Exhibit 5-E **Item 1 of Aetna's 2010 Annual Report on Form 10-K.**

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.

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*®, 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 Connections℠, our integrated disease management program and Aetna Vision Preferred℠, 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℠ 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 Vision℠ 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℠ 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:

	2010			2009			2008		
(Thousands)	**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 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.