The Course of Leadership

AETNA ANNUAL REPORT 2001

Table of Contents

3 ON COURSE FOR SUCCESS
Letter to Shareholders

6 BUILDING A NEW AETNA
Back to Basics
Sound Planning for Uncertain Times
Getting it Right
Taking the Long View
Building Lasting Partnerships

13 HEALING THE SYSTEM

15 THE STATE OF QUALITY, 2002
Robert S. Galvin, M.D.
Director of Global Health Care
General Electric Company

17 BIOTERRORISM: A CHALLENGE TO HEALTH AND SECURITY
Margaret A. Hamburg, M.D.
Vice President for Biological Programs
NTI

19 MENTAL HEALTH PARITY
David Mechanic, Ph.D.
René Dubos University Professor of Behavioral Sciences, and
Director, Institute for Health, Health Care Policy, and Aging Research
Rutgers University

21 LONG-TERM CARE FINANCING — AN URGENT NATIONAL PRIORITY
The Honorable Nancy L. Johnson (R-Conn.)
U.S. House of Representatives

23 MEDICINE'S INDUSTRIAL REVOLUTION
J.D. Kleinke, Chairman
Health Strategies Network, Inc.

25 TORT REFORM LESSONS
David E. Bernstein
Associate Professor
George Mason University School of Law

27 CONSUMER-DRIVEN HEALTH CARE
Regina E. Herzlinger, D.B.A.
Nancy R. McPherson Professor of Business Administration Chair
Harvard Business School

28 THE COURSE OF LEADERSHIP

29 FINANCIAL AND CORPORATE INFORMATION
Selected Financial Data
Consolidated Statements of Income
Consolidated Balance Sheets
Board of Directors and Management
For More Information
Shareholder Information

For additional financial information, see the 2002 Aetna Inc. Notice of Annual Meeting and Proxy Statement and Aetna 2001 Annual Report, Financial Report under separate cover (form GR-57956).

Health Care Today

Perhaps no other aspect of American life is currently as changing and challenging as health care. Many forces are stressing a system that must serve and satisfy many needs. As technology makes more treatments possible and scientific discovery makes more diseases preventable, costs rise, and the public's expectations rise even higher.

Aetna is — and will remain — a leader in the health care field. And as we strengthen and restore Aetna's abilities to provide what people really want — more choices, more control over their health care, efficient claims payment and clear information — we maintain a steady focus on the future of our industry. This report underscores Aetna's commitment both to revitalize our company and to participate in the reinvention of America's health care system.

JOHN W. ROWE, M.D.
Chairman, President and Chief Executive Officer

On Course for Success

TO OUR SHAREHOLDERS: In 2001, our first year as an independent health care and related benefits company, Aetna set out three imperatives: organize for success, improve business operations and set a new strategic direction. Despite financial results that were extremely disappointing to us and our shareholders, I am pleased to say that we made notable progress on all three fronts.

We changed Aetna's leadership and organizational structure, and our entire approach to the marketplace. We tackled underlying causes of our poor financial performance and laid the groundwork for improvement. And we crafted a new strategic direction, which will define our company in the years ahead.

ORGANIZING FOR SUCCESS

The first component of Aetna's turnaround has been to organize for success. In 2001, we assembled a new team of senior leaders from inside and outside Aetna. We brought in talented, experienced and well-regarded executives such as Ron Williams, head of Health Operations; Bill Popik, M.D., chief medical officer; Wei-Tih Cheng, chief information officer; and David Kelso, head of the newly created organization, Strategy & Finance. At the same time, we promoted talented Aetna veterans — such as Alan Bennett, chief financial officer — who understand deeply Aetna's business, its legacy and its proud tradition.

We created new interdisciplinary corporate councils to help Aetna become a more strategic and high-performance organization. And we realigned our business structure to allow Aetna to serve better the needs of our customers in our target market segments. Today, I am confident we have the right team and the right organizational structure in place for our turnaround.

STRIVING FOR OPERATIONAL EXCELLENCE

Second, we addressed many operational problems in our health business. Faced with financial setbacks early in the year — resulting from higher-than-anticipated medical costs — we conducted a top-to-bottom review of our health operations, developed plans to correct the identified deficiencies and began implementing the necessary actions. Concurrently, we began sharpening our focus on the health plan membership we can serve best. This led to the difficult, but necessary, exiting of certain markets, programs and products, and reducing our membership and workforce.

We made, and continue to make, substantial enhancements in many aspects of our business — service, pricing, underwriting, network contracting and patient management — to serve better the employers who purchase our plans and the individuals who use them. In the following pages, several of Aetna's senior leaders describe these activities in detail.

SETTING A NEW STRATEGIC DIRECTION

Third, while engaged in the daily work of our turnaround, we also began looking ahead, formulating a new strategic direction that aims to significantly improve Aetna's margins and returns on capital, and reduce our risk exposure and volatility. This new direction leverages our existing strengths, targets specific product market segments and is aligned with where the market is headed. The implications for our business are numerous: an increased presence in the midsize employer market, a more disciplined approach in the small-business market, a shift toward self-insured accounts and an increased emphasis on our group insurance products.

Already, Aetna offers a wide variety of health plans and robust ancillary products such as dental and pharmacy. And unlike many of our health competitors, we offer a range of long-term care, disability and life insurance products. Going forward, we intend to take advantage of this breadth of offerings, as we bolster our ability to anticipate and respond to new consumer demands for more choice and control with innovative products such as our new Aetna HealthFund™ health plan.

TARGETED IMPROVEMENTS IN 2002

Our priorities for 2002 are clear: Building on the important work begun in 2001, we will further improve pricing, manage medical costs appropriately, reduce administrative expenses and recover profitability. We intend to raise service levels even higher; increase member and customer satisfaction; and improve relations with our health care providers, brokers, consultants and other key stakeholders. And building on the new strategic direction, we will develop a detailed strategic plan, while putting in place companywide initiatives that, over time, will help us to develop a high-performance culture that engages all employees in creating Aetna's future.

This year will bring the early fruits of our labors. As a smaller and more focused company, we will be better able to serve the customer segments that align with our strengths and establish a base from which we can profitably grow.

FIXING THE SYSTEM

All of us at Aetna are devoting tremendous energy and resources to improving our operations and recapturing our leadership position. That doesn't mean, however, our focus is only on getting our own house in order. We will continue to play a key role in focusing attention on the challenges confronting our industry and the nation. These are many and multidimensional. How do we reconcile outstanding issues of health care quality, skyrocketing medical costs and a nation largely unprepared to deal with the issues surrounding long-term care? How do we respond to demands for greater choice, more control, lower costs and greater coverage — all at the same time? And how do we respond to the challenges of patient safety and unprecedented threats such as bioterrorism?

Later in this report, a group of experts will discuss these and other health challenges. Their insights will be invaluable as we work with our industry partners to find solutions for a better health care system.

RESTORATION AND REBIRTH

2001 was a defining year for Aetna — both difficult and productive. Top to bottom and across our entire operation, Aetna's dedicated employees stepped up to do what needed to be done. In 2002, Aetna is building on the work we've completed and moving closer to our ultimate goal of restoring our industry leadership position.

As Chairman of Aetna, I am acutely aware of the legacy entrusted to me and the opportunity inherent in our quest to restore this great company. I know I speak for all employees when I say we are bound together in pursuit of a single mission: to create a stronger Aetna — one that is both respected in the industry and trusted by millions of Americans to help them access the very best in health care.

JOHN W. ROWE, M.D.
Chairman, President and Chief Executive Officer

WILLIAM H. DONALDSON

After a quarter of a century of dedicated service to Aetna, we bid farewell to William H. Donaldson, who served as Aetna's Chairman from February 2000 to April 2001, and now, in accordance with company policy, is retiring from Aetna's Board of Directors. Bill provided essential leadership during a critical period in Aetna's history and set the company on a new course.

Early in 2000, at a time of challenge, the Board asked Bill to step in as Chairman and CEO. Co-founder of Donaldson, Lufkin and Jenrette, Inc.; past Chairman and CEO of the New York Stock Exchange; founding dean of the Yale School of Management; and former U.S. Undersecretary of State, Bill had the experience and vision needed to get Aetna back on track.

Bill saw that Aetna's business model had fallen out of rhythm with the marketplace. He ordered a comprehensive review of Aetna's businesses and quickly made tough decisions about how to reposition the company for the future. The sale of Aetna Financial Services and Aetna International to ING Groep N.V. substantially increased shareholder value by providing Aetna shareholders approximately $35.33 in exchange for each of their shares, plus stock in a new health company.

Looking toward the future, Bill initiated programs to reshape our product portfolio, enhance relations with doctors and hospitals, and improve the quality of customer service. He reinvigorated Aetna and increased our ability to serve the millions of people who rely on us for their health care and related benefits needs.

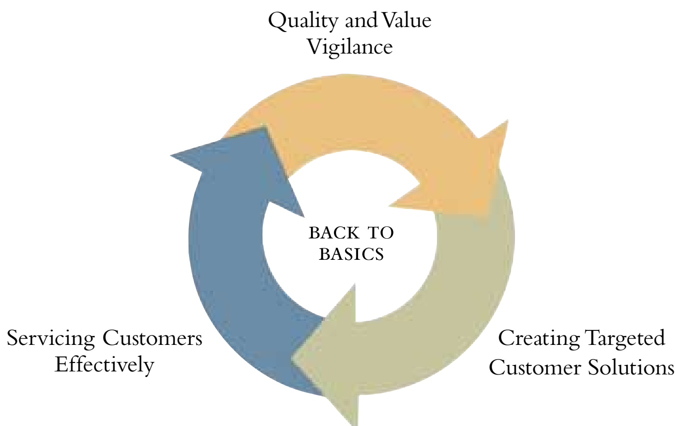
We offer our heartfelt gratitude to Bill Donaldson for all he has given Aetna and wish him all the best.

RONALD A. WILLIAMS
Executive Vice President and
Chief of Health Operations

Back to Basics

In 2001, Aetna went back to basics — focusing on the specific needs of our customers and how we can deliver the most value for them.

Our new customer segment strategy — national accounts, middle market and small business — allows us to understand more closely and to address the unique needs of customers in each segment and geography.



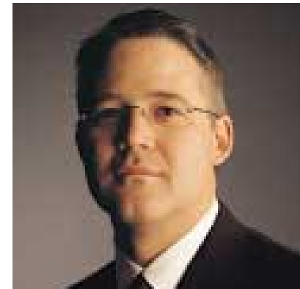
Consumers are demanding more choice and control over how their health care dollars are spent, as they take on more decision-making responsibilities for their health.

Aetna offers consumers many options, including Aetna Open Access™ health plans with no referrals and plans that allow a choice of any physician or hospital.

Also, Aetna HealthFund™, an innovative new product that allows consumers to choose how and when their health care dollars will be spent, features an employer-funded account that can be rolled over if not used.

RUSSELL D. FISHER
Senior Vice President
National Accounts and
Aetna Global Benefits

C. TIMOTHY BROWN
Senior Vice President
Select & Key Accounts



WILLIAM H. ROTH
Senior Vice President
Small Group Business
and Medicare

Aetna is a leader in serving large, multistate Fortune 1000 companies that want a broad array of products, superior customer service, plus programs that enhance the quality of health care their employees receive.

In the rapidly growing middle market segment, a key to success is strengthening positive relationships with our broker and consultant business partners.

We are taking a more disciplined approach to our small business accounts with new product choices, enhanced broker relationships and simplified administration.

Across all our segments we can package dental, pharmacy, life, disability and long-term care insurance with our health plans for convenience, service and value.

Sound Planning for Uncertain Times

FROLLY M. BOYD
Senior Vice President, Group Insurance
and Large Case Pensions

"It's daunting to plan for a lifetime of unknowns. In 2001, we changed our focus from simply delivering competitive life, disability and long-term care products to helping employees prepare for life's uncertainties."

As our society continues to age, chronic-care issues become more pervasive. We aren't sure what is adequate coverage or how to go about securing it. So Aetna is providing our members with better education and information about how to protect against the consequences of serious injury, extended illness or death before they face those difficult times.

Two-thirds of consumers feel unsure about life insurance and financial planning matters.

Approximately 1.3 million Americans filed for bankruptcy in 1999. Almost half were due to the financial effects of an illness or injury, despite having health insurance.

In 2002 we'll enhance our programs by offering access to discounted legal and financial planning services. We'll help transition disabled employees back to productivity through vocational rehabilitation and job assistance programs.

We're working to bring employers innovative solutions that meet the unique life stages of all their employees — for now and for tomorrow.

Getting it Right

Our customers want peace of mind. We can put them at ease by improving the quality of service with greater simplicity and fewer hassles.

Our customers expect us to fulfill their expectations the first time, every time. To process claims correctly and to provide courteous, professional service that satisfies their needs. We call this "getting the basics right," and it's the core of our service strategy.

Our innovative First Claim Resolution program is increasing the number of claims that are paid right the first time. This avoids the rework, delays and customer dissatisfaction associated with multiple submissions.

25%	28%
2000-2001	*2000-2001*
Claim turnaround time improvement	*Average speed of answer improvement*

Our First Call Resolution program seeks to give our members the right information and service they need in just one call. Our customers assume that we will respond to telephone inquiries without delays, internal hand-offs or the need to call back for follow-up.

We are responding to our members' desire to make the health care experience simpler and easier to understand. Our InteliHealth® Web site and Aetna Navigator™, our online health information and benefits management tool, are giving customers the information they need to access the best possible health care.

"At the heart of what we do every day is the promise we made when our members chose Aetna for their health plan. We want to be certain that they benefit from all plan features, and that we deliver outstanding customer service, as defined by the quality of each interaction and service experience."

GAIL K. BOUDREAUX
Vice President, Customer Service

DAVID B. KELSO
Executive Vice President, Strategy & Finance

Taking the Long View

Strategy is an ongoing process, not a one-time project. In 2002, we'll make further progress in understanding customer segments, choosing to focus on those we can most effectively serve.

Strategy is about making choices—not only about what you WILL do, but also what you will NOT do. Even the most elegant strategy also requires excellent execution.

We're witnessing a period of rapid change; old paradigms no longer apply. As costs skyrocket, employers and consumers want new ways to secure access to the best of today's medicine. Consumers and physicians want fewer restrictions and more choices, fewer hassles and more information.

We will be the leader in providing products and services that help people choose the right benefits and access those benefits to protect their health and financial security.

PATRICIA A. FARRELL
Vice President
Strategy

ELEASE E. WRIGHT
Senior Vice President
Human Resources

For 149 years, Aetna has been a reliable partner for people seeking protection from various risks. Today, we are building on that foundation a new, high-performance culture that places the customer at the center of everything we do.

We will be engaging, motivating, critical thinkers, accountable for decisions and results. We will serve our customers, constituents and colleagues with distinction; taking great pride in the company, our mission, the value we deliver and our performance in the marketplace.

Our vision is sharp, our path true. We are headed in a new direction, toward a territory rife with promise.

Building Lasting Partnerships

"Listening to doctors and responding to their concerns has become our top priority."

WILLIAM C. POPIK, M.D.
Senior Vice President and Chief Medical Officer

To help our members access affordable, high-quality health care, we need to work cooperatively with physicians.

It begins with streamlining physicians' interactions with us. Eliminating hassles. We've trimmed referral and precertification requirements. Instead, we're working with physicians and hospitals through case management and discharge planning.

Electronic claims processing eliminates paperwork and returns faster, more accurate payments.

We have the largest health database in the industry, helping us target populations for special support. Disease management programs get members actively involved in the day-to-day control of their chronic illnesses.

In 2001, Aetna sent colorectal cancer screening kits to more than 1.7 million Aetna members age 50 and over. Of the 156,000 tests returned, more than 4,700 positive results were detected and sent to the members' physicians.

90%

Cure rate for colorectal cancer when detected early, studies show

Physician-contracting improvements are key to positive negotiations with doctors and hospitals. Our growing network of more than 315,000 physicians is one of the largest in the industry, giving members more choice.

8%

2000-2001
Increase in number of network physicians

Healing the System

As a leader, innovator and partner in health care, Aetna continues to encourage and foster meaningful dialogue on many of America's pressing health care issues. As we did in last year's Annual Report, the new Aetna has enlisted a cross section of highly respected leaders to share their diverse perspectives. The essays that follow are unedited, and we may not agree with everything each author has to say. Yet, we appreciate their commitment to improving the health care system.

The State of Quality, 2002

ROBERT S. GALVIN, M.D.
Director of Global Health Care, General Electric Company

Consumerism, with its demands for transparency and public disclosure, is the most powerful influence on quality.

In 1917, Dr. Ernst Codman of Massachusetts General Hospital stated, "I am considered eccentric for saying in public … that hospitals should welcome publicity not only for their successes, but for their errors." In 2002, the state of quality in the U.S. health care system exhibits stunning pockets of excellence, particularly in high-tech procedures, alongside striking degrees of variance and a dated approach to measuring and improving quality. The Institute of Medicine's 1999 report, *To Err Is Human*, declared that an American dies from a preventable error every 5-10 minutes in U.S. hospitals. Although there is debate about the absolute accuracy of this number, the context is compelling: Our National Academy of Sciences has stated that *preventable* errors are either the fifth or eighth leading cause of death. The question is, will Dr. Codman's words have any more traction today than they did 85 years ago?

I think the answer is yes. First, the fact that the independent and widely respected Institute of Medicine stated, "Serious and widespread quality problems exist throughout American medicine" is unprecedented. A second factor is the organization of the financing of health care. Today, large payers of health care, both public and private, are demanding data on quality. A third difference is the scientific basis of the evaluation of quality. A generation of health services researchers have built on the pioneering work of Dr. John E. Wennberg and demonstrated fivefold variations in adherence to expert guidelines.

But the most powerful difference is the societal trend of consumerism. Although there are no controlled studies, there is a belief that transparency and public disclosure improves quality. Public release of measures has occurred in multiple sectors, from electronics and automobiles to financial services. Medicare now publishes outcome data from dialysis centers and nursing homes, and has announced its intention to expand its measures. At least five states and the private-sector organization, NCQA, publicly release performance information. Driving public transparency is the point of the Leapfrog Group, the public-private partnership consisting of 96 large companies, which publicly released hospital-oriented safety data in January 2002. As a sign of the growing interest in public disclosure, attendees at the Leapfrog press conference included the CEO of Verizon; senior leaders from Medicare, AARP and the International Brotherhood of Machinists; as well as an overflow crowd of national media.

There can be no assurance of success. Externalities like economic downturns and war can radically alter society's interest. But I think Dr. Codman would agree that the two greatest threats are internal: physicians' lack of enthusiasm and a financing system that often discourages, and rarely rewards, quality. There is growing interest in developing a "business case for quality" among payers, and within the physician community, an intensifying dialogue about taking a leadership role in improving quality. However, it is consumers and patients, and their demand to be informed, that will ultimately determine whether Dr. Codman's "eccentric" opinions will be translated into action in the early 21st century.

Bioterrorism: A Challenge to Health and Security

MARGARET A. HAMBURG, M.D.
Vice President for Biological Programs, NTI

The tragic events this past fall brought new attention to our nation's vulnerability to terrorism, including bioterrorism.

Few today are complacent about the possibility that a biological agent might be intentionally used to cause widespread panic, disruption, disease and death. As we mobilize to address an array of national security threats, a comprehensive program to counter and prevent bioterrorism must rank high on the priority list.

Bioterrorism differs fundamentally from other terrorist threats. Most likely it would unfold as an infectious disease epidemic, spread in time and place before authorities even realize that an attack has occurred. In fact, it may prove difficult to ever identify the perpetrators, the site of release, or even determine whether the outbreak was natural or intentional.

In most scenarios, diagnosis will be delayed because medical providers and laboratories would not readily recognize the disease agents of concern. Further, medical interventions may be limited, and the window of opportunity for their delivery narrow. Because of ongoing contagion or continuing exposure, disease might persist over a prolonged period.

The potential devastation is extraordinary, but unlike other weapons of mass destruction, biological weapons are relatively easy to produce, inexpensive; and significant damage can be done even without large quantities of material or an elaborate delivery mechanism.

So what can be done? First, we must recognize that public health is an essential component of our national security framework. Long neglected, our public health system to detect, track and contain infectious disease requires urgent attention. Resources are needed to strengthen and extend surveillance systems, enhance laboratory facilities, and improve communication.

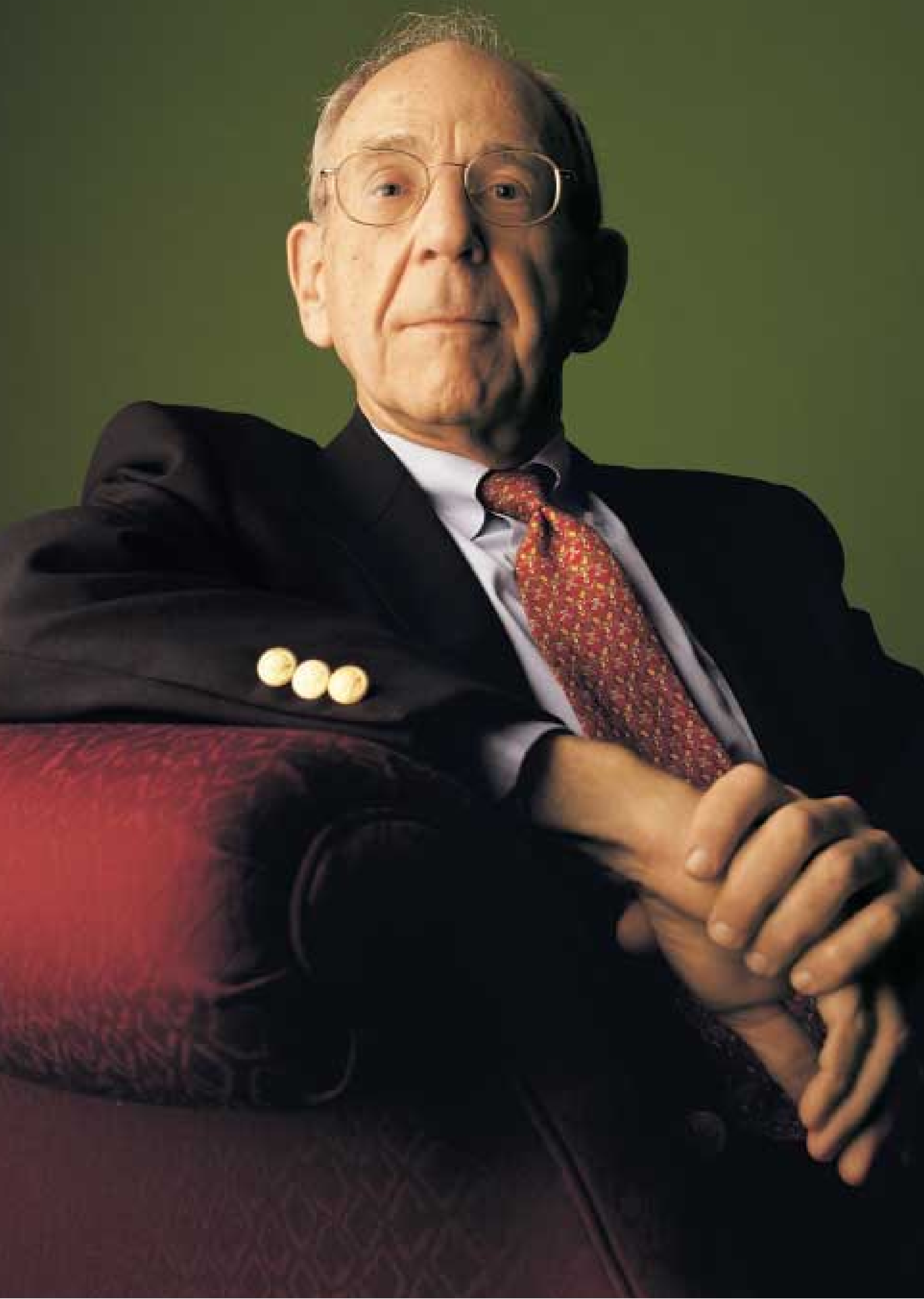
In addition, we must prepare for the possibility of a sudden surge of patients in the health care system. Careful advance planning is needed, since most hospitals now are operating at or near capacity. Furthermore, release of a biological weapon may require rapid access to quantities of antibiotics, vaccines or antidotes not routinely available. A national stockpile now exists, but needs augmentation, including plans for swift, on-the-ground distribution and extra production capability.

Additional investments in basic and applied research to develop new drugs, vaccines, rapid diagnostics and other medical weapons will add to the arsenal against bioterrorism. An effective research agenda may someday provide the tools to render the threat of biological weapons obsolete.

Finally, prevention must be a primary goal. Improved information about potential threats is key. For bioterrorism, this requires new partnerships between law enforcement, intelligence agencies, and the public health and scientific communities.

Sadly, we must recognize the possibility of bioweapons threats emerging from legitimate research. Can we prevent the tools of modern biology from being misused to create new, more dangerous pathogens? Reducing access to dangerous pathogens will also require enhanced efforts by the scientific community to improve laboratory security and assure safe storage and handling.

Bioterrorism confronts us with extraordinary challenges, yet there is a clear path for meaningful action. Moreover, investments made to strengthen public health, improve medical management and support research will greatly benefit protection against outbreaks of naturally occurring infectious disease.



Mental Health Parity

DAVID MECHANIC, PH.D.
René Dubos University Professor of Behavioral Sciences, and Director, Institute for Health, Health Care Policy, and Aging Research, Rutgers University

Mental disorders are among the most disabling of illnesses.

They destroy individual and family functioning; undermine productivity; and cause disruption in the home, workplace and community. In recent decades, advances in treatment and rehabilitation through improved medications, better focused psychotherapies and careful case management have done much to increase function and reduce despair. Large gaps remain in access to effective treatments. Major barriers are the lack and inadequacies of insurance coverage for mental health treatment, the stigma of mental illness and limited public understanding of the benefits of treatment.

Resistance to parity in insurance coverage of mental disorders resulted from the lack of clear treatment standards, the predominance of long-term psychotherapy as the preferred treatment choice, and concern about "moral hazard," the tendency for persons to seek more treatment when care is insured. Since psychotherapy was a cultural source of self-actualization as well as a treatment, it was feared that insurance coverage would induce unnecessary demand. The stigma of mental illness also made it easier to impose greater deductibles, co-insurance, coverage limitations and ceilings than those for other medical conditions, even medical conditions that had no clearer treatment standards. In short, persons with mental illness faced and continue to face discrimination.

Many of the concerns used to justify discrimination have been substantially remedied. The effectiveness of mental health treatments is now comparable to treatments for many medical conditions. Medications have improved, and psychotherapies are now more focused and time limited. Diagnostic assessment is now more rigorous, and practice standards have been clarified. Moreover, the current evidence is persuasive that mental health coverage on the same basis as other illnesses that are managed does not impose large or unaffordable cost increases. There is even basis for the conclusion that the potential reduction of unnecessary medical treatment that people with untreated mental illness receive, and the increase in function and productivity resulting from appropriate treatment, substantially offset the costs.

Three issues must be kept in mind. Medical parity alone is not enough for the small subgroup who have the most severe mental illnesses, and others who have the most profound and disabling diseases and disabilities. These persons may require, in addition, services typically not covered by insurance such as residential care, rehabilitation and housing assistance.

Persons with serious mental illness are commonly high-cost patients because they often have co-morbidities and seek a variety of medical services. Plans and providers may limit coverage to avoid such patients, who pose financial risks. Requiring basic mental health coverage in all plans comparable to that for other medical conditions reduces risk selection. Improved methods of risk adjustment for fair financing and reimbursement are also essential to reduce competition to avoid risk.

Finally, the public must accept the necessity of expert management of the mental health benefit based on sound diagnostic assessment and evidence-based standards. A well-managed benefit offers an extraordinary opportunity to close gaps in treatment and improve the quality of care at affordable cost.

Long-Term Care Financing — An Urgent National Priority

THE HONORABLE NANCY L. JOHNSON (R-CONN.)
U.S. House of Representatives

The cost of essential medical care shouldn't impoverish working Americans.

I have visited with seniors who worked very hard all their lives, who did not take extravagant vacations or spend needlessly, but who now face poverty in paying for essential care for their spouses. The anguish in these folks' eyes is real and terrible. We must act!

Nearly 40 percent of Americans will need some form of long-term care during their lives — but no one plans for its cost. Many think that Medicare pays for extended long-term care expenses, but it does not. We need to help families secure access to the long-term care that their loved ones need and not break the backs of our kids to pay for it. If we continue to rely on publicly financed programs like Medicaid to pay for nursing homes, the resulting tax levels — borne by our descendants — will be unsustainable.

We have public (Social Security) and private retirement security programs, and public (Medicare) and privately financed health care insurance. The need to supplement publicly financed long-term care with privately financed options has the same level of importance.

Because no one is immune from aging or disability, we all should have some plan to finance a long-term nursing home stay or extended period of home health care. Many of us have had to provide long-term care for an elderly parent or relative and are all too familiar with its costs.

I have introduced legislation that provides tax deductions for purchasing long-term care insurance and tax credits to help offset the cost of providing care to a loved one at home. This measure, endorsed by both the HIAA and AARP, would offer a tax deduction for long-term care insurance policies and a tax credit for expenses incurred by caregiving families. Coupled with strong consumer protections, my legislation would help families pay for the care of their loved ones.

Long-term care has the potential to wipe out a senior's retirement savings. As America's population has gotten older, its seniors are living longer with multiple, chronic health problems that require more years of increasingly expensive long-term care. Americans spent approximately $33 billion on long-term care in 2000, and costs are estimated to rise fivefold over the next 30 years. The government is currently the predominant payer of long-term care costs, paying over $75 billion annually. Faced with this demographic tidal wave of aging baby boomers, we must change the way we finance long-term care so that it is fairer and more effective.

Currently, annual long-term care expenses for an individual are about $51,000. How can the average American family afford that high cost for even one year? We need to help families plan how to finance the long-term care that their loved ones may need. More important, we need to allow families to do so without impoverishing themselves to qualify for assistance.

I hope my colleagues in Congress will work with me in passing meaningful long-term care reform. We must take strong steps to assure long-term care security — to make real the promise of retirement and health security — for America's families.

Medicine's Industrial Revolution

J.D. KLEINKE
Health information technology entrepreneur, medical economist, author

We are in the middle of an industrial revolution in health care.

The steam engine that drove the revolution of the 19th century has been replaced by the pharmaceutical engine of the 21st.

Pharmacy costs have been ballooning for years, to the dismay of employers, health plans and consumers. But rather than fret about outsized growth in one spending category, we should celebrate. Why? Because high-priced new drugs are the *cheapest* weapon we have in our ongoing struggle against increasing *overall* health care costs. Pricey prescriptions are a bargain, compared to the cost of surgeries, lengthy hospital stays, and chronic diseases that new drugs often delay, manage or prevent. Some of the most expensive new drugs today keep patients with asthma, diabetes, heart disease and schizophrenia medically stable, away from the hospital, and less dependent on physician care.

Increased spending on drugs that manage disease represents the economics of progress — a profound, permanent rotation in our health care system away from medical labor and toward medical technology — the essence of any industrial revolution. The economic leverage inherent in breakthrough medicines was quantified in a landmark study last year: For every dollar we spend on new drugs, we save three dollars elsewhere in the medical-cost equation. So why the fuss? Because too often in our sprawling health care system, causes and effects are isolated. Stakeholders choking on rapid growth in one spending category often see the costs, but none of the benefits of medicine's rotation from labor to technology. Our health insurance system — including Medicare, originally built to mirror that system — is struggling to reorganize itself around this rotation. The absence of a Medicare prescription benefit is the most glaring illustration of the fact that many of the ways we administer health coverage today emerged decades ago, in a world of fewer drugs, poorly equipped doctors, long hospital stays, and sicker patients.

So how do we harvest rather than harangue against medicine's industrial revolution? With good data. We have made few honest attempts to quantify the constellation of economic impacts of our pharmaceutical progress. Some breakthrough drugs (e.g., protease inhibitors for HIV/AIDS) pay for themselves in directly reduced medical costs; others (e.g., TNF-alpha blockers for rheumatoid arthritis) pay for themselves not in reduced medical costs, but in improved workplace productivity. Unfortunately, most new drugs reside in an economic gray area between these two extremes. The same drug that keeps a severely depressed patient out of the hospital is also prescribed to alleviate another's shyness: in one case, a bargain for the health plan; in the other, a costly way to marginally improve a patient's quality of life. It is our job — and a glorious, purposeful one — to figure out the difference.

With better data comes greater clarity on how we manage the fruits of our progress — and new opportunities to partner across stakeholder groups struggling to deal with its costs. This begins with our recognition that much of the value of pharmaceutical progress is captured not by health plans, but by employers, the government, drug companies, providers and, ultimately, patients, who benefit most from medicine's industrial revolution by leading happier, healthier, more productive lives.

Tort Reform Lessons

DAVID E. BERNSTEIN
Associate Professor, George Mason University School of Law

By all reasonable measures, the American tort system is a disaster.

It resembles a wealth-redistribution lottery more than an efficient system designed to compensate those injured by the wrongful actions of others.

The proliferation of unfounded lawsuits has created an understandable fear of the tort system among businesspeople. They (correctly) see modern tort law as a particularly inefficient, irrational, and onerous form of state health and safety regulation.

Lawsuits with an implicit regulatory agenda strike at the very heart of the managed care industry, which arose from the need to replace fee-for-service plans with a more efficient system based on the latest knowledge regarding the costs and benefits of particular treatments. Managed care has evolved over the years, in response to patient and regulatory demand, and will continue to evolve in response to changing circumstances. To the extent that serious concerns about the conduct of the managed care industry arise, they should be dealt with by political authorities who are accountable to the public for the regulatory choices they make, not by unaccountable judges, juries and trial lawyers.

Sensible procedural reforms can mend the tort system even without restricting its scope. One way to find out what reforms are valuable is to examine the tort systems of nations such as the United Kingdom, Canada and Australia. These systems share the American system's underlying, common-law basis but have managed to avoid the enervating litigation virus, particularly in the tort area, that currently plagues the United States.

The tort systems of these jurisdictions remain basically similar to the American system, but the American system has a few damaging idiosyncracies: (1) civil jury trials prevail in the United States, but have been largely abolished elsewhere; (2) only in the United States is the losing party not responsible for the legal fees and costs of the winner; and (3) American law, unlike other common-law jurisdictions, puts no limits on contingency fees. All of these eccentricities encourage speculative tort litigation, which is perhaps the biggest problem facing the American tort system.

One can define a speculative claim as one whose success depends not on the intrinsic legal merits of the claim, but on fortuity. These cases are brought by plaintiffs' attorneys who know that the cases have a high economic value because an occasional jury can be persuaded to issue a verdict based on sympathy for the plaintiff or distaste for the defendant. Other cases are brought by plaintiffs' attorneys with the intention of engaging in a "fishing expedition" in hopes of coercing a large settlement by finding an embarrassing document or two during the discovery phase of litigation.

Limitations on jury discretion through stricter pretrial screening of plaintiffs' experts' claims and other reforms, implementation of the loser-pays rule, and replacement of contingency fees with conditional fees that have a set maximum hourly rate would each substantially reduce unwarranted litigation. If these measures were implemented, the United States would have a rational tort system like other common-law nations, and economic and regulatory innovation would no longer be stunted by fear of the tort consequences.

Consumer-Driven Health Care

REGINA E. HERZLINGER, D.B.A.
Nancy R. McPherson Professor of Business Administration Chair, Harvard Business School

We live in a democratic, consumer-driven country whose prosperity and freedom serve as models for others.

Such a consumer-driven society is not easy to attain; but prior "Great Generations" and today's brave soldiers, including my son, currently an infantry officer, fight the good fight to secure the life we want.

Since we got rid of Britain's micromanagement, we have been able to vote for candidates and buy products that best meet our needs. Cars, computers, chickens, automobile insurance, mutual funds — you can get what you need at a fair price. Producers continually innovate to gain our custom. Car manufacturers, for example, successfully respond to seemingly impossible consumer demands for more choice; lower costs; and improved safety, reliability, and environmental characteristics. Readily available, excellent quality ratings help ordinary people, like you and me, to buy complex products, like cars, intelligently.

Health care is the one exception to these happy circumstances. Most insurance policies are plain vanilla — virtually the same benefits, co-pays and deductibles, and access to essentially the same providers. And despite the excellence of providers and technology, quality problems abound. Costs are so high that, to our shame, more than 40 million Americans lack health insurance. As for the quality ratings of providers that consumers want and need, they are the "Emperor's New Clothes."

No wonder Americans give health insurers bottom ratings.

Why is health care such an exception?

Some blame the incompetence, greed and frivolous product differentiation of health insurers. They want government to take over. With a single bureaucracy firmly imposing standardized benefits, supplanting competitive health insurers, they claim costs will be reduced. But most Americans and those who have experienced government-controlled health care systems elsewhere are hardly euphoric about this prospect.

Instead, many who support a consumer-driven economy believe that health care problems are caused by a shortage of *consumers*, not *government*. After all, a third party usually purchases health insurance. How can Harvard University, or any third party, know what benefits I want at what price? So buyers simplify by limiting product differentiation. Small wonder that competition through consumer-driven innovations is notably absent in health care.

As I predicted in my 1999 Harvard Business School Conference on Consumer-Driven Health Care, 2001 spawned the movement with the widespread introduction of lower-cost catastrophic insurance products. Under the corporate umbrella, employers will follow defined-contribution pension models, creating a supermarket stocked with a vastly enlarged menu of new, highly differentiated health insurance products and quality ratings to help employees choose wisely. They will also give their employees money to help buy insurance. The resulting competition will create the better, cheaper health care system we all want.

The transition will not be easy. Single-payer advocates and the insurance firms that fear competition will promulgate many scare stories to stop its dissemination. Providers will kick and scream about being evaluated.

But in the end, the American people will prevail, as they always have, and finally include health care in our hard-won consumer-driven society.

The Course of Leadership

In 2001, Aetna continued to make progress for its constituents with new and innovative consumer-oriented products and improved customer service, closer collaboration with physicians, and a renewed commitment to work with all who are interested in improving the health care system. All of us at the new Aetna will continue our efforts to improve the company and be a major advocate for health care innovation across America.

30 Selected Financial Data
31 Consolidated Statements of Income
32 Consolidated Balance Sheets
33 Board of Directors and Management
34 For More Information
35 Shareholder Information

SELECTED FINANCIAL DATA

	For the Years Ended December 31,				
(Millions, except per common share data)	2001	2000	1999	1998	1997
Total revenue	$25,190.8	$26,818.9	$22,109.7	$16,589.0	$14,674.4
Income (loss) from continuing operations	(291.0)	(127.4)	399.4	450.4	525.7
Net income (loss)	(279.6)	127.1	716.5	846.8	899.5
Net realized capital gains (losses), net of tax (included above)	73.6	(14.2)	21.4	189.0	160.5
Total assets	43,255.1	47,673.0	52,667.6	53,355.2	53,354.5
Total short-term debt	109.7	1,592.2	1,725.0	1,370.1	163.3
Total long-term debt	1,591.3	–	2,093.9	1,593.3	1,892.1
Aetna-obligated mandatorily redeemable preferred securities of subsidiary limited liability company holding primarily debentures guaranteed by former Aetna	–	–	–	275.0	275.0
Shareholders' equity	9,890.3	10,127.1	10,703.2	11,429.5	11,082.0
Per common share data: (1)					
Dividends declared (2)	$ .04	$ –	$ –	$ –	$ –
Earnings (loss) per common share: (3)					
Income (loss) from continuing operations:					
Basic	(2.03)	(.90)	2.56	2.74	3.15
Diluted (4)	–	–	2.54	2.72	3.12
Net income (loss):					
Basic	(1.95)	.90	4.76	5.49	5.66
Diluted (4)	–	–	4.72	5.40	5.59

(1) Per common share data is based on former Aetna common shares and share equivalents through December 13, 2000 and Aetna Inc. thereafter.

(2) Prior to December 13, 2000, dividends were declared and paid by former Aetna to its shareholders and therefore, such dividends are not included herein.

(3) For 1999 (through the redemption date of July 19, 1999), 1998 and 1997, preferred stock dividends of former Aetna are deducted from income from continuing operations and net income as the preferred stock issued by former Aetna was for the acquisition of U.S. Healthcare in 1996.

(4) Since the Company reported a loss from continuing operations in 2001 and 2000, the effect of dilutive securities has been excluded from earnings per common share computations for those years because including such securities would be anti-dilutive.

The foregoing financial information should be read in conjunction with the financial statements and related notes as presented in Aetna Inc.'s 2001 Annual Report on Form 10-K.

CONSOLIDATED STATEMENTS OF INCOME

	For the Years Ended December 31,		
(Millions, except per common share data)	2001	2000	1999
Revenue:			
Health care premiums	$19,940.4	$21,746.6	$17,145.7
Other premiums	1,831.6	1,468.3	1,495.8
Administrative services contract fees	1,835.2	1,925.9	1,674.5
Net investment income	1,411.6	1,631.6	1,601.8
Other income	75.9	86.6	129.4
Net realized capital gains (losses)	96.1	(40.1)	62.5
Total revenue	25,190.8	26,818.9	22,109.7
Benefits and expenses:			
Health care costs	17,938.8	18,884.1	14,641.0
Current and future benefits	2,458.3	2,153.5	2,231.0
Operating expenses:			
Salaries and related benefits	2,290.4	2,328.7	1,866.2
Other	2,224.6	2,501.1	2,050.8
Interest expense	142.8	248.2	232.7
Amortization of goodwill	198.1	204.9	206.0
Amortization of other acquired intangible assets	218.5	230.7	214.4
Goodwill write-off	–	310.2	–
Severance and facilities charges	192.5	142.5	–
Reductions of reserve for anticipated future losses on discontinued products	(94.5)	(146.0)	(77.2)
Total benefits and expenses	25,569.5	26,857.9	21,364.9
Income (loss) from continuing operations before income taxes (benefits) and cumulative effect adjustment	(378.7)	(39.0)	744.8
Income taxes (benefits):			
Current	(13.6)	242.1	268.5
Deferred	(73.6)	(153.7)	76.9
Total income taxes (benefits)	(87.2)	88.4	345.4
Income (loss) from continuing operations before cumulative effect adjustment	(291.5)	(127.4)	399.4
Cumulative effect adjustment, net of tax	.5	–	–
Income (loss) from continuing operations	(291.0)	(127.4)	399.4
Discontinued operations, net of tax:			
Income from operations	–	428.5	317.1
Sale and spin-off related costs	11.4	(174.0)	–
Net Income (loss)	$ (279.6)	$ 127.1	$ 716.5
Results per common share:			
Income (loss) from continuing operations:			
Basic	$ (2.03)	$ (.90)	$ 2.56
Diluted [(1)]	–	–	2.54
Income from discontinued operations:			
Basic	.08	1.80	2.20
Diluted [(1)]	–	–	2.18
Net income (loss):			
Basic	(1.95)	.90	4.76
Diluted [(1)]	–	–	4.72

(1) Since the Company reported a loss from continuing operations in 2001 and 2000, the effect of dilutive securities has been excluded from earnings per common share computations for those years because including such securities would be anti-dilutive.

The foregoing financial information should be read in conjunction with the financial statements and related notes as presented in Aetna Inc.'s 2001 Annual Report on Form 10-K.

CONSOLIDATED BALANCE SHEETS

(Millions, except share data)	As of December 31, 2001	2000
Assets		
Current assets:		
Cash and cash equivalents	$ 1,398.2	$ 1,652.5
Investment securities	14,260.1	14,308.8
Other investments	167.7	374.6
Premiums receivable, net	604.9	838.6
Other receivables, net	528.0	735.8
Accrued investment income	232.3	260.3
Collateral received under securities loan agreements	621.7	596.8
Loaned securities	608.1	584.1
Deferred income taxes	114.1	112.3
Other current assets	216.1	303.7
Total current assets	18,751.2	19,767.5
Long-term investments	1,575.6	1,571.6
Mortgage loans	1,887.8	1,826.6
Investment real estate	359.7	319.2
Reinsurance recoverables	1,269.7	1,318.5
Goodwill, net	6,583.8	6,781.9
Other acquired intangible assets, net	703.0	921.5
Property and equipment, net	327.0	390.0
Deferred income taxes	360.5	295.0
Other long-term assets	146.8	128.7
Separate Accounts assets	11,290.0	14,352.5
Total assets	$43,255.1	$47,673.0
Liabilities and shareholders' equity		
Current liabilities:		
Health care costs payable	$ 2,986.7	$ 3,171.1
Future policy benefits	800.5	832.0
Unpaid claims	574.6	528.2
Unearned premiums	208.0	274.7
Policyholders' funds	1,052.8	1,089.0
Collateral payable under securities loan agreements	621.7	596.8
Short-term debt	109.7	1,592.2
Income taxes payable	147.4	297.8
Accrued expenses and other current liabilities	1,637.2	1,621.6
Total current liabilities	8,138.6	10,003.4
Future policy benefits	8,621.5	8,912.1
Unpaid claims	1,203.6	1,211.6
Policyholders' funds	2,245.1	2,649.6
Long-term debt	1,591.3	–
Other long-term liabilities	274.7	416.7
Separate Accounts liabilities	11,290.0	14,352.5
Total liabilities	33,364.8	37,545.9
Commitments and contingent liabilities		
Shareholders' equity:		
Common stock and additional paid-in capital ($.01 par value, 759,900,000 shares authorized, 144,265,912 issued and outstanding in 2001 and $.01 par value, 762,500,000 shares authorized, 142,618,551 issued and outstanding in 2000)	3,913.8	3,898.7
Accumulated other comprehensive income	68.5	35.1
Retained earnings	5,908.0	6,193.3
Total shareholders' equity	9,890.3	10,127.1
Total liabilities and shareholders' equity	$43,255.1	$47,673.0

The foregoing financial information should be read in conjunction with the financial statements and related notes as presented in Aetna Inc.'s 2001 Annual Report on Form 10-K.

BOARD OF DIRECTORS

Betsy Z. Cohen
Chairman and Chief Executive Officer
Resource Asset Investment Trust

William H. Donaldson
Retired Chairman, President and
Chief Executive Officer
Aetna Inc.
Co-founder
Donaldson, Lufkin & Jenrette, Inc.

Barbara Hackman Franklin
President and Chief Executive Officer
Barbara Franklin Enterprises
Former U.S. Secretary of Commerce

Jeffrey E. Garten
Dean
Yale School of Management

Earl G. Graves
Chairman and Chief Executive Officer
Earl G. Graves, Ltd.
Publisher, Black Enterprise magazine

Gerald Greenwald
Retired Chairman and
Chief Executive Officer
UAL Corporation

Ellen M. Hancock
Former Chairman and
Chief Executive Officer
Exodus Communications, Inc.

Michael H. Jordan
Retired Chairman and
Chief Executive Officer
CBS Corporation

Jack D. Kuehler
Retired Vice Chairman
International Business Machines Corporation

Joseph P. Newhouse
John D. MacArthur Professor of
Health Policy and Management
Harvard University

Judith Rodin
President
University of Pennsylvania

John W. Rowe, M.D.
Chairman, President and
Chief Executive Officer
Aetna Inc.

COMMITTEES OF THE BOARD

Audit
Barbara Hackman Franklin*
Jeffrey E. Garten
Earl G. Graves
Ellen M. Hancock

Compensation and Organization
Betsy Z. Cohen
Gerald Greenwald
Michael H. Jordan*
Jack D. Kuehler

Executive
Earl G. Graves
Judith Rodin
John W. Rowe, M.D.*

Investment
Betsy Z. Cohen
William H. Donaldson
Jack D. Kuehler*
Joseph P. Newhouse
Judith Rodin

Nominating and Corporate Governance
William H. Donaldson
Barbara Hackman Franklin
Earl G. Graves
Gerald Greenwald*
Ellen M. Hancock
Michael H. Jordan

* *Committee Chairman*

MANAGEMENT

Office of the Chairman

John W. Rowe, M.D.
Chairman, President and
Chief Executive Officer

David B. Kelso
Executive Vice President
Strategy & Finance

L. Edward Shaw, Jr.
Executive Vice President and
General Counsel

Ronald A. Williams
Executive Vice President and
Chief of Health Operations

Alan M. Bennett
Senior Vice President and
Chief Financial Officer

Roger Bolton
Senior Vice President
Communications

Frolly M. Boyd
Senior Vice President
Group Insurance and Large Case Pensions

William J. Casazza
Vice President and Corporate Secretary

Wei-Tih Cheng
Senior Vice President and
Chief Information Officer

Patricia Hassett
Chief of Staff
Office of the Chairman

Timothy A. Holt
Senior Vice President
Investment Management Group

Vanda B. McMurtry
Senior Vice President
Federal Government Relations

Dennis Oakes
Vice President
Investor Relations

William C. Popik, M.D.
Senior Vice President and
Chief Medical Officer

Elease E. Wright
Senior Vice President
Human Resources

FOR MORE INFORMATION

Robert S. Galvin, M.D., contributor of the essay *The State of Quality, 2002,* is Director of Global Health Care at General Electric Company, Fairfield, Conn. For more information about General Electric, consult its Web site at http://www.ge.com.

Margaret A. Hamburg, M.D., contributor of the essay *Bioterrorism: A Challenge to Health and Security,* is Vice President for Biological Programs, NTI, Washington, D.C. NTI is a charitable organization working to reduce the global threats from nuclear, biological and chemical weapons. For more information about NTI, consult its Web site at http://www.nti.org.

David Mechanic, Ph.D., contributor of the essay *Mental Health Parity,* is the René Dubos University Professor of Behavioral Sciences, and Director, Institute for Health, Health Care Policy, and Aging Research at Rutgers University, New Brunswick, N.J. For more information about the Institute for Health, consult its Web site at http://www.ihhcpar.rutgers.edu.

Congresswoman Nancy L. Johnson (R-Conn.), contributor of the essay *Long-Term Care Financing — An Urgent National Priority,* represents Connecticut's sixth Congressional District, and is Chairman of the Ways and Means Health Subcommittee.

J.D. Kleinke, contributor of the essay *Medicine's Industrial Revolution,* is Chairman of Health Strategies Network, Inc., a health information technology development company headquartered in Denver, Colo. His most recent book is *Oxymorons: The Myth of a U.S. Health Care System.* For more information about Health Strategies Network, consult its Web site at http://www.hs-net.com.

David E. Bernstein, contributor of the essay *Tort Reform Lessons,* is an Associate Professor at George Mason University School of Law in Arlington, Va.

Regina E. Herzlinger, D.B.A., contributor of the essay *Consumer-Driven Health Care,* is the Nancy R. McPherson Professor of Business Administration Chair at Harvard Business School, Boston, Mass. Prof. Herzlinger is author of *Market-Driven Health Care* (Paperback: Perseus, 2000) and *Consumer-Driven Health Care* (Jossey-Bass, 2002).

Design: VSA Partners, Inc.; Portrait photography: Michael O'Brien; "World Trade Center at Night": Bruce Davidson; Printing: Litho Inc.

SHAREHOLDER INFORMATION

CORPORATE HEADQUARTERS

151 Farmington Avenue
Hartford, Connecticut 06156
860-273-0123

ANNUAL MEETING

The annual meeting of shareholders of Aetna Inc. will be held on Friday, April 26, 2002, at 9:30 a.m. at the company's headquarters in Hartford, Conn.

STOCK EXCHANGE LISTING

Aetna's common stock is listed on the New York Stock Exchange. The NYSE symbol for the common stock is AET. As of January 31, 2002, there were 14,698 record holders of Aetna's common stock.

FINANCIAL INFORMATION

Aetna's report to the Securities and Exchange Commission on Form 10-K provides additional details about the company's business, as well as other financial information not included in this Annual Report. To receive a copy of the Annual Report on Form 10-K, please call 1-800-237-4273, or visit Aetna's Web site at http://www.aetna.com.

Other Aetna reports also are available by calling the above telephone number or by visiting Aetna's Web site at http://www.aetna.com.

Aetna mails quarterly financial results only to those shareholders who request copies. Shareholders may call 1-800-237-4273 to listen to the company's quarterly earnings release and dividend information, and to request faxed or mailed copies of the quarterly results.

INVESTOR RELATIONS

Securities analysts and institutional investors should contact:

Dennis Oakes, Vice President
860-273-6184
Fax: 860-273-3971
Internet mail: oakesd@aetna.com

SHAREHOLDER SERVICES

EquiServe Trust Company, N.A. maintains a telephone response center to service registered shareholder accounts. Registered owners may contact the center to inquire about replacement dividend checks, address changes, stock transfers and other account matters.

EquiServe Trust Company, N.A.
P.O. Box 2500
Jersey City, New Jersey 07303-2500
1-800-446-2617

For direct deposit of dividends, registered shareholders may call EquiServe at 1-800-870-2340.

Registered shareholders with e-mail addresses can send account inquiries electronically to EquiServe at http://www.equiserve.com.

Additionally, registered shareholders now have available online access to their accounts through the Internet at EquiServe's Web site at http://www.equiserve.com.

DirectSERVICE Investment Program
Current shareholders and new investors can purchase shares of Aetna's common stock and reinvest cash dividends through EquiServe Trust Company, N.A. All inquiries for materials or information about this program should be directed to EquiServe at 1-800-446-2617.

Other Shareholder Inquiries
Office of the Corporate Secretary
Aetna Inc.
151 Farmington Avenue, RC4A
Hartford, Connecticut 06156-3215
860-273-3945

AETNA STOCK OPTION PARTICIPANTS

Employees with outstanding stock options should address all questions regarding their accounts, outstanding options or shares received through option exercises to:

UBS PaineWebber Inc.
Corporate Employee Financial Services
300 Lighting Way, 6th Floor
Secaucus, New Jersey 07094-3672
1-888-793-7631, *or* 1-800-238-6247
and follow the stock option prompt

Online access
http://www.cefs.ubspainewebber.com/aet

Remember

It is appropriate to set aside space in this report to honor and commemorate those affected by the attacks of September 11, 2001. It is a day America and the world will look back on with horror and deep sorrow.

To the victims, their families and their loved ones who have experienced devastating losses as a result of this tragedy, the thoughts and prayers of the entire Aetna family remain with you. To our fellow citizens, Aetna's long-standing "Culture of Caring" for its communities endures, thanks to thousands of dedicated Aetna employees who have stepped forward with donations of money, time and other assistance, just as they always have in times of need.

Since its founding in 1853, Aetna has been in the business of helping individuals and families protect against life's many risks and uncertainties. In all that time — through years of war, days of natural disaster and moments of private and personal tragedy — Aetna has never lost sight of the role it plays in the lives of those we serve.

151 Farmington Avenue, Hartford, CT 06156
1-800-US-AETNA
http://www.aetna.com

GR-57955