June 1, 2026

2026 Annual Meeting FAQs

Note: Any financial information included in this document is based on data from the company's April 21, 2026, earnings release. This information is provided for reference only and should not be interpreted as a reaffirmation of prior guidance, outlook, or financial results.

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Executive Compensation

Compensation philosophy

- Our overall compensation philosophy is built on pay-for-performance, market competitiveness, and long-term alignment. Our independent compensation committee emphasizes long-term compensation delivered in stock and multi-year incentives, with a substantial portion of pay at risk and earned only through sustained company performance and shareholder value creation.
- Independent oversight and shareholder input matter. The compensation committee sets performance measures, exercises judgment on outcomes, and incorporates shareholder feedback through Say-on-Pay and engagement with shareholders to ensure compensation is competitive, disciplined, and aligned with performance results.

Stephen Hemsley's compensation

- Following the 2025 Say-on-Pay vote and direct engagement with shareholders, the compensation committee deliberately reshaped Mr. Hemsley's compensation to reflect what it heard: a clear expectation for restraint, accountability and strong alignment with long-term shareholder value.
- Guided by the compensation committee and independent directors, the compensation committee approved a structure that limits guaranteed pay and places most potential value at risk through cliff-vested stock options that only have value if the share price increases above the exercise price.
- Mr. Hemsley's annualized compensation is positioned competitively against peers (large, diversified U.S. companies) and includes no annual cash incentive and no additional stock grants for three years.
- The structure reinforces accountability and continuity, with stock options forfeited if he voluntarily leaves or is terminated for cause during the three-year period, reflecting the compensation committee's commitment to disciplined governance and pay-for-performance alignment.
- Following the 2025 Say-on-Pay vote and direct engagement with shareholders, in February 2026, Mr. Hemsley's stock option grant was amended to add a two-year holding requirement following completion of the three-year cliff vesting to reflect shareholder desire for stronger alignment with long-term performance.

Annual incentive payout for named executive officers below target

- For 2025, the compensation committee approved below-target payouts under the annual incentive plan, with outcomes ranging from 0% to 88% of target, reflecting the company's overall performance against pre-determined goals.
- The compensation committee evaluated financial performance, non-financial performance and broader business conditions, and determined that results did not warrant incentive payouts for executive officers at, or above target levels.
- This outcome reflects the company's continued application of disciplined pay-for-performance standards.

2023-2025 performance shares 0% payout

- For the 2023-2025 performance share cycle, threshold performance was not achieved and as a result, no performance shares were earned for this period – demonstrating accountability to shareholders for performance against plan as well as robust independent compensation committee oversight.
- UnitedHealth Group's executive compensation program is performance-based, with long-term incentive awards tied to multi-year performance goals, including cumulative adjusted EPS and average return on equity.

CEO pay ratio

- The CEO pay ratio this year is an anomaly — driven by a one-time event, which is outside of our regular pay structure.
- The CEO-to-median employee pay ratio for 2025 is 748:1, reflecting CEO compensation of $60,950,571 and median employee compensation of $81,474, calculated in accordance with SEC requirements.
- The ratio is elevated this year primarily due to a one-time stock option grant awarded at the time of Mr. Hemsley's appointment as CEO, and the company expects the ratio to decline significantly in future years as that one-time award is excluded from the calculation.
- If the ratio were calculated by annualizing the one-time grant over the three-year period, the ratio would be 257:1.

TSR in line with its peers

- UnitedHealth Group's cumulative total shareholder return has compared favorably with the S&P 500 Health Care Index over several measurement periods, though results have varied, including underperformance in the most recent year and over the five-year period ended Dec. 31, 2025.

Year-over-year changes in CAP

- A large portion of executive pay is tied to the stock and long-term performance, so the value rises or falls with our stock price.
- "Compensation Actually Paid" (CAP) is an SEC-defined measure and does not reflect actual pay earned in a given year; rather, it mainly captures changes in the value of stock awards that have not yet vested, including awards granted in prior years.

Board Chair/separation of CEO and Chair

- Mr. Hemsley has an excellent track record as both board chair and as CEO, so the board felt it was in the company's best interest at this unique moment to have him serve in both roles.
- It is not our intention to continue this practice indefinitely, but we believe having a chair who is embedded in company leadership is in the best interests of the company and its shareholders at this time.
- The board has undergone significant refreshment in recent years, adding new independent directors and reducing average tenure to bring fresh perspectives while maintaining continuity.
- Eight of the nine nominees are independent, meaning they do not work for the company and can provide objective oversight of management.

Andrew Witty's advisory role and 2025 compensation

- Andrew Witty led UnitedHealth Group with compassion and dignity during some of the most challenging times any company has ever faced.
- His salary was reduced after he stepped down in May. He did not receive an annual incentive payout – consistent with the company's below-target results — and his 2025-2027 performance share award granted in February 2025 was cancelled.
- The outstanding stock awards reflected in the proxy were granted as part of UHG's standard long-term incentive program prior to Andrew stepping down as CEO. Consistent with other NEOs, Andrew's 2023-2025 performance share award paid out at 0%, meaning no value was realized from that award.

CEO & Enterprise Leadership Succession Planning

- When Mr. Hemsley returned as CEO in May 2025, he agreed to stay in the role for at least three years.

- The governance committee reviews the CEO succession plan regularly. The plan has two components: an emergency succession plan and a long-term succession plan. The board regularly engages in executive talent and succession planning discussions. The company has a deep bench of leadership talent and is well-positioned for the future.
- The strength of this organization lies in its resilience, restlessness and the profound sense of compassion and accountability leaders feel to make healthcare work better for every person who needs it.
- The company will continue to focus on building its traditionally deep bench of leadership talent. It frequently transitions top talent from one set of challenges and experiences to the next to develop their business acumen and broaden their leadership exposure.
- Throughout the year, the board reviews and discusses succession plans for the company's senior leaders, with an emphasis on both long-term succession planning and contingency planning for unexpected events.

Financial Performance

Note: The following financial performance metrics are drawn from the company's first quarter earnings results that were released on April 21, 2026.

- In April, the company reported its first quarter results exceeded expectations across all segments, with $111.7B in revenue, $6.90 EPS and $7.23 adjusted EPS[1], reflecting improving fundamentals and disciplined execution.
- Medical care ratio (MCR) of 83.9% reflects pricing discipline, medical management and favorable prior period reserve development.
- Robust cash flow, stronger balance sheet: $8.9B in operating cash flow supported resuming share repurchase activity and deleveraging, with debt-to-capital improving toward a ~40% year-end target.
- Full-year adjusted EPS guidance increased to >$18.25 from >$17.75, balancing strong early performance while awaiting more robust claims and utilization experiences as the year progresses.

Medicare Advantage

- CMS's 2027 MA rate decision is a constructive step toward better aligning funding with elevated care utilization and cost trends and reflects the program's dynamics and importance.
- We continue to engage with CMS and support thoughtful program modernization, offering practical, data-driven solutions to improve stability, transparency, and long-term sustainability.
- Still, medical costs remain meaningfully above funding levels, reinforcing the need for continued pricing discipline and thoughtful benefit design to maintain program sustainability.
- Through the first quarter, care utilization and costs remain elevated, but progressing in line with our expectations. We are seeing early signs of better alignment between pricing and underlying cost dynamics.
- As we plan for 2027, the decisive actions we've taken to reposition the portfolio have set us on a stronger course than in years past and we are refining plan design, benefits and pricing to mitigate the gap between funding and elevated cost trends while maintaining durable offerings for members.

Addressing MCR

- Through the first quarter of 2026, MCR continues to reflect the elevated cost environment across all lines of business, as well as some impacts from a lighter flu season and favorable prior period

[1] Adjusted earnings per share is a non-GAAP financial measure. See page 20 for a reconciliation to GAAP measure.

medical development — some of which was directly driven by improved care coordination within Optum Health.
- We remain diligent around appropriate price setting, trend forecasts, and care coordination — using better data and acting earlier to address unusual cost spikes and improve consistency, while taking steps in more variable areas to deliver steadier, more predictable results over time.

Optum Health

- We continue to see progress across Optum Health, serving more than 20 million patients, including more than 4 million in fully accountable value-based care arrangements, reflecting sustained demand for integrated care.
- At the same time, prior performance has not met expectations, and we have been clear about improving through more disciplined execution, cost management and a sharper focus on fundamentals.
- We are seeing progress from actions taken over the past several quarters, including improving clinical management, better aligning contracts with appropriate risk, strengthening operational execution and re-aligning Optum Financial Services to Optum Insight.
- We are getting back to a disciplined, integrated value-based care model — using better data, clinical leadership and coordinated interventions to improve outcomes and drive more predictable performance.
- We are also strengthening core operations, including standardizing practices and improving productivity across markets.
- Leadership alignment remains central to this reset, with Optum Health CEO Krista Nelson along with a strengthened team focused on execution and long-term performance improvement.

Actions to Strengthen Performance, Transparency & Accountability

- During the last 12 months, we have taken meaningful steps to strengthen performance, transparency, and accountability — working to improve how we operate, make decisions and serve patients and care providers, while recognizing there is more to do.
- We are moving with greater urgency to simplify processes, address issues more directly and deliver more consistent, easier experiences over time.

Leadership, focus & prioritization

- Refocused the organization on U.S. healthcare, exiting non-U.S. businesses.
- Refreshed nearly half of our top 100 leadership roles as we continue to evolve our enterprise to better meet the responsibilities our mission imposes.
- Accelerated simplification and modernization, including substantial AI and cybersecurity investments:
    - April 2026 — Committed to ~$1.5B AI investment for 2026
    - March 2026 — Launched Avery AI assistant for member navigation
    - October 2025 — Introduced Optum Real real-time claims platform

Modernizing core business practices

- We have advanced a growing reform agenda across Optum and UnitedHealthcare in areas such as data and process interoperability, prior authorization, transparency, pharmacy practices and more, including:
    - Supporting providers through prior authorization reform (UHC)

        - By 2027, UHC committed to fully standardized electronic PA processes to accelerate approvals and reduce administrative burden — continuing to simplify the experience while preserving the clinical safeguards that protect patients
        - May 2026: UHC committed to eliminate nearly two-thirds of prior authorizations for pediatric care services by the end of 2026
        - May 2026: UHC introduced prior authorization waivers for certain procedures performed at leading comprehensive pediatric hospitals, reflecting these facilities' consistent use of well-established care practices
        - May 2026: UHC committed to eliminate 30% of total prior authorization volume (selected surgeries, diagnostics, outpatient therapies)
        - April 2026: UHC committed to electronic prior authorization submission standards covering >50% of volume → 70%+ by the end of 2026
        - March 2026: UHC published prior authorization metrics, launches transparency website
        - 2025: UHC removed prior authorization requirements for home health (~10% of volume)
        - 2025: UHC expanded Gold Card eligibility
        - 2025: UHG alignment with six AHIP industry commitments

    - Reforming drug pricing & pharmacy model (Optum Rx)
        - May 2026: Launched fully transparent, fee-based PBM model for all clients
        - January 2026: Reduced reauthorizations; 25%+ eliminated (≈10% of pharmacy PA) across 270 drugs
        - September 2025: Increased reimbursement minimums for ~2,300 independent pharmacies
        - January 2025: Committed to 100% rebate pass-through by 2028

    - Strengthening governance, oversight & transparency
        - Created a Public Responsibility Committee of the board
        - Naming of a new Lead Independent Director (Bill McNabb) and committee chairs
        - Adding a new independent director (Dr. Scott Gottlieb)

    - Strengthening rural care, social impact & affordability
        - April 2026: Expanded support to ~1,500 rural hospitals; accelerated payments ~50% (to ~2 weeks) and reduced prior authorization requirements
        - April 2026: Launched hub-and-spoke care partnerships with health systems
        - March 2026: Expanded doula coverage; 7M+ members eligible by 2027
        - January 2026: Committed to return 100% of ACA individual market profits

Business & Policy Themes

Access

Network access

- UnitedHealthcare maintains one of the largest provider networks in the country, with 1.7M+ physicians and health professionals and 7,000+ hospitals, ensuring broad access to care close to where people live.
- We are focused on making care easier to access and navigate — using tools like Smart Choice to help members find in-network providers (those who have agreed to negotiated, lower-cost rates) based on availability, location, quality and cost, so they can get faster access to high-quality, more affordable care.

Vaccine coverage

- We will continue to align with the ACIP-recommended vaccine schedule, covering vaccines at no cost in our standard commercial plans — including COVID-19, flu and routine childhood and adult vaccines.
- Coverage is also available for Medicare and Medicaid members based on CMS and state requirements, while consumers in self-insured plans should confirm their specific benefits.

Affordability

Premiums

- Higher medical costs and increased use of care are the primary drivers of insurance increases, particularly in areas like drugs, hospital care and specialty services.
- We work aggressively on behalf of our customers to manage those costs — negotiating with hospitals and physicians to ensure rates are fair and support continued access to care.
- Our focus is on balancing affordability and access — because higher provider costs ultimately flow through to premiums and out-of-pocket costs. We aim to secure sustainable rates that protect both members and the broader health system.

ACA premiums & rebates

- UnitedHealthcare serves more than 1 million of the ~24 million ACA exchange enrollees. Despite that scale, the ACA business has generated minimal profitability over time — including losses last year and an average annual profit of about $6 million during the past 12 years.
- To further support affordability, we announced in January 2026 that we are voluntarily eliminating and rebating any profits from our individual ACA plans this year.
- We intend to return any profit directly to policyholders, working closely with CMS to ensure that is administered appropriately, alongside transparent reporting such as annual Medical Loss Ratio disclosures.

Advancing value-based care

Transition to a value-based system

- The U.S. health system is largely built on fee-for-service models that put the burden of navigating care on patients, while incentivizing the volume of care activity instead of the quality of its outcomes.
- Value-based care is gaining traction as a more effective model for all participants — an integrated approach that connects services, aligns incentives and supports patients more holistically to improve outcomes and reduce costs.
- For many years, policymakers, clinicians and health system leaders have broadly aligned around value-based care as a more effective path to improving outcomes and managing costs.
- UnitedHealth Group continues to invest in this shift — aligning providers, data and care delivery models to expand access, improve affordability and drive more consistent, high-quality outcomes over time.

Value of preventive care & chronic disease management

- Shifting from a transactional, episodic model to whole-person, preventive care leads to better outcomes at lower cost.
- For patients, this means simpler, more coordinated care, while clinicians have more time to focus on patients, supported by better data and tools.
- Today, we support more than 4M people in value-based care models — including seniors, Medicaid and commercial members — many with complex or chronic needs.
- The results are clear: people in these models receive more preventive care, have fewer hospital stays, better chronic condition control, and — especially in Medicare Advantage — lower overall costs for both patients and taxpayers.

Clinical outcomes

- Multiple peer reviewed studies show value-based care delivers better patient health outcomes compared with traditional fee-for-service models, particularly in Medicare Advantage.
- Recent research shows patients in full-risk arrangements have 36%-43% fewer hospitalizations, 39% fewer readmissions, 19% fewer avoidable ER visits and 23% lower use of high-risk medications.
- These models are especially effective for patients with complex needs.
- By aligning incentives around outcomes instead of volume, value-based care helps improve quality while reducing unnecessary utilization and overall system costs.

Physician employment & contracting

- Optum's physician footprint remains limited and independent: Optum employs fewer than 10,000 physicians as of the fourth quarter of 2025. Optum employs less than 2% of physicians nationally. There are only three states where Optum's share of physicians exceeds 2%, and in no state does its share exceed 10%.
- Compensation and contracting are consistent with the broader market: Optum physicians are paid on terms comparable to non-Optum providers, and UnitedHealthcare negotiates market competitive rates across all providers to ensure fairness and affordability.
- Multi-payer, multi-provider model supports competition: UHC and Optum maintain thousands of contracts with non-Optum providers and hundreds of relationships with other payers, reinforcing a competitive, open network.
- Flexible payment models support care and choice: UnitedHealthcare uses a mix of fee-for-service and value-based arrangements across affiliated and non-affiliated providers, helping ensure access, competition and long-term sustainability.

Health benefits

Value of Medicare Advantage

- Medicare Advantage delivers real value for seniors: It provides more coordinated care, better health outcomes and lower out-of-pocket costs — especially for people with more complex health needs.
- The results are strong and consistent: MA beneficiaries report high satisfaction (95%) and save about 54% on medical expenses, while experiencing meaningfully better outcomes.
- Multiple peer reviewed studies show value-based care delivers better patient health outcomes compared with traditional fee-for-service models, particularly in Medicare Advantage.
- Recent research shows patients in full-risk arrangements have 36%-43% fewer hospitalizations, 39% fewer readmissions, 19% fewer avoidable ER visits and 23% lower use of high-risk medications.
- It delivers for both patients and taxpayers at scale: Today, MA serves more than 35 million Americans, generates approximately 9% savings for the federal government, and consistently performs better on quality, access and affordability measures than traditional Medicare.
- Recent policy and rate decisions reflect a growing recognition of the importance of MA and the need to modernize it thoughtfully — while reinforcing the importance of stability, adequate funding and careful implementation to avoid unintended impacts on seniors, particularly those with complex needs.
- We support thoughtful, data-driven improvements: Modernization should continue in a measured, transparent way — ensuring MA remains sustainable and continues to deliver high-quality, affordable, whole-person care for beneficiaries over the long term.

Value of HouseCalls

- Expands access to care for vulnerable seniors: HouseCalls brings in-home clinical visits to people who face barriers to traditional care — including those in rural and underserved communities —

with more than 575,000 visits in low-income areas and 539,000 visits across 1,635 rural counties in 2024.

- Drives follow-up care and better outcomes: The program helps connect patients to ongoing care — 75% of participants have a follow-up appointment within 90 days — with clinicians identifying 280,000+ urgent conditions in 2024 and helping patients access timely treatment.
- Strengthens coordination with local providers: HouseCalls is designed to complement — not replace — primary care, with active coordination before, during, and after visits, including real-time outreach, referrals, and detailed reporting to primary care providers.
- Reinforcing integrity and oversight of the program: We are strengthening governance and accountability through independent review, enhanced policies and clearer enterprise-wide standards to ensure consistent, accurate practices and maintain confidence in how the program operates.

Integrity of coding practices

- Strong controls and industry-leading accuracy: We have robust safeguards in place — including certified coding professionals, quality assurance reviews, provider training and third-party oversight — to ensure accurate coding, with CMS audits validating ~90% of conditions, outperforming industry benchmarks.
- Independent validation of our practices: In 2025, we engaged FTI Consulting to conduct a comprehensive, independent review of our Medicare Advantage risk assessment processes, which confirmed strong documentation, control structures, and routine oversight across our operations. Where reviewers found opportunities to further strengthen these practices, the company quickly implemented their recommendations.
- Ongoing enhancements to governance and transparency: We are strengthening enterprise-wide standards through clearer policies, annual reviews, centralized documentation and enhanced oversight — while formalizing coding governance with periodic audits, defined credential standards and a second-line compliance function.
- Chart reviews are distinct from HouseCalls — and serve a different purpose: HouseCalls are in-home clinical visits, while chart reviews are a standard administrative process that ensures medical records accurately reflect diagnoses already made by providers and submitted to CMS.
- Chart reviews are essential to accuracy, fairness, and care coordination: Chart reviews help close documentation gaps, support better care coordination and ensure appropriate payment for complex patients — without them, serious conditions could be underreported, leading to misaligned funding and potential harm to vulnerable seniors.

Claims

- Our approach is that clinical judgment is exercised by qualified medical professionals, not by AI or automated tools. When medical judgment is required, a qualified medical professional reviews the request; AI may help speed routine steps and may automatically approve some requests, but it is used to support — not replace — clinical judgment.
- While we are constantly evaluating how this rapidly evolving technology can be used to help keep healthcare accessible and affordable, our touchstone is that clinical decisions must be made by human beings.
- Strong safeguards: Prior authorization helps ensure care is safe and appropriate, yet 98% of claims require no prior approval, and less than 1% are denied for clinical reasons.
- We are fully committed to a modernization agenda to make healthcare easier to navigate for providers and patients, and in last year have made industry-leading commitments to standardize and eliminate prior authorization requirements and provide greater transparency in our practices, including:
    - By 2027, UHC committed to fully standardized electronic prior authorization processes to accelerate approvals and reduce administrative burden — continuing to simplify the experience while preserving the clinical safeguards that protect patients

    - May 2026: UHC introduced prior authorization waivers for certain procedures performed at leading comprehensive pediatric hospitals, reflecting these facilities' consistent use of well-established care practices
    - May 2026: UHC committed to removing nearly two-thirds of prior authorization requirements for pediatric care (including diagnostic services, routine surgical procedures, and care services in subspecialties such as cardiology, neurology, pulmonology and orthopedics) by the end of 2026
    - May 2026: UHC committed to eliminate 30% of total prior authorization volume (selected surgeries, diagnostics, outpatient therapies)
    - March 2026: UHC published prior authorization metrics, launches transparency website
    - 2025: UHC removed prior authorization requirements for home health services (~10% reduction) and select diagnostics (e.g., imaging and ultrasound)

Appeals

- High approval rates and fast processing: About 90% of claims are paid quickly, and after review, ~98% of eligible claims are approved when submitted correctly.
- Very few claims are denied for clinical reasons: Of the small share not approved, most are due to plan design (what's covered) with less than 1% denied based on medical necessity or patient safety.
- Appeals often resolve with more information: Many initial denials are reversed when additional clinical details are provided, reflecting incomplete submissions by healthcare providers rather than inappropriate care decisions.

Prior authorization | UnitedHealthcare

- Prior authorization plays an important role in patient safety and affordability. It helps make sure care is appropriate and evidence-based, supports better outcomes, protects patients from unnecessary or harmful services, and helps prevent fraud, waste and abuse.
- Today, 98% of claims do not require prior authorization, and for the small share that do, more than 90% are approved — often within 24 hours, with <1% denied for clinical reasons.
- We are fully committed to a modernization agenda to make healthcare easier to navigate for providers and patients, and in last year have made industry-leading commitments to standardize and eliminate prior authorization requirements and provide greater transparency in our practices, including:
    - By 2027, UHC committed to fully standardized electronic prior authorization processes to accelerate approvals and reduce administrative burden — continuing to simplify the experience while preserving the clinical safeguards that protect patients
    - May 2026: UHC introduced prior authorization waivers for certain procedures performed at leading comprehensive pediatric hospitals, reflecting these facilities' consistent use of well-established care practices
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Pharmacy care

Value of PBMs

- Our role is to improve access and affordability: Optum Rx helps ensure patients get the medications they need while managing costs for both clients and members in a system where drug manufacturers set and control prices.

- We act as a counterweight to rising drug prices: The average retail price of brand-named drugs has more than doubled since 2009 (inflation-adjusted) and specialty drugs have increased from ~$18,000 to more than $52,000 annually over the past decade — while manufacturers capture margins up to 10x higher than intermediaries.
- We use clinical expertise and proven tools to help lower costs: This includes using evidence to guide drug lists and care decisions, negotiating rebates, encouraging lower-cost alternatives within drug classes, and giving clients flexibility to choose what works best for their members — without making coverage decisions for them.
- We are increasing transparency and pass-through: Optum Rx has committed to pass through 100% of rebates to clients by 2028, ensuring savings benefit customers and members.
- In May we introduced a new transparent, fee-based pharmacy care model that simplifies pricing, aligns incentives with patients and plan sponsors, and makes medication costs easier to understand and manage.

PBM reimbursement rates

- Consistent, market-based reimbursement: Optum Rx reimburses pharmacies — both affiliated and independent — using contract-based terms, ensuring fair and consistent pricing across its network.
- Independent analysis shows lower overall markups: A 2025 study found reimbursement at PBM-affiliated pharmacies averaged 2.1% below NADAC, compared to 3.8% above NADAC at non-affiliated pharmacies — indicating lower costs for plans and consumers.

Prior authorization | Optum Rx

- Pharmacy prior authorization supports safe, effective and cost-conscious care: It ensures medications are clinically appropriate, evidence-based and aligned with plan coverage — reviewed by pharmacists and physicians to protect patients and promote the right therapy at the right time.
- We are streamlining decisions and improving speed: We use electronic submissions, provider data integration and clinical tools to fast-track approvals and reduce friction — while maintaining access to alternative, clinically appropriate medications when needed.
    - In 2025 Optum Rx eliminated 25% of reauthorizations — representing >10% of pharmacy prior authorization volume — across 180 chronic condition drugs and ended annual reauthorizations for 80+ commonly prescribed medications.
- Continuous review to reduce burden: We continue to evaluate drug management programs to identify opportunities to simplify processes, reduce unnecessary reviews and improve the experience for patients and providers.
- Commitment going forward: These efforts reflect a broader focus on using data, technology, and clinical rigor to make pharmacy prior authorization faster, more transparent and easier to navigate — while preserving the safeguards that protect patients and manage costs.

AI & intelligent technologies

- AI use is guided by strong governance and human oversight, focused on reducing complexity, supporting care teams and enabling more proactive care.
- Patients benefit from simpler access and clearer information, including smoother approvals and better visibility into coverage and costs.
- Clinicians and care teams use AI to work more efficiently and act earlier, spending more time with patients and less on administrative tasks.
- The company is scaling investment in AI (~$1.5B in 2025), with ongoing commitment to expand impact and improve the healthcare system over time.

AI tools making healthcare easier to find, navigate and get

- AI tools help patients navigate care more easily, including finding providers, coordinating treatment and predicting issues like missed prescriptions.
- In the UHC app, AI-powered tools improve provider search, personalization and cost transparency — helping consumers better understand out-of-pocket costs before care is delivered.
- The Claims Assistant tool simplifies out-of-network claims, reducing submission time from 12-15 minutes to ~3 minutes and nearly doubling completion rates.
- The Benefit Assist program proactively identifies supplemental payments — delivering ~4x more cash benefits than other plans, with 94% of payments automated in 2025.
- Optum's real-time claims platform (Optum Real) improves speed and accuracy, giving patients instant clarity on cost and coverage at the point of care.
- AI-driven payment integrity solutions and Optum Serve help detect fraud, waste and abuse earlier — recovering billions of dollars annually for federal programs over more than 20 years of partnership with CMS.

Responsible use and governance

- AI use is anchored in strong governance frameworks, human oversight, and clinical judgment, ensuring technology supports — rather than replaces — professional decision-making.
- The board provides formal oversight through multiple committees, including Audit and Finance and Health and Clinical Practice Policies.
- A structured governance model separates development (first line) from compliance and risk oversight (legal and compliance teams) to ensure accountability and independent review.
- The company maintains a Responsible AI program with inventory tracking, policies, and internal/external advisory input, reinforcing transparency, ethical use, and alignment with its mission.
- The company's Responsible AI program is also advised by internal and external bodies with multidisciplinary expertise:
    - The Responsible AI Program Office maintains our AI-solution inventory, ensures AI solutions are appropriately reviewed and maintains our responsible AI policies and various guidance materials on the responsible use and development of AI — a set of policies and documents supporting industry-leading standards of practice.
    - The Artificial Intelligence Review Board is an internal group comprised of technologists, clinicians, medical ethicists, data scientists, security experts, privacy and legal professionals and member advocates. It serves as a key control in our risk-based AI governance program.
    - The Artificial Intelligence Review Board has the authority to approve AI models or require that AI models be removed from production use.
- The Internal Executive Advisory Council and the External Executive Advisory Board support the overall alignment of our Responsible AI Program, policies and practices with our mission and industry standards, enable representation of cross-functional perspectives across the enterprise and contribute AI expertise and healthcare community perspectives.

Policy & regulatory issues

Forced pharmacy closures (Arkansas, Tennessee)

- Our priority is protecting access for vulnerable patients: These policies affect access to specialized pharmacy services for patients with complex conditions — many of whom rely on coordinated clinical support, including individuals with cancer, HIV and serious mental illness.
- Specialty, mail-order, and behavioral health pharmacies play a critical role in managing complex therapies and ensuring patients receive the right medications and support throughout treatment.
- We have been working with state leaders, providers, employers and community organizations to share data, highlight patient impact, and support thoughtful policy approaches.
- Employers, patient advocates, and community partners have raised concerns about potential disruptions — particularly for rural communities, seniors and individuals with complex care needs.

- While proposals are being considered in multiple states, many have been modified or not advanced, reflecting continued dialogue on how to strengthen affordability while protecting access.

Market competition

- UHG faces powerful incentives to keep prices low and offer health plan members and patients exceptional value.
- We are focused on advancing solutions to expand access to care, improve affordability, enhance care experiences, combat healthcare inequity and achieve better health outcomes. Physician-affiliated management service organizations have an integral role to play in furthering high-quality, cost-efficient, value-based care delivery.
- Commercial Insurance: We operate in highly competitive markets across all our services. In commercial insurance, our market share is typically in the teens — similar to our peers — and often less than half the share of Blue Cross Blue Shield-affiliated plans.
- Medicare Advantage: Our presence remains modest at scale — UnitedHealthcare serves less than 30% of Medicare Advantage enrollment nationally, and Optum employs less than 2% of physicians nationally, with only three states above 2% and none exceeding 10%.
- The approach to contracting at both UHC and Optum is “multi-payer, multi-provider” — UHC has thousands of contracts with non-Optum providers, and Optum has hundreds of contracts with non-UHC payers and other healthcare-related entities.
- This multi-payer, multi-provider approach is critical for both UHC and Optum to remain market competitive. As such, there is no indication that the value-based approach of UHG restricts choice or competition for patients.
- The company maintains robust and appropriate firewalls between its UnitedHealthcare and Optum businesses.

Vertical integration

- The $5 trillion U.S. health system is highly fragmented and largely driven by fee-for-service models, which put the burden of finding and coordinating care on patients and often leads to unnecessary cost, duplication and uneven outcomes. The cost of healthcare is largely driven by hospital and drug pricing.
- UnitedHealth Group’s capabilities are designed to help address this — connecting care, coverage, and services to support a more coordinated, proactive model that improves outcomes, lowers costs and better supports people over time.

Engagement with CMS

- We have always been an adaptable enterprise that collaborates with government officials and regulatory agencies.
- We continue to engage regularly with policymakers — bringing forward practical, data-driven ideas and solutions to help strengthen programs and ensure they work better for both the people who rely on them and the taxpayers who ultimately fund these services.

Political contributions

- We participate in the political process to inform healthcare policy decisions that affect our company and the people we are privileged to serve.
- Political contributions are just one part of our efforts to engage in the policy process.
- We make political contributions on a bipartisan basis. Contributions do not mean we agree with every official on every issue that may come before them.

Legal Topics

Insulin pricing

- Optum Rx has for many years successfully negotiated with drug manufacturers and taken additional actions to lower prescription insulin costs for its health plan customers and their members, who now pay on average $12 per month for insulin.

DOJ matters

- The company is complying with formal criminal and civil requests. The company has full confidence in its practices and is committed to working cooperatively with the department throughout this process.
- The company has a long record of responsible conduct and effective compliance. Independent CMS audits confirm that the company's practices are among the most accurate in the industry and, following a decade-long civil challenge by the department to aspects of our Medicare Advantage business, a court-appointed special master concluded there was no evidence to support claims of wrongdoing.
- To provide our stakeholders with transparency and confidence in the company's practices, the company, as previously announced, has proactively launched its own initiative to conduct third party reviews of policies, practices and associated processes and performance metrics for risk assessment coding, managed care practices and pharmacy services.
- The company is committed to maintaining the integrity of its business practices.

Mission Fund proposal and lawsuit

- In December 2025, a shareholder (Mission Fund) proposed requiring UHG to produce a report on the "healthcare consequences" of its acquisitions over the past decade.
- Mission Fund filed a lawsuit to force inclusion, but the court ruled the proposal was overly broad and did not address a significant policy issue beyond ordinary business, after which Mission Fund withdrew the lawsuit.

Cybersecurity

- UnitedHealth Group is committed to safeguarding its systems and continually working to strengthen its cyber defenses.
- The evolving cyberthreat landscape means that the need to improve security is never complete.
- Cyberattacks are increasing in frequency and sophistication, and even the most diligent companies, particularly in the healthcare sector, find themselves targets of attack.
- The company repels an attempted intrusion every 70 seconds — thwarting more than 450,000 intrusions per year. These criminals continue to adapt and develop more sophisticated and malicious methodologies, and they have increasingly targeted critical infrastructure, including schools and government agencies. While a daunting challenge, protecting the private information of the individuals we serve from these unlawful attacks is a top priority.

Board oversight of cybersecurity

- The audit and finance committee oversees cybersecurity strategy, risks and mitigation efforts, with regular updates from the enterprise information security team, including evolving threats like ransomware.
- Continuous strengthening of defenses: We are consistently enhancing our cybersecurity capabilities — modernizing infrastructure, improving detection and response and adapting to a rapidly evolving threat landscape.
- Embedded in business processes, including M&A: Cybersecurity is integrated into core operations, including a formal due diligence framework for acquisitions, to assess and manage risk before integration.
- Supported by experienced leadership and external expertise: The program is guided by a chief security officer and deputy CSO, with additional input from external cybersecurity advisors.

Status of TFAP loans

- The company extended more than $9 billion in temporary financial assistance to more than 10,000 provider tax ID numbers.
- To date, a significant majority of these funds have been repaid.
- In 2025, we undertook restructuring activities across the enterprise to position the company for 2026 and beyond. This included a true-up for cyberattack-related activities, including ~$800 million pretax (~$600 million post-tax) for net collection expectations associated with provider loans and other customer balances.

Workforce & Compensation Topics

Employee compensation

- Our approach emphasizes alignment with company performance and long-term value, supported by a high-performing, diverse workforce that helps advance our mission.
- Disciplined, market-aligned framework: Compensation decisions reflect a combination of skills, experience, individual and enterprise performance and competitive market benchmarks, ensuring a consistent and balanced approach across the organization.
- Commitment to pay equity and consistency: We are committed to fair and equitable pay practices and regularly assess compensation to help ensure consistency for employees performing similar work at similar levels across our workforce.

Addressing pressures in key areas such as labor, pay and inflation

- Ongoing, disciplined review of compensation: We regularly assess market conditions and business needs, considering factors such as performance, talent attraction and retention, employee feedback, and competitive market benchmarks across our workforce.
- Flexible and responsive approach: When appropriate, we make targeted adjustments outside the annual cycle — including compensation, equity and benefits — to remain competitive and support our workforce.
- Market-competitive Total Rewards strategy: Our Total Rewards programs are designed to attract and retain talent, with compensation positioned competitively in the U.S. and globally and aligned with our business priorities and performance.

Executive security

- We provide personal and home security services for our executive leaders. We believe that these security services are warranted given the risks associated with such positions at the company.
- We continue to partner with local law enforcement to ensure a safe work environment and reinforce security guidelines and building access policies.

Employee median salary

- The company's median employee compensation for 2025 was $81,474, calculated in accordance with SEC pay ratio requirements.
- The calculation reflects the annual compensation of UnitedHealth Group's global workforce, including full-time, part-time, temporary and seasonal employees, with limited exclusions permitted under SEC rules.

Fair and equitable compensation practices

- UnitedHealth Group is committed to and continues to prioritize fair and equitable compensation practices for all employees within a pay-for-performance framework.
- Compensation at UnitedHealth Group is based on required skills, experience, market rate for the position and employee performance.

Workforce planning

- We prioritize meeting the healthcare needs of our customers and members and providing exceptional service now and in the future. We regularly review our products, services and

workforce to ensure our team has the talents and skills to meet the changing needs of the people and customers we are honored to serve.

Trends in the labor market

- The labor market landscape continues to be balanced between employers and job seekers. Our ability to continue to attract talent to our brand remains strong, with most of our workforce being in talent groups critical to advancing our mission and strategic growth pillars.
- We're focused on providing opportunities for employees to grow and develop their careers, which has great retentive value. This includes equitable access to learning by giving all employees access to personalized learning; investing in building skills and capabilities, especially among clinical, technology, customer-facing, and ops-center talent; and building high-performing, future-ready leaders today.

Shareholder Topics

Say-on-Pay

- Following the 2025 shareholder meeting, we:
  - Reached out directly to 46 shareholders representing ~60% of shares
  - Engaged directly with 21 shareholders (~51% of shares), including 12 who voted against Say-on-Pay
  - Ensured an independent director participated in every discussion
- We were pleased to hear strong shareholder support for the overall design of our executive compensation program.
- Where shareholders indicated perspectives seeking to further strengthen key elements of the executive compensation program and its practices, we listened and made enhancements to address some of these concerns.
- Key enhancements include adopting a policy to not grant front-loaded awards in the future absent extraordinary circumstances, adding a two-year holding requirement to Mr. Hemsley's 2025 option award, increasing the CEO stock ownership requirement from eight times to ten times base salary, and providing additional clarity regarding long-term stock award performance criteria.
- We remain committed to engaging with shareholders, listening carefully to their perspectives, and continuing to refine our programs to strengthen pay-for-performance alignment and long-term value creation.

Election of Directors — Board recommends FOR

- Shareholders are voting to elect nine people to the company's board of directors: Charles Baker, Timothy Flynn, Paul Garcia, Kristen Gil, Scott Gottlieb, Stephen Hemsley, F. William McNabb III, Valerie Montgomery Rice and John Noseworthy. These individuals are responsible for overseeing the company's strategy, leadership and performance.
- The nominees bring a broad mix of experience, including healthcare, finance, government and technology — skills the company believes are essential for overseeing a large, complex organization.
- The board has undergone significant refreshment in recent years, adding new independent directors and reducing average tenure to bring fresh perspectives while maintaining continuity.
- Eight of the nine nominees are independent, meaning they do not work for the company and can provide objective oversight of management.

Auditor Ratification — Board recommends FOR

- Shareholders are voting to confirm Deloitte & Touche LLP as the company's independent auditor for 2026. The auditor reviews the company's financial statements to ensure they are accurate and compliant.

- The board's audit committee values Deloitte's deep knowledge of the company's operations and consistently delivers high-quality audit work.
- The firm is evaluated every year for independence, performance and cost, and the committee concluded it remains a strong fit.

Shareholder Proposal: Require an Independent Board Chair — Board recommends AGAINST

- A shareholder proposal was submitted requiring the company to separate the roles of CEO and board chair and ensure the chair is always an independent director.
- We agree that independence is important — but also believe a strict rule would be too rigid and would limit the board's ability to respond to unusual situations — and, as a result, would not serve in the best interests of shareholders.
- Right now, Mr. Hemsley also serves as chair, but we do not intend for the same individual to serve as both chair and CEO indefinitely. We note that the company had separate individuals serving in the CEO and chair roles for nearly 20 years prior to Mr. Hemsley's recent appointment. Existing safeguards, including a strong lead independent director and fully independent board committees, already provide meaningful oversight.
- We are not aware of any concrete proof, nor has the proponent offered any, that companies and shareholders universally benefit from requiring the chair to always be an independent director.

Board independence

- Our board of directors has adopted the company's Standards for Director Independence, which align with the independence requirements of the NYSE.
- The board has determined that director nominees Charles Baker, Timothy Flynn, Paul Garcia, Kristen Gil, F. William McNabb III, Valerie Montgomery Rice, M.D., John Noseworthy, M.D. and Scott Gottlieb, M.D. are independent under NYSE rules and the company's standards, with no material relationships that would impair their independence.

Tenure

- Consistent with many other large public companies, we do not have a formal director tenure policy. Our governance committee strives to maintain a balance of tenure on the board. Long-serving directors bring valuable experience with our company and familiarity with the successes and challenges the enterprise has faced over the years, while newer directors contribute fresh perspectives and ideas.
- The board continues to assess its composition to ensure that it has the right balance of skills and operating experience needed to oversee long-term strategy and provide effective oversight.
- Scott Gottlieb's appointment marks the fourth new independent director added to the board since 2021 and has resulted in an average independent director tenure of 5.6 years, a decline of 61% since 2021.

Dividend strategy

- The board of directors has historically reviewed the dividend, and approved any increases, at the board meeting coinciding with our annual meeting of shareholders.
- We consider many variables to determine our dividend strategy, including:
    - The expected long-term growth in earnings and cash flow
    - The outlook for our businesses and the industries in which we compete
    - Capital and liquidity requirements for our businesses
    - Economic and market conditions
    - Acquisition and organic investment prospects
    - The return of capital practices of our peer groups — such as the Fortune 50, S&P 500 and the healthcare industry, broadly defined
    - Other considerations that impact available capital, such as regulations and tax law

Company's debt ratio fluctuating from time to time

- The board of directors has oversight of and approves all material items impacting our leverage ratio, including bond issuances, M&A and share repurchase authorizations.

- We expect to have managed leverage in the 40% Debt-to-Total Capital area over the long run. There may be short-term increases in leverage for various purposes.
- We enjoy a long-track record of the strongest cash flow, credit metrics and credit ratings among our healthcare peer groups and are doing the hard work to rebuild that record.

Transactions with shareholders who hold 5% or more of the company

- Related-person transactions are prohibited unless approved by the governance committee of the board in accordance with our policy. Such transactions last year included:
    - BlackRock beneficially owned approximately 7.99% of our common stock as of April 2, 2026. The company paid BlackRock $7.8 million for investment management fees and $454,533 for medical/pharmacy rebates in 2025. BlackRock maintains a self-funded health insurance plan through the company and paid the company $3.1 million for administrative services, $216,453 in premium payments and $135,344 for the employee assistance program in 2025.
    - The Vanguard Group beneficially owned approximately 10.11% of our common stock as of April 2, 2026. The company and its employees paid Vanguard approximately $8.1 million for benefits program management fees in 2025.

Potential conflict of interest because a 5% shareholder manages retirement plan assets

- All service providers for our retirement plans are selected by plan fiduciaries acting in the interest of the plan participants. The service providers were selected through a competitive bidding process, without consideration of whether the service provider holds any UNH shares. Corporate management is not involved in the selection or monitoring of service providers to our retirement plans.

Rise of passive shareholders in general

- We value all of our shareholders. As in other industries, passive investing has been growing in healthcare, including passive ownership of UNH shares.

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Forward-Looking Statements

This document speaks only as of the date it is published. We do not undertake to update or revise any information included herein, including any forward-looking statements as described below, except as required by law.

The statements, estimates, projections, guidance or outlook contained in this document include "forward-looking" statements which are intended to take advantage of the "safe harbor" provisions of the federal securities laws. The words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" and similar expressions identify forward-looking statements. These statements may contain information about financial prospects, economic conditions and trends and involve risks and uncertainties. Actual results could differ materially from those that management expects, depending on the outcome of certain factors including: our ability to effectively estimate, price for and manage medical costs; new or changes in existing healthcare laws or regulations, or their enforcement or application; cyberattacks, other privacy/data security incidents, or our failure to comply with related regulations; reductions in revenue or delays to cash flows received under government programs; changes in Medicare, the CMS star ratings program or the application of risk adjustment data validation audits; the DOJ's legal actions concerning our participation in the Medicare program; our ability to maintain and achieve improvement in quality scores impacting revenue; failure to maintain effective and efficient information systems or if our technology products do not operate as intended; risks and uncertainties associated with our businesses providing pharmacy care services; competitive pressures, including our

ability to maintain or increase our market share; changes in or challenges to our public sector contract awards; failure to achieve targeted operating cost productivity improvements; failure to develop and maintain satisfactory relationships with healthcare payers, physicians, hospitals and other service providers; the impact of potential changes in tax laws and regulations; increases in costs and other liabilities associated with litigation, government investigations, audits or reviews; risks and uncertainties associated with our increasing use of artificial intelligence and other emerging technologies; failure to complete, manage or integrate strategic transactions; risks and uncertainties associated with the sale of our remaining operations in South America; risks associated with public health crises arising from large-scale medical emergencies, pandemics, natural disasters and other extreme events; failure to attract, develop, retain, and manage the succession of key employees and executives; our investment portfolio performance; impairment of our goodwill and intangible assets; failure to protect proprietary rights to our databases, software and related products; downgrades in our credit ratings; and our ability to obtain sufficient funds from our regulated subsidiaries or from external financings to fund our obligations, reinvest in our business, maintain our debt to total capital ratio at targeted levels, maintain our quarterly dividend payment cycle, or continue repurchasing shares of our common stock.

This above list is not exhaustive. We discuss these matters, and certain risks that may affect our business operations, financial condition and results of operations, more fully in our filings with the SEC, including our reports on Forms 10-K, 10-Q and 8-K. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual results may vary materially from expectations expressed or implied in this document or any of our prior communications. You should not place undue reliance on forward-looking statements.

UNITEDHEALTH GROUP
RECONCILIATION OF NON-GAAP FINANCIAL MEASURES
(in millions, except per share data; unaudited)

Adjusted Net Earnings Per Share[(a)]

	Three Months Ended March 31, 2026
Net earnings attributable to UnitedHealth Group common shareholders	$6,280
Intangible amortization	334
Net portfolio divestitures and South American impacts	(158)
Restructuring and other	204
Tax effect of adjustments	(82)
Adjusted net earnings attributable to UnitedHealth Group common shareholders	$6,578
Diluted earnings per share	$6.90
Intangible amortization per share	0.37
Net portfolio divestitures and South American impacts per share	(0.17)
Restructuring and other per share	0.22
Tax effect of adjustments per share	(0.09)
Adjusted diluted earnings per share	$7.23

(a) Adjusted net earnings per share is a non-GAAP financial measure. Non-GAAP financial measures should be considered in addition to, but not as a substitute for, or superior to, financial measures prepared in accordance with GAAP. Adjustments made to these measures are as follows:

Intangible Amortization: Adjusted net earnings per share excludes intangible amortization from the relevant GAAP measure. As amortization fluctuates based on the size and timing of the company's acquisition activity, management believes this exclusion provides a more useful comparison of the company's underlying business performance and trends from period to period. While intangible assets contribute to the Company's revenue generation, the intangible amortization is not directly related. Therefore, the related revenues are included in adjusted earnings per share.

Net Portfolio Divestitures and South American Impacts: Adjusted net earnings per share excludes net portfolio divestitures and South American impacts. Net portfolio divestitures and South American impacts relate to the actions taken by management in the fourth quarter of 2025 as a result of a strategic review of our assets and businesses aimed at advancing and scaling our operations, including our value-based care business at Optum Health. In the first quarter of 2026, these actions resulted in a net gain on the sales of businesses previously classified as held for sale as of December 31, 2025 and net incremental losses on other businesses held for sale, including our remaining South American operations. Portfolio divestitures are not representative of the Company's underlying business and management believes that the exclusion of these items presents a more useful comparison of the Company's underlying business performance and trends from period to period.

Restructuring and Other: Adjusted net earnings per share excludes restructuring and other items. In the first quarter of 2026, restructuring and other items included a contribution to the United Health Foundation ($400 million) funded by the cash gain on the disposition of an Optum Insight business. This was partially offset by the reduction of loss contract reserves established in the fourth quarter of 2025 ($137 million) and net valuation gains on equity securities ($59 million). These items are not representative of the Company's underlying business and management believes that the exclusion of these items presents a more useful comparison of the Company's underlying business performance and trends from period to period.