HUMANA INC
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The following communication was distributed on Aetna's external website:

September 24, 2015

Patients win as larger insurers seek to cut costs with better service

On September 24, 2015, the Tribune News Service ran an article that says industry consolidations will lead to better medical care at lower costs. Author Jon Kaplan, senior partner at the Boston Consulting Group, pointed to improved care for seniors in the private Medicare Advantage program as particularly telling. "In recent years the large health insurers have learned a lot about patient health, managing care and the role incentives play. The mergers should enhance their capabilities, leading to additional reforms and better health care for all of us."

[Link to: http://www.sanluisobispo.com/2015/09/24/3822951_patients-win-as-larger-insurers.html?rh=1]

The following article written by a third party was made available via link provided in the above communication:

Patients win as larger insurers seek to cut costs with better service

BY JON KAPLAN

Tribune News Service September 24, 2015

The planned mergers of several of America's largest health insurers - Aetna combining with Humana, and Anthem with Cigna - is almost certain to be good for the insurers, reducing overhead and improving their bargaining position as they attempt to negotiate better rates with providers.

But what's in it for you and me? The answer may surprise you: In all likelihood, the mergers will lead to better medical care at lower costs.

There is little doubt that consolidation will reduce the insurers' administrative overhead. Aetna estimates, for example, that its merger with Humana could produce approximately $1.25 billion in annual cost savings by 2018.

To reduce costs further, however, the insurers will have to look elsewhere. The best possible approach they could take is aiming to improve patient health. This has not always been the focus of health insurers, but it is likely to be the big story that comes out of consolidation.

Most Americans get medical care today from an often-disorganized assortment of primary care doctors, medical specialists, therapists, diagnostic facilities, hospitals, pharmacies and so on. Costs and outcomes vary widely among providers in the same general locality and are usually unknown until after the fact. The right hand often doesn't know what the left hand is doing, and incentives - payments to providers based on quantity rather than quality, for example - are out of whack. The system is less than ideal.

Insurers - since they are the primary bill payers, along with government - have been looking for a better way. The model that's emerging as the most effective mirrors the Medicare Advantage program, which is an alternative to traditional Medicare sponsored by the U.S. government. It is offered by private insurers and accountable care organizations, or ACOs, and is chosen completely and independently by the senior citizen.

Currently, some 16.8 million Americans are enrolled in Medicare Advantage plans, mostly (about 64 percent) in health maintenance organizations, or HMOs, according to the Henry J. Kaiser Family Foundation, a nonprofit that focuses on health care issues.

What makes these plans different and effective is their organization and focus: networks of “preferred providers” with a strong emphasis on primary care, financial incentives aligned with clinical best practices, and active “care management” programs focused on keeping patients healthy, which reduces the need for hospital admissions.

Research shows that this type of active care management is not only less costly than traditional fee-for-service medicine, but it also improves patient health.

The Boston Consulting Group confirmed this in 2013 when my colleague Daniel Gorlin and I did a detailed comparison of claims data for some 3 million Medicare patients.

What we found was that patients in the more managed programs, such as Medicare Advantage HMOs, had lower mortality rates and enjoyed better health and fewer complications than traditional fee-for-service patients.

Single-year mortality rates, for example, fell from 6.8 percent in the fee-for-service sample to 1.8 percent in the managed care models. These death rates declined quickly, within the first year of enrollment.

The lowest mortality rates and the best performance overall were seen in “capitated” HMO plans, where the HMO receives a flat fee for each patient and is then responsible for all of the patient's medical needs.

Our research also showed that the Medicare Advantage patients averaged shorter hospital stays and fewer readmissions. Compared to the fee-for-service sample, the capitated HMO sample had hospital stays that were on average 19 percent shorter.

The big insurers have continued to learn from their experience with Medicare Advantage.

One company's chronic care program, for example, developed in 2012, reduced hospital admissions among the 235,000 participants by some 45 percent.

The big merger story isn't so much about who buys whom. It's what the newly consolidated companies do with their newfound scale, market position and, above all, expertise.

In recent years the large health insurers have learned a lot about patient health, managing care and the role incentives play. The mergers should enhance their capabilities, leading to additional reforms and better health care for all of us.

Important Information For Investors And Stockholders

This website does not constitute an offer to sell or the solicitation of an offer to buy any securities or a solicitation of any vote or approval. In connection with the proposed transaction between Aetna Inc. (“Aetna”) and Humana Inc. (“Humana”), Aetna has filed with the Securities and Exchange Commission (the “SEC”) a registration statement on Form S-4, including Amendment No. 1 thereto, containing a joint proxy statement of Aetna and Humana that also constitutes a prospectus of Aetna. The registration statement was declared effective by the SEC on August 28, 2015, and Aetna and Humana commenced mailing the definitive joint proxy statement/prospectus to shareholders of Aetna and stockholders of Humana on or about September 1, 2015. INVESTORS AND SECURITY HOLDERS OF AETNA AND HUMANA ARE URGED TO READ THE DEFINITIVE JOINT PROXY STATEMENT/PROSPECTUS AND OTHER DOCUMENTS FILED OR THAT WILL BE FILED WITH THE SEC CAREFULLY AND IN THEIR ENTIRETY BECAUSE THEY CONTAIN OR WILL CONTAIN IMPORTANT INFORMATION. Investors and security holders may obtain free copies of the registration statement and the definitive joint proxy statement/prospectus and other documents filed with the SEC by Aetna or Humana through the website maintained by the SEC at http://www.sec.gov. Copies of the documents filed with the SEC by Aetna are available free of charge on Aetna’s internet website at http://www.Aetna.com or by contacting Aetna’s Investor Relations Department

at 860-273-2402. Copies of the documents filed with the SEC by Humana are available free of charge on Humana's internet website at http://www.Humana.com or by contacting Humana's Investor Relations Department at 502-580-3622.

Aetna, Humana, their respective directors and certain of their respective executive officers may be considered participants in the solicitation of proxies in connection with the proposed transaction. Information about the directors and executive officers of Humana is set forth in its Annual Report on Form 10-K for the year ended December 31, 2014, which was filed with the SEC on February 18, 2015, its proxy statement for its 2015 annual meeting of stockholders, which was filed with the SEC on March 6, 2015, and its Current Report on Form 8-K, which was filed with the SEC on April 17, 2015. Information about the directors and executive officers of Aetna is set forth in its Annual Report on Form 10-K for the year ended December 31, 2014 ("Aetna's Annual Report"), which was filed with the SEC on February 27, 2015, its proxy statement for its 2015 annual meeting of shareholders, which was filed with the SEC on April 3, 2015 and its Current Reports on Form 8-K, which were filed with the SEC on May 19, 2015, May 26, 2015 and July 2, 2015. Other information regarding the participants in the proxy solicitations and a description of their direct and indirect interests, by security holdings or otherwise, are contained in the definitive joint proxy statement/prospectus of Aetna and Humana filed with the SEC and other relevant materials to be filed with the SEC when they become available. Except as specifically noted, information on, or accessible from, any website to which this website contains a hyperlink is not incorporated by reference into this website and does not constitute a part of this website.

Cautionary Statement Regarding Forward-Looking Statements

This website contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. You can generally identify forward-looking statements by the use of forward-looking terminology such as “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “explore,” “evaluate,” “intend,” “may,” “might,” “plan,” “potential,” “predict,” “project,” “seek,” “should negative thereof or other variations thereon or comparable terminology. These forward-looking statements are only predictions and involve known and unknown risks and uncertainties, many of which are beyond Aetna’s and Humana’s control.

Statements in this website regarding Aetna that are forward-looking, including Aetna’s projections as to the anticipated benefits of the pending transaction to Aetna, increased membership as a result of the pending transaction, the impact of the pending transaction on Aetna’s businesses and share of revenues from Government business, the methods Aetna will use to finance the cash portion of the transaction, the impact of the transaction on Aetna’s revenue and operating earnings per share, the synergies from the pending transaction, and the closing date for the pending transaction, are based on management’s estimates, assumptions and projections, and are subject to significant uncertainties and other factors, many of which are beyond Aetna’s control. In particular, projected financial information for the combined businesses of Aetna and Humana is based on management’s estimates, assumptions and projections and has not been prepared in conformance with the applicable accounting requirements of Regulation S-X relating to pro forma financial information, and the required pro forma adjustments have not been applied and are not reflected therein. None of this information should be considered in isolation from, or as a substitute for, the historical financial statements of Aetna or Humana. Important risk factors could cause actual future results and other future events to differ materially from those currently estimated by management, including, but not limited to: the timing to consummate the proposed acquisition; the risk that a condition to closing of the proposed acquisition may not be satisfied; the risk that a regulatory approval that may be required for the proposed acquisition is delayed, is not obtained or is obtained subject to conditions that are not anticipated; Aetna’s ability to achieve the synergies and value creation contemplated by the proposed acquisition; Aetna’s ability to promptly and effectively integrate Humana’s businesses; the diversion of management time on acquisition-related issues; unanticipated increases in medical costs (including increased intensity or medical utilization as a result of flu or otherwise; changes in membership mix to higher cost or lower-premium products or membership-adverse selection; medical cost increases resulting from unfavorable changes in contracting or re-contracting with providers (including as a result of provider consolidation and/or integration); and increased pharmacy costs (including in Aetna’s health insurance exchange products)); the profitability of Aetna’s public health insurance exchange products, where membership is higher than Aetna projected and may have more adverse health status and/or higher medical benefit utilization than Aetna projected; uncertainty related to Aetna’s accruals for health care reform’s reinsurance, risk adjustment and risk corridor programs (“3R’s”); the implementation of health care reform legislation, including collection of health care reform fees, assessments and taxes through increased premiums; adverse legislative, regulatory and/or judicial changes to or interpretations of existing health care reform legislation and/or regulations (including those relating to minimum MLR rebates); the implementation of health insurance exchanges; Aetna’s ability to offset Medicare Advantage and PDP rate pressures; and changes in Aetna’s future cash requirements, capital requirements, results of operations, financial condition and/or cash flows. Health care reform will continue to significantly impact Aetna’s business operations and financial results, including Aetna’s pricing and medical benefit ratios. Key components of the legislation will continue to be phased in through 2018, and Aetna will be required to dedicate material resources and incur material expenses during 2015 to implement health care reform. Certain significant parts of the legislation, including aspects of public health insurance

exchanges, Medicaid expansion, reinsurance, risk corridor and risk adjustment and the implementation of Medicare Advantage and Part D minimum medical loss ratios ("MLRs"), require further guidance and clarification at the federal level and/or in the form of regulations and actions by state legislatures to implement the law. In addition, pending efforts in the U.S. Congress to amend or restrict funding for various aspects of health care reform, and litigation challenging aspects of the law continue to create additional uncertainty about the ultimate impact of health care reform. As a result, many of the impacts of health care reform will not be known for the next several years. Other important risk factors include: adverse changes in health care reform and/or other federal or state government policies or regulations as a result of health care reform or otherwise (including legislative, judicial or regulatory measures that would affect Aetna's business model, restrict funding for or amend various aspects of health care reform, limit Aetna's ability to price for the risk it assumes and/or reflect reasonable costs or profits in its pricing, such as mandated minimum medical benefit ratios, or eliminate or reduce ERISA pre-emption of state laws (increasing Aetna's potential litigation exposure)); adverse and less predictable economic conditions in the U.S. and abroad (including unanticipated levels of, or increases in the rate of, unemployment); reputational or financial issues arising from Aetna's social media activities, data security breaches, other cybersecurity risks or other causes; Aetna's ability to diversify Aetna's sources of revenue and earnings (including by creating a consumer business and expanding Aetna's foreign operations), transform Aetna's business model, develop new products and optimize Aetna's business platforms; the success of Aetna's Healthagen® (including Accountable Care Solutions and health information technology) initiatives; adverse changes in size, product or geographic mix or medical cost experience of membership; managing executive succession and key talent retention, recruitment and development; failure to achieve and/or delays in achieving desired rate increases and/or profitable membership growth due to regulatory review or other regulatory restrictions, the difficult economy and/or significant competition, especially in key geographic areas where membership is concentrated, including successful protests of business awarded to Aetna; failure to adequately implement health care reform; the outcome of various litigation and regulatory matters, including audits, challenges to Aetna's minimum MLR rebate methodology and/or reports, guaranty fund assessments, intellectual property litigation and litigation concerning, and ongoing reviews by various regulatory authorities of, certain of Aetna's payment practices with respect to out-of-network providers and/or life insurance policies; Aetna's ability to integrate, simplify, and enhance Aetna's existing products, processes and information technology systems and platforms to keep pace with changing customer and regulatory needs; Aetna's ability to successfully integrate Aetna's businesses (including Humana, Coventry, bswift LLC and other businesses Aetna may acquire in the future) and implement multiple strategic and operational initiatives simultaneously; Aetna's ability to manage health care and other benefit costs; adverse program, pricing, funding or audit actions by federal or state government payors, including as a result of sequestration and/or curtailment or elimination of the Centers for Medicare & Medicaid Services' star rating bonus payments; Aetna's ability to reduce administrative expenses while maintaining targeted levels of service and operating performance; failure by a service provider to meet its obligations to us; Aetna's ability to develop and maintain relationships (including collaborative risk-sharing agreements) with providers while taking actions to reduce medical costs and/or expand the services Aetna offers; Aetna's ability to demonstrate that Aetna's products and processes lead to access to quality affordable care by Aetna's members; Aetna's ability to maintain Aetna's relationships with third-party brokers, consultants and agents who sell Aetna's products; increases in medical costs or Group Insurance claims resulting from any epidemics, acts of terrorism or other extreme events; changes in medical cost estimates due to the necessary extensive judgment that is used in the medical cost estimation process, the considerable variability inherent in such estimates, and the sensitivity of such estimates to changes in medical claims payment patterns and changes in medical cost trends; a downgrade in Aetna's financial ratings; and adverse impacts from any failure to raise the U.S. Federal government's debt ceiling or any sustained U.S. Federal government shut down. For more discussion of important risk factors that may materially affect Aetna, please see the risk factors contained in Aetna's 2014 Annual Report on Form 10-K ("Aetna's 2014 Annual Report") on file with the Securities and Exchange Commission ("SEC"). You should also read Aetna's 2014 Annual Report and Aetna's Quarterly Report on Form 10-Q for the quarter ended June 30, 2015, on file with the SEC, for a discussion of Aetna's historical results of operations and financial condition. Except as specifically noted, information on, or accessible from, any website to which this website contains a hyperlink is not incorporated by reference into this website and does not constitute a part of this website.

No assurances can be given that any of the events anticipated by the forward-looking statements will transpire or occur, or if any of them do occur, what impact they will have on the results of operations, financial condition or cash flows of Aetna or Humana. Neither Aetna nor Humana assumes any duty to update or revise forward-looking statements, whether as a result of new information, future events or otherwise, as of any future date.