each table details the net realized capital gains or losses and any other items excluded from net income, and the footnotes to each table describe the nature of each other item and why we believe it is appropriate to exclude that item from net income.

## HEALTH CARE

Health Care consists of medical, pharmacy benefits management, dental, behavioral health and vision plans offered on both an Insured basis and an ASC basis. Medical products include point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit plans. Medical products also include health savings accounts and Aetna HealthFund®, consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account. We also offer Medicare and Medicaid products and services, as well as specialty products, such as medical management and data analytics services, medical stop loss insurance and products that provide access to our provider networks in select markets. We separately track premiums and health care costs for Medicare and Medicaid products; all other medical, dental and other Health Care products are referred to as Commercial.

## Operating Summary

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Premiums:			
Commercial	\$ 20,632.2	\$ 21,581.6	\$ 20,096.2
Medicare	5,896.1	5,735.8	4,816.1
Medicaid	1,082.3	926.4	595.0
Total premiums	27,610.6	28,243.8	25,507.3
Fees and other revenue	3,413.3	3,418.0	3,202.6
Net investment income	418.8	392.5	341.3
Net realized capital gains (losses)	161.3	19.0	(276.2)
Total revenue	31,604.0	32,073.3	28,775.0
Health care costs	22,719.6	24,061.2	20,785.5
Operating expenses:			
Selling expenses	1,148.4	1,158.7	1,055.2
General and administrative expenses	4,884.8	4,602.9	4,424.3
Total operating expenses	6,033.2	5,761.6	5,479.5
Amortization of other acquired intangible assets	88.3	90.3	101.3
Total benefits and expenses	28,841.1	29,913.1	26,366.3
Income before income taxes	2,762.9	2,160.2	2,408.7
Income taxes	954.2	744.9	875.1
Net income	\$ 1,808.7	\$ 1,415.3	\$ 1,533.6

The table presented below reconciles net income reported in accordance with GAAP to operating earnings <sup>(1)</sup>:

(Millions)	2010	2009	2008
Net income	\$ 1,808.7	\$ 1,415.3	\$ 1,533.6
Net realized capital (gains) losses	(131.0)	(19.0)	213.1
Transaction-related costs	43.1	-	-
Litigation-related insurance proceeds	(101.5)	(24.9)	-
Severance and facilities charge	30.8	60.9	35.6
ESI settlement	-	(19.6)	-
Contribution for the establishment of an out-of-network pricing database	-	-	20.0
<b>Operating earnings</b>	<b>\$ 1,650.1</b>	<b>\$ 1,412.7</b>	<b>\$ 1,802.3</b>

In addition to net realized capital (gains) losses, the following other items are excluded from operating earnings because we believe they neither relate to the ordinary course of our business nor reflect our underlying business performance:

- <sup>(1)</sup>
- In 2010, we recorded transaction-related costs of \$43.1 million (\$66.2 million pretax). These costs related to the PBM Agreement and the announced acquisition of Medicity.
  - Following a Pennsylvania Supreme Court ruling in June 2009, we recorded proceeds of \$101.5 million (\$156.3 million pretax) for 2010 and \$24.9 million (\$38.2 million pretax) for 2009 from our liability insurers related to certain litigation we settled in 2003.
  - In 2010, 2009 and 2008 we recorded severance and facilities charges of \$30.8 million (\$47.4 million pretax), \$60.9 million (\$93.7 million pretax) and \$35.6 million (\$54.7 million pretax), respectively. The 2010 severance and facilities charges related to actions taken in 2010 or committed to be taken in 2011. The 2009 and 2008 severance and facilities charges related to actions previously taken.
  - In 2009, we reached an agreement with Express Scripts, Inc. and one of its subsidiaries (collectively "ESI") to settle certain litigation in which we were the plaintiff. Under the applicable settlement, we received approximately \$19.6 million (\$30.2 million pretax), net of fees and expenses, in 2009.
  - As a result of our agreement with the New York Attorney General to discontinue the use of Ingenix databases at a future date, in 2008 we committed to contribute \$20.0 million to a non-profit organization to help create a new independent database for determining out-of-network reimbursement rates. We made that contribution in October 2009.

### Operating earnings in 2010 improved over 2009.

2010 operating earnings were higher than 2009, primarily due to higher Commercial underwriting margins driven by management actions to appropriately price the business, members' lower utilization and favorable development of prior-period health care cost estimates, partially offset by the effect of lower Commercial Insured membership in 2010 (refer to discussion of Commercial results below). Operating earnings in 2009, when compared to 2008, were negatively impacted by significantly higher health care costs as well as unfavorable development of health care cost estimates from 2008, particularly for Commercial products, partially offset by growth in premiums and fees and other revenue, higher net investment income and continued operating expense efficiencies (total operating expenses divided by total revenue). The growth in premiums in 2009 resulted from increases in membership levels as well as premium rate increases for renewing membership.

In 2010, total operating expenses increased compared to 2009 reflecting seasonal spending and the implementation of the PBM Agreement and other major programs. Total operating expenses in 2009 increased compared to 2008 as a result of higher employee-related costs and other expenses associated with higher membership and higher selling expenses.

We calculate the medical benefit ratio ("MBR") for our Health Care segment by dividing health care costs by premiums. Our MBRs by product for the last three years were:

	2010	2009	2008
Commercial	80.6%	84.5%	80.3%
Medicare	87.3%	87.1%	85.6%
Medicaid	87.5%	88.6%	87.4%
<b>Total</b>	<b>82.3%</b>	<b>85.2%</b>	<b>81.5%</b>

Refer to the following discussion of Commercial and Medicare results for an explanation of the changes in our MBRs.

### Our Commercial operating results reflect higher underwriting margins but lower Insured membership in 2010.

Commercial premiums were \$949 million lower in 2010 than 2009, primarily due to lower Commercial Insured membership and the mix of business, partially offset by premium rate increases. Commercial premiums increased

approximately \$1.5 billion in 2009 compared to 2008 reflecting premium rate increases on renewing business and higher membership levels.

Our Commercial MBRs were 80.6%, 84.5% and 80.3% for 2010, 2009 and 2008, respectively. The lower Commercial MBR in 2010 compared to 2009 reflects favorable development of prior-period health care cost estimates and a percentage increase in our per member health care premiums that exceeded the increase in per member health care costs. Included in the 2010 Commercial MBR is approximately \$60 million of favorable development of prior-period health care cost estimates. This development primarily resulted from lower than projected paid claims in the first half of 2010 for claims incurred in the latter part of 2009 caused by lower than projected utilization of medical services driven by the abatement of H1N1 and other flu, among other factors. Excluding this development, Commercial MBR decreased from 2009 reflecting a percentage increase in our per member premiums that outpaced the percentage increase in per member health care costs.

Our Commercial MBR in 2009 increased when compared to 2008, reflecting a percentage increase in our per member health care costs that outpaced the percentage increase in per member premiums. Included in the 2009 Commercial MBR is approximately \$97 million of unfavorable development of prior period health care cost estimates. This development was related to unusually high paid claims activity for the first half of 2009, primarily related to claims incurred in the second half of 2008. The increase in per member health care costs in 2009 was driven primarily by higher facility claim intensity, higher costs from H1N1 influenza, and higher costs from increased participation rates in health care continuation coverage afforded to individuals under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA").

We had no significant development of prior-period health care cost estimates that affected operating results in 2008.

The calculation of Health Care Costs Payable is a critical accounting estimate (refer to "Critical Accounting Estimates – Health Care Costs Payable" beginning on page 18 for additional information).

#### **Medicare results reflects growth in 2010 and 2009**

Medicare premiums increased approximately \$160 million in 2010 compared to 2009, and increased approximately \$920 million in 2009 compared to 2008. The increase in 2010 is primarily attributable to an increase in Medicare membership in 2010. The increase in 2009 primarily reflects the introduction of our new private fee-for-service ("PFFS") product as well as increases in supplemental premiums across all of our Medicare Advantage products, rate increases from CMS and true-ups for specified risk adjustments from CMS. We discontinued our remaining PFFS products in 2011.

Our Medicare MBRs were 87.3% for 2010, 87.1% for 2009, and 85.6% for 2008. We had approximately \$40 million of favorable development and \$11 million of unfavorable development of prior-period Medicare health care cost estimates in 2010 and 2009, respectively. We had no significant development of prior-period health care cost estimates in 2008. Our Medicare MBR for 2010 remained relatively flat when compared to 2009. The increase in our Medicare MBR in 2009 reflects a percentage increase in our per member premiums that was outpaced by the percentage increase in per member health care costs.

#### **Other Sources of Revenue**

Fees and other revenue for 2010 remained relatively flat when compared to 2009. Fees and other revenue for 2009 increased \$215 million compared to 2008 reflecting growth in ASC membership, partially offset by lower fee yields and revised product and service mix.

Net realized capital gains for 2010 were due primarily to net gains on the sales of debt securities partially offset by losses from derivative transactions. Net realized capital losses in 2008 were due primarily to other-than-temporary impairments ("OTTI") of debt securities (refer to our discussion of "Investments – Net Realized Capital Gains and Losses" on page 13 for additional information) and net losses on the sale of debt securities.

## Membership

Health Care membership at December 31, 2010 and 2009 was as follows:

(Thousands)	2010			2009		
	Insured	ASC	Total	Insured	ASC	Total
Medical:						
Commercial	5,015	11,809	16,824	5,614	11,821	17,435
Medicare	445	-	445	433	-	433
Medicaid	381	818	1,199	310	736	1,046
Total Medical Membership	5,841	12,627	18,468	6,357	12,557	18,914
Consumer-Directed Health Plans (1)			2,184			1,868
Dental:						
Commercial	4,944	7,193	12,137	4,998	7,304	12,302
Medicare and Medicaid	177	462	639	260	432	692
Network Access (2)	-	971	971	-	1,067	1,067
Total Dental Membership	5,121	8,626	13,747	5,258	8,803	14,061
Pharmacy Benefit Management Services:						
Commercial			8,553			9,728
Medicare PDP (stand-alone)			608			346
Medicare Advantage PDP			227			240
Medicaid			27			30
Total Pharmacy Benefit Management Services			9,415			10,344
Mail Order (3)			602			669
Total Pharmacy Membership			10,017			11,013

(1) Represents members in consumer-directed health plans who also are included in Commercial medical membership above.

(2) Represents members in products that allow these members access to our dental provider network for a nominal fee.

(3) Represents members who purchased medications through our mail order pharmacy operations during the fourth quarter of 2010 and 2009, respectively, and are included in Pharmacy Benefit Management Services membership above.

Total medical membership at December 31, 2010 decreased compared to December 31, 2009, reflecting a reduction in Commercial membership due primarily to lapsed customers and in-group attrition that was partially offset by growth in Medicare and Medicaid membership.

Total dental membership decreased in 2010 primarily due to lapses exceeding new sales and membership declines from existing customers.

Total pharmacy benefit management services membership decreased in 2010 compared to 2009 primarily due to a decrease in Commercial medical enrollment partially offset by growth in Medicare PDP membership.

## GROUP INSURANCE

Group Insurance primarily includes group life insurance products offered on an Insured basis, including basic and supplemental group term life, group universal life, supplemental or voluntary programs, and accidental death and dismemberment coverage. Group Insurance also includes (i) group disability products offered to employers on both an Insured and an ASC basis, which consist primarily of short-term and long-term disability insurance (and products which combine both), (ii) absence management services offered to employers, which include short-term and long-term disability administration and leave management, and (iii) long-term care products that were offered primarily on an Insured basis, which provide benefits covering the cost of care in private home settings, adult day care, assisted living or nursing facilities. We no longer solicit or accept new long-term care customers.

## Operating Summary

(Millions)	2010	2009	2008
Premiums:			
Life	\$ 1,082.5	\$ 1,093.0	\$ 1,062.7
Disability	536.5	559.4	534.6
Long-term care	52.1	67.8	86.3
Total premiums	1,671.1	1,720.2	1,683.6
Fees and other revenue	105.0	106.9	97.9
Net investment income	275.1	274.1	240.4
Net realized capital gains (losses)	67.4	41.8	(311.2)
Total revenue	2,118.6	2,143.0	1,710.7
Current and future benefits	1,536.6	1,575.2	1,468.8
Operating expenses:			
Selling expenses	78.2	93.2	94.4
General and administrative expenses	264.3	283.4	310.1
Total operating expenses	342.5	376.6	404.5
Amortization of other acquired intangible assets	6.9	6.9	6.9
Total benefits and expenses	1,886.0	1,958.7	1,880.2
Income (loss) before income taxes	232.6	184.3	(169.5)
Income taxes	53.0	38.7	(54.2)
Net income (loss)	\$ 179.6	\$ 145.6	\$ (115.3)

The table presented below reconciles net income reported in accordance with GAAP to operating earnings:

(Millions)	2010	2009	2008
Net income (loss)	\$ 179.6	\$ 145.6	\$ (115.3)
Net realized capital (gains) losses	(51.6)	(41.8)	224.7
Allowance on reinsurance recoverable (1)	-	-	27.4
Operating earnings	\$ 128.0	\$ 103.8	\$ 136.8

(1) As a result of the liquidation proceedings of Lehman Re Ltd. ("Lehman Re"), a subsidiary of Lehman Brothers Holdings Inc., we recorded an allowance against our reinsurance recoverable from Lehman Re of \$27.4 million (\$42.2 million pretax) in 2008. This reinsurance is on a closed block of paid-up group whole life insurance business.

Operating earnings for 2010 increased \$24 million when compared to 2009, primarily due to lower operating expenses and improved underwriting margins in our disability products which were partially offset by lower underwriting margins in our long-term care and life products. Operating earnings for 2009 decreased \$33 million when compared to 2008, primarily reflecting lower disability underwriting margins partially offset by higher net investment income. In both 2010 and 2009, our underwriting margins reflect an increase in our long-term disability reserves as a result of using a lower discount rate, reflecting lower yields in the investment portfolio supporting this business. In 2009, our underwriting margins also reflected an increase in our long-term disability reserves caused by longer claim durations.

Our group benefit ratios (which represents current and future benefits divided by premiums) were 92.0% for 2010, 91.6% for 2009, and 87.2% for 2008.

Net realized capital gains for 2010 increased by \$26 million when compared to 2009, primarily reflecting higher net gains from the sales of debt securities partially offset by losses from derivative transactions. Net realized capital losses for 2008 were due primarily to losses on OTTI of debt securities (refer to our discussion of "Investments - Net Realized Capital Gains and Losses" on page 13 for additional information).

## LARGE CASE PENSIONS

Large Case Pensions manages a variety of retirement products (including pension and annuity products) primarily for tax qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. The Large Case Pensions segment includes certain discontinued products.

## Operating Summary

(Millions)	2010	2009	2008
Premiums	\$ 151.0	\$ 172.2	\$ 193.2
Net investment income	362.4	369.8	328.3
Other revenue	11.2	11.6	12.0
Net realized capital losses	(1.2)	(5.8)	(68.5)
Total revenue	523.4	547.8	465.0
Current and future benefits	476.8	502.9	469.9
General and administrative expenses	12.6	10.0	14.9
Reduction of reserve for anticipated future losses on discontinued products	-	-	(43.8)
Total benefits and expenses	489.4	512.9	441.0
Income before income taxes	34.0	34.9	24.0
Income taxes	5.0	8.5	1.2
Net income	\$ 29.0	\$ 26.4	\$ 22.8

The table presented below reconciles net income reported in accordance with GAAP to operating earnings:

(Millions)	2010	2009	2008
Net income	\$ 29.0	\$ 26.4	\$ 22.8
Net realized capital (gains) losses	(1.2)	5.8	44.5
Reduction of reserve for anticipated future losses on discontinued products (1)	-	-	(28.5)
Operating earnings	\$ 27.8	\$ 32.2	\$ 38.8

(1) In 1993 we discontinued the sale of our fully-guaranteed large case pension products and established a reserve for anticipated future losses on these products, which we review quarterly. We reduced the reserve for anticipated future losses on discontinued products by \$28.5 million (\$43.8 million pretax) in 2008. We believe excluding any changes to the reserve for anticipated future losses on discontinued products provides more meaningful information as to our continuing products and is consistent with the treatment of the operating results of these discontinued products, which are credited or charged to the reserve and do not affect our operating results.

Operating earnings declined in each of the last three years, which is consistent with the run-off nature of this segment.

### Discontinued Products in Large Case Pension

Prior to 1993, we sold single-premium annuities (“SPAs”) and guaranteed investment contracts (“GICs”), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products to Large Case Pensions customers, and now we refer to these products as discontinued products.

We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate future losses over their life (which is greater than 30 years); so we established a reserve for anticipated future losses at the time of discontinuance. We provide additional information on this reserve, including key assumptions and other important information, in Note 20 of Notes to Consolidated Financial Statements beginning on page 97.

The operating summary for Large Case Pensions above includes revenues and expenses related to our discontinued products, with the exception of net realized capital gains and losses which are recorded as part of current and future benefits. Since we established a reserve for future losses on discontinued products, as long as our expected future losses remain consistent with prior projections, the operating results of our discontinued products are applied against the reserve and do not impact operating earnings or net income for Large Case Pensions. However, if actual or expected future losses are greater than we currently estimate, we may have to increase the reserve, which could adversely impact net income. If actual or expected future losses are less than we currently estimate, we may have to decrease the reserve, which could favorably impact net income. In those cases, we disclose such adjustment separately in the operating summary.

The activity in the reserve for anticipated future losses on discontinued products for the last three years (pretax) was:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Reserve, beginning of period	\$ 789.2	\$ 790.4	\$ 1,052.3
Operating losses	(15.4)	(34.8)	(93.4)
Net realized capital gains (losses)	111.0	(8.5)	(124.7)
Cumulative effect of new accounting standard as of April 1, 2009 <sup>(1)</sup>	-	42.1	-
Reserve reduction	-	-	(43.8)
<b>Reserve, end of period</b>	<b>\$ 884.8</b>	<b>\$ 789.2</b>	<b>\$ 790.4</b>

(1) The adoption of new accounting guidance for OTTI of debt securities issued in 2009 resulted in a cumulative effect adjustment at April 1, 2009. Refer to Note 2 beginning on page 57 for additional information. This amount is not reflected in accumulated other comprehensive loss and retained earnings in shareholders' equity since the results of discontinued products do not impact our operating results.

During 2010, discontinued products reflected net realized capital gains primarily attributable to gains from sales of debt securities and investment real estate and an operating loss. During 2009 and 2008, discontinued products reflected operating losses and net realized capital losses, both attributable to the unfavorable investment conditions that existed from the latter half of 2008 through the second quarter of 2009. Net realized capital losses in 2008 were due primarily to OTTI of debt securities (refer to "Investments – Net Realized Capital Gains and Losses" on page 13 for additional information) and derivative losses partially offset by net gains on sales of equity securities.

We review the adequacy of the discontinued products reserve quarterly and, as a result, the reserve at December 31, 2010 reflects our best estimate of anticipated future losses. Specifically, we evaluated the operating losses in 2010 and 2009 against expectations of future cash flows assumed in estimating this reserve and do not believe an adjustment to this reserve was required at December 31, 2010 or 2009. In the year ended December 31, 2008, \$44 million (\$29 million after tax) was released from this reserve. The 2008 reserve reduction was primarily due to favorable mortality and retirement experience compared to assumptions we previously made in estimating the reserve.

## INVESTMENTS

At December 31, 2010 and 2009, our investment portfolio consisted of the following:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>
Debt and equity securities available for sale	\$ 16,961.6	\$ 17,159.7
Mortgage loans	1,509.8	1,594.0
Other investments	1,244.6	1,220.1
<b>Total investments</b>	<b>\$ 19,716.0</b>	<b>\$ 19,973.8</b>

The risks associated with investments supporting experience-rated pension and annuity products in our Large Case Pensions business are assumed by the contract holders and not by us (subject to, among other things, certain minimum guarantees). Anticipated future losses associated with investments supporting discontinued fully-guaranteed Large Case Pensions products are provided for in the reserve for anticipated future losses on discontinued products.

As a result of the foregoing, investment risks associated with our experience-rated and discontinued products generally do not impact our operating results. Investments supported the following products at December 31, 2010 and 2009:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>
Experience-rated products	\$ 1,690.2	\$ 1,681.1
Discontinued products	3,712.3	3,681.8
Remaining products	14,313.5	14,610.9
<b>Total investments</b>	<b>\$ 19,716.0</b>	<b>\$ 19,973.8</b>

Assets supporting experience-rated products may be subject to contract holder or participant withdrawals. Experience-rated contract holder and participant-directed withdrawals for the last three years were as follows:

(Millions)	2010	2009	2008
Scheduled contract maturities and benefit payments <sup>(1)</sup>	\$ 261.2	\$ 267.2	\$ 338.8
Contract holder withdrawals other than scheduled contract maturities and benefit payments <sup>(2)</sup>	25.9	10.6	31.1
Participant-directed withdrawals <sup>(2)</sup>	3.9	3.1	3.9

(1) Includes payments made upon contract maturity and other amounts distributed in accordance with contract schedules.

(2) Approximately \$527.8 million, \$537.0 million and \$524.3 million at December 31, 2010, 2009 and 2008, respectively, of experience-rated pension contracts allowed for unscheduled contract holder withdrawals, subject to timing restrictions and formula-based market value adjustments. Further, approximately \$95.3 million, \$95.9 million and \$93.2 million at December 31, 2010, 2009 and 2008, respectively, of experience-rated pension contracts supported by general account assets could be withdrawn or transferred to other plan investment options at the direction of plan participants, without market value adjustment, subject to plan, contractual and income tax provisions.

### Debt and Equity Securities

Debt securities had an average quality rating of A and A+ at December 31, 2010 and 2009, respectively, with approximately \$4.4 billion at December 31, 2010 and \$4.9 billion at December 31, 2009 rated AAA. The debt securities that were rated below investment grade (that is, having a quality rating below BBB-/Baa3) at December 31, 2010 and 2009 were \$1.2 billion and \$1.3 billion, respectively (of which 17% and 15% at December 31, 2010 and 2009, respectively, supported our discontinued and experience-rated products).

At December 31, 2010 and 2009, we held approximately \$707 million and \$486 million, respectively, of municipal debt securities and \$2 million and \$34 million, respectively, of structured product debt securities that were guaranteed by third parties, collectively representing approximately 4% and 3%, respectively, of our total investments. These securities had an average credit rating of A+ at both December 31, 2010 and December 31, 2009 with the guarantee. Without the guarantee, the average credit rating of the municipal debt securities was A and A+ at December 31, 2010 and 2009, respectively. The structured product debt securities are not rated by the rating agencies on a standalone basis. We do not have any significant concentration of investments with third party guarantors (either direct or indirect).

We classify debt and equity securities as available for sale and carry them at fair value on our balance sheet. Approximately 2% and 3% of our debt and equity securities at December 31, 2010 and 2009, respectively, were valued using inputs that reflect our own assumptions (categorized as Level 3 inputs in accordance with GAAP - Refer to Note 10 of Notes to Consolidated Financial Statements beginning on page 73 for additional information on the methodologies and key assumptions we use to determine the fair value of investments).

At December 31, 2010 and 2009, debt and equity securities had net unrealized gains of \$985 million and \$717 million, respectively, of which \$301 million and \$207 million, respectively, related to our experience-rated and discontinued products.

Refer to Note 8 of Notes to Consolidated Financial Statements beginning on page 67 for details of net unrealized capital gains and losses by major security type, as well as details on our debt securities with unrealized losses at December 31, 2010 and 2009. We regularly review our debt securities to determine if a decline in fair value below the carrying value is other-than-temporary. If we determine a decline in fair value is other-than-temporary, we will write-down the carrying value of the security as a credit impairment. The amount of the credit-related impairment is included in our operating results, and the non-credit component is included in other comprehensive income (if we do not intend to sell the security). Accounting for OTTI of our debt securities is considered a critical accounting estimate. Refer to "Critical Accounting Estimates - Other-Than-Temporary Impairment of Debt Securities" on page 23 for additional information.

### Net Realized Capital Gains and Losses

Net realized capital gains (losses) were \$228 million in 2010, \$55 million in 2009 and \$(656) million in 2008. The net realized capital gains in 2010 and 2009 primarily reflect sales of debt securities. In 2010, these gains were partially offset by losses on derivative transactions while in 2009, these gains were also attributable to gains on derivative transactions partially offset by OTTI losses. Net realized capital losses in 2008 primarily reflect OTTI losses as depicted on page 70. The increase in net realized capital gains in 2009 compared to 2008 was primarily due to a

change in the accounting guidance for the recognition of OTTI of debt securities and an overall general improvement in the economic environment during 2009 compared to 2008. Prior to the adoption of new accounting guidance for OTTI of debt securities on April 1, 2009, both yield- and credit-related OTTI were recognized in earnings if we could not assert our intention to hold the security until recovery. In contrast, after April 1, 2009, only credit-related impairments are recognized in earnings unless we have the intention to sell the security in an unrealized loss position, in which case the yield-related OTTI is also recognized in earnings. Refer to Note 2 of Notes to Consolidated Financial Statements beginning on page 57 for additional information.

Yield-related OTTI losses were not significant in 2010. In 2009, yield-related OTTI losses were \$76 million, primarily related to U.S. Treasury and corporate securities that were temporarily in a loss position due to changes in interest rates and the widening of credit spreads on corporate securities relative to the interest rates on U.S. Treasury Securities in the first half of 2009. Because we did not assert our intention to hold these securities, under applicable accounting guidance, we recorded a yield-related OTTI loss. In 2008, yield-related OTTI losses were \$523 million. These yield-related impairments were primarily due to the widening of credit spreads relative to the interest rates on U.S. Treasury securities in 2008 and the application of the then-applicable accounting guidance for OTTI which required us to assert our intention to hold to recovery, which we could not make. During 2008, significant declines in the U.S. housing market resulted in the credit and other capital markets experiencing volatility and limitations on the ability of companies to issue debt or equity securities. The lack of available credit, lack of confidence in the financial sector, increased volatility in the financial markets and reduced business activity resulted in credit spreads widening during 2008.

Included in net realized capital losses for 2008 were \$120 million of credit-related OTTI losses, of which \$105 million related to investments in debt securities of Lehman Brothers Holdings Inc. and Washington Mutual, Inc. We had no other individually material realized capital losses on debt or equity securities that impacted our operating results in 2010, 2009 or 2008.

### **Mortgage Loans**

Our mortgage loan portfolio (which is collateralized by commercial real estate) represented 8% of our total invested assets at both December 31, 2010 and 2009. There were no material impairment reserves on these loans at December 31, 2010 or 2009. Refer to Notes 2 and 8 of Notes to Consolidated Financial Statements beginning on pages 57 and 67, respectively, for additional information.

### **Risk Management and Market-Sensitive Instruments**

We manage interest rate risk by seeking to maintain a tight match between the durations of our assets and liabilities where appropriate. We manage credit risk by seeking to maintain high average quality ratings and diversified sector exposure within our debt securities portfolio. In connection with our investment and risk management objectives, we also use derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. Our use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swap agreements, forward contracts, futures contracts and credit default swaps. Additionally, from time to time, we receive warrants from our vendors. These instruments, viewed separately, subject us to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, we expect these instruments to reduce overall risk.

We regularly evaluate our risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. We also regularly evaluate the appropriateness of investments relative to our management-approved investment guidelines (and operate within those guidelines) and the business objectives of our portfolios. On a quarterly basis, we review the impact of hypothetical net losses in our investment portfolio on our consolidated near-term financial position, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes represent the most material risk exposure category for us. We determine the potential effect of interest rate risk on near-term net income, cash flow and fair value based on commonly-used models. The models project the impact of interest rate changes on a wide range of factors, including duration, put options and call options. We also estimate the impact on fair value based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which we believe represents a moderately adverse scenario and is

approximately equal to the historical annual volatility of interest rate movements for our intermediate-term available-for-sale debt securities) and an immediate decrease of 25% in prices for domestic equity securities.

The theoretical change to the fair values of our market sensitive instruments from this evaluation was \$371 million (\$570 million pretax) at December 31, 2010. Approximately \$213 million (\$327 million pretax) was the result of a theoretical reduction of the fair value of our long-term debt. Changes in the fair value of our long-term debt do not impact our financial position or operating results. Additionally, \$158 million (\$243 million pretax) was from a theoretical reduction in the fair value of our investment securities and a theoretical reduction in the value of interest rate sensitive liabilities. We do not record our liabilities at fair value. Reductions in the fair value of our investment securities would be reflected as an unrealized loss in equity, as we do not have a trading portfolio. Based on our overall exposure to interest rate risk and equity price risk, we believe that these changes in market rates and prices would not materially affect our consolidated near-term financial position, operating results or cash flows as of December 31, 2010.

## LIQUIDITY AND CAPITAL RESOURCES

### Cash Flows

We meet our operating cash requirements by maintaining liquidity in our investment portfolio, using overall cash flows from premiums, deposits and income received on investments and issuing commercial paper. We monitor the duration of our portfolio of highly marketable debt securities and mortgage loans, and execute purchases and sales of these investments with the objective of having adequate funds available to satisfy our maturing liabilities. Overall cash flows are used primarily for claim and benefit payments, contract withdrawals, operating expenses, share repurchases and shareholder dividends. In addition, we maintain a committed short-term borrowing capacity of \$1.5 billion through our revolving credit facility.

Presented below is a condensed statement of cash flows for each of the last three years (the full statements of cash flows are presented on page 56). We present net cash flows used for operating activities and net cash flows provided by investing activities separately for our Large Case Pensions segment because changes in the insurance reserves for the Large Case Pensions segment (which are reported as cash used for operating activities) are funded from the sale of investments (which are reported as cash provided by investing activities). Refer to the Consolidated Statements of Cash Flows on page 56 for additional information.

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
<b>Cash flows from operating activities</b>			
Health Care and Group Insurance (including Corporate Financing)	<b>\$ 1,644.9</b>	\$ 2,711.5	\$ 2,397.6
Large Case Pensions	<b>(232.8)</b>	(223.2)	(190.7)
<b>Net cash provided by operating activities</b>	<b>1,412.1</b>	2,488.3	2,206.9
<b>Cash flows from investing activities</b>			
Health Care and Group Insurance	<b>429.8</b>	(2,380.0)	(1,485.2)
Large Case Pensions	<b>204.7</b>	380.3	411.9
<b>Net cash provided by (used for) investing activities</b>	<b>634.5</b>	(1,999.7)	(1,073.3)
<b>Net cash used for financing activities</b>	<b>(1,382.6)</b>	(464.5)	(1,208.1)
<b>Net increase (decrease) in cash and cash equivalents</b>	<b>\$ 664.0</b>	\$ 24.1	\$ (74.5)

### Cash Flow Analysis

Cash flows provided by operating activities for Health Care and Group Insurance were approximately \$1.6 billion in 2010, \$2.7 billion in 2009 and \$2.4 billion in 2008. In 2010, we made payments of approximately \$328 million (\$505 million pretax) for voluntary contributions to the Aetna Pension Plan and \$191 million for the return of excess Medicare payments received in 2009.

Cash flows from investing activities in 2010 increased from 2009 primarily from an increase in the sale of our subsidiaries' investment securities to fund dividends to our parent company. Also in 2009, we spent \$70 million on an acquisition we expect will enhance our existing product capabilities and future growth opportunities in behavioral health products. There were no acquisitions in 2010 or 2008. During December 2010, we entered into an agreement to acquire Medicity for approximately \$500 million. That transaction closed in January 2011. Refer to Note 3 of Notes to Consolidated Financial Statements beginning on page 64 for additional information.

Cash flows used for financing activities primarily reflect share repurchases partially offset by the issuances of debt in 2010 and 2008. Refer to Debt below for additional information. During the last three years, we repurchased our common stock under various repurchase programs authorized by our Board. In 2010, 2009 and 2008, we repurchased approximately 52 million, 29 million and 43 million shares of common stock at a cost of \$1.6 billion, \$773 million and \$1.8 billion, respectively. At December 31, 2010, the capacity remaining under our Board-approved share repurchase program was approximately \$735 million.

On September 24, 2010, our Board declared an annual cash dividend of \$.04 per common share to shareholders of record at the close of business on November 15, 2010. The dividend was paid on November 30, 2010. On February 3, 2011, our Board moved us to a quarterly dividend payment cycle and declared a cash dividend of \$0.15 per common share that will be paid on April 29, 2011 to shareholders of record at the close of business on April 14, 2011. Declaration and payment of future dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change. Prior to February 2011, our policy had been to pay an annual dividend. Our Board reviews our common stock dividend at least annually. Among the factors considered by our Board in determining the amount of dividends are our operating results and the capital requirements, growth and other characteristics of our businesses.

*Debt*  
In August 2010, we issued \$750 million of 3.95% senior notes due 2020 in anticipation of the 2011 scheduled maturity of certain of our senior notes. In September 2008, we issued \$500 million of senior notes to secure long-term favorable rates.

From time to time, we use short-term commercial paper borrowings to address timing differences between cash receipts and disbursements. The maximum amount of commercial paper borrowings outstanding during 2010 was \$747 million.

Our committed short-term borrowing capacity consists of a \$1.5 billion revolving credit facility which terminates in March 2013 (the "Facility"). The Facility also provides for the issuance of letters of credit at our request, up to \$200 million, which count as usage of the available commitments under the Facility. The Facility permits the aggregate commitments under the Facility to be expanded to a maximum of \$2.0 billion upon our agreement with one or more financial institutions. There were no amounts outstanding under the Facility at any time during 2010.

Our debt to capital ratio (calculated as the sum of all short- and long-term debt outstanding ("total debt") divided by the sum of shareholders' equity plus total debt) was approximately 31% and 30% at December 31, 2010 and 2009, respectively. We continually monitor existing and alternative financing sources to support our capital and liquidity needs, including, but not limited to, debt issuance, preferred or common stock issuance, reinsurance and pledging or selling of assets.

Interest expense was \$255 million, \$243 million and \$236 million for 2010, 2009 and 2008, respectively. The increase in interest expense over this period was due to higher overall average long-term debt levels as a result of the issuance of senior notes in August 2010 and September 2008.

Refer to Note 14 of Notes to Consolidated Financial Statements on page 89 for additional information on our short-term and long-term debt.

## Contractual Obligations

The following table summarizes certain estimated future obligations by period under our various contractual obligations at December 31, 2010. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2010 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements). We believe that funds from future operating cash flows, together with cash, investments and other funds available under the Facility or from public or private financing sources, will be sufficient to meet our existing commitments as well as our liquidity needs associated with future operations, including strategic transactions.

(Millions)	2011	2012 - 2013	2014 - 2015	Thereafter	Total
Long-term debt obligations, including interest	\$ 1,125.5	\$ 414.8	\$ 414.8	\$ 5,868.7	\$ 7,823.8
Operating lease obligations	132.9	147.3	75.3	56.2	411.7
Purchase obligations	199.5	172.8	52.1	6.4	430.8
Other liabilities reflected on our balance sheet: (1)					
Future policy benefits (2)	728.4	1,358.4	1,052.8	3,865.2	7,004.8
Unpaid claims (2)	593.3	465.3	320.1	728.9	2,107.6
Policyholders' funds (2) (3)	918.1	119.1	91.3	653.9	1,782.4
Other liabilities (4)	2,361.9	153.4	112.1	249.7	2,877.1
<b>Total</b>	<b>\$ 6,059.6</b>	<b>\$ 2,831.1</b>	<b>\$2,118.5</b>	<b>\$ 11,429.0</b>	<b>\$ 22,438.2</b>

(1) Payments of other long-term liabilities exclude Separate Account liabilities of approximately \$5.3 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of our business.

(2) Total payments of future policy benefits, unpaid claims and policyholders' funds include approximately \$751.4 million, \$49.5 million and \$181.3 million, respectively, of reserves for contracts subject to reinsurance. We expect the assuming reinsurance carrier to fund these obligations and have reflected these amounts as reinsurance recoverable assets on our consolidated balance sheet.

(3) Customer funds associated with group life and health contracts of approximately \$347.0 million have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt and equity securities supporting experience-rated products of \$105.3 million have been excluded from the table above.

(4) Other liabilities in the table above include general expense accruals and other related payables and exclude the following:

- Employee-related benefit obligations of \$1.0 billion including our pension, other postretirement and post-employment benefit obligations and certain deferred compensation arrangements. These liabilities do not necessarily represent future cash payments we will be required to make, or such payment patterns cannot be determined. However, other long-term liabilities include an expected voluntary contribution to the Aetna Pension Plan of \$60.0 million in 2011 and expected benefit payments of approximately \$456.3 million over the next ten years for our nonqualified pension plan and our postretirement benefit plans, which we primarily fund when paid by the plans.
- Deferred gains of \$50.4 million which will be recognized in our earnings in the future in accordance with GAAP.
- Net unrealized capital gains of \$149.3 million supporting discontinued products.
- Minority interests of \$74.3 million consisting of subsidiaries that we own less than 100%. This amount does not represent future cash payments we will be required to make.
- Income taxes payable of \$20.0 million related to uncertain tax positions.

## Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to Aetna as a holding company, since Aetna is not an HMO or an insurance company. The additional regulations applicable to our HMO and insurance company subsidiaries are not expected to affect our ability to service our debt, meet our other financing obligations or pay dividends, or the ability of any of our subsidiaries to service other financing obligations, if any. Under regulatory requirements, at December 31, 2010, the amount of dividends that our insurance and HMO subsidiaries could pay to Aetna without prior approval by regulatory authorities was approximately \$1.6 billion in the aggregate.

We maintain capital levels in our operating subsidiaries at or above targeted and/or required capital levels and dividend amounts in excess of these levels to meet our liquidity requirements, including the payment of interest on debt and shareholder dividends. In addition, at our discretion, we use these funds for other purposes such as funding share repurchase programs, investments in new businesses and other purposes we consider necessary.

### **Off-Balance Sheet Arrangements**

We do not have guarantees or other off-balance sheet arrangements that we believe, based on historical experience and current business plans, are reasonably likely to have a material impact on our current or future operating results, financial condition or cash flows. Refer to Notes 8 and 18 of Notes to Consolidated Financial Statements beginning on page 67 and 91, respectively, for additional detail of our variable interest entities and guarantee arrangements, respectively, at December 31, 2010.

### **Solvency Regulation**

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2010, the RBC Ratio of each of our primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2010, at that date, each of our active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own RBC standards when they determine a company's rating.

### **CRITICAL ACCOUNTING ESTIMATES**

We prepare our consolidated financial statements in accordance with GAAP. The application of GAAP requires management to make estimates and assumptions that affect our consolidated financial statements and related notes. The accounting estimates described below are those we consider critical in preparing our consolidated financial statements. We use information available to us at the time the estimates are made; however, as described below, these estimates could change materially if different information or assumptions were used. Also, these estimates may not ultimately reflect the actual amounts of the final transactions that occur.

#### **Health Care Costs Payable**

Approximately 90% and 88% of health care costs payable are estimates of the ultimate cost of claims that have been incurred but not yet reported to us and of those which have been reported to us but not yet paid (collectively "IBNR") at December 31, 2010 and 2009, respectively. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables and accruals for state assessments. We develop our estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, we consider the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate to be the most critical assumptions. In developing our estimate of IBNR, we consistently apply these actuarial principles and assumptions each period, with consideration to the variability of related factors.

We analyze historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." We estimate completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents our estimate of claims remaining to be paid as of the financial statement date and is included in our health care costs payable. We use completion factors predominantly to estimate reserves for claims with claim incurred dates greater than three months prior to the financial statement date. The completion factors we use reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in membership and product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months prior to the financial statement date have less activity, we use a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. We place a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

Our health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including our ability to manage health care costs through underwriting criteria, product design, negotiation of favorable provider contracts and medical management programs. The aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs, direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and our health care cost trend rate.

For each reporting period, we use an extensive degree of judgment in the process of estimating our health care costs payable, and as a result, considerable variability and uncertainty is inherent in such estimates; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period we recognize our best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. We believe our estimate of health care costs payable is reasonable and adequate to cover our obligations at December 31, 2010; however, actual claim payments may differ from our estimates. A worsening (or improvement) of our health care cost trend rates or changes in completion factors from those that we assumed in estimating health care costs payable at December 31, 2010 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, we re-examine previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that our estimates of health care costs payable could develop either favorably, (that is, our actual health care costs for the period were less than we estimated) or unfavorably. The changes in our estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. As reported in the rollforward of our health care costs payable in Note 6 of our Notes to Consolidated Financial Statements on page 65, our prior year estimates of health care costs payable decreased by approximately \$326 million, \$66 million and \$163 million in 2010, 2009 and 2008, respectively. These reductions were offset by current year health care costs when we established our estimate of current period health care costs payable. Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for health care costs payable. When significant decreases (increases) in prior-periods' health care cost estimates occur that we believe significantly impact our current period operating results, we disclose that amount as favorable (unfavorable) development of prior-period health care cost estimates. In 2010, we had approximately \$118 million of favorable development of prior-period health care cost estimates that primarily resulted from lower than projected paid claims in the first half of 2010 for claims incurred in the latter part of 2009 caused by lower than projected utilization of medical services driven by the abatement of H1N1 and other flu, among other factors. In 2009, we had approximately \$116 million of unfavorable development of prior-period health care cost estimates that was driven by unusually high paid claims activity in the first half of 2009 related to the second half of 2008. This unfavorable development of prior year health care cost estimates offset the amount of the 2009 reduction in our estimate of health care costs payable for prior years.

During 2010, we observed an increase in our completion factors relative to those assumed at year end 2009. During 2009 we observed essentially no change in our completion factors relative to those assumed at year end 2008. After considering the claims paid in 2010 and 2009 with dates of service prior to the fourth quarter of the previous year, we observed the assumed weighted average completion factors were 50 basis points higher and approximately flat, respectively, than previously estimated, resulting in a decrease of approximately \$23 million in 2010 and \$7 million in 2009 in health care costs payable that related to the prior year. We have considered the pattern of changes in our completion factors when determining the completion factors used in our estimates of IBNR at December 31, 2010. However, based on our historical claim experience, it is reasonably possible that our estimated completion factors may vary by plus or minus 50 basis points from our assumed rates, which could impact health care costs payable by approximately plus or minus \$32 million pretax.

Also during 2010 and 2009, we observed that our health care cost trend rates for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2010 and 2009 with claim incurred dates for the fourth quarter of the previous year, we observed health care cost trend rates that were approximately 6.3% and .9%, respectively, lower than previously estimated, resulting in a reduction of approximately \$303 million in 2010 and \$59 million in 2009 in health care costs payable that related to the prior year.

We consider historical health care cost trend rates together with our knowledge of recent events that may impact current trends when developing our estimates of current health care cost trend rates. When establishing our reserves at December 31, 2010, we increased our assumed health care cost trend rates for the most recent three months by 5.3% from health care cost trend rates recently observed. However, based on our historical claim experience, it is reasonably possible that our estimated health care cost trend rates may vary by plus or minus 5.5% from our assumed rates, which could impact health care costs payable by approximately plus or minus \$265 million pretax.

Health care costs payable as of December 31, 2010 and 2009 consisted of the following products:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>
Commercial	\$ 2,059.3	\$ 2,295.0
Medicare	421.5	492.0
Medicaid	150.1	108.3
<b>Total health care costs payable</b>	<b>\$ 2,630.9</b>	<b>\$ 2,895.3</b>

#### *Premium Deficiency Reserves*

We recognize a premium deficiency loss when it is probable that expected future health care costs will exceed our existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of expected losses for certain contracts. Any such reserves established would normally cover expected losses until the next policy renewal dates for the related policies. We did not have any premium deficiency reserves for our Health Care business at December 31, 2010 or 2009.

#### **Other Insurance Liabilities**

We establish insurance liabilities other than health care costs payable for benefit claims related to our Group Insurance segment. We refer to these liabilities as other insurance liabilities. These liabilities relate to our life, disability and long-term care products.

#### *Life and Disability*

The liabilities for our life and disability products reflect benefit claims that have been reported to us but not yet paid, estimates of claims that have been incurred but not yet reported to us, and future policy benefits earned under insurance contracts. We develop these reserves and the related benefit expenses using actuarial principles and assumptions that consider, among other things, discount, resolution and mortality rates. Completion factors are also evaluated when estimating our reserves for claims incurred but not yet reported for life products. We also consider the benefit payments from the U.S. Social Security Administration for which our disability members may be eligible and which may offset our liability for disability claims (this is known as the Social Security offset). Each period, we estimate these factors, to the extent relevant, based primarily on historical data, and use these estimates to determine the assumptions underlying our reserve calculations. Given the extensive degree of judgment and uncertainty used in developing these estimates, it is possible that our estimates could develop either favorably or unfavorably.

The discount rate is the interest rate at which future benefit cash flows are discounted to determine the present value of those cash flows. The discount rate we select is a critical estimate, because higher discount rates result in lower reserves. We determine the discount rate based on the current and estimated future yield of the asset portfolio supporting our life and disability reserves. If the discount rate we select in estimating our reserves is lower (higher) than our actual future portfolio returns, our reserves may be higher (lower) than necessary. Our discount rates for life waiver of premiums and long-term disability reserves at December 31, 2010 both decreased by .4%, when compared to the rates used at December 31, 2009. Our discount rates for life and disability reserves at December 31, 2009 decreased by .5%, when compared to the rates used at December 31, 2008. The discount rates we selected for disability and life reserves at December 31, 2010 and 2009 were lower than the rates we selected in the previous year due to lower projected future yields on the investment portfolio supporting these reserves. Additionally, 2009 reserves

increased due to longer disability claim durations. Based on our historical experience, it is reasonably possible that the assumed discount rates for our life and disability reserves may vary by plus or minus .5% from year to year. A .5% decrease in the discount rates selected for both our life and disability reserves would have increased current and future life and disability benefit costs by approximately \$37 million pretax for 2010.

For disability claims and a portion of our life claims, we must estimate the timing of benefit payments, which takes into consideration the maximum benefit period and the probabilities of recovery (i.e., recovery rate) or death (i.e., mortality rate) of the member. Benefit payments may also be affected by a change in employment status of a disabled member, for example, if the member returns to work on a part-time basis. Estimating the recovery and mortality rates of our members is complex. Our actuaries evaluate our current and historical claim patterns, the timing and amount of any Social Security offset (for disability only), as well as other factors including the relative ages of covered members and the duration of each member's disability when developing these assumptions. For disability reserves, if our actual recovery and mortality rates are lower (higher) than our estimates, our reserves will be lower (higher) than required to cover future disability benefit payments. For certain life reserves, if the actual recovery rates are lower (higher) than our estimates or the actual mortality rates are higher (lower) than our estimates, our reserves will be lower (higher) than required to cover future life benefit payments. We use standard industry tables and our historical claim experience to develop our estimated recovery and mortality rates. Claim reserves for our disability and life products are sensitive to these assumptions. Our historical experience has been that our recovery or mortality rates for our life and disability reserves vary by less than ten percent during the course of a year. A ten percent less (more) favorable assumption for our recovery or mortality rates would have increased (decreased) current and future life and disability benefit costs by approximately \$68 million pretax for 2010. When establishing our reserves at December 31, 2010, we have adjusted our estimates of these rates based on recent experience.

We estimate our reserve for claims incurred but not yet reported to us for life products largely based on completion factors. The completion factors we use are based on our historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. At December 31, 2010, we held approximately \$198 million in reserves for life claims incurred but not yet reported to us.

#### *Long-term Care*

We established reserves for future policy benefits for the long-term care products we issued based on the present value of estimated future benefit payments less the present value of estimated future net premiums. In establishing this reserve, we evaluated assumptions about mortality, morbidity, lapse rates and the rate at which new claims would be submitted to us. We estimated the future policy benefits reserve for long-term care products using these assumptions and actuarial principles. For long-term care insurance contracts, we use our original assumptions throughout the life of the policy and do not subsequently modify them unless we deem the reserves to be inadequate. A portion of our reserves for long-term care products also reflect our estimates relating to future payments to members currently receiving benefits. These reserves are estimated primarily using recovery and mortality rates, as described above.

#### *Premium Deficiency Reserves*

We recognize a premium deficiency loss when it is probable that expected future policy benefit costs will exceed our existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of expected losses for certain contracts. Any such reserves established would normally cover expected losses until the next policy renewal dates for the related policies. We did not have any premium deficiency reserves for our Group Insurance business at December 31, 2010 or 2009.

#### *Large Case Pensions Discontinued Products Reserve*

We discontinued certain Large Case Pensions products in 1993 and established a reserve to cover losses expected during the run-off period. Since 1993, we have made several adjustments resulting in a reduction to this reserve that have increased our net income. These adjustments occurred primarily because our investment experience as well as our mortality and retirement experience have been better than the experience we projected at the time we discontinued the products. There was no release of this reserve in 2010 or 2009. In 2008, we reduced this reserve by \$44 million due to favorable mortality and retirement experience compared to assumptions we previously made in estimating the

reserve. There can be no assurance that adjustments to the discontinued products reserve will occur in the future or that they will increase net income. Future adjustments could positively or negatively impact our net income.

#### **Recoverability of Goodwill and Other Acquired Intangible Assets**

We have made acquisitions that included a significant amount of goodwill and other intangible assets. Goodwill is subject to an annual (or under certain circumstances more frequent) impairment test based on its estimated fair value. Other intangible assets that meet certain criteria continue to be amortized over their useful lives and are also subject to a periodic impairment test. For these impairment evaluations, we use an implied fair value approach, which uses a discounted cash flow analysis and other valuation methodologies. These impairment evaluations use many assumptions and estimates in determining an impairment loss, including certain assumptions and estimates related to future earnings. If we do not achieve our earnings objectives, the assumptions and estimates underlying these impairment evaluations could be adversely affected, which could result in an asset impairment charge that would negatively impact our operating results. There were no impairment losses recognized in any of the three years ended December 31, 2010.

#### **Measurement of Defined Benefit Pension and Other Postretirement Benefit Plans**

We sponsor defined benefit pension ("pension") and other postretirement benefit ("OPEB") plans for our employees and retirees. Effective December 31, 2010, our employees will no longer earn future pension service credits in the Aetna Pension Plan, although the Aetna Pension Plan will continue to operate and account balances will continue to earn annual interest credits.

Major assumptions used in the accounting for our defined benefit plans include the expected return on plan assets and the discount rate. We select our assumptions based on our information and market indicators, and we evaluate our assumptions at each annual measurement date. A change in any of our assumptions would have an effect on our pension and OPEB plan costs. A discussion of our assumptions used to determine the expected return on plan assets can be found in Note 11 of Notes to Consolidated Financial Statements beginning on page 78.

The discount rates we used in accounting for our pension and OPEB plans were calculated using a yield curve as of our annual measurement date. The yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds (that is, bonds with a rating of Aa or better from Moody's Investors Service or a rating of AA or better from Standard and Poor's). We project the benefits expected to be paid from each plan at each point in the future based on each participant's current service (but reflecting expected future pay increases). These projected benefit payments are then discounted to the measurement date using the corresponding rate from the yield curve. A lower discount rate increases the present value of benefit obligations and increases costs. In 2010, we decreased our weighted average discount rate to 5.50% and 5.20% for our pension and OPEB plans, respectively, from 5.89% and 5.64%, respectively, at the previous measurement date in 2009. A one-percentage point decrease in the assumed discount rate would have a negligible effect on our annual pension and OPEB costs.

At December 31, 2010, the pension and OPEB plans had aggregate actuarial losses of \$2.5 billion. These losses are primarily due to a lower discount rate used to remeasure the obligation at December 31, 2010 and investment losses incurred in 2008. The accumulated actuarial loss is amortized over the expected life of pension plan participants (estimated to be up to 31 years at December 31, 2010) and the expected life of OPEB plan participants (estimated to be up to 15 years at December 31, 2010) to the extent the loss is outside of a corridor established in accordance with GAAP. The corridor is established based on the greater of 10% of the plan assets or 10% of the projected benefit obligation. At December 31, 2010, \$1.9 billion of the actuarial loss was outside of the corridor, resulting in amortization of approximately \$41 million after tax in our 2011 pension and OPEB expense.

Our expected return on plan assets and discount rate discussed above will not affect the cash contributions we are required to make to our pension and OPEB plans because we have met all minimum funding requirements. However, during the third quarter of 2010, we made \$505 million in voluntary cash contributions to the Aetna Pension Plan.

Refer to Note 11 of Notes to Consolidated Financial Statements beginning on page 78 for additional information on our defined benefit pension and other postretirement benefit plans.

### **Other-Than-Temporary Impairment of Debt Securities**

We regularly review our debt securities to determine whether a decline in fair value below the carrying value is other than temporary. If a decline in fair value is considered other than temporary, the cost basis or carrying amount of the security is written down. The write-down is then bifurcated into its credit and non-credit related components. The credit-related component is included in our operating results, and the non-credit related component is included in other comprehensive loss if we do not intend to sell the security. We analyze all facts and circumstances we believe are relevant for each investment when performing this analysis, in accordance with applicable accounting guidance promulgated by the Financial Accounting Standards Board and the U.S. Securities and Exchange Commission.

Among the factors we consider in evaluating whether a decline is other than temporary are whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole and the prospects for realizing the carrying value of the security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, we determine whether we intend to sell the security or if it is more likely than not that we will be required to sell the security before recovery of its cost basis. If either case is true, we recognize an OTTI and the cost basis/carrying amount of the security is written down to fair value.

Securities in an unrealized loss position for which we believe we will not recover the amortized cost due to the quality of the security or the credit-worthiness of the issuer are categorized as credit-related OTTI.

The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our projections and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell securities that were not impaired in prior reporting periods.

### **Revenue Recognition (Allowance for Estimated Terminations and Uncollectable Accounts)**

Our revenue is principally derived from premiums and fees billed to customers in the Health Care and Group Insurance businesses. In Health Care, revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in our records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. In Group Insurance, premium for group life and disability products is recognized as revenue, net of allowances for uncollectable accounts, over the term of coverage. Amounts received before the period of coverage begins are recorded as unearned premiums.

Health Care billings may be subsequently adjusted to reflect changes in the number of covered employees due to terminations or other factors. These adjustments are known as retroactivity adjustments. We estimate the amount of future retroactivity each period and adjust the recorded revenue accordingly. We also estimate the amount of uncollectable receivables each period and establish an allowance for uncollectable amounts. We base such estimates on historical trends, premiums billed, the amount of contract renewal activity during the period and other relevant information. As information regarding actual retroactivity and uncollectable amounts becomes known, we refine our estimates and record any required adjustments to revenues in the period they arise. A significant difference in the actual level of retroactivity or uncollectable amounts when compared to our estimated levels would have a significant effect on Health Care's operating results.

### **NEW ACCOUNTING STANDARDS**

Refer to Note 2 of Notes to Consolidated Financial Statements, beginning on page 57, for a discussion of recently issued accounting standards.

### **REGULATORY ENVIRONMENT**

#### **General**

Our operations are subject to comprehensive federal, state, local and international regulation in the jurisdictions in which we do business. The laws and rules governing our business and interpretations of those laws and rules continue to become more restrictive each year and are subject to frequent change. The enactment of Health Care Reform makes extensive changes to the U.S. health care system and significantly increases the regulation of our business. There also

continues to be a heightened review by federal and state regulators of the health care benefits industry's business and reporting practices.

Further, we must obtain and maintain regulatory approvals to price and market many of our products. Supervisory agencies, including CMS, and the newly-created Center for Consumer Information and Insurance Oversight ("CCIIO"), as well as state health, insurance and managed care departments and state boards of pharmacy have broad authority to:

- Grant, suspend and revoke our licenses to transact business;
- Suspend or limit our authority to market products;
- Regulate many aspects of the products and services we offer;
- Audit us and our performance of our contracts;
- Impose sanctions;
- Assess fines and/or penalties;
- Monitor our solvency and reserve adequacy; and/or
- Regulate our investment activities on the basis of quality, diversification and other quantitative criteria.

Our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by these agencies as well as state attorneys general, the Office of the Inspector General (the "OIG"), the Office of Personnel Management (the "OPM") and other state and federal government authorities. In addition, from time to time we receive, and expect to continue to receive, subpoenas and other requests for information from CMS, various state insurance and health care regulatory authorities, state attorneys general, the CCIIO, the OIG, the OPM, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, U.S. attorneys and other state and federal governmental authorities regarding, among other things, certain of our business practices. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds to members, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible loss of licensure or suspension or exclusion from participation in government programs.

The political environment is uncertain. The federal and state governments continue to enact and seriously consider many broad-based legislative and regulatory proposals that have or could materially impact various aspects of the health care system, including pending efforts in the U.S. Congress to repeal, amend or restrict funding for various aspects of Health Care Reform and pending litigation challenging the constitutionality of Health Care Reform.

Health Care Reform, enacted in March 2010, makes broad-based changes to the U.S. health care system which could significantly affect the U.S. economy and will significantly impact our business operations and financial results, including our pricing and medical benefit ratios. Health Care Reform presents us with new business opportunities, but also with new financial and other challenges. It is reasonably possible that Health Care Reform, in the aggregate, could have a material adverse effect on our business operations and financial results.

Components of the legislation will be phased in over the next seven years. We are and will continue to be required to dedicate material resources and incur material expenses during that time to implement and comply with Health Care Reform as well as state level health care reform. While the federal government has begun to issue regulations implementing Health Care Reform, many significant parts of the legislation require further guidance and clarification both at the federal level and in the form of regulations and actions by state legislatures to implement the law. As a result, many of the impacts of Health Care Reform will not be known for several years. Pending efforts in the U.S. Congress to repeal, amend or restrict funding for various aspects of Health Care Reform and the pending litigation challenging the constitutionality of Health Care Reform create additional uncertainty about the ultimate impact of the legislation. For example, we could be materially and adversely affected by the elimination of Health Care Reform's obligation to purchase health care coverage (the "individual mandate") unless our obligation to offer health insurance coverage to each person who purchases it also is eliminated. We cannot predict whether future federal or state legislation will change various aspects of Health Care Reform or the impact those changes will have on our business operations or financial results, but the effect could be materially adverse.

The expansion of health care coverage contemplated by Health Care Reform will be funded in part by material additional fees and taxes on us and other health insurers, health plans and other market participants and individuals beginning in 2014, as well as reductions to the reimbursements we and other health plans are paid by the federal government for our Medicare members, among other sources. While not all-inclusive, we are evaluating the impact of the following key provisions of Health Care Reform (assuming it is implemented in its current form) to determine the impact that they will have on our business operations and financial results:

- Requirements that began in September 2010 for health plans to submit and justify rates, provide dependent coverage up to age 26, eliminate certain lifetime and annual maximum limits on the dollar value of coverage, eliminate payments by members for covered preventive services, provide required reimbursements for emergency services, eliminate prohibited policy rescissions and implement new claim appeal procedures. Regulations issued to date, among other things: permit specified lifetime and minimum annual coverage limits, which will be phased out by 2014; effectively guarantee issuance of insurance coverage for enrollees under age 19 beginning in 2010; clarify the rules applicable to grandfathered status; clarify regulations regarding appeals; delay application of anti-discrimination requirements; and provide implementation guidance across a range of topics.
- Closure of the gap in coverage for Medicare Part D prescription drug coverage (the so-called “donut hole”) which began to close in 2010 and will incrementally close until the coverage gap is eliminated in 2020.
- Required minimum MLRs, as defined by interim final regulations, for insured plans of 85% for the large group market and 80% for the individual and small group markets beginning January 1, 2011, with rebates issued to employers and/or members for the amount under the minimum beginning in 2012.
- Enhanced rate review and disclosure processes on the part of states or the HHS for premium increases above a specified threshold. HHS has filed a Notice of Proposed Rulemaking outlining its expectations of state review as well as circumstances under which HHS would intervene in the review process. The final rules are expected to be issued in 2011.
- Freezing 2011 Medicare Advantage payment rates for payments to us based on 2010 levels, with additional reductions over a multi-year period beginning in 2012 based on regionally-adjusted benchmarks and the linking of Medicare Advantage payments to a plan’s CMS quality rating or “star rating.”
- Non-deductibility of employee compensation in excess of \$500,000 beginning in 2013. Additionally, there will be material annual taxes and assessments on health insurance providers beginning in 2014.
- Multiple insurance reforms beginning in 2014, including rating limits and benefit requirements, guaranteed issue and renewability of coverage in the individual and small group markets, elimination of pre-existing conditions exclusions for all re-enrollees, elimination of annual limits on the dollar value of coverage, and a prohibition on eligibility waiting periods beyond 90 days.
- Establishment of Exchanges for the individual and small group markets by 2014.
- Expansion of state-based Medicaid coverage beginning in 2014.
- Establishment of individual and employer mandates for insurance coverage, federal assistance to purchase health coverage for individuals, and detailed public reporting and disclosure requirements for health plans, each beginning in 2014.
- A 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2018.

The law also specifies required benefit designs, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal oversight of health plans, including regulations and processes that could delay or limit our ability to appropriately increase our health plan premiums. This in turn could adversely affect our ability to continue to participate in certain product lines and/or geographies we serve today. Health Care Reform will require us to phase out many of our current limited benefit product offerings no later than 2014, and the application of minimum MLR standards to both our limited benefit and student health products may have an adverse effect on our ability to sell these products in the future. For additional information on health care reform, refer to “Forward-Looking Information/Risk Factors” beginning on page 35.

At the state level, all 50 states and the District of Columbia will hold regular legislative sessions in 2011. In 2010, state legislatures focused on the impact of Health Care Reform and state budget deficits. Some states are responding to Health Care Reform by creating commissions and advisory groups to discuss the potential impact on the state health care community and systems as well as to evaluate new requirements applicable to the state itself. Health Care Reform significantly alters the federal structure that shapes the state regulation of health insurance, and requires states to

significantly amend numerous existing statutes and regulations. This implementation of Health Care Reform has been delayed in many states due to the pending legal challenges to the constitutionality of Health Care Reform.

We expect some of that state level legislation to be enacted in 2011. We also expect state legislatures to continue to focus on the impact of Health Care Reform and state budget deficits in 2011. In addition, we expect some states to continue to consider legislation to extend coverage to the uninsured through the Exchanges and Medicaid expansions, restrict health plan rescission of individual coverage, mandate minimum medical benefit ratios, implement rating reforms and mandate autism coverage. For example, regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either enforcing existing legal requirements more stringently or proposing different regulatory standards; requiring us and other health plans to price to specified minimum loss ratios and demonstrate that pricing in rate filings; and imposing taxes on insurers and other health plans to finance the Exchanges. We cannot predict what provisions the legislation or regulation will contain in any state or what effect the legislation or regulation will have on our business operations or financial results, but the effect could be materially adverse.

## **Health Care Regulation**

### **General**

Federal, state and foreign governments have adopted laws and regulations that govern our business activities in various ways. These laws and regulations, including Health Care Reform, restrict how we conduct our business and result in additional burdens and costs to us.

In addition to the expanded regulation created by Health Care Reform discussed above, areas of governmental regulation include:

- Licensure
- Premium rates and rating methodologies
- Medical benefit ratios
- Underwriting rules and procedures
- Policy forms, including plan design and disclosures
- Benefit mandates
- Market conduct
- Utilization review activities
- Payment of claims, including timeliness and accuracy of payment
- Member rights and responsibilities
- Sales and marketing activities
- Quality assurance procedures
- Disclosure of medical and other information
- In-network and out-of-network provider rates of payment
- General assessments
- Provider contract forms
- Pharmacy and pharmacy benefit management operations
- Required participation in coverage arrangements for high-risk insureds, either directly or through an assessment or other risk-pooling mechanism
- Delegation of risk and other financial arrangements
- Producer licensing and compensation
- Entry into and exit from geographic and product markets and market segments
- Financial condition (including reserves) and
- Corporate governance.

These laws and regulations are different in each jurisdiction.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. To establish a new insurance company or an HMO in a state, we generally would have to obtain such a certificate. The time necessary to obtain such a certificate varies from state to state. Each health insurer and HMO must file periodic

financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of our regulated subsidiaries to pay dividends. In addition, some of our business and related activities may be subject to PPO, managed care organization, utilization review or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, but may contain network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for our delivery of services, payment of claims, fraud prevention, protection of consumer health information and payment for covered benefits and services. With the amendment of the Annual Financial Reporting Model Regulation by the NAIC to incorporate elements of the Sarbanes-Oxley Act of 2002, we expect states will continue to expand their regulation of the corporate governance and internal control activities of HMOs and insurance companies.

### **Pricing and Underwriting Restrictions**

Pricing and underwriting regulation by states limits our underwriting and rating practices and that of other health insurers, particularly for small employer groups and individuals. These laws and regulations vary by state. In general, they apply to certain business segments and limit our ability to set prices or renew business, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict our ability to price for the risk we assume and/or reflect reasonable costs in our pricing. Health Care Reform expands the rate review process by, among other things, requiring our rates to be reviewed for "reasonableness" at either the state or the federal level. HHS' proposed rulemaking does not replace the current state rate approval process; it adds an analysis and disclosure related to reasonableness to that process, which may impact state approval decision-making and further affect our ability to price for the risk we assume. Health Care Reform also specifies minimum MLRs, as defined by interim final regulations, of 85% for the large group market and 80% for the individual and small group markets beginning in 2011, with rebates issued to employers and/or members for the amount under the minimum beginning in 2012. Because Health Care Reform is structured as a "floor" for many of its requirements, states have the latitude to enact more stringent rules governing its various restrictions. States may adopt higher minimum MLR requirements, use more stringent definitions of MLR, require prior approval of rates, or impose other requirements related to minimum MLR. For example, California has issued emergency regulations requiring rate filings for individual products to price prospectively to the 80% medical loss ratio. Actions by states such as New Jersey's existing minimum loss ratio legislation, New York's new 82% minimum loss ratio for the small group and individual markets and California's new regulations will further inhibit our ability to price for the risk we assume. Both the rate approval process and the application of minimum MLR thresholds may further restrict our ability to price for the risk we assume, which could adversely affect our ability to operate our business profitably in certain product lines and geographies we serve today.

Many of these laws and regulations also limit the differentials in rates insurers and other carriers may charge between new and renewal business, and/or between groups or individuals based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal rates, restrict the application of pre-existing condition exclusions and limit the ability of a carrier to terminate coverage of an employer group. In addition, HHS' proposed rulemaking on rates imposes additional public disclosure requirements on any rate filings which exceed the "reasonableness" threshold and requires additional review of these rates.

In addition to Health Care Reform requirements, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") generally requires insurers and other carriers that cover small employer groups in any market to accept for coverage any small employer group applying for a basic and standard plan of benefits. HIPAA also mandates guaranteed renewal of health care coverage for most employer groups, subject to certain defined exceptions, and provides for specified employer notice periods in connection with product and market withdrawals. The law further limits exclusions based on pre-existing conditions for individuals covered under group policies to the extent the individuals had prior creditable coverage within a specified time frame. Like Health Care Reform, HIPAA is structured as a "floor" requirement, allowing states latitude to enact more stringent rules governing each of these restrictions. For example, certain states have modified HIPAA's definition of a small group (2-50 employees) to include groups of one employee.

In addition, a number of states provide for a voluntary reinsurance mechanism to spread small group risk among participating insurers and other carriers. In a small number of states, participation in this pooling mechanism is mandatory for all small group carriers. In general, we have elected not to participate in voluntary pools, but even in

the voluntary pool states, we may be subject to certain supplemental assessments related to the state's small group experience.

#### **HIPAA Administrative Simplification and Privacy; Gramm-Leach-Bliley Act**

The regulations under the administrative simplification provisions of HIPAA, as further modified by Health Care Reform, also impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors. The law authorizes HHS to issue standards for electronic transactions, as well as privacy and security of medical records and other individually identifiable health information ("Administrative Simplification").

Administrative Simplification requirements apply to self-funded group health plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically ("Covered Entities"). Regulations adopted to implement Administrative Simplification also require that business associates acting for or on behalf of these Covered Entities be contractually obligated to meet HIPAA standards. The Administrative Simplification regulations establish significant criminal penalties and civil sanctions for noncompliance.

Under Administrative Simplification, HHS has released rules mandating the use of standard formats in electronic health care transactions (for example, health care claims submission and payment, plan eligibility, precertification, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits). HHS also has published rules requiring the use of standardized code sets and unique identifiers for employers and providers. By 2013, the federal government will require that healthcare organizations, including health insurers, providers and laboratories, upgrade to an updated and expanded set of standardized diagnosis and procedure codes used for describing health conditions. Implementing this new set of standardized codes, known as ICD-10, will require substantial investments from health care organizations, including us, over the next several years. We currently estimate that our ICD-10 project costs will be between \$50 million and \$70 million each year for 2011, 2012 and 2013.

The HIPAA privacy regulations adopted by HHS establish limits on the use and disclosure of medical records and other individually identifiable health information by Covered Entities. In addition, the HIPAA privacy regulations provide patients with new rights to understand and control how their health information is used. The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may apply to us and other Covered Entities, including laws that place stricter controls on the release of information relating to specific diseases or conditions, and complying with additional state requirements could require us to make additional investments beyond those we have made to comply with the HIPAA regulations. HHS has also adopted security regulations designed to protect member health information from unauthorized use or disclosure.

In addition, states have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. In addition to health insurance, the GLBA regulations apply to life and disability insurance. Like HIPAA, this law sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. GLBA also gives banks and other financial institutions the ability to affiliate with insurance companies, which may lead to new competitors in the insurance and health care benefits businesses.

#### **Other Legislative Initiatives and Regulatory Initiatives**

In addition to the Health Care Reform measures discussed above, the federal and state governments continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care system. For example:

- On February 17, 2009, the American Recovery and Reinvestment Act of 2009 ("ARRA") was enacted into law. Among other things, ARRA expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of Protected Health Information ("PHI"). ARRA requires us and other covered entities to report any unauthorized release of, use of, or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. Business associates (e.g., entities that

provide services to health plans, such as electronic claims clearinghouses, print and fulfillment vendors, consultants, and us for the administrative services we provide to our ASC customers) must also comply with certain HIPAA provisions. In addition, ARRA establishes greater civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires the HHS to issue regulations implementing its privacy and security enhancements. We will continue to assess the impact of these regulations on our business as they are issued.

- On October 3, 2008, the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act 2008 (the "Mental Health Parity Act") was enacted into law. The Mental Health Parity Act became effective for plan years beginning on or after October 3, 2009 and requires that financial requirements and treatment limitations applicable to mental health or substance abuse disorder benefits be no more restrictive than those imposed on medical/surgical benefits. The Mental Health Parity Act does not require plans to offer mental health or substance use disorder benefits. The regulations implementing the Mental Health Parity Act are more far reaching than anticipated and required us to revise our benefit offerings and some of our business practices.
- In 2008, the U.S. Congress reduced funding for Medicare Advantage plans beginning in 2010 and imposed new marketing requirements on PDPs beginning in 2009.

Other legislative measures under consideration include the following:

- Amending or supplementing the Employee Retirement Income Security Act of 1974 ("ERISA") to impose greater requirements on the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, assessments for uninsured or high-risk pools, assessments for uncompensated care, or assessments to defray provider medical malpractice insurance costs.
- Reducing government funding of government-sponsored health programs in which we participate.
- Mandating minimum medical benefit ratios or otherwise restricting health plans' profitability.
- Extending malpractice and other liability exposure for decisions made by health plans.
- Mandating coverage for certain conditions and/or specified procedures, drugs or devices (for example, treatment for autism and infertility and experimental pharmaceuticals).
- Mandating expanded employer and consumer disclosures and notices.
- Regulating e-connectivity.
- Mandating or regulating the disclosure of provider fee schedules and other data about our payments to providers.
- Mandating or regulating disclosure of provider outcome and/or efficiency information.
- Imposing substantial penalties for our failure to pay claims within specified time periods.
- Imposing payment levels for services rendered to our members by providers who do not have contracts with us.
- Exempting physicians from the antitrust laws that prohibit price fixing, group boycotts and other horizontal restraints on competition.
- Restricting health plan claim processing, review, payment and related procedures.
- Mandating internal and external grievance and appeal procedures (including expedited decision making and access to external claim review).
- Enabling the creation of new types of health plans or health carriers, which in some instances would not be subject to the regulations or restrictions that govern our operations.
- Allowing individuals and small groups to collectively purchase health care coverage without any other affiliations.
- Imposing requirements and restrictions on the administration of pharmacy benefits, including restricting or eliminating the use of formularies for prescription drugs, limiting or eliminating rebates on pharmaceuticals, restricting the configuration of pharmacy networks, and restricting or eliminating the use of certain drug pricing methodologies.

- Creating or expanding state-sponsored health benefit purchasing risk pools, in which we may be required to participate.
- Imposing requirements and restrictions on certain plan designs and funding options, including consumer driven health plans and/or health savings accounts.
- Restricting the ability of health plans to establish member financial responsibility.
- Further regulating the individual coverage market by restricting or mandating premium levels, restricting our underwriting discretion or restricting our ability to rescind coverage based on a member's misrepresentations or omissions.

Some of the changes, if enacted, could provide us with business opportunities. However, it is uncertain whether we can counter the potential adverse effects of such potential legislation or regulation, including whether we can recoup, through higher premiums, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments or other increased costs.

Our business also may be affected by other legislation. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") was signed into law on July 21, 2010. The Financial Stability Oversight Council (the "Council") created by the Financial Reform Act is empowered to designate systemically important nonbank financial companies that are subject to Federal Reserve Board ("Federal Reserve") supervision. We cannot predict whether the Council will designate us a "systemically important" nonbank financial company, which the Financial Reform Act identifies as those that could pose a threat to financial stability either due to the potential of material financial distress at the company or due to the company's ongoing activities, and thus be subject to intensive bank-like supervision, regulation, examination and enforcement. It is difficult to predict the scope and content of systemic risk regulations or their effect on us, should we be designated a systemically important nonbank financial company, but it would likely be adverse. In addition, the Financial Reform Act creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs, reduces the burden of proof under the FCPA and creates a Federal Insurance Office ("FIO") within the Department of Treasury, with limited powers that include information-gathering and subpoena authority. Although the FIO does not have authority over health insurance, it will have authority over other parts of our business, primarily life insurance.

We also may be adversely impacted by court and regulatory decisions that expand the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Among other issues, federal and state courts continue to consider cases addressing group life insurance payment practices and the pre-emptive effect of ERISA on state laws. In general, limitations to ERISA pre-emption have the effect of increasing our costs, liability exposures, or both. The legislative initiatives discussed above include proposals in the U.S. Congress to restrict the pre-emptive effect of ERISA and state legislative activity in several states that, should it result in enacted legislation that is not pre-empted by ERISA, could increase our liability exposure and could result in greater state regulation of our operations.

#### **The Employee Retirement Income Security Act of 1974**

The provision of services to certain employee benefit plans, including certain Health Care, Group Insurance and Large Case Pensions benefit plans, is subject to ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor (the "DOL"). ERISA regulates certain aspects of the relationships between us and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities may also be subject to regulation under ERISA. ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the preemption continues to be reviewed by courts.

DOL regulations under ERISA set standards for claim payment and member appeals along with associated notice and disclosure requirements. Certain final and proposed regulations would require additional disclosures to employers of certain types of indirect compensation we receive. We have invested significant resources to comply with these standards, which represent an additional regulatory burden for us.

Certain Large Case Pensions and Group Insurance products and services are also subject to potential issues raised by certain judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, we may have ERISA fiduciary duties with respect to certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those assets are subject to conflict of interest and other

restrictions, and we must provide certain disclosures to policyholders annually. We must comply with these restrictions or face substantial penalties.

#### **Federal Employees Health Benefits (“FEHB”) Program**

Our subsidiaries contract with the OPM to provide managed health care services under the FEHB Program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program, and generally also require that FEHB plans receive pricing that is at least as favorable as similarly sized groups (“SSSG”) in the applicable market. Compliance with the SSSG requirements complicates pricing of our Commercial business and can result in the payment of an unanticipated premium rebate to the OPM. Managing to these rules will be further complicated in 2011 and thereafter by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of Health Care Reform. The OPM conducts periodic audits of its contractors to, among other things, verify that the premiums established under its contracts are in compliance with the SSSG and other requirements under FEHB Program. The OPM may seek premium refunds or institute other sanctions against us if we fail to comply with the program requirements.

#### **Medicare**

Our Medicare products are regulated by CMS. The regulations and contractual requirements applicable to us and other participants in Medicare programs are complex and subject to change. We have invested significant resources to comply with Medicare standards, and our Medicare compliance efforts will continue to require significant resources. CMS may seek premium refunds, prohibit us from continuing to market and/or enroll members in one or more Medicare products, exclude us from participating in one or more Medicare programs and/or institute other sanctions against us if we fail to comply with CMS regulations or our contractual requirements.

Effective April 21, 2010 CMS imposed intermediate sanctions on us suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone PDP contracts. CMS has granted us a limited waiver of these sanctions to allow us to continue to enroll eligible members into existing, contracted group Aetna Medicare Advantage Plans and Standalone PDPs through March 31, 2011. As a result of these sanctions, our 2011 Medicare membership was adversely affected because we did not participate in the 2010 open enrollment for individual 2011 Medicare plans, which occurred between November 15, 2010 and December 31, 2010.

CMS regularly audits our performance to determine our compliance with CMS’s regulations, our contracts with CMS and the quality of services we provide to our Medicare members. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies’ Medicare plans by considering the applicable health status of Medicare members as supported by information maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions and document their medical records. Medicare Advantage plans and PDPs receive increased premiums for members who have certain medical conditions identified with specific health condition codes. Federal regulators review and audit the providers’ medical records and related health condition codes that determine the members’ health status and the resulting premium payments to us. CMS has instituted risk adjustment data validation (“RADV”) audits of various Medicare Advantage plans, including two of Aetna’s contracts for the 2007 contract year. Although these two audits are ongoing, we do not believe that they will have a material impact on our operating results, financial position or cash flows.

We believe that the OIG also is auditing risk adjustment data, and we expect CMS and the OIG to continue auditing risk adjustment data for the 2007 contract year and beyond. Aetna and other Medicare Advantage organizations have provided comments to CMS in response to CMS’s December 2010 proposed RADV sampling and payment error calculation methodology by which CMS proposes to calculate and extrapolate RADV audit payment error rates for, and determine premium refunds payable by, Medicare Advantage plans. Our concerns with CMS’s proposed methodology include the fact that the proposed methodology does not take into account the “error rate” in the original Medicare fee-for-service data that was used to develop the risk adjustment system and that retroactive audit and payment adjustments undermine the actuarial soundness of Medicare Advantage bids. CMS has indicated that it may make retroactive contract-level premium payment adjustments based on the results of these RADV audits, which could occur as early as 2011. CMS’s premium adjustments could be implemented prior to our or other Medicare Advantage plans, having an opportunity to appeal the audit or payment error calculation results or methodology. We are unable to predict the ultimate outcome of CMS’s final RADV audit methodology, other audits for the 2007 contract year or subsequent contract years, the amounts of any retroactive refunds of, or prospective adjustments to, premium payments

made to us, or whether any audit findings would cause a change to our method of estimating future premium revenue in bid submissions to CMS for the current or future contract years or compromise premium assumptions made in our bids for prior contract years. Any premium refunds or adjustments resulting from regulatory audits, including those resulting from CMS's selection of its final RADV audit methodology, whether as a result of RADV or other audits by CMS or OIG or otherwise, could be material and could adversely affect our operating results, financial position and cash flows.

Since 2005, we have generally expanded the Medicare markets we serve and Medicare products we offer. This expansion of the Medicare markets we serve and Medicare products we offer and the Medicare-related provisions of Health Care Reform increase our exposure to changes in government policy with respect to and/or regulation of the various Medicare programs in which we participate, including changes in the amounts payable to us under those programs. For example, on July 15, 2008, the U.S. Congress overrode the President's veto and passed a Medicare funding bill that reduced amounts payable to health plans that offer Medicare Advantage plans beginning in 2010 and imposed new marketing requirements for Medicare Advantage and Medicare Part D Prescription Drug plans beginning in 2009. In addition, Health Care Reform contains significant reductions in the reimbursements we receive for our Medicare Advantage members, including freezing 2011 rates based on 2010 levels, with additional reductions in future years based on regionally adjusted benchmarks. Beginning in 2012, Health Care Reform also ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star rating" of quality based on a variety of factors specified by CMS. As a result, these star ratings are likely to be a significant determinant of overall profitability for our Medicare Advantage plans. It is not possible to predict the longer term adequacy of payments we receive under these programs. We currently believe that the payments we receive and will receive in the near term are adequate to justify our continued participation in these programs, although there are economic and political pressures to continue to reduce spending on these programs, and this outlook could change.

Going forward, we expect the U.S. Congress to continue to closely scrutinize each component of the Medicare program (including Medicare Part D drug benefits) and possibly seek to limit the private insurers' role. For example, the federal government may seek to negotiate drug prices for PDPs and Medicare Advantage-Prescription Drug Plans, a function we currently perform as a plan sponsor. It is not possible to predict the outcome of this Congressional oversight or any legislative activity, either of which could adversely affect us.

#### **Medicaid**

In 2007, we substantially increased our Medicaid product offerings through our acquisition of Schaller Anderson. As a result, we also increased our exposure to changes in government policy with respect to and/or regulation of the various Medicaid programs in which we participate, including changes in the amounts payable to us under those programs. In addition, Health Care Reform includes a significant expansion of Medicaid coverage in 2014. Medicaid premiums are paid by each state and differ from state to state. The federal government and the states in which we have Medicaid business are also considering various proposals and legislation that would implement certain Medicaid program reforms or redesigns, including changes to benefits, reimbursement or payment levels or eligibility criteria. Current Medicaid funding and premium revenue may not be sustainable due to state and federal budgetary constraints, which have become particularly acute at the state level in the past few years, and continuing efforts to reduce health care costs. In addition, our Medicaid contracts with states are subject to cancellation by the state after a short notice period without cause or in the event of insufficient state funding.

Our Medicaid products are also regulated by CMS, which has the right to audit our performance to determine compliance with CMS contracts and regulations. Our Medicaid products and State Children's Health Insurance Program ("SCHIP") contracts also are subject to federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The regulations and contractual requirements applicable to us and other participants in Medicaid programs are complex and subject to change. Although we have invested significant resources to comply with these standards, our Medicaid compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may seek premium refunds, prohibit us from continuing to market and/or enroll members in one or more Medicaid products, exclude us from participating in one or more Medicaid programs and/or institute other sanctions against us if we fail to comply with CMS or state regulations or our contractual requirements.

### **HMO and Insurance Holding Company Laws**

A number of states, including Pennsylvania and Connecticut, regulate affiliated groups of HMOs and insurers such as the Company under holding company statutes. These laws may require us and our subsidiaries to maintain certain levels of equity. Holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file reports with those states' insurance departments regarding capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, various notice or prior regulatory approval requirements apply to transactions between insurance companies, HMOs and their affiliates within an insurance holding company system, depending on the size and nature of the transactions. With the amendment of the Annual Financial Reporting Model Regulation by the National Association of Insurance Commissioners to incorporate elements of the Sarbanes-Oxley Act of 2002, we expect that the states in which our insurance and HMO subsidiaries are licensed will continue to expand the regulation of corporate governance and internal control activities of HMOs and insurance companies.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year.

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as a company's RBC declines and provides for four different levels of regulatory attention depending on the ratio of a company's total adjusted capital (defined as the total of its statutory capital, surplus and asset valuation reserve) to its risk-based capital. The level of regulatory oversight ranges from requiring the company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its RBC, to mandatory regulatory intervention requiring a company to be placed under regulatory control in a rehabilitation or liquidation proceeding. As of December 31, 2010, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC thresholds.

For information regarding restrictions on certain payments of dividends or other distributions by HMO and insurance company subsidiaries of our company, refer to Note 16 of Notes to Consolidated Financial Statements on page 90.

The holding company laws for the states of domicile of Aetna and certain of its subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as our parent company, Aetna Inc.) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

### **Audits and Investigations**

We typically have been and are currently involved in various governmental investigations, audits, examinations, reviews, subpoenas and other requests for information, the frequency and depth of which continue to increase. These include routine, regular and special investigations, audits, examinations and reviews by, as well as subpoenas and other requests for information from, CMS, various state insurance and health care regulatory authorities, state attorneys general, the CCIIO, the OIG, the OPM, committees, subcommittees, and members of the U.S. Congress, the U.S. Department of Justice, U.S. attorneys and other state and federal governmental authorities. Such government actions may result and have resulted in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds to members, assessments of damages, civil or criminal fines or penalties (including under the False Claims Act), or other sanctions, including the possible loss of licensure or suspension or exclusion from participation in government programs. For example, effective April 21, 2010, CMS imposed intermediate sanctions on us suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone PDP Contracts. In addition, CMS has instituted RADV audits of our risk adjustment

payments under certain of our Medicare Advantage contracts. For additional information on these Medicare matters, refer to "Medicare" beginning on page 31.

In January 2009, we agreed with the New York Attorney General to discontinue the use of Ingenix databases at a future date and to utilize a new database for a period of at least five years in connection with out-of-network reimbursements in those benefit plans that employ a reasonable and customary standard for such reimbursements. We used the Ingenix database for many plans to determine the level of reimbursement when our members utilize providers who do not have a contract with us. We have begun to transition to other databases and use methodologies to determine these payments; however, payment levels for non-contracted provider services will likely remain the subject of further investigations, challenges and regulations.

Refer to "Litigation and Regulatory Proceedings" in Note 18 of Notes to Consolidated Financial Statements beginning on page 92 for more information.

### **Federal and State Reporting**

We are subject to extensive financial and business reporting requirements at both the state and federal level. Health Care Reform significantly expands these reporting requirements and adds additional penalties for inaccuracies and omissions. In some instances, our ability to comply with these requirements will depend on receipt of information from third parties, particularly employers that we do not receive today and that may not be readily available or reliably provided in all instances. We are and will continue to be required to modify our information systems, dedicate significant resources and incur significant expenses to comply with these requirements.

### **Fraud and Abuse Laws**

Federal and state governments have 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 members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicare and Medicaid are often the subject of fraud and abuse investigations, as well as False Claims Act (whistle-blower) lawsuits. The regulations and contractual requirements applicable to us and other participants in these public-sector programs are complex and subject to change. We have invested significant resources to comply with Medicare and Medicaid standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

### **Product Design and Sales Practices**

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, is increasing as are the penalties being imposed for inappropriate practices. Medicare and Medicaid products and products offering more limited benefits, such as those we issue and sell through Strategic Resource Company, which we acquired in January 2005, and some of our student health plans, in particular are attracting increased regulatory scrutiny.

### **Guaranty Fund Assessments/Solvency Protection**

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our premiums in the state compared to the premiums of other insurers. Certain states allow recoverability of assessments as offsets to premium taxes. Some states have similar laws relating to HMOs. The Pennsylvania Insurance Commissioner has placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and has petitioned a state court for liquidation. If Penn Treaty is declared insolvent and placed in liquidation, we and other insurers likely would be assessed over a period of years by guaranty associations for the payments the guaranty associations are required to make to Penn Treaty policyholders. We are currently unable to predict the ultimate outcome of this potential insolvency. It is reasonably possible that in future reporting periods we may record a liability and expense relating to Penn Treaty or other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While we historically have recovered more than half of guaranty fund assessments through statutorily-permitted premium tax offsets, significant increases in assessments could jeopardize future recovery of these assessments. In addition, changes to regulations or their interpretation due to regulators' increasing concerns

regarding insurance company and/or HMO solvency due, among other things, to the current economic downturn, could negatively impact our business in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

#### **Regulation of Pharmacy Operations**

On July 27, 2010, we entered into the PBM Agreement, under which CVS Caremark provides certain PBM services to us and our customers and members. The PBM Agreement has a term of up to 12 years, although we have certain termination rights beginning in January 2018. CVS Caremark began providing services under the PBM Agreement on January 1, 2011. Notwithstanding our contracting with CVS Caremark, we will remain responsible to regulators and members for the delivery of PBM services. In addition, we continue to own two mail order pharmacy facilities and one specialty pharmacy facility (the "Pharmacies"). One mail order pharmacy is located in Missouri and the specialty pharmacy and our second mail order pharmacy are located in Florida. The Pharmacies dispense pharmaceuticals throughout the U.S. and are participating providers in Medicare, Medicare Part D and various Medicaid programs. The pharmacy practice is generally regulated at the state level by state boards of pharmacy. The Pharmacies are required to be licensed in the state where they are located, as well as the states that require registration or licensure with the state's board of pharmacy or similar regulatory body. The Pharmacies also must register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances and must comply with applicable Medicare, Medicaid and other provider rules and regulations, including federal and state false claims and anti-kickback laws. Loss or suspension of any such licenses or registrations could have a material adverse effect on our ability to meet our commitments to our customers, which could, in turn, have a material adverse effect on our pharmacy business and/or operating results.

#### **Regulation of Pharmacy Benefit Management Operation**

Our pharmacy benefit management ("PBM") services are regulated directly and indirectly at the federal and state levels, including federal and state false claims and anti-kickback laws. These laws and regulations govern, and proposed legislation may govern, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers, disclosure of data to third parties, drug utilization management practices, the level of duty a PBM owes its customers and registration or licensing of PBMs. Failure by us or CVS Caremark to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on our operating results.

#### **Life and Disability Insurance**

Our life insurance and disability operations are subject to extensive regulation. Changes in these regulations, such as expanding the definition of disability or changing claim determination, settlement and/or payment practices, could have a material impact on our life insurance and/or disability insurance operations and/or operating results.

#### **International Regulation**

We continue to expand our Health Care operations that are conducted in foreign countries. These international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; various privacy, insurance, tax, tariff and trade laws and regulations; and corporate, employment, intellectual property and investment laws and regulations. In addition, the expansion of our operations into foreign countries increases our exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the Foreign Corrupt Practices Act of 1977.

#### **Anti-Money Laundering Regulations**

Certain of our lines of business are subject to U.S. Department of the Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their affected products comply with the regulations.

#### **FORWARD-LOOKING INFORMATION/RISK FACTORS**

The Private Securities Litigation Reform Act of 1995 (the "1995 Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We want to take advantage of these safe harbor provisions.

Certain information contained in this MD&A is forward-looking within the meaning of the 1995 Act or SEC rules. This information includes, but is not limited to: the “Outlook for 2011” on page 5, “Risk Management and Market-Sensitive Instruments” beginning on page 14 and “Regulatory Environment” beginning on page 23. In addition, throughout this MD&A, we use the following words, or variations or negatives of these words and similar expressions, when we intend to identify forward-looking statements:

- Expects
- Projects
- Anticipates
- Outlook
- Intends
- Plans
- Believes
- Guidance
- Seeks
- Estimates
- May
- Will
- Should
- Could
- Potential
- Continue
- View

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these factors are outside our control. You should not put undue reliance on forward-looking statements. We disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events or otherwise.

### **Risk Factors**

You should carefully consider each of the following risks and all of the other information set forth in this MD&A or elsewhere in our Annual Report or our Annual Report on Form 10-K. These risks and other factors may affect forward-looking statements, including those we make in this MD&A or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect our business. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events, this could have a material adverse effect on our business, cash flows, financial condition or operating results. In that case, the trading price of our common stock could decline materially.

#### **The continuing public policy debate on Health Care Reform, additional changes to the U.S. health care system and the stressed economic environment, with high U.S. unemployment, present overarching risks to all aspects of our enterprise.**

The political environment in which we operate remains uncertain. There can be no assurance that the implementation of Health Care Reform, additional changes to the U.S. health care system, including changes to Health Care Reform, or the impact of the economic environment will not adversely affect our business, cash flows, financial condition or operating results. See “Regulatory Environment – General” beginning on page 23 and “Adverse economic conditions in the U.S. and abroad can significantly and adversely affect our businesses and profitability, and we do not expect these conditions to improve in the near future” beginning on page 38.

#### **We are subject to potential changes in public policy and Health Care Reform that can adversely affect the markets for our products and services and our profitability. The federal and state governments continue to enact and seriously consider many broad-based legislative and regulatory measures that have materially impacted and will continue to materially impact various aspects of the health care system and our business.**

The political environment in which we operate remains uncertain. It is not possible to predict with certainty or eliminate the impact of additional fundamental public policy changes, including changes to Health Care Reform, that could adversely affect us. Examples of these changes include policy changes that would fundamentally change the dynamics of our industry, such as the federal or one or more state governments assuming a larger role in the health care industry or managed care operations, fundamentally restructuring or reducing the funding available for Medicare or Medicaid programs, or a repeal or significant alteration of Health Care Reform, such as the elimination of the obligation to purchase health care coverage (the “individual mandate”) without the elimination of our obligation to offer health insurance to each person who purchases it. Our business and operating results could be materially and adversely affected by such changes even if we correctly predict their occurrence. For more information on these matters, refer to “Regulatory Environment” beginning on page 23.

In March 2010, Health Care Reform was enacted, legislating broad-based changes to the U.S. health care system. Components of the legislation will be phased in over the next seven years, and there are many significant parts of Health Care Reform, including minimum MLR, that will require further guidance and clarification both at the federal level and in the form of regulations and actions by state legislatures to implement the law. In addition, at the state level, each state and the District of Columbia will hold regular legislative sessions in 2011. The state legislatures focused on the impact of federal health care reform legislation and state budget deficits in 2010. For more information on these matters, refer to "Regulatory Environment" beginning on page 23.

We will need to dedicate material resources and incur material expenses to implement and comply with Health Care Reform at both the state and federal level, including implementing and complying with the future regulations that will provide guidance on and clarification of significant parts of the legislation. In addition, we anticipate that additional health care reforms will be enacted at the state level; however, we cannot predict what provisions they will contain in any state or what effect they will have on our business operations or financial results. While health care reform at the state and federal level presents us with new business opportunities and new financial and other challenges and may, for example, cause membership in our health plans to increase or decrease or make doing business in particular states more or less attractive, it is reasonably possible that our business operations and financial results could be materially adversely affected by such reform.

**We must continue to differentiate our products and services from those of our competitors; we operate in an evolving industry that requires us to anticipate changes in customer preferences and to innovate and deliver products and services that demonstrate value to our customers, particularly in response to market changes from public policy.**

We operate in a highly competitive environment and in an industry that is subject to significant ongoing changes from market pressures brought about by customer demands, business consolidations, strategic alliances, Health Care Reform, and other legislative and regulatory changes and marketing practices. For example, beginning in 2014, we expect to compete for sales on the Exchanges. In addition, our customers generally, and our larger customers particularly, are well informed and organized and can easily move between us and our competitors. These factors require us to differentiate our products and services, anticipate changes in customer preferences and innovate and deliver new and existing products and services that demonstrate value to our customers, particularly in response to market changes from public policy. Failure to differentiate our products and services, anticipate changes in customer preferences or innovate and deliver products and services that demonstrate value to our customers can affect our ability to retain or grow profitable membership, which can adversely affect our operating results.

**Our ability to anticipate and detect medical cost trends and achieve appropriate pricing affects our profitability, and our business and profitability may continue to be adversely affected by prevailing economic conditions. There can be no assurance that future health care and other benefit costs will not deviate from our projections.**

Adverse economic conditions and unanticipated increases in our health care and other benefit costs can significantly and adversely affect our businesses and profitability in a number of ways. The current economic environment is challenging and less predictable than the economic environment of the recent past, which has caused and may continue to cause unanticipated volatility in our health care and other benefit costs. Premium revenues from our Insured Health Care products comprised approximately 81% of our total consolidated revenues for both 2010 and 2009. We continue to be vigilant in our pricing and have generally increased our premium rates for Insured business under contract in 2011. Our health care premiums are generally fixed for one-year periods. Accordingly, cost increases in excess of health care or other benefit cost projections reflected in our pricing cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts of the increases in health care and other benefit costs that we expect to occur during the fixed premium period. Those forecasts typically are made several months before the fixed premium period begins and are dependent on our ability to anticipate and detect medical cost trends. For example, during the year ended December 31, 2010, medical costs were lower than we projected, while during the year ended December 31, 2009, medical costs were higher than we projected. As a result of this volatility, accurately detecting medical cost trends and forecasting, managing and reserving for future health care and other benefit costs for ourselves and our self-insured customers have become more challenging. There can be no assurance regarding the accuracy of the health care or other benefit cost projections reflected in our pricing, and our health care and other benefit costs can be affected by external events over which we have no control, such as the higher-than-projected H1N1 influenza and COBRA-related health care costs we

experienced in 2009. Relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our operating results. For more information, see "Critical Accounting Estimates - Health Care Costs Payable" beginning on page 18. If the rate of increase in our health care or other benefit costs in 2011 were to exceed the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our operating results would be adversely affected.

**Our ability to manage health care and other benefit costs affects our profitability.**

Our profitability depends in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, negotiation of favorable provider contracts and medical management programs. Government-imposed limitations on Medicare and Medicaid reimbursement also have caused the private sector to bear a greater share of increasing health care and other benefits costs. The aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising health care and other benefit costs. Changes as a result of Health Care Reform and other changes in the regulatory environment, changes in health care practices, general economic conditions such as inflation and employment levels, new technologies, increases in the cost of prescription drugs, direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, health care provider or member fraud and numerous other factors affecting the cost of health care can be beyond any health plan's control and may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our operating results.

**We face risks from industry, public policy and economic forces that can change the fundamentals of the health and related benefits industry and adversely affect our business and operating results.**

Various factors particular to the health and related benefits industry may affect our business model. Those factors include, among others, the rapid evolution of the business model, particularly as that model moves to a direct sales to the consumer model, such as the model contemplated by the Exchanges, shifts in public policy, including those embodied in Health Care Reform, adverse changes in laws and regulations or the interpretation of laws and regulations, consumerism, pricing actions by competitors, competitor and supplier consolidation and a declining number of commercially insured people. We also face the potential of competition from existing or new companies that have not historically been in the health or group insurance industries, such as health information technology ("HIT") companies. If we are unable to anticipate or detect these and other relevant external factors, and deploy meaningful responses to all relevant external factors, our business, and operating results may be adversely affected.

**Adverse economic conditions in the U.S. and abroad can significantly and adversely affect our businesses and profitability, and we do not expect these conditions to improve in the near future.**

The current recessionary U.S. and global economic environment has resulted in significantly diminished expectations for the global economy, particularly the U.S. economy, going forward. Our customers, medical providers and the other companies with which we do business are generally headquartered in the U.S.; however, many of our largest customers are global companies with operations around the world. As a result, adverse economic conditions in the U.S. and abroad have and can in the future significantly and adversely affect our businesses and profitability by:

- Leading to reductions in workforce by our customers, which would reduce both our revenues and the number of members we serve.
- Leading our customers and potential customers, particularly those with the most members, and state and local governments, to force us to compete more vigorously on factors such as price and service, including service and other performance guarantees, to retain or obtain their business.
- Leading our customers and potential customers to purchase less profitable different mixes of products from us (i.e., purchase products that generate less profit for us (such as our administrative services products) than the ones they currently purchase or otherwise would have purchased) or purchase fewer products from us.
- Leading our customers and potential customers, particularly smaller employers and individuals, to forego obtaining or renewing their health and other coverage with us.
- Adversely affecting state and federal budgets, resulting in reduced reimbursements or payments to us in Medicare, Medicaid, SCHIP and/or other federal and state government health care coverage programs.
- Causing unanticipated increases and volatility in utilization of medical and other covered services by our members and/or increases in medical unit costs, each of which would increase our health care and other benefit costs and limit our ability to accurately detect, forecast, manage and reserve for our and our self-insured customers' medical cost trends and/or future health care and other benefit costs.
- Increasing our medical unit costs as hospitals and other providers attempt to maintain revenue levels in their efforts to adjust to their own economic challenges.

- Causing, over time, inflation that could cause interest rates to increase and thereby increase our interest expense and reduce our operating results, as well as decrease the value of the debt securities we hold in our investment portfolio, which likely would reduce our operating results and/or financial position.
- Weakening the ability or perceived ability of the issuers and/or guarantors of the debt or other securities we hold in our investment portfolio to perform on their obligations to us, which could result in defaults in those securities or reduce the value of those securities and create realized capital losses for us that reduce our operating results.
- Weakening the ability of our customers, medical providers and the other companies with which we do business to perform their obligations to us or causing them not to perform those obligations, either of which could reduce our operating results.
- Causing governments to impose new or higher taxes or assessments on us in response to budgetary pressures.

Furthermore, reductions in workforce by our customers in excess of, or at a faster rate than, those we project could reduce both our revenue and membership below our projected levels and cause unanticipated increases in our health care and other benefit costs. There can be no assurance that our health care and other benefit costs, business and profitability will not be adversely affected by these economy-related conditions or other factors.

**Our continued business success is dependent on our ability to diversify our sources of revenue and earnings.**

As a result of Health Care Reform, the declining number of commercially insured people and other factors, our ability to grow profitably through the sale of traditional Insured health care benefits products in the U.S. is limited. In order to profitably grow our business in the future, we must diversify the sources of our revenue and earnings through international expansion and a transformational change to our business model. Accomplishing these strategic objectives will require us to simultaneously acquire and develop new personnel, products and systems to serve existing and new markets and enhance our existing information technology, control and compliance processes and systems to deliver the new products and, in the case of international operations, meet country-specific customer and member preferences as well as country-specific legal requirements, including those relating to data location, protection and security. Accomplishing these objectives will require us to devote significant senior management and other resources to acquisitions or other transactions and to develop new products, services and technology internally before any significant revenues or earnings are generated. In addition, many of our international and HIT competitors have longer operating histories, better brand recognition and greater scale in many of the areas in which we are seeking to expand. If we are not able to expand our international business in countries where we currently operate and in targeted new countries and acquire and/or develop and launch products and services outside of our core Health Care products and services, our ability to profitably grow our business could be adversely affected.

Our international operations face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations. Our exposure to these risks will increase as our international operations expand. These risks vary widely by country and include government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets, pricing issues and currency exchange controls or other restrictions that prevent us from transferring funds from these operations out of the countries in which they operate or converting local currencies that we hold into U.S. dollars or other currencies. Additionally, foreign currency exchange rates and fluctuations may have an impact on the future costs of or on future revenues and cash flows from our international operations, and any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective. Some of our operations are, and are likely to increasingly be, in emerging markets where these risks are heightened. In addition, our international business relies on local sales forces and other staff for some of its operations and may encounter labor laws, labor problems and less flexible employee relationships that can be difficult and expensive to terminate. In some countries, our international business operates or is required to operate with local business partners with the resulting risk of managing partner relationships in addition to managing the business to reach business objectives. International operations also increase our exposure to and require us to devote significant management resources to comply with the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. (including the Foreign Corrupt Practices Act of 1977 (the “FCPA”)) and United Kingdom law and similar laws in other jurisdictions and to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones.

**We are subject to funding and other risks with respect to revenue received from our participation in Medicare and Medicaid programs. We are also subject to retroactive adjustments to certain premiums, including as a result of CMS risk adjustment data validation (“RADV”) audits.**

We continue to increase our focus on the non-Commercial part of our Health Care segment as part of our business diversification efforts. In many instances, to acquire and retain this business, we must bid for it against our competitors, and winning bids increasingly are being challenged successfully. For the government-funded health program business we obtain, such as Medicare and Medicaid, our revenues are dependent on annual funding by the federal government and/or applicable state governments, and both federal and state governments have the right to cancel their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions and budgetary constraints at the federal or applicable state level and general political issues and priorities. For example, in 2008, the U.S. Congress reduced funding for Medicare Advantage plans beginning in 2010 and imposed new marketing requirements on Medicare Advantage and PDP plans beginning in 2009. Under Health Care Reform, 2011 Medicare Advantage payment rates to us will be frozen based on 2010 levels with additional reductions over a multi-year period beginning in 2012 based on regionally adjusted benchmarks, and competitive bidding will be introduced for Medicare Advantage plans for the 2012 plan year. In addition, most states currently face significant budget challenges, and several states are currently seeking to reduce their Medicaid expenditures; other states may take similar action. Our government customers also determine the premium levels and other aspects of these programs that affect the number of persons eligible for or enrolled in these programs, the services provided to enrollees under the programs, and our administrative and health care and other benefit costs under these programs. In the past, determinations of this type have adversely affected our financial results from and willingness to participate in such programs, and may do so in the future. For example, if a government customer reduces the premium levels or increases premiums by less than the increase in our costs and we cannot offset the impact of these actions with supplemental premiums and/or changes in benefit plans, then our business and operating results could be adversely affected.

In addition, premiums for certain federal government employee groups, Medicare members and Medicare beneficiaries are subject to retroactive adjustments by the federal and applicable state governments. CMS regularly audits our performance to determine our compliance with CMS’s regulations, our contracts with CMS and the quality of services we provide to our Medicare members. CMS has instituted RADV audits of certain of our Medicare Advantage contracts for the 2007 contract year. We believe that the OIG also is auditing risk adjustment data, and we expect CMS and the OIG to continue auditing risk adjustment data for the 2007 contract year and beyond. We are unable to predict the ultimate outcome of CMS’s final RADV audit methodology, other audits for the 2007 contract year or subsequent contract years, the amounts of any retroactive refunds of, or prospective adjustments to, premium payments made to us, or whether any audit findings would cause a change to our method of estimating future premium revenue in bid submissions to CMS for the current or future contract years or compromise premium assumptions made in our bids for prior contract years. For additional information, refer to “Regulatory Environment” beginning on page 23. Any premium refunds or adjustments resulting from regulatory audits, including those resulting from CMS’s selection of its final RADV audit methodology, whether as a result of RADV or other audits by CMS or OIG or otherwise, could be material and could adversely affect our operating results, financial position and cash flows.

**We operate in a highly-competitive environment; loss of membership or failure to achieve profitable membership growth and diversify the geographic concentrations in our core Insured membership (including strategies to increase membership for targeted product types and customers, such as commercial or public sector business) could materially adversely affect our profitability.**

Competitive factors (including our customers’ flexibility in moving between us and our competitors), the current economic environment and ongoing changes in the health care benefits industry (including merger and acquisition and strategic alliance activity in the industry) and Health Care Reform create pressure to contain premium price increases despite being faced with increasing health care and other benefit costs. Our customer contracts are subject to renegotiation, and our Medicare, Medicaid and SCHIP products are subject to periodic re-bid and rate adjustment, as customers seek to contain their benefit costs, particularly in a slow economy. Customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, although such elections also may reduce our health care and other benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable, or move to a competitor to obtain more favorable pricing. Our membership is also concentrated in certain geographic areas in the U.S., and unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas could therefore have a disproportionately

adverse effect on our operating results. Among other factors, we compete on the basis of overall cost, plan design, customer service, quality and sufficiency of medical provider networks and quality of medical management programs. In addition to competitive pressures affecting our ability to obtain new customers or retain existing customers, our membership has been and may continue to be affected by reductions in workforce by existing customers due to unfavorable general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. Failure to profitably grow and diversify our membership geographically or by product type may adversely affect our revenue and operating results.

**Our business success and profitability depend in part on effective information technology systems and on continuing to develop and implement improvements in technology; we have several significant multi-year strategic information technology projects in process and have increased our commitment to health information technology products and services.**

Our businesses depend in large part on our information and other technology systems to adequately price our products and services; accurately establish reserves, process claims and report financial results; and interact with providers, employer plan sponsors, members and vendors, including CVS Caremark, in an efficient and uninterrupted fashion. We have many different information systems supporting our businesses.

With our acquisition of Medicity in January 2011, we also have increased our commitment to HIT products and services, which is rapidly changing and highly competitive. There is no assurance that we will be able to earn a profit in our HIT business, successfully adapt to changes to the HIT business or compete effectively in the HIT business or that we have been able to identify and mitigate the significant risks of pursuing that business, including protection of our proprietary rights. In addition, although the HIT industry is not currently subject to significant regulation, as we continue to implement our HIT initiatives, uncertainty surrounding the regulatory authority and requirements in this area, as well as new legislation and/or regulation may make it difficult to achieve and maintain compliance and could adversely affect our ability to compete in the HIT business and the operating results of our HIT business.

Our business strategy involves providing customers with differentiated, easy to use, secure products that leverage information to meet the needs of those customers. The marketplace is evolving, and the level of service that is acceptable to customers and members today will not necessarily be acceptable tomorrow. Our success therefore is dependent in large part on modifying existing core and other technology systems to maintain their effectiveness, on integrating and deploying Medicity's resources and on continuing to timely develop, redesign and enhance technology systems that support our business strategy initiatives and processes in a compliant and cost and resource efficient manner, including through acquisitions, strategic alliances, joint ventures and technology outsourcing, within the context of our existing business partnership relationships and a limited budget of human resources and capital. Certain of our technology systems (including software) are older, legacy systems that are less efficient and require an ongoing commitment of significant capital and human resources to maintain.

We also need to effectively deploy our Medicity resources, modify our existing systems or develop new systems to meet current and expected standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, including the MLR rebates and other aspects of Health Care Reform, and changing customer demands. For example, the federal government has mandated that by 2013 the health care industry, including health insurers, providers and laboratories, upgrade to an updated and expanded set of standardized diagnosis and procedure codes used for describing health conditions. Implementing this new set of standardized codes, known as ICD-10, will require a substantial investment of resources by us and the health care industry in general over the next several years, including significant information technology investments, changes in business processes and documentation and extensive employee education and training. If we and/or the health care industry fail to adequately implement ICD-10, we may suffer a significant loss in the resources invested and in productivity, and/or fluctuations in our cash flows.

We also have several significant multi-year strategic information technology projects in process in addition to preparing for ICD-10. System development and other information technology projects are long-term in nature and may take longer and cost more than we expect to complete and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently manage and upgrade our technology portfolio, we could, among other things, have problems determining health care cost and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of providers, employer plan sponsors and members, or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

**In order to remain competitive, we must further integrate our businesses and processes; significant acquisitions, strategic alliances, joint ventures and/or our ability to manage multiple multi-year strategic projects could make this integration more challenging; we expect to continue to pursue acquisitions and other inorganic growth strategies.**

Ineffective integration of our businesses and processes may adversely affect our ability to compete by, among other things, increasing our costs relative to competitors. This integration task may be made more complex by significant acquisitions, strategic alliances, joint ventures, multi-year strategic projects, our existing business partnership relationships and a limited budget of human resources and capital, particularly if we pursue multiple transactions or other initiatives designed to diversify our sources of revenue and earnings simultaneously. For example, as a result of our acquisition activities, we have acquired a number of information technology systems that we must effectively and efficiently consolidate with our own systems. Our strategy includes effectively investing our capital in appropriate acquisitions, strategic projects and current operations in addition to share repurchases. If we are unable to successfully integrate acquired businesses and other processes to realize anticipated economic and other benefits on a timely basis, it could result in substantial costs or delays or other operational or financial problems.

Our strategic projects include, among other things, addressing rising health care and other benefit costs, achieving profitable membership growth, further improving the efficiency of our operations, managing certain significant technology projects, further improving relations with health care providers, negotiating contract changes with customers and providers, and implementing other business process improvements. The future performance of our businesses will depend in large part on our ability to design and implement these initiatives, some of which will occur over several years. If these initiatives result in increased health care or other benefit costs or do not achieve their objectives, our operating results could be adversely affected.

We have completed a number of acquisitions and strategic alliances over the last several years, and we expect to continue to pursue acquisitions and other inorganic growth opportunities as part of our growth strategy. See “Our continued business success is dependent on our ability to diversify our sources of revenue and earnings” beginning on page 39. In addition to integration risks, some additional risks we face with respect to acquisitions and other inorganic growth strategies include:

- The acquired business may not perform as projected;
- We may assume liabilities that we do not anticipate, including those that were not disclosed to us or which we underestimated;
- Acquisitions and other inorganic growth strategies could disrupt our ongoing business, distract management, divert resources and make it difficult to maintain our current business standards, controls and procedures;
- We may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- We may incur additional debt related to future acquisitions and inorganic growth strategies;
- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies; and
- We may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other workforce of companies we acquire, which may be difficult to accomplish.

**Managing executive succession and key talent retention, recruitment and development is critical to our success given the current environment.**

We would be adversely affected if we fail to adequately plan for succession of our executives and senior management and the retention, recruitment and development of key talent particularly given the current environment. While we have succession plans in place and we have employment arrangements with certain key executives, these do not guarantee that the services of these or suitable successor executives will continue to be available to us.

**Our ability to manage general and administrative expenses affects our profitability.**

Our profitability depends in part on our ability to drive our general and administrative expenses to competitive levels through controlling salaries and related benefits and information technology and other general and administrative costs, while being able to implement Health Care Reform, attract and retain key employees, maintain robust management practices and controls, implement improvements in technology and achieve our strategic goals.

**Our business activities are highly regulated; Health Care Reform as well as new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially adversely affect our business and profitability.**

Our business is subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations change frequently (as evidenced by Health Care Reform as well as other new laws and regulations) and generally are designed to benefit and protect members and providers rather than our investors. In addition, the governmental authorities that administer our business have broad latitude to make, interpret and enforce the regulations that govern us.

The federal and many state governments have enacted and continue to consider legislative and regulatory changes related to health products, and changes in the interpretation, enforcement and/or application of existing laws and regulations, and the likelihood of adverse changes is increasing due to state and federal budgetary pressures. We must implement Health Care Reform and monitor these and other changes and promptly implement any revisions to our business processes that these changes require. At this time, we are unable to predict the full impact of Health Care Reform or the impact of future changes, although we anticipate that some aspects of Health Care Reform and other existing measures and new measures, if enacted, could materially adversely affect our health care operations and/or operating results including:

- Reducing our ability to obtain adequate premium rates (including denial or delays in approval and implementation of those rates),
- Restricting our ability to price for the risk we assume and/or reflect reasonable costs or profits in our pricing, including mandating minimum medical benefit ratios and/or pricing to minimum medical benefit ratios,
- Reducing our ability to manage health care or other benefit costs,
- Increasing health care or other benefit costs and operating expenses,
- Increasing our exposure to lawsuits and other adverse legal proceedings,
- Regulating levels and permitted lines of business,
- Restricting our ability to underwrite and operate our individual health business,
- Imposing new or increasing taxes and financial assessments, and/or
- Regulating business practices.

For example, premium rates generally must be filed with state insurance regulators and are subject to their approval, either before or after rates take effect. Health Care Reform requires review of unreasonable premium rate increases by HHS in conjunction with state regulators. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also are considering conducting hearings on proposed premium rate increases, which could result in substantial delay in implementing proposed rate increases even if they ultimately are approved. Rate reviews create risk for us in the current political and regulatory environment. There is no guaranty that we will be able to obtain rate increases that are actuarially justified or that are sufficient to make our policies profitable in any product line or geography. We anticipate additional regulatory or legislative action with respect to regulation of premium rates in our Insured business, some of which could materially and adversely affect our ability to earn adequate returns on Insured business in one or more states or cause us to withdraw from certain markets.

In addition, our Medicare, Medicaid and specialty and mail order pharmacy products are more highly regulated than our Commercial products. The laws and regulations governing participation in Medicare and Medicaid programs are complex, are subject to interpretation and can expose us to penalties for non-compliance. If we fail to comply with the applicable laws and regulations we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or enrollment of members, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in these and other programs, cash flows, financial condition and operating results. In addition, legislative or regulatory changes to these programs could have a material adverse effect on our business, cash flows, financial condition and operating results. Effective April 21, 2010, CMS imposed intermediate sanctions on us, suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone PDP contracts. CMS has granted us a limited waiver of these sanctions to allow us to continue to enroll eligible members into existing, contracted group Aetna Medicare Advantage Plans and Standalone PDPs through March 31, 2011. As a result of these sanctions, our 2011 Medicare membership was adversely affected because we did

not participate in the 2010 open enrollment for individual 2011 Medicare plans, which occurred between November 15, 2010 and December 31, 2010. We are cooperating fully with CMS on its review and are working to resolve the issues CMS has raised as soon as possible. If the CMS sanctions remain in effect or we fail to obtain extensions of the limited waiver through the end of those sanctions, our Medicare membership and operating results could be adversely affected. Any failure of our prevention, detection or control systems related to regulatory compliance and/or compliance with our internal policies could adversely affect our reputation and also expose us to whistle-blower, class action and other litigation, other proceedings, fines, sanctions and/or penalties, any of which could adversely affect our business, cash flows, operating results or financial condition.

There continues to be a heightened review by federal and state regulators of the health insurance industry's business and reporting practices, including utilization management, payment of providers with whom the payor does not have a contract and other claim payment practices, as well as heightened review of the general insurance industry's brokerage, sales and marketing practices. As one of the largest national health and related benefits providers, we are regularly the subject of routine, regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, CMS, various state insurance and health care regulatory authorities, state attorneys general, the OIG, the OPM, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, U.S. Attorneys and other state and federal governmental authorities. Several such audits, investigations and reviews currently are pending, some of which may be resolved during 2011. These routine, regular and special governmental audits, investigations and reviews could result in changes to or clarifications of our business practices, and also could result in significant or material fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs, changes in the way we conduct business and loss of licensure. CMS has instituted RADV audits of certain of our Medicare Advantage contracts. For additional information on these Medicare matters, refer to "Regulatory Environment" beginning on page 23 and "We are subject to funding and other risks with respect to revenue received from our participation in Medicare and Medicaid Programs. We are also subject to retroactive adjustments to certain premiums, including as a result of CMS risk adjustment data validation ("RADV") audits", beginning on page 40. In January 2009, Aetna and the New York Attorney General announced an agreement relating to an industry-wide investigation into certain payment practices with respect to out-of-network providers. As a result of that 2009 agreement, Aetna contributed \$20 million towards the establishment of an independent database system to provide fee information regarding out-of-network reimbursement rates. Our business also may be adversely impacted by judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA, or reduce the scope of ERISA pre-emption of state law claims.

Our business also may be affected by other legislation. There can be no assurance that the Financial Reform Act and the related rules will not impact our business. For instance, we likely would be adversely affected if the Council designated us a "systematically important" nonbank financial company for purposes of the Financial Reform Act.

For more information regarding these matters, refer to "Regulatory Environment" beginning on page 23 and "Litigation and Regulatory Proceedings" in Note 18 of Notes to Consolidated Financial Statements beginning on page 92.

**We would be adversely affected if our prevention, detection or control systems fail to detect and implement required changes to maintain regulatory compliance.**

Federal and state governments have made investigating and prosecuting health care and other insurance fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other participants are complex and subject to change. We have invested significant resources to comply with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

Similarly, failure of our prevention, detection or control systems related to regulatory compliance and/or compliance with our internal policies, including data systems security issues and/or unethical conduct by managers and/or employees, could adversely affect our reputation and also expose us to litigation and other proceedings, fines, temporary or permanent suspension from participating in government health care programs and/or other penalties, any

of which could adversely affect our business, cash flows, operating results or financial condition. For example, effective April 21, 2010, CMS imposed intermediate sanctions on us, suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone PDP contracts. The sanctions relate to our compliance with certain Medicare Part D requirements. Refer to “Regulatory Environment” beginning on page 23 for more information.

**We face increasing risks related to litigation, regulatory audits and investigations and other regulatory proceedings. In addition, as a government contractor, we are exposed to additional risks that may adversely affect our business or our willingness to participate in government health care programs. If these matters are resolved adversely to us or these risks materialize, our financial position, operating results and cash flows could be adversely affected.**

We are growing by expanding into certain segments and subsegments of the health care marketplace. Some of the segments and subsegments we have targeted for growth include Medicare, Medicaid, individual, public sector and labor customers who are not subject to ERISA’s limits on state law remedies. In addition, over the last several years we have entered product lines in which we previously did not participate, including health information technology (such as Medicity and ActiveHealth), Insured Medicaid, Medicaid management and care coordination and care management on behalf of state regulators, international managing general underwriting, Medicare PDP, mail order pharmacy and specialty pharmacy. These products subject us to regulatory and other risks that are different from the risks of providing Commercial managed care and health insurance products and may increase the risks we face from intellectual property and other litigation, regulatory reviews, audits and investigations and other adverse legal proceedings. For example, our Medicare and Medicaid products are more highly regulated than our Commercial products, and our mail order and specialty pharmacies dispense medications directly to members. There is the possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, including if we do not comply with program rules or are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the False Claims Act. For example, effective April 21, 2010, CMS imposed intermediate sanctions on us, suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone PDP contracts. Refer to “Regulatory Environment” beginning on page 23 for more information. Any such suspension also could adversely affect our other businesses, including by harming our reputation. In addition to the risks of purported dispensing and other operational errors, failure to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our pharmacy subsidiaries to civil and criminal penalties.

In addition, we are routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal proceedings arising in the ordinary course of our businesses. Certain of these lawsuits are purported to be class actions. The majority of these cases relate to the conduct of our health care operations and allege various violations of law. Many of these cases seek substantial damages (including non-economic or punitive damages and treble damages) and may also seek changes in our business practices. We may also be subject to additional litigation and other adverse legal proceedings in the future. Litigation and other adverse legal proceedings could materially adversely affect our business or operating results because of reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. For example, during 2009, Aetna and the New York Attorney General announced an agreement relating to an industry-wide investigation into certain payment practices with respect to out-of-network providers. Among other things, the agreement required Aetna to contribute \$20 million towards the establishment of an independent database system to provide fee information regarding out-of-network reimbursement rates. Refer to “Litigation and Regulatory Proceedings” in Note 18 of Notes to Consolidated Financial Statements beginning on page 92 for more information.

**Our products providing PBM services face regulatory and other risks and uncertainties associated with the PBM and/or pharmacy industries that may differ from the risks of our core business of providing managed care and health insurance products.**

The following are some of the PBM and pharmacy related risks that could have a material adverse effect on our business, cash flows, financial condition or operating results:

- Federal and state anti-kickback and other laws that govern our PBM and mail order and specialty mail order pharmacies’ relationship with pharmaceutical manufacturers, customers and consumers.

- Compliance requirements for PBM fiduciaries under ERISA, including compliance with fiduciary obligations under ERISA in connection with the development and implementation of items such as drug formularies and preferred drug listings.
- Federal and state legislative proposals under consideration that could adversely affect a variety of pharmacy benefit industry practices, including without limitation the receipt or required disclosure of rebates from pharmaceutical manufacturers, the regulation of the development and use of formularies, legislation imposing additional rights to access to drugs for individuals enrolled in health care benefits plans, and restrictions on the use of average wholesale prices.
- The application of federal, state and local laws and regulations to the operation of our mail order pharmacy and mail order specialty pharmacy products.
- The risks inherent in the dispensing, packaging and distribution of pharmaceuticals and other health care products, including claims related to purported dispensing errors.

In addition, on July 27, 2010, we entered into the PBM Agreement with CVS Caremark, under which CVS Caremark provides certain PBM services to us and our customers and members. The PBM Agreement has a term of up to 12 years, although we have certain termination rights beginning in January 2018. CVS Caremark began providing services under the PBM Agreement on January 1, 2011. If the PBM Agreement were to terminate for any reason, we may not be able to find an alternative supplier in a timely manner or on acceptable financial terms. As a result, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and operating results.

Failure by us or CVS Caremark to adhere to the laws and regulations that apply to our PBM and/or pharmacies' products could expose our PBM and/or pharmacy subsidiaries to civil and criminal penalties and/or have a material adverse effect on our business, cash flows, financial condition and operating results.

**Our reputation is one of our most important assets; negative public perception of the health care benefits industry, or of the industry's or our practices, can adversely affect our profitability.**

The health care benefits industry regularly is subject to negative publicity, which can arise from, among other things, the ongoing public debate over Health Care Reform and/or from actual or perceived shortfalls regarding the industry's or our own business practices and/or products. The risk of negative publicity is particularly high as a result of Health Care Reform and related issues. This risk may be increased as states and the federal government implement and continue to debate Health Care Reform and as we continue to offer new products, such as products with limited benefits, targeted at market segments, such as the uninsured, part-time and hourly workers, students and those eligible for Medicaid, beyond those in which we traditionally have operated. Negative publicity of the health benefits industry in general or Aetna in particular can further increase our costs of doing business and adversely affect our profitability and our stock price by:

- Adversely affecting the Aetna brand particularly;
- Adversely affecting our ability to market and sell our products and/or services;
- Requiring us to change our products and/or services; and/or
- Increasing the regulatory and legislative requirements with which we must comply.

**We would be adversely affected if we fail to adequately protect member and customer related health, financial and other sensitive information, including taking steps to ensure that our business associates who obtain access to sensitive information maintain its confidentiality.**

The use and disclosure of personal health and other sensitive information is regulated at the federal, state and international levels, and these laws and rules are subject to change by legislation or administrative or judicial determination. HIPAA now requires business associates as well as covered entities to comply with certain privacy and security requirements.

We collect, process, maintain, retain and distribute large amounts of personal health and financial information and other confidential and sensitive data about our members and customers in the ordinary course of our business. Our business therefore depends substantially on our members' and customers' willingness to entrust us with their health related and other sensitive information. Events that negatively affect that trust, including failing to keep sensitive information secure, whether as a result of our action or inaction or that of one of our business associates or other vendors, including CVS Caremark, could adversely affect our reputation and also expose us to mandatory disclosure to

the media, litigation and other enforcement proceedings, material fines and/or penalties, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our business, operating results or financial condition. As we expand our HIT business, including through our acquisition of Medicity, and expand internationally, our exposure to this risk increases.

**We would be adversely affected if we do not effectively deploy our capital.**

Our operations generate significant capital, and we have the ability to raise additional capital. In deploying our capital to fund our investments in operations (including information technology and other strategic projects), share repurchases, dividends, acquisitions, potential acquisitions or other capital uses, our financial position and operating results could be adversely affected if we do not appropriately balance the risks and opportunities that are inherent in each method of deploying our capital.

The manner in which we deploy our capital impacts our financial strength, claims paying ability and credit ratings by recognized rating organizations. We believe ratings are important factors in establishing the competitive position of insurance companies and health care benefits companies. Information about ratings issued by nationally-recognized ratings organizations is broadly distributed and generally used throughout our industry. We believe the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our products to certain of our customers. In addition, Aetna Inc.'s credit ratings impact the cost and availability of future borrowings, and accordingly our cost of capital. Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. Downgrades in our ratings, should they occur, could adversely affect our business, cash flows, financial condition and operating results.

**We must continue to provide our customers with quality service that meets their expectations.**

Our ability to attract and retain membership is dependent upon providing quality customer service operations (such as call center operations, claim processing, mail order pharmacy prescription delivery, specialty pharmacy prescription delivery and customer case installation) that meet or exceed our customers' expectations. We depend on third parties for certain of our customer service operations. For example, as a result of our PBM Agreement with CVS Caremark, we obtain certain PBM services from CVS Caremark. Failure by us or our vendors to provide service that meets our customers' expectations, including failures resulting from operational performance issues, can affect our ability to retain or grow profitable membership which can adversely affect our operating results.

**Our profitability may be adversely affected if we are unable to contract with providers on competitive terms and otherwise develop and maintain favorable provider relationships.**

Our profitability is dependent in part upon our ability to contract competitively while developing and maintaining favorable relationships with hospitals, physicians, pharmaceutical benefit service providers, pharmaceutical manufacturers and other health care benefits providers. That ability is affected by the rates we pay providers for services rendered to our members (including financial incentives to deliver quality medical services in a cost-effective manner), by our business practices and processes and by our provider payment and other provider relations practices, as well as factors not associated with us that impact these providers, such as merger and acquisition activity and other consolidations among providers and increasing revenue and other pressures on providers. The breadth and quality of our networks of available providers is also an important factor when customers consider our products and services. Our contracts with providers generally may be terminated by either party without cause on short notice. The failure to maintain or to secure new cost-effective health care provider contracts may result in a loss in membership, higher health care or other benefits costs, less desirable products for our customers and/or difficulty in meeting regulatory or accreditation requirements, any of which could adversely affect our operating results.

In addition, some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers about the amount of compensation that is due to these providers for services rendered to our members. In some states, the amount of compensation due to these non-participating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us. For example, we are currently

involved in litigation with non-participating providers, and during 2009, we settled a matter with the New York Attorney General that has caused us to begin to transition to other databases and use different methodologies to determine the amount we pay non-participating providers.

These matters are described in more detail in "Litigation and Regulatory Proceedings" in Note 18 of Notes to Consolidated Financial Statements beginning on page 92.

**We must demonstrate that our products and processes lead to access by our members to quality care by their providers, or delivery of care by us.**

Failure to demonstrate that our products and processes (such as disease management and patient safety programs, provider credentialing and other quality of care and information management initiatives) lead to access by our members to quality care by providers or delivery of quality care by us would adversely affect our ability to differentiate our product and/or service offerings from those of competitors and could adversely affect our operating results.

**Sales of our products and services are dependent on our ability to attract, retain and provide support to a network of internal sales personnel and independent third-party brokers, consultants and agents.**

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently also recommend and/or market health benefits products of our competitors, and we must compete intensely for their services and allegiance. We recently changed the compensation model for some of the brokers, consultants and agents who sell our Commercial Insured Health Care products. Under the revised model, in certain circumstances, for sales to groups of fifty-one or more employees, we will not pay commissions; and in these circumstances, the third-party broker or agent must negotiate compensation directly with its customer; and for sales to groups of fifty or fewer employees and individuals, we have reduced the amounts we pay third-party brokers and agents in order to reduce our administrative costs. This new model may negatively affect our relationships with brokers, consultants and agents. Our sales could be adversely affected if we are unable to attract or retain sales personnel and third-party brokers, consultants and agents or if we do not adequately provide support, training and education to this sales network regarding our product portfolio, which is complex, or if our sales strategy is not appropriately aligned across distribution channels.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

**We face a wide range of risks, and our success depends on our ability to identify, prioritize and appropriately manage our enterprise risk exposures.**

As a large company operating in a complex industry, we encounter a variety of risks. The risks we face include, among other matters, the range of industry, competitive, regulatory, financial, operational or external risks identified in this Risk Factors discussion. We continue to devote resources to further develop and integrate our enterprise-wide risk management processes. Failure to identify, prioritize and appropriately manage or mitigate these risks, including risk concentrations across different industries, segments and geographies, can adversely affect our profitability, our ability to retain or grow business, or, in the event of extreme circumstances, our financial condition or business operations.

**We hold reserves for expected claims, which are estimated, and these estimates involve an extensive degree of judgment; if actual claims exceed reserve estimates, our operating results could be materially adversely affected.**

Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of claims that have been incurred by our members but not yet reported to us and claims that have been reported to us but not yet paid. We estimate health care costs payable periodically, and any resulting adjustments are reflected in current-period operating results within health care costs. Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience. A large portion of health care claims are not submitted to us

until after the end of the quarter in which services are rendered by providers to our members. As a result, an extensive degree of judgment is used in this estimation process, considerable variability is inherent in such estimates, and the adequacy of the estimate is highly sensitive to changes in medical claims submission and payment patterns, changes in membership and product mix, utilization of health care services, and changes in medical cost trends. A worsening (or improvement) of medical cost trend or changes in claim payment patterns from those that were assumed in estimating health care costs payable at December 31, 2010 would cause these estimates to change in the near term, and such a change could be material. Furthermore, if we are not able to accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions may be limited, which would further exacerbate the extent of any negative impact on our operating results. Refer to our discussion of “Critical Accounting Estimates – Health Care Costs Payable” beginning on page 18 for more information.

**Any requirement to restate financial results due to the inappropriate application of accounting principles or other matters could also have a material adverse effect on us and/or the trading price of our common stock.**

The appropriate application of accounting principles in accordance with GAAP is required to ensure the soundness and accuracy of our financial statements. An inappropriate application of these principles may lead to a restatement of our financial results and/or a deterioration in the soundness and accuracy of our reported financial results. If we experienced such a deterioration, users of our financial statements may lose confidence in our reported results, which could adversely affect the trading price of our common stock, our credit ratings and/or our access to capital markets.

**We are dependent on our ability to manage, engage and retain a very large and diverse workforce.**

Our products and services and our operations require a large number of employees. Our business could be adversely affected if our retention, development, succession and other human resource management techniques are not aligned with our strategic objectives. In addition, as we expand internationally, we face the added challenge of integrating, educating, managing and retaining a more culturally diverse workforce. The impact of the external environment or other factors on employee morale and engagement could also significantly impact the success of our company.

**Epidemics, pandemics, terrorist attacks, natural disasters or other extreme events or the continued threat of these extreme events could materially increase health care utilization, pharmacy costs and/or life and disability claims and impact our business continuity; and we cannot predict with certainty whether any such events will occur.**

Extreme events, including terrorism, can affect the U.S. economy in general, our industry and us specifically. Such events could adversely affect our business, cash flows and operating results, and, in the event of extreme circumstances, our financial condition or viability. Other than obtaining insurance coverage for our facilities and limited reinsurance of our Health Care and/or Group Insurance liabilities, there are few, if any, commercial options through which to transfer the exposure from terrorism away from us. In particular, in the event of bioterrorism attacks, epidemics or other extreme events, we could face significant health care (including behavioral health), life insurance and disability costs depending on the government’s actions and the responsiveness of public health agencies and other insurers. In addition, our life insurance members and our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be exposed to these events. Our business could also be adversely affected if we do not maintain adequate procedures to ensure disaster recovery and business continuity during and after such events.

**Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our profitability and/or our financial position.**

The global capital markets, including credit markets, experienced extreme volatility, uncertainty and disruption during 2008 and continued volatility in 2009 and 2010. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised particularly of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S., and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments’ monetary policy, particularly the easing of U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our profitability and/or our financial position by:

- Significantly reducing the value of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders’ equity.

- Reducing interest rates on high-quality short-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results.
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity.
- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results.
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit exposures, a failure to adequately do so could adversely affect our net income and our financial condition.

**We outsource and obtain PBM services and certain information technology systems and other services from independent third parties and also delegate selected functions to independent practice associations and specialty service providers; portions of our operations are subject to their performance.**

We take steps to monitor and regulate the performance of independent third parties who provide PBM services, systems-related or other services or facilities to us or to whom we delegate selected functions. Certain of these third parties provide us with significant portions of our requirements. These third parties include CVS Caremark, information technology system providers, independent practice associations and call center and claim and billing service providers. These arrangements may make our operations vulnerable if those third parties fail to comply with applicable laws or regulations or to satisfy their obligations to us, whether because of our failure to adequately monitor and regulate their performance, or changes in their own financial condition or other matters outside our control. A termination of our agreements with one or more of these service providers could result in reduced service quality and effectiveness, inability to meet our obligations to our customers or less favorable contract terms that may adversely affect our operating results.

Under the PBM Agreement, CVS Caremark provides certain PBM services to us and our customers and members. The PBM Agreement is for a term of up to 12 years, although we have certain termination rights beginning in January, 2018. CVS Caremark began providing services under the PBM Agreement on January 1, 2011. If the PBM Agreement were to terminate for any reason, we may not be able to find an alternative supplier in a timely manner or on acceptable financial terms. As a result, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and operating results.

In addition, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us. Certain legislative authorities have in recent years also discussed or proposed legislation that would restrict outsourcing and, if enacted, could materially increase our costs. We also could become overly dependent on key vendors, which could cause us to lose core competencies if not properly monitored. In recent years, certain third parties to whom we delegated selected functions, such as independent practice associations and specialty services providers, have experienced financial difficulties, including bankruptcy, which may subject us to increased costs and potential health care benefits provider network disruptions, and in some cases cause us to incur duplicative claims expense.

**Our pension plan expenses are affected by general market conditions, interest rates and the accuracy of actuarial estimates of future benefit costs.**

We have pension plans that cover a large number of current employees and retirees. Even though our employees will no longer earn future pension service credits in the Aetna Pension Plan effective December 31, 2010, the Aetna Pension Plan will continue to operate. Therefore, unfavorable investment performance, interest rate changes or changes in estimates of benefit costs, if significant, could adversely affect our operating results or financial condition by significantly increasing our pension plan expense and obligations. For example, due to market-driven unfavorable investment performance in 2008, our pension expense increased in 2009 and remained significant in 2010.

**We also face other risks that could adversely affect our business, operating results or financial condition, which include:**

- Health care benefits provider fraud that is not prevented or detected and impacts our medical cost trends or those of our self-insured customers. In addition, during an economic downturn, our businesses may see increased fraudulent claims volume, which may lead to additional costs because of an increase in disputed claims and litigation;
- A significant failure of internal control over financial reporting;
- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Financial loss from inadequate insurance coverage due to self-insurance levels or unavailability of insurance and reinsurance coverage for credit or other reasons; and
- Failure to protect our proprietary information.

## Selected Financial Data

(Millions, except per common share data)	For the Years Ended December 31,				
	2010	2009	2008	2007	2006
Revenue	\$ 34,246.0	\$ 34,764.1	\$ 30,950.7	\$ 27,599.6	\$ 25,145.7
Income from continuing operations	1,766.8	1,276.5	1,384.1	1,831.0	1,685.6
Net income	1,766.8	1,276.5	1,384.1	1,831.0	1,701.7
Net realized capital gains (losses), net of tax	183.8	55.0	(482.3)	(47.9)	24.1
Assets	37,739.4	38,550.4	35,852.5	50,724.7	47,626.4
Short-term debt	-	480.8	215.7	130.7	45.0
Long-term debt	4,382.5	3,639.5	3,638.3	3,138.5	2,442.3
Shareholders' equity	9,890.8	9,503.8	8,186.4	10,038.4	9,145.1
<b>Per common share data:</b>					
Dividends declared	\$ .04	\$ .04	\$ .04	\$ .04	\$ .04
Income from continuing operations:					
Basic	4.25	2.89	2.91	3.60	3.09
Diluted	4.18	2.84	2.83	3.47	2.96
Net income:					
Basic	4.25	2.89	2.91	3.60	3.12
Diluted	4.18	2.84	2.83	3.47	2.99

See Notes to Consolidated Financial Statements and MD&A for significant events affecting the comparability of results as well as material uncertainties.

## Consolidated Statements of Income

(Millions, except per common share data)	For the Years Ended December 31,		
	2010	2009	2008
Revenue:			
Health care premiums	\$ 27,610.6	\$ 28,243.8	\$ 25,507.3
Other premiums	1,822.1	1,892.4	1,876.8
Fees and other revenue (1)	3,529.5	3,536.5	3,312.5
Net investment income	1,056.3	1,036.4	910.0
Net realized capital gains (losses)	227.5	55.0	(655.9)
<b>Total revenue</b>	<b>34,246.0</b>	<b>34,764.1</b>	<b>30,950.7</b>
Benefits and expenses:			
Health care costs (2)	22,719.6	24,061.2	20,785.5
Current and future benefits	2,013.4	2,078.1	1,938.7
Operating expenses:			
Selling expenses	1,226.6	1,251.9	1,149.6
General and administrative expenses	5,292.4	5,131.1	4,601.9
<b>Total operating expenses</b>	<b>6,519.0</b>	<b>6,383.0</b>	<b>5,751.5</b>
Interest expense	254.6	243.4	236.4
Amortization of other acquired intangible assets	95.2	97.2	108.2
Reduction of reserve for anticipated future losses on discontinued products	-	-	(43.8)
<b>Total benefits and expenses</b>	<b>31,601.8</b>	<b>32,862.9</b>	<b>28,776.5</b>
Income before income taxes	2,644.2	1,901.2	2,174.2
Income taxes	877.4	624.7	790.1
<b>Net income</b>	<b>\$ 1,766.8</b>	<b>\$ 1,276.5</b>	<b>\$ 1,384.1</b>
Earnings per common share:			
Basic	\$ 4.25	\$ 2.89	\$ 2.91
Diluted	\$ 4.18	\$ 2.84	\$ 2.83

(1) Fees and other revenue include administrative services contract member copayments and plan sponsor reimbursements related to our mail order and specialty pharmacy operations of \$83 million, \$81 million and \$60 million (net of pharmaceutical and processing costs of \$1.4 billion, \$1.6 billion and \$1.6 billion) for 2010, 2009 and 2008, respectively.

(2) Health care costs have been reduced by Insured member copayments related to our mail order and specialty pharmacy operations of \$148 million, \$122 million and \$111 million for 2010, 2009 and 2008, respectively.

Refer to accompanying Notes to Consolidated Financial Statements.

## Consolidated Balance Sheets

(Millions)	At December 31,	
	2010	2009
Assets:		
Current assets:		
Cash and cash equivalents	\$ 1,867.6	\$ 1,203.6
Investments	2,169.7	2,922.7
Premiums receivable, net	661.9	630.4
Other receivables, net	692.6	626.7
Accrued investment income	203.4	209.2
Collateral received under securities loan agreements	210.6	210.0
Income taxes receivable	210.1	89.5
Deferred income taxes	327.0	439.5
Other current assets	651.3	551.4
<b>Total current assets</b>	<b>6,994.2</b>	<b>6,883.0</b>
Long-term investments	17,546.3	17,051.1
Reinsurance recoverables	960.1	986.9
Goodwill	5,146.4	5,146.2
Other acquired intangible assets, net	495.5	590.7
Property and equipment, net	529.3	551.0
Deferred income taxes	29.9	277.3
Other long-term assets	742.4	781.1
Separate Accounts assets	5,295.3	6,283.1
<b>Total assets</b>	<b>\$ 37,739.4</b>	<b>\$ 38,550.4</b>
Liabilities and shareholders' equity:		
Current liabilities:		
Health care costs payable	\$ 2,630.9	\$ 2,895.3
Future policy benefits	728.4	739.6
Unpaid claims	593.3	559.5
Unearned premiums	318.7	306.4
Policyholders' funds	918.1	788.3
Collateral payable under securities loan agreements	210.8	210.0
Short-term debt	-	480.8
Current portion of long-term debt	899.9	-
Accrued expenses and other current liabilities	2,436.8	2,380.0
<b>Total current liabilities</b>	<b>8,736.9</b>	<b>8,359.9</b>
Future policy benefits	6,276.4	6,470.1
Unpaid claims	1,514.3	1,453.0
Policyholders' funds	1,316.6	1,294.1
Long-term debt, less current portion	3,482.6	3,639.5
Other long-term liabilities	1,226.5	1,546.9
Separate Accounts liabilities	5,295.3	6,283.1
<b>Total liabilities</b>	<b>27,848.6</b>	<b>29,046.6</b>
Commitments and contingencies (Note 18)		
Shareholders' equity:		
Common Stock (\$.01 par value; 2.7 billion shares authorized; 384.4 million and 430.8 million shares issued and outstanding in 2010 and 2009, respectively) and additional paid-in capital	651.5	470.1
Retained earnings	10,401.9	10,256.7
Accumulated other comprehensive loss	(1,162.6)	(1,223.0)
<b>Total shareholders' equity</b>	<b>9,890.8</b>	<b>9,503.8</b>
<b>Total liabilities and shareholders' equity</b>	<b>\$ 37,739.4</b>	<b>\$ 38,550.4</b>

Refer to accompanying Notes to Consolidated Financial Statements.

## Consolidated Statements of Shareholders' Equity

(Millions)	Number of Common Shares Outstanding	Common Stock and Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income	Total Shareholders' Equity	Comprehensive (Loss) Income
<b>Balance at December 31, 2007</b>	496.3	\$ 188.8	\$ 10,138.0	\$ (288.4)	\$ 10,038.4	
Comprehensive loss:						
Net income	-	-	1,384.1	-	1,384.1	\$ 1,384.1
Other comprehensive loss (Note 9):						
Net unrealized loss on securities	-	-	-	(282.6)	(282.6)	
Net foreign currency and derivative losses	-	-	-	(15.7)	(15.7)	
Pension and OPEB plans	-	-	-	(1,294.6)	(1,294.6)	
Other comprehensive loss	-	-	-	(1,592.9)	(1,592.9)	(1,592.9)
Total comprehensive loss						<u>\$ (208.8)</u>
Common shares issued for benefit plans, including tax benefits	2.9	162.9	-	-	162.9	
Repurchases of common shares	(42.9)	(.5)	(1,787.2)	-	(1,787.7)	
Dividends declared (\$.04 per share)	-	-	(18.4)	-	(18.4)	
<b>Balance at December 31, 2008</b>	456.3	351.2	9,716.5	(1,881.3)	8,186.4	
Cumulative effect of adopting new accounting standard at April 1, 2009 (Note 2)	-	-	53.7	(53.7)	-	
Comprehensive income:						
Net income	-	-	1,276.5	-	1,276.5	\$ 1,276.5
Other comprehensive income (Note 9):						
Net unrealized gain on securities	-	-	-	619.0	619.0	
Net foreign currency and derivative gains	-	-	-	34.0	34.0	
Pension and OPEB plans	-	-	-	59.0	59.0	
Other comprehensive income	-	-	-	712.0	712.0	712.0
Total comprehensive income						<u>\$ 1,988.5</u>
Common shares issued for benefit plans, including tax benefits	3.4	119.2	-	-	119.2	
Repurchases of common shares	(28.9)	(.3)	(772.7)	-	(773.0)	
Dividends declared (\$.04 per share)	-	-	(17.3)	-	(17.3)	
<b>Balance at December 31, 2009</b>	430.8	470.1	10,256.7	(1,223.0)	9,503.8	
Comprehensive income:						
Net income	-	-	1,766.8	-	1,766.8	\$ 1,766.8
Other comprehensive income (Note 9):						
Net unrealized gain on securities	-	-	-	114.3	114.3	
Net foreign currency and derivative losses	-	-	-	(52.6)	(52.6)	
Pension and OPEB plans	-	-	-	(1.3)	(1.3)	
Other comprehensive income	-	-	-	60.4	60.4	60.4
Total comprehensive income						<u>\$ 1,827.2</u>
Common shares issued for benefit plans, including tax benefits	6.0	181.9	-	-	181.9	
Repurchases of common shares	(52.4)	(.5)	(1,605.5)	-	(1,606.0)	
Dividends declared (\$.04 per share)	-	-	(16.1)	-	(16.1)	
<b>Balance at December 31, 2010</b>	384.4	\$ 651.5	\$ 10,401.9	\$ (1,162.6)	\$ 9,890.8	

Refer to accompanying Notes to Consolidated Financial Statements.

## Consolidated Statements of Cash Flows

(Millions)	For the Years Ended December 31,		
	2010	2009	2008
Cash flows from operating activities:			
Net income	\$ 1,766.8	\$ 1,276.5	\$ 1,384.1
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized capital (gains) losses	(227.5)	(55.0)	655.9
Depreciation and amortization	444.4	416.0	378.3
Equity in earnings of affiliates, net	(33.1)	(15.7)	159.1
Stock-based compensation expense	110.4	90.7	95.7
Accretion of net investment discount	(28.9)	(67.0)	(15.2)
Changes in assets and liabilities:			
Accrued investment income	5.8	(15.6)	(4.4)
Premiums due and other receivables	(38.6)	(53.7)	(106.2)
Income taxes	182.8	(14.4)	(137.5)
Other assets and other liabilities	(309.3)	570.4	(116.3)
Health care and insurance liabilities	(458.6)	357.6	(82.1)
Other, net	(2.1)	(1.5)	(4.5)
<b>Net cash provided by operating activities</b>	<b>1,412.1</b>	<b>2,488.3</b>	<b>2,206.9</b>
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	11,966.7	10,029.6	11,681.2
Cost of investments	(11,043.4)	(11,592.2)	(12,307.9)
Additions to property, equipment and software	(288.7)	(362.0)	(446.6)
Cash used for acquisitions, net of cash acquired	(.1)	(75.1)	-
<b>Net cash provided by (used for) investing activities</b>	<b>634.5</b>	<b>(1,999.7)</b>	<b>(1,073.3)</b>
Cash flows from financing activities:			
Proceeds from issuance of long-term debt, net of issuance costs	697.8	-	484.8
Net (repayment) issuance of short-term debt	(480.8)	266.1	85.6
Deposits and interest credited for investment contracts	8.0	7.1	8.5
Withdrawals of investment contracts	(9.5)	(9.0)	(38.4)
Common shares issued under benefit plans	43.2	14.8	29.7
Stock-based compensation tax benefits	22.5	5.1	27.8
Common shares repurchased	(1,606.0)	(773.0)	(1,787.7)
Dividends paid to shareholders	(16.1)	(17.3)	(18.4)
Collateral on interest rate swaps	(41.7)	41.7	-
<b>Net cash used for financing activities</b>	<b>(1,382.6)</b>	<b>(464.5)</b>	<b>(1,208.1)</b>
Net increase (decrease) in cash and cash equivalents	664.0	24.1	(74.5)
Cash and cash equivalents, beginning of period	1,203.6	1,179.5	1,254.0
<b>Cash and cash equivalents, end of period</b>	<b>\$ 1,867.6</b>	<b>\$ 1,203.6</b>	<b>\$ 1,179.5</b>

Refer to accompanying Notes to Consolidated Financial Statements.

## Notes to Consolidated Financial Statements

### 1. Organization

We conduct our operations in three business segments:

- **Health Care** consists of medical, pharmacy benefits management, dental and vision plans offered on both an Insured basis (where we assume all or a majority of the risk for medical and dental care costs) and an employer-funded basis (where the plan sponsor under an administrative services contract (“ASC”) assumes all or a majority of this risk). Medical products include point-of-service (“POS”), preferred provider organization (“PPO”), health maintenance organization (“HMO”) and indemnity benefit plans. Medical products also include health savings accounts and Aetna HealthFund®, consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). We also offer Medicare and Medicaid products and services and specialty products, such as medical management and data analytics services, behavioral health plans and stop loss insurance, as well as products that provide access to our provider network in select markets.
- **Group Insurance** primarily includes group life insurance products offered on an Insured basis, including basic and supplemental group term life, group universal life, supplemental or voluntary programs and accidental death and dismemberment coverage. Group Insurance also includes (i) group disability products offered to employers on both an Insured and an ASC basis which consist primarily of short-term and long-term disability insurance, (ii) absence management services offered to employers, which include short-term and long-term disability administration and leave management, and (iii) long-term care products that were offered primarily on an Insured basis, which provide benefits covering the cost of care in private home settings, adult day care, assisted living or nursing facilities. We no longer solicit or accept new long-term care customers.
- **Large Case Pensions** manages a variety of retirement products (including pension and annuity products) primarily for tax qualified pension plans. These products provide a variety of funding and benefit payment distribution options and other services. Large Case Pensions also includes certain discontinued products (refer to Note 20 beginning on page 97 for additional information).

Our three business segments are distinct businesses that offer different products and services. Our Chief Executive Officer evaluates financial performance and makes resource allocation decisions at these segment levels. The accounting policies of the segments are the same as those described in the summary of significant accounting policies in Note 2, below. We evaluate the performance of these business segments based on operating earnings (net income or loss, excluding net realized capital gains or losses and other items) (refer to Note 19 beginning on page 95 for segment financial information).

### 2. Summary of Significant Accounting Policies

#### Principles of Consolidation

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally-accepted accounting principles (“GAAP”) and include the accounts of Aetna and the subsidiaries that we control. All significant intercompany balances have been eliminated in consolidation. The Company has evaluated subsequent events from the balance sheet date through the date the financial statements were issued and determined there were no other items to disclose.

#### Reclassifications

Certain reclassifications were made to the 2009 financial information to conform to the 2010 presentation.

#### New Accounting Standards

##### *Variable Interest Entities*

In June 2009, the Financial Accounting Standards Board (the “FASB”) released revised accounting guidance for variable interest entities (“VIEs”). This accounting guidance removes the quantitative-based risks-and-rewards calculation previously used to assess whether a company must consolidate a VIE and, instead, requires a variable interest holder to qualitatively assess whether it has a controlling financial interest in the VIE. This accounting

guidance was effective on January 1, 2010. The adoption of this new accounting guidance did not impact our financial position or operating results. Refer to Note 8 beginning on page 67 for additional information.

#### *Recognition and Presentation of Other-Than-Temporary Impairments*

Effective April 1, 2009, we adopted new accounting guidance issued by the FASB for other-than-temporary impairments (“OTTI”) of debt securities. This guidance establishes new criteria for the recognition of OTTI on debt securities and also requires additional financial statement disclosure. The new criteria require OTTI to be recognized if either a credit-related loss is deemed to have occurred or we have the intention to sell a security that is in an unrealized loss position. Refer to Notes 8 and 9 beginning on pages 67 and 72, respectively, for additional information.

Upon adoption of this new guidance, we evaluated securities held at April 1, 2009 for which a previous OTTI was recognized, and identified those securities that we did not intend to sell. As a result of this analysis, we recorded a \$54 million (\$83 million pretax) cumulative effect adjustment that increased retained earnings and accumulated other comprehensive loss as of April 1, 2009.

#### *Fair Value Measurements – Assessing Fair Value in Market Conditions That Are Not Orderly*

In April 2009, the FASB released updates to the accounting guidance for measuring the fair value of assets and liabilities. These updates provide clarification as to how to determine the fair value of assets and liabilities in distressed economic conditions and also require greater disaggregation of debt and equity securities within our fair value measurements disclosures (refer to Note 10 beginning on page 73). This accounting guidance was effective on June 30, 2009 and did not impact our financial position or operating results.

### **Future Application of Accounting Standards**

#### *Deferred Acquisition Costs*

In October 2010, the FASB released new accounting guidance for costs associated with acquiring or renewing insurance contracts. This guidance clarifies that such costs qualify for capitalization when affiliated with the successful acquisition of new and renewed insurance contracts. The new guidance is effective beginning January 1, 2012. Since our acquisition costs related to our Health Care and Group Insurance products are generally expensed as incurred, we do not expect the adoption of this accounting guidance to have a significant impact to our financial position or operating results.

### **Use of Estimates**

The preparation of the accompanying consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the amounts reported in the accompanying consolidated financial statements and notes. We consider the following accounting estimates critical in the preparation of the accompanying consolidated financial statements: health care costs payable, other insurance liabilities, recoverability of goodwill and other acquired intangible assets, measurement of defined benefit pension and other postretirement benefit plans, other-than-temporary impairment of debt securities and revenue recognition. We use information available to us at the time estimates are made; however, these estimates could change materially if different information or assumptions were used. Additionally, these estimates may not ultimately reflect the actual amounts of the final transactions that occur.

### **Cash and Cash Equivalents**

Cash and cash equivalents include cash on hand and debt securities with a maturity of three months or less when purchased. The carrying value of cash equivalents approximates fair value due to the short-term maturity of these investments.

### **Investments**

#### *Debt and Equity Securities*

Debt and equity securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt and equity securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless we intend to sell an investment within the next twelve months, in which case it is classified as current on our balance sheets. We have classified our debt and equity securities as available for sale and carry them at fair value. Refer to Note 10 beginning on page 73 for additional information on how we estimate the fair value of these investments. The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest

method over the estimated remaining term of the securities, adjusted for anticipated prepayments. We regularly review our debt and equity securities to determine whether a decline in fair value below the carrying value is other-than-temporary. When a debt or equity security is in an unrealized capital loss position, we monitor the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. Beginning April 1, 2009, we recognize an impairment on debt securities when we intend to sell a security that is in an unrealized loss position or if we determine a credit-related loss has occurred. Prior to April 1, 2009, we would recognize an impairment if we did not have the intention and ability to hold the security until it recovered its value (refer to New Accounting Standards beginning on page 57 for additional information). We do not accrue interest on debt securities when management believes the collection of interest is unlikely.

We lend certain debt and equity securities from our investment portfolio to other institutions for short periods of time. Borrowers must post cash collateral in the amount of 102% to 105% of the fair value of the loaned security. The fair value of the loaned securities is monitored on a daily basis, with additional collateral obtained or refunded as the fair value of the loaned securities fluctuates. The collateral is retained and invested by a lending agent according to our guidelines to generate additional income for us.

#### *Mortgage Loans*

We carry the value of our mortgage loan investments on our balance sheets at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default within 3 years) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. We apply our loan impairment policy individually to all loans in our portfolio. We record full or partial charge-offs of loans at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on an impaired loan is accrued to the extent we deem it collectable and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on our balance sheets.

#### *Other Investments*

Other investments consist primarily of alternative investments (which are comprised of private equity and hedge fund limited partnerships), investment real estate and derivatives. We typically do not have a controlling ownership in our alternative investments, and therefore we apply the equity method of accounting for these investments. We invest in real estate for the production of income. We carry the value of our investment real estate on our balance sheet at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any of our real estate investments are considered held-for-sale, we carry it at the lower of its carrying value or fair value less estimated selling costs. We generally estimate fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, we record the difference between the sales price and the carrying value as a realized capital gain or loss.

We make limited use of derivatives in order to manage interest rate, foreign exchange, price risk and credit exposure. The derivatives we use consist primarily of futures contracts, forward contracts, interest rate swaps, credit default swaps and warrants. Derivatives are reflected at fair value on our balance sheets.

When we enter into a derivative contract, if certain criteria are met, we may designate the derivative as one of the following: a hedge of the fair value of a recognized asset or liability or of an unrecognized firm commitment; a hedge of a forecasted transaction or of the variability of cash flows to be received or paid related to a recognized asset or liability; or a foreign currency fair value or cash flow hedge.

#### **Net Investment Income and Realized Capital Gains and Losses**

Net investment income and realized capital gains and losses on investments supporting Health Care's and Group Insurance's liabilities and Large Case Pensions' products (other than experience-rated and discontinued products) are reflected in our operating results. Realized capital gains and losses are determined on a specific identification basis. Unrealized capital gains and losses (other than experience-rated and discontinued products) are reflected in

shareholders' equity, net of tax, as a component of accumulated other comprehensive loss. We reflect purchases and sales of debt and equity securities and alternative investments on the trade date. We reflect purchases and sales of mortgage loans and investment real estate on the closing date.

Experience-rated products are products in the Large Case Pensions business where the contract holder, not us, assumes investment and other risks, subject to, among other things, minimum guarantees provided by us. The effect of investment performance is allocated to contract holders' accounts daily, based on the underlying investment's experience and, therefore, does not impact our operating results (as long as minimum guarantees are not triggered). Realized and unrealized capital gains and losses on investments supporting experience-rated products in the Large Case Pensions business are reflected in policyholders' funds on our balance sheets. Net investment income supporting Large Case Pensions' experience-rated products is included in net investment income in our statements of income and is credited to contract holders in current and future benefits.

When we discontinued the sale of our fully-guaranteed Large Case Pensions products, we established a reserve for anticipated future losses from these products and segregated the related investments. These investments are managed as a separate portfolio. Net investment income and realized capital gains and losses on this separate portfolio are ultimately credited/charged to the reserve and, generally, do not impact our operating results. Unrealized capital gains or losses on this segregated portfolio are reflected in other long-term liabilities on our balance sheets. Refer to Note 20 beginning on page 97 for additional information on our discontinued products.

### **Reinsurance**

We utilize reinsurance agreements primarily to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit us to recover a portion of our losses from reinsurers, although they do not discharge our primary liability as direct insurer of the risks reinsured. Failure of reinsurers to indemnify us could result in losses; however, we do not expect charges for unrecoverable reinsurance to have a material effect on our operating results or financial position. We evaluate the financial position of our reinsurers and monitor concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of our reinsurers. At December 31, 2010, our reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations.

In the normal course of business, we enter into agreements with other insurance companies under which we assume reinsurance, primarily related to our group life and health products (refer to Note 17 on page 91 for additional information). We do not transfer any portion of the financial risk associated with our HMO products to third parties, except in areas where we participate in state-mandated health insurance pools. We did not have material premiums ceded to or assumed from unrelated insurance companies in the three years ended December 31, 2010.

### **Goodwill**

We evaluate goodwill for impairment (at the reporting unit level) annually, or more frequently if circumstances indicate a possible impairment, by comparing an estimate of the fair value of the applicable reporting unit to its carrying value, including goodwill. If the carrying value exceeds fair value, we compare the implied fair value of the applicable goodwill to its carrying amount to measure the amount of goodwill impairment, if any. Our reporting units with goodwill are our Health Care and Group Insurance segments. Impairments, if any, would be classified as an operating expense. After performing our analysis, we determined that there was no impairment of goodwill in each of the three years ended December 31, 2010.

Our annual impairment tests were based on an evaluation of future discounted cash flows. These evaluations utilized the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Collectively, these evaluations were our best estimates of projected future cash flows. Our discounted cash flow evaluations used a range of discount rates that corresponds to our weighted-average cost of capital. This discount rate range is consistent with that used for investment decisions and takes into account the specific and detailed operating plans and strategies of the Health Care and Group Insurance reporting units. Certain other key assumptions utilized, including changes in membership, revenue, health care costs, operating expenses and effective tax rates, are based on estimates consistent with those utilized in our annual planning process that we believe are reasonable. If we do not achieve our earnings objectives, the assumptions and estimates underlying these goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment.

### **Property and Equipment and Other Acquired Intangible Assets**

We report property and equipment and other acquired intangible assets at historical cost, net of accumulated depreciation or amortization. At December 31, 2010 and 2009, the historical cost of property and equipment was approximately \$1.0 billion and \$1.1 billion, respectively, and the related accumulated depreciation was approximately \$473 million and \$543 million, respectively. We calculate depreciation and amortization primarily using the straight-line method over the estimated useful lives of the respective assets ranging from three to forty years.

We regularly evaluate whether events or changes in circumstances indicate that the carrying value of property and equipment or other acquired intangible assets may not be recoverable. If we determine that an asset may not be recoverable, we estimate the future undiscounted cash flows expected to result from future use of the asset and its eventual disposition. If the sum of the expected undiscounted future cash flows is less than the carrying value of the asset, we recognize an impairment loss for the amount by which the carrying value of the asset exceeds its fair value. There were no material impairment losses recognized in the three years ended December 31, 2010.

### **Separate Accounts**

Separate Account assets and liabilities in the Large Case Pensions business represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income and net realized capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from our other businesses. Deposits, withdrawals, net investment income and netrealized and net unrealized capital gains and losses on Separate Account assets are not reflected in our statements of income or cash flows. Management fees charged to contract holders are included in fees and other revenue and recognized over the period earned.

### **Health Care and Other Insurance Liabilities**

#### *Health care costs payable*

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs and other amounts due to health care providers pursuant to risk-sharing arrangements related to Health Care's POS, PPO, HMO, Indemnity, Medicare and Medicaid products. Unpaid health care claims include our estimate of payments we will make on claims reported to us but not yet paid and for health care services rendered to members but not yet reported to us as of the balance sheet date (collectively, "IBNR"). Also included in these estimates is the cost of services that will continue to be rendered after the balance sheet date if we are obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of health care services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors. We reflect changes in these estimates in health care costs in our operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the member. Approximately five percent of our health care costs related to capitated arrangements in each of the last three years. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the balance sheet date.

#### *Future policy benefits*

Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts in the Large Case Pensions business and long-duration group life and long-term care insurance contracts in the Group Insurance business. Reserves for limited payment contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 1.8% to 11.3% in 2010 and from 2.0% to 11.3% in 2009. We periodically review mortality assumptions against both industry standards and our experience. Reserves for long-duration group life and long-term care contracts represent our estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. Assumed interest rates on such contracts ranged from 2.5% to 8.8% in both 2010 and 2009. Our estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions.

### *Unpaid claims*

Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts in the Group Insurance business, including an estimate for IBNR as of the balance sheet date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon our estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. We develop our reserves for IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. We discount certain claim liabilities related to group long-term disability and premium waiver contracts. The discounted unpaid claim liabilities were \$1.9 billion and \$1.8 billion at December 31, 2010 and 2009, respectively. The undiscounted value of these unpaid claim liabilities was \$2.6 billion and \$2.4 billion at December 31, 2010 and 2009, respectively. The discount rates generally reflect our expected investment returns for the investments supporting these liabilities and ranged from 4.0% to 5.8% in 2010 and 5.8% to 6.3% in 2009. The discount rates for retrospectively-rated contracts are set at contractually specified levels. Our estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in our statements of income in the period they are determined.

### *Policyholders' funds*

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts in the Large Case Pensions business and customer funds associated with group life and health contracts in the Health Care and Group Insurance businesses. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus credited interest thereon, net of experience-rated adjustments. In 2010, interest rates for pension and annuity investment contracts ranged from 3.5% to 11.8%, and interest rates for group life and health contracts ranged from 0% to 4.0%. In 2009, interest rates for pension and annuity investment contracts ranged from 3.5% to 10.5% and interest rates for group life and health contracts ranged from 0% to 4.2%. Reserves for contracts subject to experience rating reflect our rights as well as the rights of policyholders and plan participants.

We review health care and insurance liabilities periodically. We reflect any necessary adjustments during the current period in operating results. While the ultimate amount of claims and related expenses are dependent on future developments, it is management's opinion that the liabilities that have been established are adequate to cover such costs. The health care and insurance liabilities that are expected to be paid within twelve months are classified as current on our balance sheets.

### *Premium Deficiency Reserves*

We evaluate our insurance contracts to determine if it is probable that a loss will be incurred. We recognize a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. We did not have any premium deficiency reserves at December 31, 2010 or 2009.

### **Health Care Contract Acquisition Costs**

Health care benefits products included in the Health Care segment are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to our prepaid health care and health indemnity contracts are generally expensed as incurred.

### **Revenue Recognition**

Health care premiums are recognized as income in the month in which the enrollee is entitled to receive health care services. Health care premiums are reported net of an allowance for estimated terminations and uncollectable amounts. Other premium revenue for group life, long-term care and disability products is recognized as income, net of allowances for termination and uncollectable accounts, over the term of the coverage. Other premium revenue for Large Case Pensions' limited payment pension and annuity contracts is recognized as revenue in the period received. Premiums related to unexpired contractual coverage periods are reported as unearned premiums in our balance sheets.

The balance of the allowance for estimated terminations and uncollectable accounts on premiums receivable was \$80 million and \$107 million at December 31, 2010 and 2009, respectively, and is reflected as a reduction of premiums receivable in our balance sheets. The balance of the allowance for uncollectable accounts on other receivables was \$26 million and \$55 million at December 31, 2010 and 2009, respectively, and is reflected as a reduction of other receivables in our balance sheets.

Some of our contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of members. Such adjustments are reasonably estimable (based on actual experience of the customer emerging under the contract and the terms of the underlying contract) and are recognized as the experience emerges.

Fees and other revenue consists primarily of ASC fees which are received in exchange for performing certain claim processing and member services for health and disability members and are recognized as revenue over the period the service is provided. Some of our contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's claim experience will fall within a certain range. With any of these guarantees, we are financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to us by the customer involved. We accrue for any such exposure upon occurrence.

In addition, fees and other revenue also include charges assessed against contract holders' funds for contract fees, participant fees and asset charges related to pension and annuity products in the Large Case Pensions business. Other amounts received on pension and annuity investment-type contracts are reflected as deposits and are not recorded as revenue. Some of our Large Case Pension contract holders have the contractual right to purchase annuities with life contingencies using the funds they maintain on deposit with us. Since these products are considered an insurance contract, when the contract holder makes this election, we treat the accumulated investment balance as a single premium and reflect it as both premiums and current and future benefits in our statements of income.

#### *Accounting for the Medicare Part D Prescription Drug Program ("PDP")*

We were selected by the Centers for Medicare & Medicaid Services ("CMS") to be a national provider of PDP in all 50 states to both individuals and employer groups in 2010, 2009 and 2008. Under these annual contracts, CMS pays us a portion of the premium, a portion of, or a capitated fee for, catastrophic drug costs and a portion of the health care costs for low-income Medicare beneficiaries and provides a risk-sharing arrangement to limit our exposure to unexpected expenses.

We recognize premiums received from, or on behalf of, members or CMS and capitated fees as premium revenue ratably over the contract period. We expense the cost of covered prescription drugs as incurred. Costs associated with low-income Medicare beneficiaries (deductible, coinsurance, etc.) and the catastrophic drug costs paid in advance by CMS are recorded as a liability and offset health care costs when incurred. For individual PDP coverage, the risk-sharing arrangement provides a risk corridor whereby the amount we received in premiums from members and CMS based on our annual bid is compared to our actual drug costs incurred during the contract year. Based on the risk corridor provision and PDP activity to date, an estimated risk-sharing receivable or payable is recorded on a quarterly basis as an adjustment to premium revenue. We perform a reconciliation of the final risk-sharing, low-income subsidy and catastrophic amounts after the end of each contract year.

#### **Allocation of Operating Expenses**

We allocate to the business segments centrally-incurred costs associated with specific internal goods or services provided to us, such as employee services, technology services and rent, based on a reasonable method for each specific cost (such as membership, usage, headcount, compensation or square footage occupied). Interest expense on third-party borrowings and the financing components of our pension and other post-retirement benefit plan expense is not allocated to the reporting segments, since it is not used as a basis for measuring the operating performance of the segments. Such amounts are reflected in Corporate Financing in our segment financial information. Segment results were restated for this change in expense allocation. Refer to Note 19 beginning on page 95 for additional information.

#### **Income Taxes**

We are taxed at the statutory corporate income tax rates after adjusting income reported for financial statement purposes for certain items. We recognize deferred income tax assets and liabilities for the differences between the

financial and income tax reporting basis of assets and liabilities based on enacted tax rates and laws. Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. Deferred income tax expense or benefit primarily reflects the net change in deferred income tax assets and liabilities during the year.

Our current income tax provision reflects the tax results of revenues and expenses currently taxable or deductible. Penalties and interest on our tax positions are classified as a component of our income tax provision.

### 3. Acquisition

During 2010, we entered into an agreement to acquire Medicity Inc., a health information exchange company, for approximately \$500 million. This transaction closed in January 2011 and was funded using available resources.

In 2009, we acquired Horizon Behavioral Services, LLC (“Horizon”), a leading provider of employee assistance programs, for approximately \$70 million in available cash. We recorded goodwill related to this transaction of approximately \$56 million in 2009, of which \$37 million will be tax deductible. All of the goodwill related to this acquisition was assigned to our Health Care segment. Refer to Note 7 on page 66 for additional information.

### 4. Earnings Per Common Share

Basic earnings per share (“EPS”) is computed by dividing net income by the weighted average number of common shares outstanding during the reporting period. Diluted EPS is computed in a similar manner, except that the weighted average number of common shares outstanding is adjusted for the dilutive effects of our outstanding stock-based compensation awards, but only if the effect is dilutive.

The computations of basic and diluted EPS for 2010, 2009 and 2008 were as follows:

<b>(Millions, except per common share data)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Net Income	<b>\$ 1,766.8</b>	\$ 1,276.5	\$ 1,384.1
Weighted average shares used to compute basic EPS	<b>415.7</b>	441.1	475.5
Dilutive effect of outstanding stock-based compensation awards <sup>(1)</sup>	<b>7.2</b>	8.4	12.8
Weighted average shares used to compute diluted EPS	<b>422.9</b>	449.5	488.3
Basic EPS	<b>\$ 4.25</b>	\$ 2.89	\$ 2.91
Diluted EPS	<b>\$ 4.18</b>	\$ 2.84	\$ 2.83

(1) Approximately 18.6 million, 19.3 million and 9.7 million stock appreciation rights (“SARs”) (with exercise prices ranging from \$29.20 to \$59.76, \$25.94 to \$59.76 and \$25.94 to \$59.76, respectively) were not included in the calculation of diluted EPS for 2010, 2009 and 2008, respectively, and approximately 5.7 million, 6.2 million and 1.6 million stock options (with exercise prices ranging from \$33.38 to \$42.35) were not included in the calculation of diluted EPS for 2010, 2009 and 2008 respectively, as their exercise prices were greater than the average market price of Aetna common shares during such periods.

## 5. Operating Expenses

For 2010, 2009 and 2008, selling expenses (which include broker commissions, the variable component of our internal sales force compensation and premium taxes) and general and administrative expenses were as follows:

(Millions)	2010	2009	2008
Selling expenses	\$ 1,226.6	\$ 1,251.9	\$ 1,149.6
General and administrative expenses:			
Salaries and related benefits	3,076.4	2,971.8	2,619.8
Other general and administrative expenses (1)	2,216.0	2,159.3	1,982.1
Total general and administrative expenses (2)	5,292.4	5,131.1	4,601.9
Total operating expenses	\$ 6,519.0	\$ 6,383.0	\$ 5,751.5

- (1) Includes the following for 2010: transaction-related costs of \$66.2 million and litigation-related insurance proceeds of \$156.3 million. Includes the following for 2009: litigation-related insurance proceeds of \$38.2 million. Includes the following charges for 2008: a \$20.0 million contribution for the establishment of an out-of-network pricing database and a \$42.2 million allowance on a reinsurance recoverable. Refer to the reconciliation of operating earnings to net income in Note 19 beginning on page 95 for additional information.
- (2) In 2010, 2009 and 2008, we recorded severance and facilities charges of \$47.4 million, \$93.7 million and \$54.7 million, respectively. Refer to the reconciliation of operating earnings to net income in Note 19 beginning on page 95 for additional information.

## 6. Health Care Costs Payable

The following table shows the components of the change in health care costs payable during 2010, 2009 and 2008:

(Millions)	2010	2009	2008
Health care costs payable, beginning of the period	\$ 2,895.3	\$ 2,393.2	\$ 2,177.4
Less: Reinsurance recoverables	1.9	2.0	2.9
Health care costs payable, beginning of the period, net	2,893.4	2,391.2	2,174.5
Acquisition of businesses	-	1.1	-
Add: Components of incurred health care costs			
Current year	23,045.6	24,127.2	20,948.5
Prior years	(326.0)	(66.0)	(163.0)
Total incurred health care costs	22,719.6	24,061.2	20,785.5
Less: Claims paid			
Current year	20,588.5	21,401.1	18,726.4
Prior years	2,395.3	2,159.0	1,842.4
Total claims paid	22,983.8	23,560.1	20,568.8
Health care costs payable, end of period, net	2,629.2	2,893.4	2,391.2
Add: Reinsurance recoverables	1.7	1.9	2.0
Health care costs payable, end of the period	\$ 2,630.9	\$ 2,895.3	\$ 2,393.2

Our prior year estimates of health care costs payable decreased by approximately \$326 million, \$66 million and \$163 million in 2010, 2009 and 2008, respectively, resulting from claims being settled for amounts less than originally estimated. These reductions were primarily the result of lower than expected health care cost trends as well as the actual claim submission time being faster than we assumed in establishing our health care costs payable in the prior year. These reductions were offset by estimated current period health care costs when we established our estimate of current year health care costs payable. When significant decreases (increases) in prior-period health care cost estimates occur that we believe significantly impact our current period operating results, we disclose that amount as favorable (unfavorable) development of prior period health care cost estimates. In 2010, we had approximately \$118 million of favorable development of prior-year health care cost estimates that primarily resulted from lower than projected paid claims in the first half of 2010 for claims incurred in the latter part of 2009 caused by lower than projected utilization of medical services driven by the abatement of H1N1 and other flu, among other factors. In 2009, we had approximately \$116 million of unfavorable development of prior-year health care cost estimates that was driven by unusually high paid claims activity in the first half of 2009 related to the second half of 2008. This unfavorable development of prior year health care cost estimates offset the amount of the 2009 reduction in our estimate of health care costs payable for prior years. We had no significant development of prior-year health care cost estimates that affected our operating results in 2008.

## 7. Goodwill and Other Acquired Intangible Assets

As a result of recent acquisitions, in accordance with applicable accounting guidance, we allocated the amount paid to the fair value of the net assets acquired, with any excess amounts recorded as goodwill. The increase in goodwill in 2010 and 2009 was as follows:

(Millions)	2010	2009
Balance, beginning of the period	\$ 5,146.2	\$ 5,085.6
Goodwill acquired:		
Horizon	(	56.8
	5)	
Schaller Anderson, Incorporated	.7	3.8
<b>Balance, end of the period <sup>(1)</sup></b>	<b>\$ 5,146.4</b>	<b>\$ 5,146.2</b>

(1) At both December 31, 2010 and 2009, approximately \$5.0 billion and \$104 million of goodwill was assigned to the Health Care and Group Insurance segments, respectively.

Other acquired intangible assets at December 31, 2010 and 2009 were comprised of the following:

(Millions)	Cost	Accumulated Amortization	Net Balance	Amortization Period (Years)
<b>2010</b>				
Other acquired intangible assets:				
Provider networks	\$ 703.2	\$ 398.9	\$ 304.3	12-25 <sup>(1)</sup>
Customer lists	420.4	262.6	157.8	4-10 <sup>(1)</sup>
Technology	25.3	25.0	.3	3-5
Other	38.1	27.3	10.8	2-15
Trademarks	22.3	-	22.3	Indefinite
<b>Total other acquired intangible assets</b>	<b>\$ 1,209.3</b>	<b>\$ 713.8</b>	<b>\$ 495.5</b>	
<b>2009</b>				
Other acquired intangible assets:				
Provider networks	\$ 703.2	\$ 369.0	\$ 334.2	12-25 <sup>(1)</sup>
Customer lists	420.4	206.3	214.1	4-10 <sup>(1)</sup>
Technology	25.3	20.7	4.6	3-5
Other	38.1	22.6	15.5	2-15
Trademarks	22.3	-	22.3	Indefinite
<b>Total other acquired intangible assets</b>	<b>\$ 1,209.3</b>	<b>\$ 618.6</b>	<b>\$ 590.7</b>	

The amortization period for our customer lists and provider networks includes an assumption of renewal or extension of these arrangements. At December 31, 2010 and 2009, the periods prior to the next renewal or extension for our provider networks primarily ranged from 1 to 3 years and the period prior to the next renewal or extension for our customer lists is approximately one year. Any costs related to the renewal or extension of these contracts is expensed as incurred.

We estimate annual pretax amortization for other acquired intangible assets over the next five years to be as follows:

(Millions)	
2011	\$ 87.7
2012	76.2
2013	67.0
2014	47.9
2015	34.4

## 8. Investments

Total investments at December 31, 2010 and 2009 were as follows:

(Millions)	2010			2009		
	Current	Long-term	Total	Current	Long-term	Total
Debt and equity securities available for sale	\$ 2,111.9	\$ 14,849.7	\$ 16,961.6	\$ 2,834.8	\$ 14,324.9	\$ 17,159.7
Mortgage loans	55.2	1,454.6	1,509.8	86.1	1,507.9	1,594.0
Other investments	2.6	1,242.0	1,244.6	1.8	1,218.3	1,220.1
<b>Total investments</b>	<b>\$ 2,169.7</b>	<b>\$ 17,546.3</b>	<b>\$ 19,716.0</b>	<b>\$ 2,922.7</b>	<b>\$ 17,051.1</b>	<b>\$ 19,973.8</b>

Debt and equity securities available for sale at December 31, 2010 and 2009 were as follows:

(Millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
<b>December 31, 2010</b>				
Debt securities:				
U.S. government securities	\$ 1,293.5	\$ 80.8	\$ (.6)	\$ 1,373.7
States, municipalities and political subdivisions	2,288.8	54.4	(46.9)	2,296.3
U.S. corporate securities	6,731.5	553.0	(21.9)	7,262.6
Foreign securities	2,667.4	231.1	(21.2)	2,877.3
Residential mortgage-backed securities	1,089.2	53.6	(2.8) (1)	1,140.0
Commercial mortgage-backed securities	1,226.4	99.5	(13.7) (1)	1,312.2
Other asset-backed securities	447.6	21.1	(4.8) (1)	463.9
Redeemable preferred securities	196.7	12.3	(12.7)	196.3
<b>Total debt securities</b>	<b>15,941.1</b>	<b>1,105.8</b>	<b>(124.6)</b>	<b>16,922.3</b>
Equity securities	35.3	5.6	(1.6)	39.3
<b>Total debt and equity securities (2)</b>	<b>\$ 15,976.4</b>	<b>\$ 1,111.4</b>	<b>\$ (126.2)</b>	<b>\$ 16,961.6</b>
<b>December 31, 2009</b>				
Debt securities:				
U.S. government securities	\$ 1,801.3	\$ 50.7	\$ (5.2)	\$ 1,846.8
States, municipalities and political subdivisions	2,022.2	80.7	(27.5)	2,075.4
U.S. corporate securities	6,741.9	497.1	(54.4)	7,184.6
Foreign securities	2,554.5	210.9	(20.9)	2,744.5
Residential mortgage-backed securities	1,375.8	49.4	(5.0) (1)	1,420.2
Commercial mortgage-backed securities	1,109.8	37.6	(104.0) (1)	1,043.4
Other asset-backed securities	419.6	25.0	(8.2) (1)	436.4
Redeemable preferred securities	381.9	27.8	(41.0)	368.7
<b>Total debt securities</b>	<b>16,407.0</b>	<b>979.2</b>	<b>(266.2)</b>	<b>17,120.0</b>
Equity securities	35.3	7.9	(3.5)	39.7
<b>Total debt and equity securities (2)</b>	<b>\$ 16,442.3</b>	<b>\$ 987.1</b>	<b>\$ (269.7)</b>	<b>\$ 17,159.7</b>

### December 31, 2009

Debt securities:

U.S. government securities	\$ 1,801.3	\$ 50.7	\$ (5.2)	\$ 1,846.8
States, municipalities and political subdivisions	2,022.2	80.7	(27.5)	2,075.4
U.S. corporate securities	6,741.9	497.1	(54.4)	7,184.6
Foreign securities	2,554.5	210.9	(20.9)	2,744.5
Residential mortgage-backed securities	1,375.8	49.4	(5.0) (1)	1,420.2
Commercial mortgage-backed securities	1,109.8	37.6	(104.0) (1)	1,043.4
Other asset-backed securities	419.6	25.0	(8.2) (1)	436.4
Redeemable preferred securities	381.9	27.8	(41.0)	368.7
<b>Total debt securities</b>	<b>16,407.0</b>	<b>979.2</b>	<b>(266.2)</b>	<b>17,120.0</b>
Equity securities	35.3	7.9	(3.5)	39.7
<b>Total debt and equity securities (2)</b>	<b>\$ 16,442.3</b>	<b>\$ 987.1</b>	<b>\$ (269.7)</b>	<b>\$ 17,159.7</b>

(1) At December 31, 2010 and 2009, we held securities for which we had recognized a credit-related impairment in the past. In 2010 we released \$23.4 million of non-credit-related impairments from other comprehensive loss related to these securities (as of December 31, 2010 these securities had a net unrealized capital gain of \$3.9 million). Effective April 1, 2009 and for the period through December 31, 2009, we recognized \$61.7 million of non-credit-related impairments in other comprehensive loss (as of December 31, 2009, these securities had a net unrealized capital loss of \$17.2 million).

(2) Investment risks associated with our experience-rated and discontinued products generally do not impact our operating results (refer to Note 20 beginning on page 97 for additional information on our accounting for discontinued products). At December 31, 2010, investments with a fair value of \$4.1 billion, gross unrealized gains of \$339.5 million and gross unrealized losses of \$38.1 million and, at December 31, 2009, investments with a fair value of \$4.0 billion, gross unrealized gains of \$285.6 million and gross unrealized losses of \$78.2 million were included in total debt and equity securities, but support our experience-rated and discontinued products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive loss.

The fair value of debt securities at December 31, 2010 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid.

<b>(Millions)</b>	<b>Fair Value</b>
Due to mature:	
Less than one year	\$ 757.7
One year through five years	3,324.5
After five years through ten years	5,068.2
Greater than ten years	4,855.8
Residential mortgage-backed securities	1,140.0
Commercial mortgage-backed securities	1,312.2
Other asset-backed securities	463.9
<b>Total</b>	<b>\$ 16,922.3</b>

*Mortgage-Backed and Other Asset-Backed Securities*

All of our residential mortgage-backed securities at December 31, 2010 were agency issued (e.g., Government National Mortgage Association, Federal National Mortgage Association and Federal Home Loan Mortgage Corporation) and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2010, our residential mortgage-backed securities had an average quality rating of AAA and a weighted average duration of 3.1 years.

Our commercial mortgage-backed securities have underlying loans that are dispersed throughout the U.S. Significant market observable inputs used to value these securities include probability of default and loss severity. At December 31, 2010, these securities had an average quality rating of AA+ and a weighted average duration of 3.6 years.

Our other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables and home equity loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2010, these securities had an average quality rating of AA- and a weighted average duration of 3.4 years.

**Unrealized Capital Losses and Net Realized Capital Gains (Losses)**

When a debt or equity security is in an unrealized capital loss position, we monitor the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. As described in Note 2 beginning on page 57, effective April 1, 2009, we recognize an OTTI on debt securities when we intend to sell a security that is in an unrealized capital loss position or if we determine a credit-related loss has occurred. Prior to April 1, 2009, we recognized an OTTI on a security in an unrealized capital loss position if we could not assert our intention and ability to hold the security until it recovered its value.

Summarized below are the debt and equity securities we held at December 31, 2010 and 2009 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

(Millions)	Less than 12 months		Greater than 12 months		Total (1)	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
<b>December 31, 2010</b>						
Debt securities:						
U.S. government securities	\$ 8.4	\$ .2	\$ 19.8	\$ .4	\$ 28.2	\$ .6
States, municipalities and political subdivisions	964.9	37.6	82.7	9.3	1,047.6	46.9
U.S. corporate securities	665.8	17.0	210.2	4.9	876.0	21.9
Foreign securities	375.9	14.6	34.6	6.6	410.5	21.2
Residential mortgage-backed securities	103.7	2.6	6.6	.2	110.3	2.8
Commercial mortgage-backed securities	103.7	2.4	78.5	11.3	182.2	13.7
Other asset-backed securities	85.9	2.0	4.9	2.8	90.8	4.8
Redeemable preferred securities	4.5	-	94.3	12.7	98.8	12.7
Total debt securities	2,312.8	76.4	531.6	48.2	2,844.4	124.6
Equity securities	.5	-	9.5	1.6	10.0	1.6
Total debt and equity securities (1)	\$ 2,313.3	\$ 76.4	\$ 541.1	\$ 49.8	\$ 2,854.4	\$ 126.2

**December 31, 2009**

Debt securities:						
U.S. government securities	\$ 1,062.5	\$ 4.8	\$ 19.3	\$ .4	\$ 1,081.8	\$ 5.2
States, municipalities and political subdivisions	292.2	10.6	216.7	16.9	508.9	27.5
U.S. corporate securities	730.2	16.8	681.4	37.6	1,411.6	54.4
Foreign securities	418.1	9.0	110.4	11.9	528.5	20.9
Residential mortgage-backed securities	383.0	4.7	8.2	.3	391.2	5.0
Commercial mortgage-backed securities	129.7	3.1	401.6	100.9	531.3	104.0
Other asset-backed securities	46.6	7.5	16.7	.7	63.3	8.2
Redeemable preferred securities	49.1	8.8	198.5	32.2	247.6	41.0
Total debt securities	3,111.4	65.3	1,652.8	200.9	4,764.2	266.2
Equity securities	3.9	1.6	18.8	1.9	22.7	3.5
Total debt and equity securities (1)	\$ 3,115.3	\$ 66.9	\$ 1,671.6	\$ 202.8	\$ 4,786.9	\$ 269.7

(1) At December 31, 2010 and 2009, debt and equity securities in an unrealized loss position of \$38.1 million and \$78.2 million, respectively, and with related fair value of \$650.5 million and \$1.0 billion, respectively, related to discontinued and experience-rated products.

We reviewed the securities in the tables above and concluded that these are performing assets generating investment income to support the needs of our business. In performing this review, we considered factors such as the quality of the investment security based on research performed by external rating agencies and our internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery.

The maturity dates for debt securities in an unrealized loss position at December 31, 2010 were as follows:

(Millions)	Supporting discontinued and experience-rated products		Supporting remaining products		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Due to mature:						
Less than one year	\$ 2.3	\$ -	\$ 60.0	\$ .6	\$ 62.3	\$ .6
One year through five years	9.3	.2	277.4	3.7	286.7	3.9
After five years through ten years	151.0	4.8	461.1	10.7	612.1	15.5
Greater than ten years	405.4	29.1	1,094.6	54.2	1,500.0	83.3
Residential mortgage-backed securities	9.9	.4	100.4	2.4	110.3	2.8
Commercial mortgage-backed securities	35.8	1.5	146.4	12.2	182.2	13.7
Other asset-backed securities	27.0	.5	63.8	4.3	90.8	4.8
Total	\$ 640.7	\$ 36.5	\$ 2,203.7	\$ 88.1	\$ 2,844.4	\$ 124.6

Net realized capital gains (losses) for the years ended December 31, 2010, 2009 and 2008, excluding amounts related to experience-rated contract holders and discontinued products, were as follows:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
OTTI losses on securities	\$ (8.9)	\$ (121.0)	\$ (643.6)
Portion of OTTI losses (released from) recognized in other comprehensive income, net	<b>(23.4)</b>	26.5	-
Net OTTI losses on securities recognized in earnings	<b>(32.3)</b>	(94.5)	(643.6)
Net realized capital gains (losses), excluding OTTI losses on securities	<b>259.8</b>	149.5	(12.3)
Net realized capital gains (losses)	<b>\$ 227.5</b>	\$ 55.0	\$ (655.9)

The net realized capital gains in 2010 and 2009 were primarily attributable to the sale of debt securities. In 2010, these gains were partially offset by losses on derivative transactions while in 2009, these gains were also attributable to gains on derivative transactions partially offset by OTTI losses. Net realized capital losses in 2008 primarily reflect OTTI losses as depicted below. The increase in net realized capital gains in 2009 compared to 2008 was primarily due to a change in the accounting guidance for the recognition of OTTI of debt securities and an overall general improvement in the economic environment during 2009 compared to 2008. Prior to the adoption of new accounting guidance for OTTI of debt securities on April 1, 2009, both yield- and credit-related OTTI were recognized in earnings if we could not assert our intention to hold the security until recovery. By contrast, after April 1, 2009, only credit-related impairments are recognized in net income unless we have the intention to sell the security in an unrealized loss position, in which case the yield-related OTTI is also recognized in earnings. Refer to Note 2 of Notes to Consolidated Financial Statements beginning on page 57 for additional information.

Yield-related OTTI losses were not significant in 2010. In 2009, yield-related OTTI losses were \$76 million, primarily related to U.S. Treasury and corporate securities that were temporarily in a loss position due to changes in interest rates and the widening of credit spreads on corporate securities relative to the interest rates on U.S. Treasury securities in the first half of 2009. Because we did not assert our intention to hold these securities, under applicable accounting guidance, we recorded a yield-related OTTI loss. In 2008, yield-related OTTI losses were \$523 million. These yield-related impairments were primarily due to the widening of credit spreads relative to the interest rates on U.S. Treasury securities in 2008 and the application of the then-applicable accounting guidance for OTTI which required us to assert our intention to hold to recovery, which we could not make. During 2008, significant declines in the U.S. housing market resulted in the credit and other capital markets experiencing volatility and limitations on the ability of companies to issue debt or equity securities. The lack of available credit, lack of confidence in the financial sector, increased volatility in the financial markets and reduced business activity resulted in credit spreads widening during 2008.

Included in net realized capital losses for 2008 were \$120 million of credit-related OTTI losses of which \$105 million related to investments in debt securities of Lehman Brothers Holdings Inc. and Washington Mutual, Inc. We had no other individually material realized capital losses on debt or equity securities that impacted our operating results during 2010, 2009 or 2008.

Excluding amounts related to experience-rated and discontinued products, proceeds from the sale of debt securities and the related gross realized capital gains and losses for 2010, 2009 and 2008 were as follows:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Proceeds on sales	\$ 7,663.4	\$ 5,506.5	\$ 5,783.8
Gross realized capital gains	<b>364.8</b>	205.0	120.6
Gross realized capital losses	<b>43.2</b>	71.6	136.8

### **Mortgage Loans**

Our mortgage loans are collateralized by commercial real estate. During 2010, we entered into \$103 million in new mortgage loans, \$129 million in loans were repaid and \$20 million in loans were foreclosed. At December 31, 2010 and 2009, we had no material problem, restructured or potential problem loans included in mortgage loans. We also had no material reserves on our mortgage loans at December 31, 2010 or 2009.

We assess our mortgage loans on a regular basis for credit impairments, and annually we assign a credit quality indicator to each loan. Our credit quality indicator is internally developed and categorizes our portfolio on a scale

from 1 to 7. Category 1 represents loans of superior quality, and Categories 6 and 7 represent loans where collections are doubtful. Most of our mortgage loans fall into the Level 2 - 4 ratings. These ratings represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes. Category 5 represents loans where credit risk is not substantial but these loans warrant management's close attention. These indicators are based upon several factors, including current loan to value ratios, property condition, market trends, borrower quality and deal structure. Based upon our most recent assessment at December 31, 2010, our mortgage loans were given the following ratings:

**(In millions, except credit ratings indicator)**

1	\$	99.4
2 - 4		1,301.5
5		86.1
6 & 7		22.8
<b>Total</b>	<b>\$</b>	<b>1,509.8</b>

At December 31, 2010 scheduled mortgage loan principal repayments were as follows:

**(Millions)**

2011	\$	55.2
2012		47.3
2013		274.3
2014		94.1
2015		153.2
Thereafter		886.7

**Variable Interest Entities**

In determining whether to consolidate VIE, we consider several factors including whether we have the power to direct activities, the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE. We have relationships with certain real estate and hedge fund partnerships that are considered VIEs but are not consolidated. We record the amount of our investment in these partnerships as long-term investments on our balance sheets and recognize our share of partnership income or losses in earnings. Our maximum exposure to loss as a result of our investment in these partnerships is our investment balance at December 31, 2010 and 2009 of approximately \$153 million and \$125 million, respectively, and the risk of recapture of tax credits related to the real estate partnerships previously recognized, which we do not consider significant. We do not have a future obligation to fund losses or debts on behalf of these investments; however, we may voluntarily contribute funds. The real estate partnerships construct, own and manage low-income housing developments and had total assets of approximately \$5.1 billion at both December 31, 2010 and 2009. The hedge fund partnerships had total assets of approximately \$6.1 billion and \$5.7 billion at December 31, 2010 and 2009, respectively.

**Non-controlling Interests**

Certain of our investment holdings are partially-owned by third parties. At December 31, 2010 and 2009, \$74 million and \$77 million, respectively, of our investment holdings were partially owned by third parties. The non-controlling entities' share of these investments was included in accrued expenses and other current liabilities. Net income (loss) attributed to these interests was \$4 million for both 2010 and 2009, and \$(11) million for 2008. These non-controlling interests did not have a material impact on our financial position or operating results.

## Net Investment Income

Sources of net investment income for 2010, 2009 and 2008 were as follows:

(Millions)	2010	2009	2008
Debt securities	\$ 911.8	\$ 907.8	\$ 877.4
Mortgage loans	118.7	118.6	116.9
Other investments	56.5	38.6	(50.4)
Gross investment income	1,087.0	1,065.0	943.9
Less: Investment expenses	(30.7)	(28.6)	(33.9)
Net investment income (1)	\$ 1,056.3	\$ 1,036.4	\$ 910.0

(1) Investment risks associated with our experience-rated and discontinued products generally do not impact our operating results (refer to Note 20 beginning on page 97 for additional information on our accounting for discontinued products). Net investment income includes \$344.9 million, \$347.8 million, and \$296.1 million for 2010, 2009 and 2008, respectively, related to investments supporting our experience-rated and discontinued products.

## 9. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive loss in 2010 and 2009:

(Millions)	Net Unrealized Gains (Losses)			Pension and OPEB Plans	Accumulated Other Comprehensive (Loss) Income
	Previously Impaired (1)	All Other	Foreign Currency and Derivatives		
<b>Balance at December 31, 2008</b>	\$ -	\$ (229.3)	\$ (8.7)	\$ (1,643.3)	\$ (1,881.3)
Cumulative effect of adopting a new accounting standard (\$83.0 pretax) (2)	(5.3)	(48.4)	-	-	(53.7)
Net unrealized gains (losses) (\$1,004.6 pretax)	106.3	592.4	34.4	(80.1)	653.0
Reclassification to earnings (\$110.5 pretax)	(.7)	(79.0)	(.4)	139.1	59.0
Other comprehensive income	100.3	465.0	34.0	59.0	658.3
<b>Balance at December 31, 2009</b>	<b>100.3</b>	<b>235.7</b>	<b>25.3</b>	<b>(1,584.3)</b>	<b>(1,223.0)</b>
Net unrealized gains (losses) (\$333.5 pretax)	42.5	327.5	(53.9)	(99.3)	216.8
Reclassification to earnings (\$172.9 pretax)	(67.7)	(188.0)	1.3	98.0	(156.4)
Other comprehensive (loss) income	(25.2)	139.5	(52.6)	(1.3)	60.4
<b>Balance at December 31, 2010</b>	<b>\$ 75.1</b>	<b>\$ 375.2</b>	<b>\$ (27.3)</b>	<b>\$ (1,585.6)</b>	<b>\$ (1,162.6)</b>

(1) Represents unrealized losses on the non-credit-related component of impaired debt securities that we do not intend to sell and subsequent appreciation in the fair value of those securities as well as those securities we intend to sell.

(2) Effective April 1, 2009, we adopted new accounting guidance for other-than-temporary impairments of debt securities. Refer to Note 2 beginning on page 57 for additional information on the cumulative effect adjustment required.

Shareholders' equity included the following activity in accumulated other comprehensive loss in 2008:

(Millions)	Net Unrealized Gains (Losses)			Pension and OPEB Plans	Accumulated Other Comprehensive (Loss) Income
	Securities	Foreign Currency and Derivatives			
<b>Balance at December 31, 2007</b>	\$ 53.3	\$ 7.0	\$ (348.7)	\$ (288.4)	
Net unrealized losses (\$3,158.9) pretax)	(756.7)	-	(1,296.6)	(2,053.3)	
Net foreign currency and derivative losses (\$25.5) pretax)	-	(16.6)	-	(16.6)	
Reclassification to earnings (\$647.7) pretax)	474.1	.9	2.0	477.0	
<b>Balance at December 31, 2008</b>	<b>\$ (229.3)</b>	<b>\$ (8.7)</b>	<b>\$ (1,643.3)</b>	<b>\$ (1,881.3)</b>	

The components of our pension and OPEB plans included the following activity in accumulated other comprehensive loss in 2010, 2009 and 2008:

(Millions)	Pension Plans		OPEB Plans		Total
	Unrecognized Net Actuarial Losses	Unrecognized Prior Service Costs	Unrecognized Net Actuarial Losses	Unrecognized Prior Service Costs	
<b>Balance at December 31, 2007</b>	\$ (348.7)	\$ 13.4	\$ (47.1)	\$ 33.7	\$ (348.7)
Unrealized net losses arising during the period (\$1,991.7) pretax)	(1,286.4)	-	(10.2)	-	(1,296.6)
Reclassification to earnings (\$3.1) pretax)	4.1	(1.4)	1.7	(2.4)	2.0
<b>Balance at December 31, 2008</b>	(1,631.0)	12.0	(55.6)	31.3	(1,643.3)
Unrealized net losses arising during the period (\$123.2) pretax)	(72.5)	-	(7.6)	-	(80.1)
Reclassification to earnings (\$214.0) pretax)	140.7	(1.4)	2.2	(2.4)	139.1
<b>Balance at December 31, 2009</b>	(1,562.8)	10.6	(61.0)	28.9	(1,584.3)
Unrealized net losses arising during the period (\$152.8) pretax)	(91.2)	-	(8.1)	-	(99.3)
Reclassification to earnings (\$150.8) pretax)	106.1	(8.8)	3.0	(2.3)	98.0
<b>Balance at December 31, 2010</b>	\$ (1,547.9)	\$ 1.8	\$ (66.1)	\$ 26.6	\$ (1,585.6)

## 10. Financial Instruments

The preparation of our consolidated financial statements in accordance with GAAP requires certain of our assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, we provide details on the fair value of financial assets and liabilities and how we determine those fair values. We present this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income or other comprehensive income separately from other financial assets and liabilities.

### Financial Instruments Measured at Fair Value in our Balance Sheets

Certain of our financial instruments are measured at fair value in our balance sheet. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information (“inputs”) that qualifies a financial asset or liability for each level:

- o **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- o **Level 2** – Inputs other than Level 1 that are based on observable market data. These include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- o **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment’s financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for our financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

**Debt Securities** - Where quoted prices are available in an active market, our debt securities are classified in Level 1 of the fair value hierarchy. Our Level 1 debt securities are comprised primarily of U.S. Treasury securities. If Level 1 valuations are not available, the fair value is determined using models such as matrix pricing, which uses quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. We obtained one price for each of our Level 2 debt securities and did not adjust any of these prices at December 31, 2010 or 2009.

We also value certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. We obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of these quotes at December 31, 2010 or 2009. The total fair value of our broker quoted securities was approximately \$153 million and \$364 million at December 31, 2010 and 2009, respectively. Examples of these Level 3 debt securities include certain U.S. and foreign corporate securities and certain of our commercial mortgage-backed securities as well as other asset-backed securities. For some of our private placement securities, our internal staff determines the values of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

**Equity Securities** - We currently have two classifications of equity securities: those that are publicly traded and those that are privately held. Our publicly-traded securities are classified as Level 1 because quoted prices are available for these securities in an active market. For privately-held equity securities, there is no active market; therefore, we classify these securities as Level 3 because we must price these securities through an internal analysis of each investment's financial statements and cash flow projections.

**Derivatives** - Our derivative instruments are valued using models that primarily use market observable inputs and therefore are classified as Level 2 because they are traded in markets where quoted market prices are not readily available.

Financial assets and liabilities with changes in fair value that are measured on a recurring basis in our balance sheets at December 31, 2010 and December 31, 2009 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total
<b>December 31, 2010</b>				
<b>Assets:</b>				
Debt securities:				
U.S. government securities	\$ 1,081.0	\$ 292.7	\$ -	\$ 1,373.7
States, municipalities and political subdivisions	-	2,292.7	3.6	2,296.3
U.S. corporate securities	-	7,201.9	60.7	7,262.6
Foreign securities	-	2,822.4	54.9	2,877.3
Residential mortgage-backed securities	-	1,140.0	-	1,140.0
Commercial mortgage-backed securities	-	1,275.3	36.9	1,312.2
Other asset-backed securities	-	407.4	56.5	463.9
Redeemable preferred securities	-	178.5	17.8	196.3
Total debt securities	1,081.0	15,610.9	230.4	16,922.3
Equity securities	1.4	-	37.9	39.3
Derivatives	-	2.6	-	2.6
Total investments	\$ 1,082.4	\$ 15,613.5	\$ 268.3	\$ 16,964.2
<b>Liabilities:</b>				
Derivatives	\$ -	\$ 6.5	\$ -	\$ 6.5

<b>December 31, 2009</b>				
<b>Assets:</b>				
Debt securities:				
U.S. government securities	\$ 1,529.4	\$ 317.4	\$ -	\$ 1,846.8
States, municipalities and political subdivisions	-	2,062.7	12.7	2,075.4
U.S. corporate securities	-	7,056.5	128.1	7,184.6
Foreign securities	-	2,545.5	199.0	2,744.5
Residential mortgage-backed securities	-	1,420.2	-	1,420.2
Commercial mortgage-backed securities	-	971.6	71.8	1,043.4
Other asset-backed securities	-	425.4	11.0	436.4
Redeemable preferred securities	-	345.8	22.9	368.7
Total debt securities	1,529.4	15,145.1	445.5	17,120.0
Equity securities	1.7	-	38.0	39.7
Derivatives	-	44.0	-	44.0
Total investments	\$ 1,531.1	\$ 15,189.1	\$ 483.5	\$ 17,203.7

The changes in the balances of Level 3 financial assets during 2010 and 2009 were as follows:

(Millions)	2010				2009			
	U.S. Corporate Securities	Foreign Securities	Other	Total	U.S. Corporate Securities	Foreign Securities	Other	Total
Beginning balance	\$ 128.1	\$ 199.0	\$ 156.4	\$ 483.5	\$ 144.6	\$ 177.1	\$ 163.3	\$ 485.0
Net realized and unrealized capital gains (losses):								
Included in earnings	(.9)	8.2	4.1	11.4	3.6	11.7	12.3	27.6
Included in other comprehensive income	.1	(2.3)	27.1	24.9	.5	21.4	12.0	33.9
Other (1)	(.8)	.5	(5.9)	(6.2)	7.2	5.7	17.4	30.3
Purchases, sales and maturities	(64.4)	(83.6)	(24.1)	(172.1)	(24.2)	(17.6)	(44.0)	(85.8)
Transfers (out of) into Level 3 (2)	(1.4)	(66.9)	(4.9)	(73.2)	(3.6)	.7	(4.6)	(7.5)
Ending Balance	\$ 60.7	\$ 54.9	\$ 152.7	\$ 268.3	\$ 128.1	\$ 199.0	\$ 156.4	\$ 483.5
Amount of Level 3 net unrealized capital losses included in net income	\$ -	\$ -	\$ (.9)	\$ (.9)	\$ -	\$ (.1)	\$ (.7)	\$ (.8)

(1) Reflects realized and unrealized capital gains and losses on investments supporting our experience-rated and discontinued products, which do not impact our operating results. Refer to Note 20 beginning on page 97 for additional information.

(2) At January 1, 2010, we changed our practice for reporting transfers into (out of) Level 3. Effective January 1, 2010, we use the fair value of these assets at the end of the reporting period for all financial asset transfers. Prior to January 1, 2010, for financial assets that were transferred into (out of) Level 3, we used the fair value of the assets at the end (beginning) of the reporting period.

The changes in the balances of Level 3 financial assets during 2008 were as follows:

(Millions)	2008		
	Debt Securities	Equity Securities	Total
Beginning balance	\$ 642.5	\$ 38.8	\$ 681.3
Net realized and unrealized capital gains (losses):			
Included in earnings	(51.9)	-	(51.9)
Included in other comprehensive income	(30.2)	(1.0)	(31.2)
Other (1)	(29.4)	10.4	(19.0)
Purchases, sales and maturities	(48.5)	(34.6)	(83.1)
Transfers into (out of) Level 3	(26.8)	15.7	(11.1)
<b>Ending Balance</b>	<b>\$ 455.7</b>	<b>\$ 29.3</b>	<b>\$ 485.0</b>
<b>Amount of Level 3 net unrealized capital losses included in net income</b>	<b>\$ (53.8)</b>	<b>\$ -</b>	<b>\$ (53.8)</b>

(1) Reflects realized and unrealized capital gains and losses on investments supporting our experience-rated and discontinued products, which do not impact our operating results. Refer to Note 20 beginning on page 97 for additional information.

Transfers into Level 3 during 2010, 2009 and 2008 were not significant. Additionally, during 2010, certain investments previously classified as Level 3 were reclassified to Level 2 because we were able to obtain observable market data.

### Financial Instruments Not Measured at Fair Value in our Balance Sheets

The following is a description of the valuation methodologies used for estimating the fair value of our financial assets and liabilities that are measured at adjusted cost or contract value.

**Mortgage loans** - Fair values are estimated by discounting expected mortgage loan cash flows at market rates that reflect the rates at which similar loans would be made to similar borrowers. These rates reflect our assessment of the credit quality and the remaining duration of the loans. The fair value estimates of mortgage loans of lower credit quality, including problem and restructured loans, are based on the estimated fair value of the underlying collateral.

#### Investment contract liabilities:

- *With a fixed maturity:* Fair value is estimated by discounting cash flows at interest rates currently being offered by, or available to, us for similar contracts.
- *Without a fixed maturity:* Fair value is estimated as the amount payable to the contract holder upon demand. However, we have the right under such contracts to delay payment of withdrawals that may ultimately result in paying an amount different than that determined to be payable on demand.

**Long-term debt:** Fair values are based on quoted market prices for the same or similar issued debt or, if no quoted market prices are available, on the current rates estimated to be available to us for debt of similar terms and remaining maturities.

The carrying value and estimated fair value of certain of our financial instruments at December 31, 2010 and 2009 were as follows:

(Millions)	2010		2009	
	Carrying Value	Estimated Fair Value	Carrying Value	Estimated Fair Value
Assets:				
Mortgage loans	\$ 1,509.8	\$ 1,526.1	\$ 1,594.0	\$ 1,506.5
Liabilities:				
Investment contract liabilities:				
With a fixed maturity	41.7	42.7	32.4	33.5
Without a fixed maturity	511.5	510.9	530.6	503.7
Long-term debt	4,382.5	4,728.9	3,639.5	3,865.9

### Separate Accounts Measured at Fair Value in our Balance Sheets

Separate Account assets in our Large Case Pensions business represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Account liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from our other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Account assets are not reflected in our statements of income, shareholders' equity or cash flows.

Separate Account assets include debt and equity securities and derivative instruments. The valuation methodologies used for these assets are similar to the methodologies described beginning on page 74. Separate Account assets also include investments in common/collective trusts and real estate that are carried at fair value. The following are descriptions of the valuation methodologies used to price these investments, including the general classification pursuant to the valuation hierarchy.

**Common/Collective Trusts** – Common trusts invest in other collective investment funds otherwise known as the underlying funds. The Separate Accounts' interests in the common trust funds are based on the fair values of the investments of the underlying funds and therefore are classified as Level 2. The underlying assets primarily consist of foreign equity securities. Investments in common trust funds are valued at their respective net asset value per share/unit on the valuation date.

**Real Estate** – The values of the underlying real estate investments are estimated using generally-accepted valuation techniques and give consideration to the investment structure. An appraisal of the underlying real estate for each of these investments is performed annually. In the quarters in which an investment is not appraised or its valuation is not updated, fair value is based on available market information. The valuation of a real estate investment is adjusted only if there has been a significant change in economic circumstances related to the investment since acquisition or the most recent independent valuation and upon the appraiser's review and concurrence with the valuation. Further, these valuations have been prepared giving consideration to the income, cost and sales comparison approaches of estimating property value. These valuations do not necessarily represent the prices at which the real estate investments would sell, since market prices of real estate investments can only be determined by negotiation between a willing buyer and seller. Therefore, these investment values are classified as Level 3.

Separate Account financial assets at December 31, 2010 and 2009 were as follows:

(Millions)	2010				2009			
	Level 1	Level 2	Level 3	Total	Level 1	Level 2	Level 3	Total
Debt securities	\$ 1,059.7	\$ 2,524.9	\$ 56.0	\$ 3,640.6	\$ 752.3	\$ 2,508.0	\$ 97.3	\$ 3,357.6
Equity securities	1,231.9	-	-	1,231.9	1,215.1	.9	-	1,216.0
Derivatives	-	.2	-	.2	-	1.2	-	1.2
Common/collective trusts	-	-	-	-	-	1,152.6	-	1,152.6
Real estate	-	-	-	-	-	-	71.4	71.4
Total (1)	\$ 2,291.6	\$ 2,525.1	\$ 56.0	\$ 4,872.7	\$ 1,967.4	\$ 3,662.7	\$ 168.7	\$ 5,798.8

(1) Excludes \$422.6 million and \$484.3 million of cash and cash equivalents and other receivables at December 31, 2010 and 2009, respectively.

The changes in the balances of Level 3 Separate Account financial assets during 2010, 2009 and 2008 were as follows:

(Millions)	Debt Securities	Real Estate	Total
<b>Balance at December 31, 2007</b>	\$ 291.2	\$ 12,541.8	\$ 12,833.0
Total losses accrued to contract holders	(16.4)	(45.6)	(62.0)
Purchases, sales and maturities	105.2	(88.7)	16.5
Transfers out of Level 3 (1)	(14.9)	-	(14.9)
Transfers of Separate Account assets	-	(12,320.8) (2)	(12,320.8)
<b>Balance at December 31, 2008</b>	\$ 365.1	\$ 86.7	\$ 451.8
Total losses accrued to contract holders	(116.7)	(15.2)	(131.9)
Purchases, sales and maturities	(114.8)	(.1)	(114.9)
Transfers out of Level 3 (1)	(36.3)	-	(36.3)
<b>Balance at December 31, 2009</b>	\$ 97.3	\$ 71.4	\$ 168.7
Total (losses) gains accrued to contract holders	(60.4)	5.2	(55.2)
Purchases, sales and maturities	19.8	.2	20.0
Transfers out of Level 3 (1)	(.7)	(76.8) (2)	(77.5)
<b>Balance at December 31, 2010</b>	\$ 56.0	\$ -	\$ 56.0

(1) At January 1, 2010, we changed our practice for reporting transfers into (out of) Level 3. Effective January 1, 2010, we use the fair value of these assets at the end of the reporting period for all financial asset transfers. Prior to January 1, 2010, for financial assets that were transferred into (out of) Level 3, we used the fair value of the assets at the end (beginning) of the reporting period.

(2) In 1996, we entered into a contract with UBS Realty Investors, LLC (formerly known as Allegis Realty Investors, LLC) under which mortgage loan and real estate Separate Account assets and corresponding liabilities transitioned out of our business.

## 11. Pension and Other Postretirement Plans

### Defined Benefit Retirement Plans

We sponsor various defined benefit plans, including two pension plans and other postretirement benefit plans (“OPEB”) that provide certain health care and life insurance benefits for retired employees, including those of our former parent company.

On August 31, 2010, we announced that pension eligible employees will no longer earn future pension service credits in our tax-qualified defined benefit pension plan (the “Aetna Pension Plan”) effective December 31, 2010. The Aetna Pension Plan will continue to operate and account balances will continue to earn annual interest credits. As a result of this action, we re-measured our pension assets and obligations as of August 31, 2010.

During 2010, we also made a \$505 million voluntary cash contribution to the Aetna Pension Plan. In each of 2009 and 2008 we made a \$45 million voluntary cash contribution.

We also sponsor a non-qualified supplemental pension plan that, prior to January 1, 2007, had been used to provide benefits for wages above the Internal Revenue Code wage limits applicable to tax qualified pension plans (such as the Aetna Pension Plan). Effective January 1, 2007, no new benefits accrue under the non-qualified supplemental pension plan, but interest will continue to be credited on outstanding supplemental cash balance accounts; and the plan may continue to be used to credit special pension arrangements.

In addition, we currently provide certain medical and life insurance benefits for retired employees, including those of our former parent company. We provide subsidized health care benefits to certain eligible employees who terminated employment prior to December 31, 2006. There is a cap on our portion of the cost of providing medical and dental benefits to our retirees. All current and future retirees and employees who terminate employment at age 45 or later with at least five years of service are eligible to participate in our group health plans at their own cost.

The information set forth in the following tables is based upon current actuarial reports using the December 31 measurement date for our pension and OPEB plans; however, certain components of the net periodic cost for the Aetna Pension Plan in 2010 also include adjustments from the re-measurement that occurred as of August 31, 2010.

The following table shows the changes in the benefit obligations during 2010 and 2009 for our pension and OPEB plans.

(Millions)	Pension Plans		OPEB Plans	
	2010	2009	2010	2009
Benefit obligation, beginning of year	\$ 5,346.1	\$ 4,742.8	\$ 330.5	\$ 329.6
Service cost	65.7	48.3	.2	.2
Interest cost	299.5	316.5	17.9	21.7
Actuarial loss	394.3	528.6	10.8	12.7
Benefits paid	(284.4)	(290.1)	(26.1)	(33.7)
Benefit obligation, end of year	\$ 5,821.2	\$ 5,346.1	\$ 333.3	\$ 330.5

The Aetna Pension Plan comprises approximately 96% of the pension plans total benefit obligation at December 31, 2010. The discount rates used to determine the benefit obligation of our pension and OPEB plans were calculated using a yield curve as of our annual measurement date. The yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve. The weighted average discount rate for our pension plans was 5.50% and 5.89% for 2010 and 2009, respectively. The discount rate for our OPEB plans was 5.20% and 5.64% for 2010 and 2009, respectively. The discount rates differ for our pension and OPEB plans due to the duration of the projected benefit payments for each plan.

The following table reconciles the beginning and ending balances of the fair value of plan assets during 2010 and 2009 for the pension and OPEB plans:

(Millions)	Pension Plans		OPEB Plans	
	2010	2009	2010	2009
Fair value of plan assets, beginning of year	\$ 4,394.9	\$ 3,877.2	\$ 67.9	\$ 67.3
Actual return on plan assets	604.7	736.2	2.0	4.6
Employer contributions	528.6	71.6	22.8	29.7
Benefits paid	(284.4)	(290.1)	(26.1)	(33.7)
Fair value of plan assets, end of year	\$ 5,243.8	\$ 4,394.9	\$ 66.6	\$ 67.9

The difference between the fair value of plan assets and the plan's benefit obligation is referred to as the plan's funded status. This funded status is an accounting-based calculation and is not indicative of our mandatory funding requirements, which are described on page 81. The funded status of our pension and OPEB plans at the measurement date for 2010 and 2009 were as follows:

(Millions)	Pension Plans		OPEB Plans	
	2010	2009	2010	2009
Benefit obligation	\$ (5,821.2)	\$ (5,346.1)	\$ (333.3)	\$ (330.5)
Fair value of plan assets	5,243.8	4,394.9	66.6	67.9
Funded status	\$ (577.4)	\$ (951.2)	\$ (266.7)	\$ (262.6)

A reconciliation of the funded status at the measurement date our pension and OPEB plans to the net amounts recognized as assets or liabilities on our balance sheets at December 31, 2010 and 2009 were as follows:

(Millions)	Pension Plans		OPEB Plans	
	2010	2009	2010	2009
Funded status	\$ (577.4)	\$ (951.2)	\$ (266.7)	\$ (262.6)
Unrecognized prior service credit	(2.8)	(16.3)	(40.8)	(44.4)
Unrecognized net actuarial losses	2,380.3	2,404.2	101.7	93.9
Amount recognized in accumulated other comprehensive loss	(2,377.5)	(2,387.9)	(60.9)	(49.5)
Net amount of liabilities recognized at December 31	\$ (577.4)	\$ (951.2)	\$ (266.7)	\$ (262.6)

The liabilities recognized on our balance sheets at December 31, 2010 and 2009 for our pension and OPEB plans were comprised of the following:

(Millions)	Pension Plans		OPEB Plans	
	2010	2009	2010	2009
Accrued benefit liabilities reflected in other current liabilities	\$ (84.6)	\$ (71.5)	\$ (26.9)	\$ (28.7)
Accrued benefit liabilities reflected in other long-term liabilities	(492.8)	(879.7)	(239.8)	(233.9)
Net amount of liabilities recognized at December 31	\$ (577.4)	\$ (951.2)	\$ (266.7)	\$ (262.6)

At December 31, 2010, we had approximately \$2.4 billion and \$102 million of net actuarial losses for our pension and OPEB plans, respectively, and approximately \$3 million and \$41 million of prior service credits for our pension and OPEB plans, respectively, that have not been recognized as components of net periodic benefit costs. We expect to recognize approximately \$58 million and \$5 million in amortization of net actuarial losses for our pension and OPEB plans, respectively, and approximately \$4 million in amortization of prior service credits for our OPEB plans in 2011. Our amortization of prior service credits for our pension plans in 2011 is not expected to be material.

Components of the net periodic benefit cost (income) in 2010, 2009 and 2008 for our pension and OPEB plans were as follows:

(Millions)	Pension Plans			OPEB Plans		
	2010	2009	2008	2010	2009	2008
Operating component						
Service cost	\$ 65.7	\$ 48.3	\$ 45.3	\$ .2	\$ .2	\$ .3
Amortization of prior service cost	(1.6)	(2.2)	(2.1)	(3.6)	(3.7)	(3.7)
Curtailment gain	(11.9)	-	-	-	-	-
Total operating component (1)	52.2	46.1	43.2	(3.4)	(3.5)	(3.4)
Financing component:						
Interest cost	299.5	316.5	312.2	17.9	21.7	20.0
Expected return on plan assets	(350.9)	(319.0)	(484.5)	(3.7)	(3.6)	(3.8)
Recognized net actuarial losses	163.3	215.8	6.3	4.6	3.4	2.6
Total financing component (1)	111.9	213.3	(166.0)	18.8	21.5	18.8
Net periodic benefit cost (income)	\$ 164.1	\$ 259.4	\$ (122.8)	\$ 15.4	\$ 18.0	\$ 15.4

(1) The operating component of this expense is allocated to our business segments, and the financing component is allocated to our Corporate Financing segment. Our Corporate Financing segment is not a business segment but is added back to our business segments to reconcile to our consolidated results. Refer to Note 19 on page 95 for additional information on our business segments.

The decrease in pension cost between 2010 and 2009 was caused by the freezing of the Aetna Pension Plan in 2010, our voluntary contribution of \$505 million to the Aetna Pension Plan in 2010, and the higher fair value of our pension assets at December 31, 2010. During the remeasurement of our pension obligation associated with the freezing of the Aetna Pension Plan, we revised the amortization period for actuarial losses from 9 to 31 years. The increase in pension benefit cost from 2008 to 2009 is primarily attributable to the approximately \$1.9 billion decline in the plan assets' fair value during 2008.

The weighted average assumptions used to determine net periodic benefit cost (income) in 2010, 2009 and 2008 for the pension and OPEB plans were as follows:

	Pension Plans			OPEB Plans		
	2010	2009	2008	2010	2009	2008
Discount rate	5.67%	6.89%	6.57%	5.64%	6.92%	6.35%
Expected long-term return on plan assets	8.00	8.50	8.50	5.50	5.50	5.50
Rate of increase in future compensation levels	4.51	4.51	4.51	-	-	-

We assume different health care cost trend rates for medical costs and prescription drug costs in estimating the expected costs of our OPEB plans. The assumed medical cost trend rate for 2011 is 8%, decreasing gradually to 5% by 2014. The assumed prescription drug cost trend rate for 2011 is 13%, decreasing gradually to 5% by 2019. These assumptions reflect our historical as well as expected future trends for retirees. In addition, the trend assumptions reflect factors

specific to our retiree medical plan, such as plan design, cost-sharing provisions, benefits covered and the presence of subsidy caps.

Our current funding strategy is to fund an amount at least equal to the minimum funding requirement as determined under applicable regulatory requirements with consideration of factors such as the maximum tax deductibility of such amounts. We may elect to voluntarily contribute amounts to the Aetna Pension Plan. We do not have any mandatory contribution requirements for 2011; however, we expect to make a voluntary contribution of approximately \$60 million to the Aetna Pension Plan in 2011. Employer contributions related to the supplemental pension and OPEB plans represent payments to retirees for current benefits. We have no plans to return any pension or OPEB plan assets to the Company in 2011.

Expected benefit payments, which reflect future employee service, as appropriate, of the pension and OPEB plans to be paid for each of the next five years and in the aggregate for the next five years thereafter at December 31, 2010 were as follows:

(Millions)	Pension Plans	OPEB Plans
2011	\$ 328.2	\$ 26.9
2012	335.4	26.2
2013	343.2	25.7
2014	351.4	25.5
2015	359.5	25.3
2016-2020	1,870.1	117.9

#### Assets of the Aetna Pension Plan

The assets of the Aetna Pension Plan (“Pension Assets”) include debt and equity securities, common/collective trusts and real estate investments. The valuation methodologies used to price these assets are similar to the methodologies described beginning on pages 74 and 77, respectively. Pension assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodology used to price these additional investments, including the general classification pursuant to the valuation hierarchy.

**Other Assets** – Other assets consist of derivatives and private equity and hedge fund limited partnerships. Derivatives are either valued with models that primarily use market observable inputs and therefore are classified as Level 2 because they are traded in markets where quoted market prices are not readily available or are classified as Level 1 because they are traded in markets where quoted market prices are readily available. The fair value of private equity and hedge fund limited partnerships are estimated based on the net asset value of the investment fund provided by the general partner or manager of the investments, the financial statements of which generally are audited. Management considers observable market data, valuation procedures in place, contributions and withdrawal restrictions collectively in validating the appropriateness of using the net asset value as a fair value measurement. Therefore, these investments are classified as Level 3.

Pension Assets with changes in fair value measured on a recurring basis, asset allocation and the target asset allocation presented as a percentage of the total plan assets at December 31, 2010 were as follows:

<b>(Millions)</b>	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	<b>Total</b>	<b>Actual Allocation</b>	<b>Target Allocation</b>
Debt securities:						<b>28-38%</b>
U.S. government securities	\$ 232.7	\$ 30.0	\$ -	\$ 262.7	5.2%	
States, municipalities and political subdivisions	-	70.8	-	70.8	1.4%	
U.S. corporate securities	-	673.3	-	673.3	13.2%	
Foreign securities	-	76.1	-	76.1	1.5%	
Residential mortgage-backed securities	-	296.0	.7	296.7	5.8%	
Commercial mortgage-backed securities	-	37.5	-	37.5	.7%	
Other asset-backed securities	-	36.1	-	36.1	.7%	
Redeemable preferred securities	-	2.2	-	2.2	-	
<b>Total debt securities</b>	<b>232.7</b>	<b>1,222.0</b>	<b>.7</b>	<b>1,455.4</b>	<b>28.5%</b>	
Equity securities and common/collective trusts:						<b>48-58%</b>
U.S. Domestic	1,281.1	1.8	-	1,282.9	25.1%	
International	871.5	-	-	871.5	17.1%	
Common/collective trusts	-	866.3	-	866.3	17.0%	
Domestic real estate	31.8	-	-	31.8	.6%	
<b>Total equity securities and common/collective trusts</b>	<b>2,184.4</b>	<b>868.1</b>	<b>-</b>	<b>3,052.5</b>	<b>59.8%</b>	
Other investments:						<b>10-18%</b>
Real estate	-	-	395.3	395.3	7.7%	
Other assets	-	.3	203.6	203.9	4.0%	
<b>Total pension investments (1)</b>	<b>\$ 2,417.1</b>	<b>\$ 2,090.4</b>	<b>\$ 599.6</b>	<b>\$ 5,107.1</b>	<b>100.0%</b>	

(1) Excludes \$136.7 million of cash and cash equivalents and other receivables.

Pension Assets with changes in fair value measured on a recurring basis, asset allocation and the target asset allocation presented as a percentage of the total plan assets at December 31, 2009 were as follows:

(Millions)	Level 1	Level 2	Level 3	Total	Actual Allocation	Target Allocation
Debt securities:						20-30%
U.S. government securities	\$ 100.6	\$ 6.7	\$ -	\$ 107.3	2.5%	
States, municipalities and political subdivisions	-	26.3	-	26.3	.6%	
U.S. corporate securities	-	656.6	-	656.6	15.3%	
Foreign securities	-	72.7	-	72.7	1.7%	
Residential mortgage-backed securities	-	266.1	-	266.1	6.2%	
Commercial mortgage-backed securities	-	15.7	-	15.7	.4%	
Other asset-backed securities	-	37.8	-	37.8	.9%	
Redeemable preferred securities	-	2.6	-	2.6	.1%	
<b>Total debt securities</b>	<b>100.6</b>	<b>1,084.5</b>	<b>-</b>	<b>1,185.1</b>	<b>27.7%</b>	
Equity securities and common/collective trusts:						50-60%
U.S. Domestic	1,141.1	-	-	1,141.1	26.7%	
International	814.3	-	-	814.3	19.1%	
Common/collective trusts	-	593.9	-	593.9	13.9%	
Domestic real estate	2.2	-	-	2.2	0.0%	
<b>Total equity securities and common/collective trusts</b>	<b>1,957.6</b>	<b>593.9</b>	<b>-</b>	<b>2,551.5</b>	<b>59.7%</b>	
Other investments:						10-20%
Real estate	-	-	353.0	353.0	8.3%	
Other assets	29.7	1.2	151.4	182.3	4.3%	
<b>Total pension investments (1)</b>	<b>\$ 2,087.9</b>	<b>\$ 1,679.6</b>	<b>\$ 504.4</b>	<b>\$ 4,271.9</b>	<b>100.0%</b>	

(1) Excludes \$123.0 million of cash and cash equivalents and other receivables.

The changes in the balances of Level 3 Pension Assets during 2010 and 2009 were as follows:

	2010			2009		
	Real Estate	Other	Total	Real Estate	Other	Total
Beginning balance	\$ 353.0	\$ 151.4	\$ 504.4	\$ 425.0	\$ 138.7	\$ 563.7
Actual return on plan assets	54.0	12.4	66.4	(92.8)	9.4	(83.4)
Purchases, sales and settlements	(11.7)	40.5	28.8	20.8	4.5	25.3
Transfers out of Level 3 (1)	-	-	-	-	(1.2)	(1.2)
<b>Ending balance</b>	<b>\$ 395.3</b>	<b>\$ 204.3</b>	<b>\$ 599.6</b>	<b>\$ 353.0</b>	<b>\$ 151.4</b>	<b>\$ 504.4</b>

(1) At January 1, 2010, we changed our practice for reporting transfers into (out of) Level 3. Effective January 1, 2010, we use the fair value of these assets at the end of the reporting period for all financial asset transfers. Prior to January 1, 2010, for financial assets that were transferred into (out of) Level 3, we used the fair value of the assets at the end (beginning) of the reporting period.

The actual and target asset allocation of the OPEB plans used at December 31, 2010 and 2009 presented as a percentage of total plan assets, were as follows:

(Millions)	2010	Target Allocation	2009	Target Allocation
Equity securities	8%	5-15%	8%	5-15%
Debt securities	90%	80-90%	87%	80-90%
Real estate/other	2%	0-10%	5%	0-10%

The Aetna Pension Plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons, and by assessing the Aetna Pension Plan's liability characteristics, our financial condition and our future potential obligations from both the pension and general corporate perspectives. Complementary investment styles and techniques are utilized by multiple professional

investment firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

Asset allocations and investment performance are formally reviewed quarterly by the plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually. More thorough analyses of assets and liabilities are also performed periodically.

We have several benefit plans for retired employees currently supported by the OPEB plan assets. OPEB plan assets are directly and indirectly invested in a diversified mix of traditional asset classes, primarily high-quality fixed income securities.

Our expected return on plan assets assumption is based on many factors, including forecasted capital market real returns over a long-term horizon, forecasted inflation rates, historical compounded asset returns and patterns and correlations on those returns. Expectations for modest increases in interest rates, normal inflation trends and average capital market real returns led us to an expected return on the Pension Assets assumption of 8.25% for January 1, 2010 through August 31, 2010, and 7.5% for September 1, 2010 through December 31, 2010 and 8.5% for 2009 and an expected return on OPEB plan assets assumption of 5.5% for both 2010 and 2009. We regularly review actual asset allocations and periodically rebalance our investments to the mid-point of our targeted allocation ranges when we consider it appropriate. At December 31, 2010, our actual asset allocations were consistent with our asset allocation assumptions. Investment returns can be volatile. Although our return on plan assets is a long-term assumption, shorter-term volatility in our annual pension costs can occur if investment returns differ from the assumed rate. For example, a one-percent deviation from the long-term 7.5% return assumption that we will use for 2011 would impact our annual pension expense by approximately \$4 million after tax and would have a negligible effect on our annual OPEB expense.

#### **401(k) Plan**

Our employees are eligible to participate in a defined contribution retirement savings plan under which designated contributions may be invested in our common stock or certain other investments. Beginning October 2010, we increased our 401(k) contribution to provide for a match of 100% of up to 6% of the eligible pay contributed by the employee. From January 1, 2010 to October 1, 2010, we matched 50% of up to 3% of the eligible pay contributed by the employee. Prior to January 1, 2010, we matched 50% of up to 6% of the eligible pay contributed by the employee. During 2010, 2009 and 2008, we made \$53 million, \$49 million and \$47 million, respectively, in matching contributions. The matching contributions are made in cash and invested according to each participant's investment elections. The plan trustee held approximately 9 million shares of our common stock for plan participants at December 31, 2010. At December 31, 2010, approximately 34 million shares of our common stock were reserved for issuance under our 401(k) plan.

## **12. Stock-based Employee Incentive Plans**

Our stock-based employee compensation plans (collectively, the "Plans") provide for awards of stock options, SARs, restricted stock units ("RSUs"), market stock units ("MSUs"), performance stock units ("PSUs"), deferred contingent common stock and the ability for employees to purchase common stock at a discount. At December 31, 2010, approximately 51 million common shares were available for issuance under the Plans. Executive, middle management and non-management employees may be granted stock options, SARs, RSUs, MSUs and PSUs, each of which are described below:

**Stock Options and SARs** - We have not granted stock options since 2005, but some remain outstanding.

Stock options were granted to purchase our common stock at or above the market price on the date of grant. SARs granted will be settled in stock, net of taxes, based on the appreciation of our stock price on the exercise date over the market price on the date of grant. SARs and stock options generally become 100% vested three years after the grant is made, with one-third vesting each year. Vested SARs and stock options may be exercised at any time during the ten years after grant, except in certain circumstances, generally related to employment termination or retirement. At the end of the ten-year period, any unexercised SARs and stock options expire.

**RSUs** - For each RSU granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. For RSUs granted prior to 2010, the RSUs will generally become 100% vested three years after the grant is made, with one-third vesting each year. Beginning in 2010, the RSUs generally will become 100% vested approximately three years from the grant date, with one-third vesting each December.

**MSUs** - The number of vested MSUs (which could range from zero to 150% of the original number of units granted) is dependent on the weighted average closing price of our common stock for the thirty trading days prior to the vesting date. The MSUs have a two-year vesting period.

**PSUs** - The number of vested PSUs (which could range from zero to 200% of the original number of units granted) is dependent upon the degree to which we achieve performance goals as determined by Aetna's Board of Directors (our "Board") Committee on Compensation and Organization (the "Compensation Committee"). The value of each vested PSU is equal to one share of common stock, net of taxes. The PSUs have a two-year vesting period. The PSUs granted in 2008 and 2009 did not vest as the underlying performance metric was not achieved by December 31, 2009 and 2010, respectively. The performance period for the 2010 PSU grants ended on December 31, 2010. The PSU grants in 2010 will vest at 200% of the original number of units granted, as the Compensation Committee has determined that the underlying performance goal has been met at the maximum level.

We estimate the fair value of SARs using a modified Black-Scholes option pricing model. We did not grant a material amount of SARs in 2010. SARs granted in 2009 and 2008 had a weighted average per share fair value of \$11.37 and \$14.71, respectively, using the assumptions noted in the following table:

	<b>2009</b>	<b>2008</b>
Dividend yield	.1%	.1%
Expected volatility	39.8%	31.7%
Risk-free interest rate	1.8%	2.5%
Expected term	4.6 years	4.4 years

We use historical data to estimate the period of time that stock options or SARs are expected to be outstanding. Expected volatilities are based on a weighted average of the historical volatility of our stock price and implied volatility from traded options on our stock. The risk-free interest rate for periods within the expected life of the stock option or SAR is based on the benchmark five-year U.S. Treasury rate in effect on the date of grant. The dividend yield assumption is based on our historical dividends declared.

The stock option and SAR transactions during 2010, 2009 and 2008 were as follows:

(Millions, except exercise price and remaining life)	Number of Stock Options and SARs	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life	Aggregate Intrinsic Value
<b>2008</b>				
Outstanding, beginning of year	40.5	\$ 24.31	5.3	\$ 1,352.6
Granted	4.9	49.34	-	-
Exercised	(2.5)	14.13	-	75.5
Expired or forfeited	(1.0)	38.19	-	-
Outstanding, end of year	41.9	\$ 27.50	4.9	\$ 347.0
Exercisable, end of year	33.4	\$ 22.48	4.0	\$ 345.9
<b>2009</b>				
Outstanding, beginning of year	41.9	\$ 27.50	4.9	\$ 347.0
Granted	5.6	32.00	-	-
Exercised	(2.5)	10.01	-	46.9
Expired or forfeited	(.9)	36.34	-	-
Outstanding, end of year	44.1	\$ 28.88	4.7	\$ 356.6
Exercisable, end of year	34.6	\$ 26.16	3.7	\$ 355.0
<b>2010</b>				
Outstanding, beginning of year	44.1	\$ 28.88	4.7	\$ 356.6
Granted	- (1)	29.20	-	-
Exercised	(5.0)	10.65	-	102.4
Expired or forfeited	(1.3)	37.32	-	-
Outstanding, end of year	37.8	\$ 31.01	4.1	\$ 232.9
Exercisable, end of year	33.3	\$ 30.22	3.6	\$ 232.1

(1) Rounds to zero.

The following is a summary of information regarding stock options and SARs outstanding and exercisable at December 31, 2010 (number of stock options and SARs and aggregate intrinsic values in millions):

Range of Exercise Prices	Outstanding				Exercisable			
	Number Outstanding	Weighted Average Remaining Contractual Life (Years)	Weighted Average Exercise Price	Aggregate Intrinsic Value	Number Exercisable	Weighted Average Exercise Price	Aggregate Intrinsic Value	
\$0.00-\$10.00	2.6	.9	\$ 8.42	\$ 57.1	2.6	\$ 8.42	\$ 57.1	
10.00-20.00	11.0	2.1	14.75	173.7	11.0	14.75	173.6	
20.00-30.00	.3	7.2	23.95	2.1	.2	23.88	1.4	
30.00-40.00	10.8	5.4	32.92	-	7.7	33.25	-	
40.00-50.00	4.8	5.6	43.22	-	4.8	43.22	-	
50.00-60.00	8.3	5.0	50.46	-	7.0	50.42	-	
\$0.00-\$60.00	37.8	4.1	\$ 31.01	\$ 232.9	33.3	\$ 30.22	\$ 232.1	

The fair value of RSUs and PSUs are based on the market price of our common stock on the date of grant. Beginning in 2010, we granted MSUs to certain employees. We estimate the fair value of MSUs using a Monte Carlo simulation. MSUs granted in 2010 had a weighted average per share fair value of \$33.85, using the assumptions noted in the following table:

	<b>2010</b>
Dividend yield	.1%
Historical volatility	58.7%
Risk-free interest rate	.9%
Initial price	<b>\$29.20</b>

The annualized volatility of the price of our common stock over the two-year period preceding the grant date was used. The risk-free interest rate for periods within the expected life of the MSUs are based on a two-year U.S. Treasury rate in effect on the date of grant. The dividend yield assumption is based on our historical dividends declared.

RSU, MSU and PSU transactions in 2010, 2009 and 2008 were as follows (number of units in millions):

	2010		2009		2008	
	RSUs, MSUs and PSUs	Weighted Average Grant Date Fair Value	RSUs and PSUs	Weighted Average Grant Date Fair Value	RSUs and PSUs	Weighted Average Grant Date Fair Value
RSUs, MSUs and PSUs at beginning of year <sup>(1)</sup>	3.1	\$ 34.60	2.4	\$ 42.98	1.4	\$ 46.15
Granted	3.8	29.22	1.8	30.27	1.5	39.81
Vested	(1.3)	34.22	(1.1)	45.11	(.4)	44.78
Forfeited	(.6)	34.78	-	38.56	(.1)	45.74
<b>RSUs, MSUs and PSUs at end of year</b>	<b>5.0</b>	<b>\$ 31.16</b>	<b>3.1</b>	<b>\$ 34.60</b>	<b>2.4</b>	<b>\$ 42.98</b>

(1) There were no MSU transactions prior to February 2010 and no PSU transactions prior to February 2008.

(2) Rounds to zero.

During 2010, 2009 and 2008, the following activity occurred under the Plans:

(Millions)	2010	2009	2008
Cash received from stock option exercises	\$ 43.2	\$ 14.9	\$ 29.7
Intrinsic value of options/SARs exercised and stock units vested	140.3	80.9	98.2
Tax benefits realized for the tax deductions from stock options and SARs exercised and stock units vested	49.1	27.6	32.5
Fair value of stock options, SARs and stock units vested	105.7	98.7	86.5

We settle our stock options, SARs, and stock units with newly-issued common stock and generally utilize the proceeds from stock options to repurchase our common stock in the open market in the same period.

In 2010, 2009 and 2008 we recorded share-based compensation expense of \$110 million, \$91 million and \$96 million, respectively, in general and administrative expenses. We also recorded related tax benefits of \$30 million, \$32 million and \$34 million in 2010, 2009 and 2008, respectively. At December 31, 2010, \$110 million of total unrecognized compensation costs related to stock options, SARs and stock units is expected to be recognized over a weighted-average period of 1.3 years.

### 13. Income Taxes

The components of our income tax provision in 2010, 2009 and 2008 were as follows:

(Millions)	2010	2009	2008
Current taxes:			
Federal	\$ 555.9	\$ 657.4	\$ 744.6
State	22.8	61.2	25.5
<b>Total current taxes</b>	<b>578.7</b>	<b>718.6</b>	<b>770.1</b>
Deferred taxes (benefits):			
Federal	288.3	(81.1)	19.4
State	10.4	(12.8)	.6
<b>Total deferred income taxes</b>	<b>298.7</b>	<b>(93.9)</b>	<b>20.0</b>
<b>Total income taxes</b>	<b>\$ 877.4</b>	<b>\$ 624.7</b>	<b>\$ 790.1</b>

Income taxes were different from the amount computed by applying the statutory federal income tax rate to income before income taxes as follows:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Income before income taxes	\$ 2,644.2	\$ 1,901.2	\$ 2,174.2
Tax rate	35%	35%	35%
Application of the tax rate	925.5	665.4	761.0
Tax effect of:			
Valuation allowance	(36.6)	(19.4)	56.0
Other, net	(11.5)	(21.3)	(26.9)
<b>Income taxes</b>	<b>\$ 877.4</b>	<b>\$ 624.7</b>	<b>\$ 790.1</b>

The significant components of our net deferred tax assets at December 31, 2010 and 2009 were as follows:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>
Deferred tax assets:		
Reserve for anticipated future losses on discontinued products	\$ 201.0	\$ 194.4
Employee and postretirement benefits	488.8	626.1
Investments, net	133.8	268.5
Deferred policy acquisition costs	41.9	51.4
Insurance reserves	107.2	172.2
Net operating losses	33.2	35.6
Other	90.3	115.8
Gross deferred tax assets	1,096.2	1,464.0
Less: Valuation allowance	33.0	71.8
Deferred tax assets, net of valuation allowance	1,063.2	1,392.2
Deferred tax liabilities:		
Unrealized gains on investment securities	227.7	194.9
Goodwill and other acquired intangible assets	267.0	256.8
Cumulative depreciation and amortization	211.6	223.7
Total gross deferred tax liabilities	706.3	675.4
<b>Net deferred tax assets (1)</b>	<b>\$ 356.9</b>	<b>\$ 716.8</b>

(1) Includes \$327.0 million and \$439.5 million classified as current assets at December 31, 2010 and 2009, respectively, and \$29.9 million and \$277.3 million classified as long-term assets at December 31, 2010 and 2009, respectively.

Valuation allowances are provided when we estimate that it is more likely than not that deferred tax assets will not be realized. A valuation allowance has been established on certain federal and state net operating losses. We base our estimates of the future realization of deferred tax assets on historic and anticipated taxable income. However, the amount of the deferred tax asset considered realizable could be adjusted in the future if we revise our estimates of anticipated taxable income.

We participate in the Compliance Assurance Process (the "CAP") with the IRS. Under the CAP, the IRS undertakes audit procedures during the tax year and as the return is prepared for filing. The IRS has concluded its CAP audit of our 2009 tax return as well as all the prior years. We expect the IRS will conclude its CAP audit of our 2010 tax return in 2011.

We are also subject to audits by state taxing authorities for tax years from 2000 through 2009. We believe we carry appropriate reserves for any exposure to state tax issues.

We paid net income taxes of \$674 million, \$634 million and \$906 million in 2010, 2009 and 2008, respectively.

At December 31, 2010 and 2009, we did not have material uncertain tax positions reflected in our consolidated balance sheet, and we do not believe uncertain tax positions will materially affect our financial position, operating results or our effective tax rates in future periods.

## 14. Debt

The carrying value of our long-term debt at December 31, 2010 and 2009 was as follows:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>
Senior notes, 5.75%, due 2011	\$ 450.0	\$ 449.9
Senior notes, 7.875%, due 2011	449.9	449.5
Senior notes, 6.0%, due 2016	747.6	747.1
Senior notes, 6.5%, due 2018	498.9	498.8
Senior notes, 3.95%, due 2020	741.7	-
Senior notes, 6.625%, due 2036	798.7	798.6
Senior notes, 6.75%, due 2037	695.7	695.6
Total long-term debt	4,382.5	3,639.5
Less current portion of long-term debt (1)	899.9	-
<b>Total long-term debt, less current portion</b>	<b>\$ 3,482.6</b>	<b>\$ 3,639.5</b>

(1) At December 31, 2010, our 7.875% senior notes due March 2011 and our 5.75% senior notes due June 2011 are classified as current in the accompanying consolidated balance sheet at December 31, 2010.

In August 2010, we issued \$750 million of 3.95% senior notes due 2020 (the “2010 senior notes”) in anticipation of the 2011 scheduled maturity of certain of our senior notes. In connection with this debt issuance, we terminated five forward-starting interest rate swaps (with an aggregate notional value of \$500 million) that we held as a hedge against interest rate exposure in anticipation of this issuance. Upon termination of the swaps, we paid \$38 million to our counterparties, which was recorded in other comprehensive income and is being amortized as an increase to interest expense over the life of the 2010 senior notes. At December 31, 2009, these interest rate swaps had an aggregate fair value of \$42 million, which was reflected in other comprehensive income.

In September 2008, we issued \$500 million of 6.5% senior notes due 2018 (the “2008 senior notes”) to secure long-term favorable rates. This debt issuance was partially hedged with forward-starting swaps prior to issuance. At the time of the debt issuance, the swaps were terminated and \$10 million was recorded in other comprehensive loss and is being amortized as an increase of interest expense over the life of the 2008 senior notes.

At December 31, 2010, we did not have any commercial paper outstanding. At December 31, 2009 we had approximately \$481 million of commercial paper outstanding with a weighted average interest rate of .38%.

We paid \$243 million, \$244 million and \$228 million in interest in 2010, 2009 and 2008, respectively.

At December 31, 2010, we had an unsecured \$1.5 billion revolving credit agreement (the “Facility”) with several financial institutions which terminates in March 2013. The Facility provides for the issuance of up to \$200 million of letters of credit at our request, which count as usage of the available commitments under the Facility. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the Facility to a maximum of \$2.0 billion. Various interest rate options are available under the Facility. Any revolving borrowings mature on the termination date of the Facility. We pay facility fees on the Facility ranging from .045% to .175% per annum, depending upon our long-term senior unsecured debt rating. The facility fee was .06% at December 31, 2010. The Facility contains a financial covenant that requires us to maintain a ratio of total debt to consolidated capitalization as of the end of each fiscal quarter at or below .5 to 1.0. For this purpose, consolidated capitalization equals the sum of total shareholders’ equity, excluding any overfunded or underfunded status of our pension and OPEB plans and any net unrealized capital gains and losses, and total debt (as defined in the Facility). We met this requirement at December 31, 2010. There were no amounts outstanding under the Facility at December 31, 2010.

## 15. Capital Stock

From time to time, the Board authorizes us to repurchase our common stock. The activity under Board authorized share repurchase programs in 2010, 2009 and 2008 was as follows:

(Millions)	Purchase Not to Exceed	Shares Purchased					
		2010		2009		2008	
		Shares	Cost	Shares	Cost	Shares	Cost
<b>Authorization date:</b>							
December 3, 2010	\$ 750.0	.4	\$ 14.8	-	\$ -	-	\$ -
July 30, 2010	1,000.0	32.9	1,000.0	-	-	-	-
February 27, 2009	750.0	19.1	591.2	5.3	158.8	-	-
June 27, 2008	750.0	-	-	23.6	614.2	5.8	135.8
February 29, 2008	750.0	-	-	-	-	17.4	750.0
September 28, 2007	1,250.0	-	-	-	-	19.7	901.9
<b>Total repurchases</b>	<b>N/A</b>	<b>52.4</b>	<b>\$ 1,606.0</b>	<b>28.9</b>	<b>\$ 773.0</b>	<b>42.9</b>	<b>\$ 1,787.7</b>
Repurchase authorization remaining at December 31,		N/A	\$ 735.2	N/A	\$ 591.2	N/A	\$ 614.2

On February 3, 2011, our Board moved us to a quarterly dividend payment cycle and declared a cash dividend of \$0.15 per common share that will be paid on April 29, 2011 to shareholders of record at the close of business on April 14, 2011. Declaration and payment of future dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change. Prior to February 2011, our policy had been to pay an annual dividend. On September 24, 2010, our Board declared an annual cash dividend of \$.04 per common share to shareholders of record at the close of business on November 15, 2010. This \$16 million dividend was paid on November 30, 2010.

In addition to the common stock disclosed on our balance sheets, 8 million shares of Class A voting preferred stock, \$.01 par value per share, have been authorized. At December 31, 2010, there were also 323 million undesignated shares that our Board has the power to divide into such classes and series, with such voting rights, designations, preferences, limitations and special rights as our Board determines.

## 16. Dividend Restrictions and Statutory Surplus

Our business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require such companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their parent corporations. The additional regulations applicable to our HMO and insurance company subsidiaries are not expected to affect our ability to service our debt or to pay dividends.

Under regulatory requirements, the amount of dividends that may be paid to Aetna by our insurance and HMO subsidiaries without prior approval by regulatory authorities as calculated at December 31, 2010 is approximately \$1.6 billion in the aggregate. There are no such restrictions on distributions from Aetna to its shareholders.

The combined statutory net income for the years ended and combined statutory capital and surplus at December 31, 2010, 2009 and 2008 for our insurance and HMO subsidiaries, were as follows:

(Millions)	2010	2009	2008
Statutory net income	\$ 1,779.7	\$ 1,308.8	\$ 1,815.8
Statutory capital and surplus	6,179.2	6,777.1	5,665.6

## 17. Reinsurance

Effective October 1, 1998, we reinsured certain policyholder liabilities and obligations related to individual life insurance (in conjunction with our former parent company's sale of this business). These transactions were in the form of indemnity reinsurance arrangements, whereby the assuming companies contractually assumed certain policyholder liabilities and obligations, although we remain directly obligated to policyholders. The liability related to our obligation is recorded in future policy benefits and policyholders' funds on our balance sheets. Assets related to and supporting these policies were transferred to the assuming companies, and we recorded a reinsurance recoverable.

Effective November 1, 1999, we reinsured certain policyholder liabilities and obligations related to paid-up group whole life insurance. In 2008, we recorded an allowance against our reinsurance recoverable from Lehman Re Ltd. ("Lehman Re") of \$42 million pretax in operating expenses. The reinsurance recoverable results from the 1999 transaction as described above. In September 2008, we took possession of assets supporting the reinsurance recoverable, which previously were held as collateral in a trust. In September 2008, Lehman Re commenced proceedings in Bermuda to liquidate itself. We intend to pursue our claims in Lehman Re's liquidation proceedings. We believe our reinsurance recoverables supporting all of these reinsurance obligations are adequate at December 31, 2010.

There is not a material difference between premiums on a written basis versus an earned basis. Reinsurance recoveries were approximately \$66 million, \$56 million and \$63 million in 2010, 2009 and 2008, respectively. Reinsurance recoverables related to these obligations were approximately \$1.0 billion at December 31, 2010, 2009 and 2008. At December 31, 2010 reinsurance recoverables with a carrying value of approximately \$943 million were associated with three reinsurers.

During 2008 and 2010, we entered into two separate agreements to reinsure certain Health Care and Group Insurance policies. We entered into these contracts to reduce the risk of catastrophic loss which in turn reduces our statutory capital and surplus requirements. These contracts do not qualify for reinsurance accounting under GAAP, and consequently they are accounted for using deposit accounting.

Effective January 2011, we entered into a three-year reinsurance agreement with Vitality Re Limited ("Vitality Re"), an unrelated insurer. The agreement allows us to reduce our required statutory capital and provides \$150 million of collateralized excess of loss reinsurance coverage on a portion of Aetna's group Commercial Insured Health Care business.

## 18. Commitments and Contingent Liabilities

### Guarantees

We have the following guarantee arrangements at December 31, 2010.

- **ASC Claim Funding Accounts** - We have arrangements with certain banks for the processing of claim payments for our ASC customers. The banks maintain accounts to fund claims of our ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, we guarantee that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is \$250 million. We can limit our exposure to this guarantee by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- **Indemnification Agreements** - In connection with certain acquisitions and dispositions of assets and/or businesses, our various issuances of long-term debt and our reinsurance relationship with Vitality Re, we have incurred certain customary indemnification obligations to the applicable seller, purchaser, underwriters and/or various other participants. In general, we have agreed to indemnify the other party for certain losses relating to the assets or business that we purchased or sold or for other matters on terms that are customary for similar transactions. Certain portions of our indemnification obligations are capped at the applicable transaction price,

while other arrangements are not subject to such a limit. At December 31, 2010, we do not believe that our future obligations under any of these agreements will be material to us.

- Separate Account assets - Certain Separate Account assets associated with the Large Case Pensions business represent funds maintained as a contractual requirement to fund specific pension annuities that we have guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were \$3.8 billion and \$4.0 billion at December 31, 2010 and 2009, respectively. Refer to Note 2 beginning on page 57 for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Account balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Accounts' investment strategy. If contract holders do not maintain the required level of Separate Account assets to meet the annuity guarantees, we would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2010 exceeded the value of the guaranteed benefit obligation. As a result, we were not required to maintain any additional liability for our related guarantees at December 31, 2010.

### **Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools**

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our premiums in the state compared to the premiums of other insurers. Certain states allow recoverability of assessments as offsets to premium taxes. Some states have similar laws relating to HMOs. The Pennsylvania Insurance Commissioner has placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and has petitioned a state court for liquidation. If Penn Treaty is declared insolvent and placed in liquidation, we and other insurers likely would be assessed over a period of years by guaranty associations for the payments the guaranty associations are required to make to Penn Treaty policyholders. We are currently unable to predict the ultimate outcome of, or reasonably estimate the loss or range of losses resulting from, this potential insolvency because we cannot predict when the state court will render a decision, the amount of the insolvency, if any, the amount and timing of associated guaranty association assessments or the amount or availability of potential offsets, such as premium tax offsets. It is reasonably possible that in future reporting periods we may record a liability and expense relating to Penn Treaty or other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While we have historically recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could jeopardize future recovery of these assessments.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

### **Litigation and Regulatory Proceedings**

#### *Out-of-Network Benefit Proceedings*

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Other major health insurers are also the subject of similar litigation or have settled similar litigation. Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix").

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits

allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), the Racketeer Influenced and Corrupt Organizations Act and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys’ fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by a health plan member and by out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the “MDL Panel”) has consolidated these class action cases in the U.S. District Court for the District of New Jersey under the caption *In re: Aetna UCR Litigation*, MDL No. 2020 (“MDL 2020”). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. Discovery is substantially complete in MDL 2020, several motions are pending, and briefing on class certification has been completed. The court has not set a trial date or a timetable for deciding class certification or other pending motions. We intend to vigorously defend ourselves against the claims brought in these cases.

We also have received subpoenas and/or requests for documents and other information from, and have been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment practices.

#### *CMS Actions*

Effective April 21, 2010, CMS imposed intermediate sanctions on us, suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone PDP contracts. The sanctions relate to our compliance with certain Medicare Part D requirements. The suspension does not affect our current Medicare enrollees who stay in their existing plans. CMS has granted us a limited waiver of these sanctions to allow us to continue to enroll eligible members into existing, contracted group Aetna Medicare Advantage Plans and Standalone PDPs through March 31, 2011. As a result of these sanctions, our 2011 Medicare membership was adversely affected because we did not participate in the 2010 open enrollment for individual 2011 Medicare plans which occurred between November 15, 2010 and December 31, 2010. We are cooperating fully with CMS on its review and are working to resolve the issues CMS has raised as soon as possible. If the CMS sanctions remain in effect or we fail to obtain extensions of the limited waiver through the end of those sanctions, our Medicare membership and operating results could be adversely affected.

CMS regularly audits our performance to determine our compliance with CMS’s regulations, our contracts with CMS and the quality of services we provide to our Medicare members. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies’ Medicare plans by considering the applicable health status of Medicare members as supported by information maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions and document their medical records. Medicare Advantage plans and PDPs receive increased premiums for members who have certain medical conditions identified with specific health condition codes. Federal regulators review and audit the providers’ medical records and related health condition codes that determine the members’ health status and the resulting premium payments to us. CMS has instituted risk adjustment data validation (“RADV”) audits of various Medicare Advantage plans, including two of Aetna’s contracts for the 2007 contract year. Although these two audits are ongoing, we do not believe that they will have a material impact on our operating results, financial position or cash flows.

We believe that the OIG also is auditing risk adjustment data, and we expect CMS and the OIG to continue auditing risk adjustment data for the 2007 contract year and beyond. Aetna and other Medicare Advantage organizations have provided comments to CMS in response to CMS’s December 2010 proposed RADV sampling and payment error calculation methodology by which CMS proposes to calculate and extrapolate RADV audit payment error rates for, and determine premium refunds payable by, Medicare Advantage plans. Our concerns with CMS’s proposed methodology include the fact that the proposed methodology does not take into account the “error rate” in the original Medicare fee-for-service data that was used to develop the risk adjustment system and that retroactive audit and payment adjustments undermine the actuarial soundness of Medicare Advantage bids. CMS has indicated that it may make retroactive contract-level premium payment adjustments based on the results of these RADV audits, which could

occur as early as 2011. CMS's premium adjustments could be implemented prior to our, or other Medicare Advantage plans, having an opportunity to appeal the audit or payment error calculation results or methodology. We are unable to predict the ultimate outcome of CMS's final RADV audit methodology, other audits for the 2007 contract year or subsequent contract years, the amounts of any retroactive refunds of, or prospective adjustments to, premium payments made to us, or whether any audit findings would cause a change to our method of estimating future premium revenue in bid submissions to CMS for the current or future contract years or compromise premium assumptions made in our bids for prior contract years. Any premium refunds or adjustments resulting from regulatory audits, including those resulting from CMS's selection of its final RADV audit methodology, whether as a result of RADV or other audits by CMS or OIG or otherwise, could be material and could adversely affect our operating results, financial position and cash flows.

#### *Other Litigation and Regulatory Proceedings*

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including employment litigation and claims of bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay medical and/or group insurance claims (including post-payment audit and collection practices), rescission of insurance coverage, improper disclosure of personal information, patent infringement and other intellectual property litigation and other litigation in our Health Care and Group Insurance businesses. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, various state insurance and health care regulatory authorities, state attorneys general, the Center for Consumer Information and Insurance Oversight, the Office of the Inspector General, the Office of Personnel Management, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, U.S. attorneys and other state and federal governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, in connection with their consideration of health care reform measures, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." There also continues to be heightened review by regulatory authorities of and increased litigation regarding the health care benefits industry's business and reporting practices, including premium rate increases, utilization management, complaint and grievance processing, information privacy, provider network structure (including the use of performance-based networks), delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices and claim payment practices (including payments to out-of-network providers). As a leading national health care benefits company, we regularly are the subject of such government actions. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds to members, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible loss of licensure or suspension from participation in government programs, including the actions taken by CMS that are described above under "CMS Actions."

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. We are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

## Other Obligations

We have operating leases for office space and certain computer and other equipment. Rental expenses for these items were \$152 million, \$170 million and \$176 million in 2010, 2009 and 2008, respectively. The future net minimum payments under non-cancelable leases for 2011 through 2015 are estimated to be \$133 million, \$92 million, \$55 million, \$43 million and \$33 million, respectively.

We also have funding obligations relating to equity limited partnership investments and commercial mortgage loans. The funding requirements for equity limited partnership investments and commercial mortgage loans for 2011 through 2015 are estimated to be \$109 million, \$56 million, \$32 million, \$16 million and \$15 million, respectively.

## 19. Segment Information

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments in order to reconcile to our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and the financing components of our pension and OPEB plan expense (the service cost components of this expense are allocated to our business segments).

Summarized financial information of our segment operations in 2010, 2009 and 2008 were as follows:

(Millions)	Health Care	Group Insurance	Large Case Pensions	Corporate Financing	Total Company
<b>2010</b>					
Revenue from external customers	\$ 31,023.9	\$ 1,776.1	\$ 162.2	\$ -	\$ 32,962.2
Net investment income	418.8	275.1	362.4	-	1,056.3
Interest expense	-	-	-	254.6	254.6
Depreciation and amortization expense	437.5	6.9	-	-	444.4
Income taxes (benefits)	954.2	53.0	5.0	(134.8)	877.4
Operating earnings (loss) (1)	1,650.1	128.0	27.8	(250.5)	1,555.4
Segment assets	20,881.5	5,039.3	11,818.6	-	37,739.4
<b>2009</b>					
Revenue from external customers	\$ 31,631.6	\$ 1,827.1	\$ 183.8	\$ -	\$ 33,642.5
Net investment income	392.5	274.1	369.8	-	1,036.4
Interest expense	-	-	-	243.4	243.4
Depreciation and amortization expense	409.1	6.9	-	-	416.0
Income taxes (benefits)	744.9	38.7	8.5	(167.4)	624.7
Operating earnings (loss) (1)	1,412.7	103.8	32.2	(310.8)	1,237.9
Segment assets	20,734.7	4,967.4	12,848.3	-	38,550.4
<b>2008</b>					
Revenue from external customers	\$ 28,709.9	\$ 1,781.5	\$ 205.2	\$ -	\$ 30,696.6
Net investment income	341.3	240.4	328.3	-	910.0
Interest expense	-	-	-	236.4	236.4
Depreciation and amortization expense	371.4	6.9	-	-	378.3
Income taxes (benefits)	875.1	(54.2)	1.2	(32.0)	790.1
Operating earnings (loss) (1)	1,802.3	136.8	38.8	(57.0)	1,920.9
Segment assets	18,754.5	4,435.0	12,663.0	-	35,852.5

(1) Operating earnings (loss) excludes net realized capital gains or losses and the other items described in the reconciliation on page 96.

A reconciliation of operating earnings (1) to net income in 2010, 2009 and 2008 was as follows:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Operating earnings	\$ 1,555.4	\$ 1,237.9	\$ 1,920.9
Net realized capital gains (losses)	183.8	55.0	(482.3)
Transaction-related costs	(43.1)	-	-
Litigation-related insurance proceeds	101.5	24.9	-
Severance and facilities charge	(30.8)	(60.9)	(35.6)
ESI settlement	-	19.6	-
Contribution for the establishment of an out-of-network pricing database	-	-	(20.0)
Allowance on reinsurance recoverable	-	-	(27.4)
Reduction of reserve for anticipated future losses on discontinued products	-	-	28.5
<b>Net income</b>	<b>\$ 1,766.8</b>	<b>\$ 1,276.5</b>	<b>\$ 1,384.1</b>

- (1) In addition to net realized capital gains (losses), the following other items are excluded from operating earnings because we believe they neither relate to the ordinary course of our business nor reflect our underlying business performance:
- In 2010, we recorded transaction related costs of \$43.1 million (\$66.2 million pretax). These costs related to our Pharmacy Benefit Management Subcontract Agreement with CVS Caremark Corporation and the announced acquisition of Medicity.
  - Following a Pennsylvania Supreme Court ruling in June 2009, we recorded proceeds of \$101.5 million (\$156.3 million pretax) in 2010 and \$24.9 million (\$38.2 million pretax) in 2009 from our liability insurers related to certain litigation we settled in 2003.
  - In 2010, 2009 and 2008, we recorded severance and facilities charges of \$30.8 million (\$47.4 million pretax), \$60.9 million (\$93.7 million pretax) and \$35.6 million (\$54.7 million pretax), respectively. The 2010 severance and facilities charges related to actions taken in 2010 or committed to be taken in 2011. The 2009 and 2008 severance and facilities charges related to actions previously taken.
  - In 2009, we reached an agreement with Express Scripts, Inc. and one of its subsidiaries (collectively "ESI") to settle certain litigation in which we were the plaintiff. Under the applicable settlement, we received approximately \$19.6 million (\$30.2 million pretax), net of fees and expenses, in 2009. As a result of our agreement with the New York Attorney General to discontinue the use of Ingenix databases at a future date, in 2008 we committed
  - to contribute \$20.0 million to a non-profit organization to help create a new independent database for determining out-of-network reimbursement rates. We made that contribution in October, 2009.
  - As a result of the liquidation proceedings of Lehman Re Ltd. ("Lehman Re"), a subsidiary of Lehman Brothers Holdings Inc., we recorded an allowance against our reinsurance recoverable from Lehman Re of \$27.4 million (\$42.2 million pretax) in 2008. This reinsurance is on a closed block of paid-up group whole life insurance business.
  - In 1993, we discontinued the sale of our fully-guaranteed large case pension products and established a reserve for anticipated future losses on these products, which we review quarterly. Changes in this reserve are recognized when deemed appropriate. We reduced the reserve for anticipated future losses on discontinued products by \$28.5 million (\$43.8 million pretax) in 2008.

Revenues from external customers by product in 2010, 2009 and 2008 were as follows:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Health care premiums	\$ 27,610.6	\$ 28,243.8	\$ 25,507.3
Health care fees and other revenue	3,413.3	3,387.8	3,202.6
Group life	1,084.9	1,095.6	1,065.2
Group disability	639.1	663.7	630.0
Group long-term care	52.1	67.8	86.3
Large case pensions	162.2	183.8	205.2
<b>Total revenue from external customers (1) (2)</b>	<b>\$ 32,962.2</b>	<b>\$ 33,642.5</b>	<b>\$ 30,696.6</b>

- (1) All within the U.S., except approximately \$429 million, \$240 million and \$145 million in 2010, 2009 and 2008, respectively, which were derived from foreign customers.
- (2) Revenue from the U.S. federal government was \$7.5 billion, \$7.2 billion and \$6.2 billion in 2010, 2009 and 2008, respectively, in the Health Care and Group Insurance segments. These amounts exceeded 10 percent of our total revenue from external customers in each of 2010, 2009 and 2008.

The following is a reconciliation of revenue from external customers to total revenues included in our statements of income in 2010, 2009 and 2008:

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Revenue from external customers	\$ 32,962.2	\$ 33,642.5	\$ 30,696.6
Net investment income	1,056.3	1,036.4	910.0
ESI settlement <sup>(1)</sup>	-	30.2	-
Net realized capital gains (losses)	227.5	55.0	(655.9)
<b>Total revenue</b>	<b>\$ 34,246.0</b>	<b>\$ 34,764.1</b>	<b>\$ 30,950.7</b>

(1) In 2009, we reached an agreement with ESI to settle certain litigation in which we were the plaintiff. Under the applicable settlement, we received approximately \$19.6 million (\$30.2 million pretax), net of fees and expenses, in 2009.

Long-lived assets, principally within the U.S., were \$529 million and \$551 million at December 31, 2010 and 2009, respectively.

## 20. Discontinued Products

Prior to 1993, we sold single-premium annuities (“SPAs”) and guaranteed investment contracts (“GICs”), primarily to employer sponsored pension plans. In 1993, we discontinued selling these products, and now we refer to these products as discontinued products.

We discontinued selling these products because they were generating losses for us, and we projected that they would continue to generate losses over their life (which is greater than 30 years); so we established a reserve for anticipated future losses at the time of discontinuance. This reserve represents the present value (at the risk-free rate of return at the time of discontinuance, consistent with the duration of the liabilities) of the difference between the expected cash flows from the assets supporting these products and the cash flows expected to be required to meet the obligations of the outstanding contracts. Because we projected anticipated cash shortfalls in our discontinued products, at the time of discontinuance we established a receivable from Large Case Pensions’ continuing products (which is eliminated in consolidation).

Key assumptions in setting this reserve include future investment results, payments to retirees, mortality and retirement rates and the cost of asset management and customer service. In 1997, we began the use of a bond default assumption to reflect historical default experience. In 1995, we modified the mortality tables used in order to reflect a more up-to-date 1994 Uninsured Pensioner’s Mortality table. Other than these changes, since 1993 there have been no significant changes to the assumptions underlying the reserve.

We review the adequacy of this reserve quarterly based on actual experience. As long as our expectation of future losses remains consistent with prior projections, the results of the discontinued products are applied to the reserve and do not affect net income. However, if actual or expected future losses are greater than we currently estimate, we may have to increase the reserve, which could adversely impact net income. If actual or expected future losses are less than we currently estimate, we may have to decrease the reserve, which could favorably impact net income. The current reserve reflects management’s best estimate of anticipated future losses. The reserve for anticipated future losses is included in future policy benefits on our balance sheet.

As a result of this review, the reserve at December 31, 2010 and 2009 reflect management’s best estimate of anticipated future losses. In the year ended December 31, 2008, \$44 million (\$29 million after tax) of the reserve was released due to favorable mortality and retirement experience compared to assumptions we previously made in estimating the reserve.

The activity in the reserve for anticipated future losses on discontinued products in 2010, 2009 and 2008 was as follows (pretax):

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>
Reserve, beginning of period	\$ 789.2	\$ 790.4	\$ 1,052.3
Operating losses	(15.4)	(34.8)	(93.4)
Net realized capital gains (losses)	111.0	(8.5)	(124.7)
Cumulative effect of new accounting standard as of April 1, 2009 <sup>(1)</sup>	-	42.1	-
Reserve reduction	-	-	(43.8)
<b>Reserve, end of period</b>	<b>\$ 884.8</b>	<b>\$ 789.2</b>	<b>\$ 790.4</b>

(1) The adoption of new accounting guidance from other-than-temporary impairments of debt securities in 2009 resulted in a cumulative effect adjustment at April 1, 2009. Refer to Note 2 beginning on page 57 for additional information. This amount is not reflected in accumulated other comprehensive loss and retained earnings in our shareholders' equity since the results of discontinued products do not impact our operating results.

During the year ended December 31, 2010, our discontinued products reflected net realized capital gains primarily attributable to gains from the sale of debt securities and investment real estate and an operating loss. During the years ended December 31, 2009 and 2008 our discontinued products reflected operating losses and net realized capital losses, both attributable to the unfavorable investment conditions that existed from the latter half of 2008 through the second quarter of 2009. We evaluated the operating loss in 2010 against our expectations of future cash flows assumed in estimating the reserve and concluded that no adjustment to the reserve was required at December 31, 2010.

The anticipated run-off of the discontinued products reserve balance at December 31, 2010 (assuming that assets are held until maturity and that the reserve run-off is proportional to the liability run-off) is as follows:

<b>(Millions)</b>	
2011	\$ 45.5
2012	44.9
2013	44.0
2014	43.0
2015	42.0
<b>Thereafter</b>	<b>665.4</b>

Assets and liabilities supporting discontinued products at December 31, 2010 and 2009 were as follows: <sup>(1)</sup>

<b>(Millions)</b>	<b>2010</b>	<b>2009</b>
<b>Assets:</b>		
Debt and equity securities available-for-sale	\$ 2,610.3	\$ 2,507.7
Mortgage loans	498.8	543.9
Other investments	603.2	630.2
<b>Total investments</b>	<b>3,712.3</b>	<b>3,681.8</b>
Other assets	90.4	118.6
Collateral received under securities loan agreements	35.1	33.4
Current and deferred income taxes	20.7	51.5
Receivable from continuing products <sup>(2)</sup>	492.4	463.4
<b>Total assets</b>	<b>\$ 4,350.9</b>	<b>\$ 4,348.7</b>
<b>Liabilities:</b>		
Future policy benefits	\$ 3,162.2	\$ 3,301.0
Policyholders' funds	10.2	12.1
Reserve for anticipated future losses on discontinued products	884.8	789.2
Collateral payable under securities loan agreements	35.1	33.4
Other liabilities <sup>(3)</sup>	258.6	213.0
<b>Total liabilities</b>	<b>\$ 4,350.9</b>	<b>\$ 4,348.7</b>

(1) Assets supporting the discontinued products are distinguished from assets supporting continuing products.

(2) The receivable from continuing products is eliminated in consolidation.

(3) Net unrealized capital gains on available-for-sale debt securities are included in other liabilities and are not reflected in consolidated shareholders' equity.

The discontinued products investment portfolio has changed since inception. Mortgage loans have decreased from \$5.4 billion (37% of the investment portfolio) at December 31, 1993 to \$499 million (13% of the investment portfolio) at December 31, 2010. This was a result of maturities, prepayments and the securitization and sale of commercial mortgages. Also, real estate decreased from \$500 million (4% of the investment portfolio) at December 31, 1993 to \$50 million (1% of the investment portfolio) at December 31, 2010, primarily as a result of sales. The resulting proceeds were primarily reinvested in debt and equity securities. Over time, the then-existing mortgage loan and real estate portfolios and the reinvested proceeds have resulted in greater investment returns than we originally assumed in 1993.

At December 31, 2010, the expected run-off of the SPA and GIC liabilities, including future interest, were as follows:

<b>(Millions)</b>	
2011	\$ 437.6
2012	420.7
2013	408.2
2014	384.8
2015	367.8
Thereafter	804.5 <sup>4</sup>

The expected run-off of the SPA and GIC liabilities can vary from actual due to several factors, including, among other things, contract holders redeeming their contracts prior to contract maturity or additional amounts received from existing contracts. The liability expected at December 31, 1993 and actual liability balances at December 31, 2010, 2009 and 2008 for the GIC and SPA liabilities were as follows:

<b>(Millions)</b>	<u>Expected</u>		<u>Actual</u>	
	<u>GIC</u>	<u>SPA</u>	<u>GIC</u>	<u>SPA</u>
2008	\$ 20.4	\$ 3,261.2	\$ 16.7	\$ 3,446.4
2009	19.1	3,103.9	12.1	3,301.0
2010	<b>18.0</b>	<b>2,943.5</b>	<b>10.2</b>	<b>3,162.2</b>

The GIC balances were lower than expected in each period because several contract holders redeemed their contracts prior to contract maturity. The SPA balances in each period were higher than expected because of additional amounts received under existing contracts.

The distributions on our discontinued products consisted of scheduled contract maturities, settlements and benefit payments of \$432.2 million, \$447.1 million and \$454.3 million for the years ended December 31, 2010, 2009 and 2008, respectively. Participant-directed withdrawals of our discontinued products were not significant in the years ended December 31, 2010, 2009 and 2008, respectively. Cash required to fund these distributions was provided by earnings and scheduled payments on, and sales of, invested assets.

### **Management's Report on Internal Control Over Financial Reporting**

Management is responsible for establishing and maintaining adequate internal control over financial reporting ("ICOFR") for the Company. ICOFR is defined as a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Our ICOFR process includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on our consolidated financial statements.

Because of its inherent limitations, ICOFR may not prevent or detect misstatements. Further, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with policies or procedures may deteriorate.

Under the supervision and with the participation of management, including our Chief Executive and Chief Financial Officers, management assessed the effectiveness of our ICOFR at December 31, 2010. In making this assessment, management used the framework set forth by the Committee of Sponsoring Organizations of the Treadway Commission in "*Internal Control – Integrated Framework*." Based on this assessment, management concluded that our ICOFR was effective at December 31, 2010. Our ICOFR as well as our consolidated financial statements have been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included on page 101.

### **Management's Responsibility for Financial Statements**

Management is responsible for our consolidated financial statements, which have been prepared in accordance with GAAP. Management believes the consolidated financial statements, and other financial information included in this report, fairly present in all material respects our financial position, results of operations and cash flows as of and for the periods presented in this report.

The financial statements are the product of a number of processes that include the gathering of financial data developed from the records of our day-to-day business transactions. Informed judgments and estimates are used for those transactions not yet complete or for which the ultimate effects cannot be measured precisely. We emphasize the selection and training of personnel who are qualified to perform these functions. In addition, our personnel are subject to rigorous standards of ethical conduct that are widely communicated throughout the organization.

The Audit Committee of Aetna's Board of Directors engages KPMG LLP, an independent registered public accounting firm, to audit our consolidated financial statements and express their opinion thereon. Members of that firm also have the right of full access to each member of management in conducting their audits. The report of KPMG LLP on their audit of our consolidated financial statements appears on page 101.

### **Audit Committee Oversight**

The Audit Committee of Aetna's Board of Directors is comprised solely of independent directors. The Audit Committee meets regularly with management, our internal auditors and KPMG LLP to oversee and monitor the work of each and to inquire of each as to their assessment of the performance of the others in their work relating to our consolidated financial statements and ICOFR. Both KPMG LLP and our internal auditors have, at all times, the right of full access to the Audit Committee, without management present, to discuss any matter they believe should be brought to the attention of the Audit Committee.

## Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders  
Aetna Inc.:

We have audited the accompanying consolidated balance sheets of Aetna Inc. and subsidiaries (the "Company") as of December 31, 2010 and 2009, and the related consolidated statements of income, shareholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2010. We also have audited the Company's internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on these financial statements and an opinion on the Company's internal control over financial reporting based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the consolidated financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2010 and 2009, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2010, in conformity with United States generally accepted accounting principles. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control - Integrated Framework* issued by COSO.

/s/ KPMG LLP

February 25, 2011

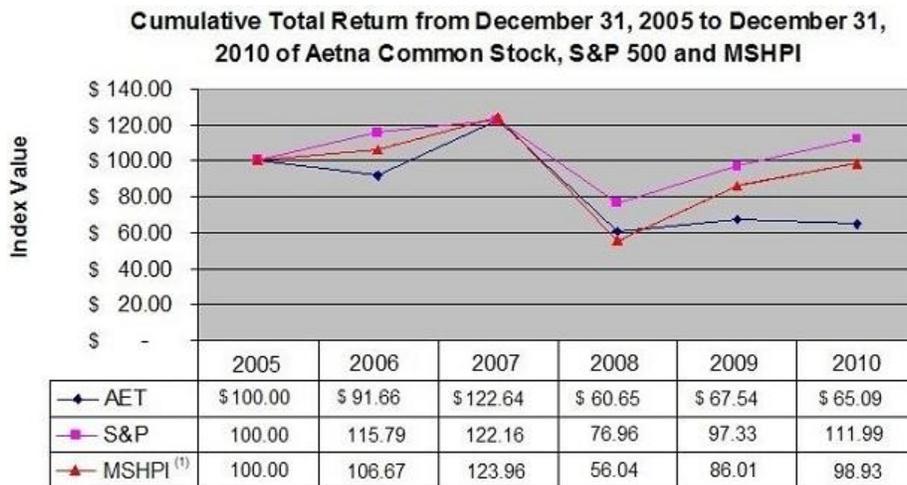
## Quarterly Data (Unaudited)

(Millions, except per share and common stock data)	First	Second	Third	Fourth
<b>2010</b>				
Total revenue	\$ 8,621.5	\$ 8,545.8	\$ 8,538.8	\$ 8,539.9
Income before income taxes	\$ 801.0	\$ 763.5	\$ 767.2	\$ 312.5
Income taxes	(238.4)	(272.5)	(269.6)	(96.9)
Net income	\$ 562.6	\$ 491.0	\$ 497.6	\$ 215.6
Net income per share - basic <sup>(1)</sup>	\$ 1.30	\$ 1.16	\$ 1.21	\$ .54
Net income per share - diluted <sup>(1)</sup>	1.28	1.14	1.19	.53
Dividends declared per share	\$ -	\$ -	\$ .04	\$ -
Common stock prices, high	35.38	35.17	31.61	31.99
Common stock prices, low	28.63	26.38	25.99	29.62
<b>2009</b>				
Total revenue	\$ 8,614.7	\$ 8,670.8	\$ 8,722.4	\$ 8,756.2
Income before income taxes	\$ 668.9	\$ 515.4	\$ 478.3	\$ 238.6
Income taxes	(231.1)	(168.8)	(152.1)	(72.7)
Net income	\$ 437.8	\$ 346.6	\$ 326.2	\$ 165.9
Net income per share - basic <sup>(1)</sup>	\$ .97	\$ .78	\$ .75	\$ .38
Net income per share - diluted <sup>(1)</sup>	.95	.77	.73	.38
Dividends declared per share	\$ -	\$ -	\$ .04	\$ -
Common stock prices, high	34.52	27.72	31.16	34.04
Common stock prices, low	18.99	21.88	24.05	25.22

(1) Calculation of net income per share is based on weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

## Corporate Performance Graph

The following graph compares the cumulative total shareholder return on our common stock (assuming reinvestment of dividends) with the cumulative total return on the published Standard & Poor's 500 Stock Index ("S&P 500") and the cumulative total return on the published Morgan Stanley Healthcare Payors Index ("MSHPI") from December 31, 2005 through December 31, 2010. The graph assumes a \$100 investment in shares of our common stock on December 31, 2005.



( At December 31, 2010, the companies included in the MSHPI were: Aetna Inc., Amerigroup Corporation,  
 1 Centene Corporation, CIGNA Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc.,  
 ) Molina Healthcare, Inc., UnitedHealth Group Incorporated, Wellcare Health Plans Inc. and Wellpoint, Inc.

Shareholder returns over the period shown on the corporate performance graph should not be considered indicative of future shareholder returns.



**Subsidiaries of Aetna Inc.**

Listed below are subsidiaries of Aetna Inc. at December 31, 2010 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below would not, in the aggregate, constitute a “significant subsidiary” of Aetna Inc., as that term is defined in Rule 1-02(w) of Regulation S-X.

- Aetna Health Holdings, LLC (Delaware)
  - o Aetna Health of California Inc. (California)
  - o Aetna Health Inc. (Connecticut)
  - o Aetna Health Inc. (Florida)
  - o Aetna Health Inc. (Georgia)
  - o Aetna Health Inc. (Maine)
  - o Aetna Health Inc. (Michigan)
  - o Aetna Health Inc. (New Jersey)
  - o Aetna Health Inc. (New York)
  - o Aetna Health Inc. (Washington)
  - o Aetna Health Inc. (Pennsylvania)
  - o Aetna Health Inc. (Texas)
  - o AET Health Care Plan, Inc. (Texas)
  - o Aetna Family Plans of Georgia Inc. (Georgia)
  - o Aetna Dental of California Inc. (California)
  - o Aetna Dental Inc. (New Jersey)
  - o Aetna Dental Inc. (Texas)
  - o Aetna Rx Home Delivery, LLC (Delaware)
  - o Aetna Health Management, LLC (Delaware)
  - o Aetna Ireland Inc. (Delaware)
  - o Chickering Claims Administrators, Inc. (Massachusetts)
  - o Aetna Specialty Pharmacy, LLC (Delaware)
  - o Cofinity, Inc. (Delaware)
  - o @Credentials Inc. (Delaware)
  - o Strategic Resource Company (South Carolina)
  - o Aetna Better Health Inc. (Connecticut)
  - o Aetna Better Health Inc. (Florida)
  - o Aetna Better Health Inc. (Illinois)
  - o Aetna Better Health, Inc. (Louisiana)
  - o Aetna Better Health Inc. (Pennsylvania)
  - o Aetna Student Health Agency Inc. (Massachusetts)
  - o Delaware Physicians Care, Incorporated (Delaware)
  - o Missouri Care, Incorporated (Missouri)
  - o SABH of Arizona, Incorporated (Arizona)
  - o Schaller Anderson Medical Administrators, Incorporated (Delaware)
  - o Schaller Anderson, L.L.C. (Arizona)
- Aetna Life Insurance Company (Connecticut)
  - o AHP Holdings, Inc. (Connecticut)
    - Aetna Insurance Company of Connecticut (Connecticut)
    - AE Fourteen, Incorporated (Connecticut)
    - Aetna Life Assignment Company (Connecticut)
  - o PE Holdings, LLC (Connecticut)
  - o Azalea Mall, L.L.C. (Delaware)
  - o Canal Place, LLC (Delaware)
  - o Aetna Ventures, LLC (Delaware)

- o Aetna Government Health Plans, LLC (Delaware)
    - o Broadspire National Services, Inc. (Florida)
  - Aetna Financial Holdings, LLC (Delaware)
    - o Aetna Behavioral Health of Delaware, LLC (Delaware)
    - o Aetna Asset Advisors, LLC (Delaware)
    - o U.S. Healthcare Properties, Inc. (Pennsylvania)
    - o Aetna Capital Management, LLC (Delaware)
      - Aetna Partners Diversified Fund, LLC (Delaware)
      - Aetna Partners Diversified Fund (Cayman), Limited (Cayman)
    - o Aetna Workers' Comp Access, LLC (Delaware)
    - o Aetna Behavioral Health, LLC (Delaware)
    - o Managed Care Coordinators, Inc. (Delaware)
    - o Aetna Integrated Informatics, Inc. (Pennsylvania)
    - o Horizon Behavioral Services, LLC
      - Employee Assistance Services, LLC (KY)
      - Health and Human Resource Center, Inc. (CA)
      - Resources for Living, LLC (TX)
      - The Vasquez Group Inc. (IL)
      - Work and Family Benefits, Inc. (NJ)
    - o Leading Benefit Solutions, LLC (Connecticut)
  - Aetna Health and Life Insurance Company (Connecticut)
  - Aetna Health Insurance Company (Pennsylvania)
  - Aetna Health Insurance Company of New York (New York)
  - Aetna Risk Indemnity Company Limited (Bermuda)
  - Aetna International Inc. (Connecticut)
    - o Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
    - o Aetna Global Benefits (UK) Limited (England & Wales)
    - o Aetna Health Services (UK) Limited (England & Wales)
    - o Aetna Global Benefits (Bermuda) Limited (Bermuda)
      - Goodhealth Worldwide (Global) Limited (Bermuda)
      - Aetna Global Benefits (Europe) Limited (England & Wales)
      - Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
      - Goodhealth Worldwide (Asia) Limited (Hong Kong)
      - GWL (UK) Limited (England & Wales)
      - Aetna Global Benefits Limited (DIFC, UAE)
      - Aetna Health Services (Middle East) FZ-LLC (DOZ-UAE)
    - o Aetna Health Insurance Company of Europe Limited (Ireland)
    - o Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
    - o Aetna Global Benefits Administrators Inc. (Florida)
    - o Aetna Global Benefits (Singapore) PTE. LTD. (Singapore)
  - AUSHC Holdings, Inc. (Connecticut)
    - o PPHSNE Parent Corporation (Delaware)
  - Active Health Management, Inc. (Delaware)
    - o Health Data & Management Solutions, Inc. (Delaware)
  - Health Re, Inc. (Vermont)
  - ASI Wings, L.L.C. (Delaware)
  - Luettgens Limited (Connecticut)
  - Dragon Acquisition Company (Delaware)
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**Consent of Independent Registered Public Accounting Firm**

The Board of Directors  
Aetna Inc.:

We consent to the incorporation by reference in the registration statement (No. 333-155961) on Form S-3 and the registration statements (No. 333-52124, 52122, 52120, 73052, 87722, 87726, 124619, 124620, 136176, 136177, 168497 and 168498) on Form S-8 of Aetna Inc. of our reports dated February 25, 2011 with respect to the consolidated balance sheets of Aetna Inc. and subsidiaries (the “Company”) as of December 31, 2010 and 2009 and the related consolidated statements of income, shareholders’ equity and cash flows for each of the years in the three-year period ended December 31, 2010 and the related financial statement schedule, and the effectiveness of internal control over financial reporting as of December 31, 2010, which reports appear in the December 31, 2010 Annual Report on Form 10-K of Aetna Inc.

/s/ KPMG LLP

Hartford, Connecticut  
February 25, 2011

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**Power of Attorney**

We, the undersigned Directors of Aetna Inc. (the "Company"), hereby severally constitute and appoint Joseph M. Zubretsky, Rajan Parmeswar and William C. Baskin III, and each of them individually, our true and lawful attorneys-in-fact, with full power to them and each of them to sign for us, and in our names and in the capacities indicated below, the Company's 2010 Annual Report on Form 10-K and any and all amendments thereto to be filed with the Securities and Exchange Commission under the Securities Exchange Act of 1934, hereby ratifying and confirming our signatures as they may be signed by any of our said attorneys to such Form 10-K and to any and all amendments thereto.

Dated: February 25, 2011

/s/ Frank M. Clark  
Frank M. Clark, Director

/s/ Earl G. Graves  
Earl G. Graves, Director

/s/ Betsy Z. Cohen  
Betsy Z. Cohen, Director

/s/ Gerald Greenwald  
Gerald Greenwald, Director

/s/ Molly J. Coye, M.D.  
Molly J. Coye, M.D., Director

/s/ Ellen M. Hancock  
Ellen M. Hancock, Director

/s/ Roger N. Farah  
Roger N. Farah, Director

/s/ Richard J. Harrington  
Richard J. Harrington, Director

/s/ Barbara Hackman Franklin  
Barbara Hackman Franklin, Director

/s/ Edward J. Ludwig  
Edward J. Ludwig, Director

/s/ Jeffrey E. Garten  
Jeffrey E. Garten, Director

/s/ Joseph P. Newhouse  
Joseph P. Newhouse, Director

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**Certification**

I, Mark T. Bertolini, certify that:

1. I have reviewed this annual report on Form 10-K of Aetna Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
  - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2011

/s/ Mark T. Bertolini  
Mark T. Bertolini  
Chief Executive Officer and President

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**Certification**

I, Joseph M. Zubretsky, certify that:

1. I have reviewed this annual report on Form 10-K of Aetna Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
  - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2011

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky  
Senior Executive Vice President and Chief Financial Officer

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**Certification**

The certification set forth below is being submitted to the Securities and Exchange Commission in connection with the Annual Report on Form 10-K of Aetna Inc. for the period ended December 31, 2010 (the "Report") solely for the purpose of complying with Rule 13a-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Mark T. Bertolini, Chief Executive Officer and President of Aetna Inc., certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Aetna Inc.

Date: February 25, 2011

/s/ Mark T. Bertolini

Mark T. Bertolini  
Chief Executive Officer and President

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**Certification**

The certification set forth below is being submitted to the Securities and Exchange Commission in connection with the Annual Report on Form 10-K of Aetna Inc. for the period ended December 31, 2010 (the "Report") solely for the purpose of complying with Rule 13a-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Joseph M. Zubretsky, Senior Executive Vice President and Chief Financial Officer of Aetna Inc., certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Aetna Inc.

Date: February 25, 2011

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky  
Senior Executive Vice President and Chief Financial Officer

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## **B.31 – Aetna Better Health Unaudited Financials**

Aetna Better Health, Inc will maintain minimum capital and surplus requirements through income from operations following the initial capitalization, and will comply with all State and Federal financial requirements.

Aetna routinely assesses the financial position of each subsidiary. An estimated net worth calculation is completed one month prior to the close of quarterly financials. Any capital contributions needed are submitted to Aetna's capital planning for transfer of funds to the subsidiary prior to the close of each quarter. In instances where a subsidiary has needed capital, Aetna, the subsidiary's parent, has made and will continue to make capital contributions (without restriction) to the subsidiary.

**Aetna Better Health, Inc. - Louisiana  
Balance Sheet  
For the Quarter Ended  
Unaudited**

	September 30, 2010	December 31, 2010	March 30, 2011
<b>ASSETS</b>			
Cash and short term investments	\$3,000,103	\$3,000,227	\$3,000,638
Accrued investment income	\$911	\$3,185	\$6,960
Investments	\$0	\$0	\$0
Health care receivables	\$0	\$0	\$0
Other assets	\$0	\$0	\$0
	<u>\$3,001,013</u>	<u>\$3,003,412</u>	<u>\$3,007,598</u>
<b>LIABILITIES</b>			
Claims payable	\$0	\$0	\$0
Accounts payable and other	355	887	2,352
	<u>355</u>	<u>887</u>	<u>2,352</u>
<b>CAPITAL AND SURPLUS</b>			
Contributed capital	3,000,000	3,000,000	3,000,000
Retained earnings	658	2,525	5,246
	<u>3,000,658</u>	<u>3,002,525</u>	<u>3,005,246</u>
	<u>\$3,001,013</u>	<u>\$3,003,412</u>	<u>\$3,007,598</u>
	-	-	-
Working Capital	3,000,658	3,002,525	3,005,246
Current Ratio	8,453.6	3,386.0	1,278.7
Quick Ratio	8,453.6	3,386.0	1,278.7
Net Worth	3,000,658	3,002,525	3,005,246
Debt-to-Worth	No debt	No debt	No debt

**Aetna Better Health, Inc. - Louisiana**  
**Income Statement**  
**For the Quarter Ended**  
**Unaudited**

	September 30, 2010	December 31, 2010	March 30, 2011
<b>REVENUE</b>			
Capitation Revenue	\$0	\$0	\$0
Delivery Suppl. Revenue	0	0	0
Other Revenue	0	0	0
<i>Total Revenue</i>	<u>0</u>	<u>0</u>	<u>0</u>
<b>EXPENSE</b>			
Medical Costs	\$0	\$0	\$0
Administration - start-up	0	\$0	0
Administration	0	\$0	\$0
<i>Total Expenses</i>	<u>0</u>	<u>0</u>	<u>0</u>
<b>Operating Income (Loss)</b>	<u>0</u>	<u>0</u>	<u>0</u>
<b>Non-Operating</b>			
Investment Income	\$1,013	\$2,871	\$4,187
	<u>1,013</u>	<u>2,871</u>	<u>4,187</u>
<b>Pre-Tax Income (Loss)</b>	<u>1,013</u>	<u>2,871</u>	<u>4,187</u>
Income Tax Provision	355	1,005	1,465
<b>Net Income (Loss)</b>	<u>\$658</u>	<u>\$1,866</u>	<u>\$2,722</u>

**Aetna Better Health, Inc. - Louisiana**  
**Statement of Cash Flows**  
**For the Quarter Ended**  
**Unaudited**

	<b>September 30, 2010</b>	<b>December 31, 2010</b>	<b>March 30, 2011</b>
<b>Cash flow from Operations:</b>			
Premiums and revenues collected	\$0	\$0	\$0
Medical expenses paid	0	0	0
General and administrative expenses paid	0	0	0
<i>Net cash provided by underwriting activities</i>	0	0	0
Net investment income	103	597	412
Taxes	0	(473)	0
<i>Net cash provided by operations</i>	103	124	412
<b>Cash flow from Investments:</b>			
Health plan capitalization	3,000,000	0	0
<b>Cash and short-term investments, beginning of year</b>	0	3,000,103	3,000,227
<b>Cash and short-term investments, end of year</b>	<b>\$3,000,103</b>	<b>\$3,000,227</b>	<b>\$3,000,638</b>