2025 Annual Meeting FAQs

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UHG CEO Transition

Steve's return as CEO

- Steve was CEO from 2006-2017 and has been chair of the Board of Directors since then. He knows the company well, and his combination of strategic vision and operational rigor and execution bias will help us return to performance delivery and value creation.
- We remain focused on doing the best we can for the people and customers we are privileged to serve.
- We have the right strategy and interconnected, patient-oriented businesses to generate sustainable value for our shareholders and other stakeholders, especially in the face of a health system that can be disconnected, inconsistent and inequitable.
- Our mission, our culture, our diverse business model, and our focus on societal return with our value-based care approaches have made meaningful progress to overcome these issues; our task now is to urgently execute more precisely along this path.
- We are also well along in critical efforts to drive innovation, breakthrough AI applications and distinctive consumer capabilities. These, and other modernization and simplification efforts, should play powerfully into our future.

Board Chair/separation of CEO and Chair

- Steve has an excellent track record as board chair and as CEO, so the board felt at this unique moment it was in the company's best interest to have him in both roles.
- Additionally, the Board includes eight highly qualified independent directors, including a strong Lead Independent Director, who execute rigorous oversight of the Company's strategy, leadership and performance.

Other candidates in addition to Steve

- Steve has an excellent track record as board chair and as CEO, so the board felt at this moment he was clearly and uniquely qualified to lead the company and deliver sustainable value creation for shareholders.

Andrew leaving as CEO

- Andrew led UnitedHealth Group with compassion and dignity during some of the most challenging times any company has ever faced, and he stepped down for personal reasons. We are grateful he will continue to help and advise Steve Hemsley.

Andrew's advisor role and exit package

- Andrew will serve as a senior adviser.
- His agreement with the company does not include special provisions triggered by his departure.

Andrew's board seat

On May 20, 2025, the board accepted Andrew's resignation as a director, effective immediately. Accordingly, Andrew will not stand for re-election as a director in connection with the company's 2025 annual shareholder meeting.

Executive Compensation

CEO compensation

- Compensation of all our executive officers is heavily weighted toward equity and long-term incentives, helping align the interests of our executive officers and our shareholders.

Hemsley compensation

- Steve Hemsley's total compensation is positioned at the median for CEOs of comparable companies and is substantially aligned with the interests of all company shareholders.

- The cliff vesting provision means the compensation package is overwhelmingly performance-based, and the value only materializes if the stock price increases, emphasizing the strong connection between executive compensation and shareholder value creation. The cliff-vesting feature of the option awarded also helps to ensure Mr. Hemsley is retained for a minimum of three years.
- Mr. Hemsley will receive no cash incentive compensation and no other equity compensation for the next three years. The only other compensation Mr. Hemsley will receive over the next three years is an annual base salary of $1 million, a cash compensation level well below peer compensation.
- During the first three years of employment, if Mr. Hemsley resigns or is terminated by UHG for cause, he will forfeit the options.

Determining compensation
Key message for both annual and long-term incentive payouts

- The Compensation Committee did not make any adjustments to the annual and long-term incentive plans that would have resulted in any benefit to management from the Change Healthcare cybersecurity incident or the $3.3 billion gain from portfolio refinement activities.

Annual incentive payout below target this year

- Our 2024 operating income and cash flow from operations performance were mixed, with the performance of both metrics calculated between threshold and target performance levels set by the board.
- Similar to 2023, we also did not fully achieve our nonfinancial goals, specifically our Net Promoter System Index and Employee Experience Index targets, which measure consumer satisfaction and employee engagement, respectively.
- The Compensation and Human Resources Committee considered the 2024 business results, economic and market conditions, and other performance considerations — including impact of the cyberattack — and reduced 2024 bonus payouts below target for our executive officers.

2022-2024 performance share payout below target this year

- UnitedHealth Group's compensation program is performance-based, with the board holding management to high performance standards, including setting rigorous cumulative AEPS and average ROE targets for UHG's performance share program.
- Our 2022-2024 cumulative adjusted earnings per share (AEPS) performance was calculated between threshold and target, then costs associated with the cyberattack were added back. This reduced adjusted EPS, resulting in a payout at 90% of target.

CEO pay ratio decrease in 2024 to 348:1 from 352:1 in 2023

- The decrease in the CEO pay ratio was driven by a 13% increase in the median employee pay (increased from $67,000 to $76,000). The change in median pay was largely due to the divestiture of UHC's Brazil business.

TSR in line with its peers

- We outperformed our peers in the S&P Health Care Index for each of the disclosed measurement periods. This result is reflected in our pay-versus-performance disclosure, our cumulative TSR performance for the year ended December 31, 2020, the two years ended December 31, 2021, the three years ended December 31, 2022, the four years ended December 31, 2023, and the five years ended December 31, 2024.

Year-over-year changes in CAP

- A significant amount of our executive officer's compensation is market-driven and stock-based long-term compensation that is earned over multiple years only if our company and stock perform for shareholders.

- The SEC's required calculation methodology for CAP does not reflect the total compensation actually earned during the period and reflects, among other things, increases and decreases in the fair value of unvested stock compensation awards granted in years prior to the disclosed year.

Other Leadership Changes

Potential for future changes

- The strength of this organization lies in our resilience, restlessness and the profound sense of compassion and accountability we feel to make health care work better for every person who needs it.
- We will continue to focus on building a deep bench of leadership talent. And we frequently transition top talent from one set of challenges and experiences to the next to develop their business acumen and broaden their leadership exposure.
- We will continue to remain focused on doing the best we can for the people and customers we are privileged to serve, and on executing on our mission so that we can return to growth in 2026.

Recent changes

- Earlier this year, Patrick Conway was announced as the Optum CEO, and in January, Tim Noel was named UHC CEO.
- In May, Optum announced several leadership changes that included Krista Nelson transitioning to Optum COO, Roger Connor transitioning to Optum CFO, Jon Mahrt becoming Optum Rx CEO, and Dhivya Suryadevara becoming CEO of Optum Insight and Optum Financial.
  We have also strengthened operational and clinical leadership at Optum Health.

Financial Performance

Updated guidance and outlook

- As you're aware, the company suspended its 2025 outlook on May 13, 2025.
- Right now, we are focused on improving our performance for the remainder of the year and into 2026. We expect to return to growth in 2026.
- We expect to share more information on our performance and outlook when we issue our second quarter results.

Moving forward

- We remain focused on doing the best we can for the people and customers we are privileged to serve and on executing on our mission so that we can return to growth in 2026.
- We must and will work to better anticipate and address the factors we outlined back in April. We believe they are highly addressable as we look ahead to 2026.
- With disciplined and urgent execution and attention to detail, we expect a return to growth in 2026.

Medicare Advantage

- The 2026 MA rate notice begins to reflect the rising use of care and the higher costs of care, which we've been seeing for some time. We believe this is a positive development that will ultimately bring some relief to seniors and indicates policymakers' understanding of the importance and the popularity of MA, which delivers higher quality care at lower cost.
- At the same time, it's important to remember that V28, IRA and changes to the Part D normalization methodology are, effectively, funding reductions for MA. We are still concerned about the potential for unintended consequences on seniors and the physicians who care for them — and especially for beneficiaries with chronic conditions and those dually eligible for Medicare and Medicaid.

- For UHC, our focus remains on a long-term, multiyear view grounded in a rational and metered response to the funding headwinds … and, consistent with our approach to date, we will continue to prioritize stability for beneficiaries as much as possible while also achieving margins within the historical range we've discussed.
- While we are experiencing more medical expenses than we predicted for 2025, the fundamentals of our business remain sound. Medicare Advantage is designed to give us an opportunity to learn and adjust each year. And that's exactly what we're doing.
- Teams across the company are already deep into 2026 product planning — building smart, strategic bids, refining our benefits, and locking in on the fundamentals that have made our Medicare products the best in the industry.

Addressing MCR

- We are proactively addressing the higher MCRs through a combination of advanced analytics, preventive care initiatives, strategic partnerships and innovative solutions. These efforts are aimed at ensuring sustainable operations while delivering high-quality care to our members.
- A major focus for improvement will be our risk assessment and pricing disciplines. We have gotten some things wrong that we never should have, so we will be forensically examining our approach and quickly making improvements, including, most notably, a significant re-tooling of our efforts to ensure more precise and more accurate forecasting of care activity.

Optum Health performance and growth

- We're proud seniors continue to choose Optum Health providers, care teams and clinics, with over 5 million fully accountable patients and a retention rate of over 90%.
- However, our performance clearly has been below expectations.
- We are taking actions proactively to identify and address the core issues. Collectively, we are confident these areas will contribute to stable performance over the balance of the year and, importantly, set us up for a much stronger 2026.
- In addition to the naming of Patrick Conway as the new CEO of Optum, we have made some additional appointments to strengthen our leadership bench:
    - Roger Connor has been appointed the chief financial officer role at Optum.
    - Krista Nelson, who was the COO of UHC and then ran our Community & State business, has transitioned to a new role as chief operating officer at Optum Health.

Size and Scale of UHG

"Vertical integration"

- UnitedHealth Group comprises a fraction of the deeply fragmented U.S. health system. It's essential that we have sufficient capabilities to move beyond the dominant fee-for-service and transaction-based health system to a model that is proactive, outcomes-driven and enables people to stay healthy over the course of a lifetime. Our diversified business enables us to do just that while also creating sustainable value for all shareholders.
- The $5 trillion U.S. health system remains deeply fragmented and rooted in costly and inefficient fee-for-service models that put the burden of finding and navigating care squarely on the shoulders of the people who need help the most. The resulting lack of coordination too often results in less-than-optimal patient outcomes, higher mortality rates, poor patient experience, redundant care and waste.
- We're helping to accelerate the transition of the U.S. health care system from volume to value; moving beyond a transaction-based health system to a model that is designed to be proactive to help keep people healthy over the course of their lifetimes; and incentivizing care delivery organizations the right way. We support a model that rewards high-quality care, delivers better health outcomes and drives lower costs.

Antitrust concerns

- We have always been an adaptable enterprise that is able to collaborate with government officials and regulatory agencies. Of course, we plan strategically for a range of possible scenarios, but we do not speculate on hypotheticals.
- We are focused on advancing solutions to expand access to care, improve affordability, enhance the care experience, combat health care 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.

Amedisys transaction

- We remain optimistic that we will complete our proposed merger with Amedisys.
- Amedisys' commitment to quality and care innovation within the home, and the patient-first culture of its people combined with Optum's deep value-based care expertise, can drive meaningful improvement in the health outcomes and experiences of more patients at lower costs, leading to continued growth for both organizations.

Potential investigations

- We don't comment or speculate on the DOJ's intentions.
- **Comment on May 14 WSJ story:**
    - We are not going to comment on allegations and speculation in the Wall Street Journal.
    - What we will say is we stand firmly behind the integrity of our MA program.
    - CMS audits health plans, with United consistently outperforming other major MA plans, demonstrating our commitment to thorough and responsible business practices.
    - We have also urged regulatory changes for CMS to conduct more frequent audits and to promote best practices in MA across the industry and are encouraged by recent steps by the Administration to do just that.

Business Model/Policy

Future of Medicare Advantage

- Today, more than 50% of Medicare beneficiaries are choosing Medicare Advantage because of the affordable, high-quality care the program offers. Compared to fee-for-service (FFS) Medicare, Medicare Advantage costs less; is more equitable; has better quality, access and outcomes with greater coverage and benefits; and has nearly 100% consumer satisfaction.
- Seniors in MA spend $2,400 less on out-of-pocket costs compared to FFS and experience a superior health care experience, with 33% fewer ER visits and 41% fewer avoidable acute hospitalizations than Medicare FFS beneficiaries.

Scrutiny of coding practices

- Coding and risk adjustment are critical to providing broad and equitable access and care for seniors. Risk adjustment revenues ensure that plans are properly reimbursed for the health care needs of the populations they serve. Through our MA and Duals plans, UHC serves a population with greater health care needs and more complex conditions than Original Medicare and all other MA private plans.
- Proactive and coordinated care models in MA identify, document and treat chronic conditions earlier than FFS Medicare. This makes a real difference in the health and well-being of seniors.
- We consistently follow CMS regulations and guidelines and perform at the top of the industry when it comes to the accuracy of our documented conditions as reflected in our RADV audit results.
- We adhere to the rules established by CMS, follow CMS and clinical guidelines, and regularly audit our programs to ensure the accuracy of our coding and diagnosis.
- **WSJ stories:** The Wall Street Journal used flawed analysis and inaccurate data to paint an incomplete picture of a program that provides better health outcomes and more affordable health care for millions of seniors. Compared to fee-for-service Medicare, Medicare Advantage costs

less and is more equitable, with broader coverage and benefits, as well as nearly 95% consumer satisfaction.

Claim denials

- The vast majority of Americans' experience is simple and straightforward.
- Most Americans never have a claim denied.
- UnitedHealthcare approves and pays 90% of claims shortly after they're submitted. The remaining 10% go through an additional review process.
- After this additional review process is completed, UnitedHealthcare's claims approval rate stands at 98% for claims for eligible members (when submitted in a timely manner with complete information, and after duplicate claims are removed).
- For the 2% of claims that are not approved, the majority are instances where the services did not meet the benefit criteria established by the plan sponsor, such as the employer, state or Centers for Medicare & Medicaid Services (CMS). Only 0.5% of claims are not approved based on clinical evidence and patient safety.
- We know and recognize this process can be frustrating for consumers and providers, which is why we are leading in technological investments to make this process simpler and easier to navigate.

Prior authorization

- When our members seek care, over 99% of the time there is no prior approval needed, or the approval is obtained quickly.
- Prior authorization serves as an important checkpoint to help ensure a service or prescription is a clinically appropriate option. And UnitedHealthcare is taking steps to modernize and streamline the process.
- One step of that journey occurred in 2023, when UnitedHealthcare eliminated nearly 20% of prior authorizations as part of a comprehensive effort to simplify the health care experience for consumers and providers. Another was Optum Rx, earlier this year, ending annual reauthorizations for over 80 commonly prescribed drugs.

Use of AI

- We use AI to cut through complexities and empower people with a smarter, more connected experience.
- We are making life easier for clinicians in two ways: Reducing administrative work, freeing up clinicians to apply their expertise with greater impact, and providing powerful insights to help clinicians better, more proactively manage their patients' health journeys.
- We are eliminating points of tension by delivering real-time information, closing the gap between when patients or providers need answers and when they receive them.
- AI is an assistant to, not a substitute for, human judgements about clinical decisions.

Employing doctor practices and future Optum Care acquisitions

- Optum Health is aligned with more than 135,000 physicians and APCs to deliver value-based care in a comprehensive, high-quality and patient-centered approach; Optum Health and Optum physician practices employ fewer than 10,000 physicians. This strategy supports the company's integrated health care model, fosters innovation and meets the growing demand for health care services, ensuring that patients receive the best possible care.
- Employed physicians work within a unified system of clinical best practices rooted in value-based care, with connections across care delivery, technology, pharmacy, benefits and financial services that are centered around the patient and provider.

CMS oversight of Medicare Advantage

- We are committed to working with the administration to support MA and the extraordinary value it represents both for individual seniors and taxpayers.

- We have always been an adaptable enterprise that is able to collaborate with government officials and regulatory agencies.
- We welcome CMS's recent announcement to audit every Medicare Advantage plan each year, a policy UnitedHealth Group has long publicly advocated for to strengthen program oversight.
- We look forward to working with CMS to develop an accurate methodology and appropriately use advanced technology to greatly enhance the auditing process.

Medicaid reform

- We won't speculate on any specifics, as the legislative process continues to play out. But regardless of any changes, our priority remains supporting the health of our members and ensuring that they have access to high-quality coverage.
- As it relates to our business, we serve people in 32 states. We have a variety of programs and products and decades of experience. So, we remain confident in the value that managed care can provide to our state partners and our ability to support our states as they navigate through any changes.

Impact of White House budget bill

- We won't speculate on any specifics, as the legislative process continues to play out.
- The challenges facing our health care system, including greater access, better quality, and affordability, are not new. We are committed to working with federal and state leaders to address these challenges.
- Health care is one of the most important and personal issues for people, and we're honored that so many have turned to UnitedHealthcare for their health care coverage. We are always eager to engage in discussions with policymakers at both the federal and state level about how we can work toward the goal of providing as many people as possible with quality, stable health care coverage.
- No matter how the health care system changes, we are committed to helping people live healthier lives and making the health system work better for everyone.
- We continue to introduce innovative approaches, products and services aimed at improving personal health and promoting healthier populations in local communities. Our unique capabilities in clinical care resources, information and technology enable us to meet the evolving needs of a changing health care environment.

Lawsuits

Shareholder lawsuits (CalPERS and recent NY filing)

- We deny the allegations of wrongdoing and will defend the matter vigorously. We will speak more directly to those allegations through our filings with the court.
- We believe in maintaining the highest ethical standards in our operations. We strive to ensure our actions are consistently aligned with regulatory requirements and to responsibly address concerns raised by our shareholders and stakeholders.
- **Comment on CalPERS:**
    - All Section 16 officers and directors must receive pre-clearance approval to trade shares. These directors and officers followed our protocols and received approval from the company.
    - Our protocols include restrictions and processes that ensure we are fully compliant with all SEC trading rules and regulations.

401K lawsuits

- Our 401(k) plan fiduciaries have always acted in accordance with ERISA and in the best interests of plan participants, and we strongly deny any allegations to the contrary.
- United will move to dismiss these cases at the earliest opportunity.

VBC

Providers embracing value-based care models

- Value-based care continues to gain traction across the health care system. This care delivery model pays physicians and hospitals based on health outcomes rather than on the number of services they provide, and its comparative benefits in outcomes and cost are supported by concrete evidence.
- Unlike fee-for-service, value-based care prioritizes the quality of care over the quantity of tests, services, medical appointments and procedures, and value-based care measures results in improved health outcomes.
- In value-based care models, physicians have more time with patients to identify potential illness and disease earlier. A team-based approach provides a more coordinated, holistic experience.
- Fundamentally, it is designed to improve the health of the patient while cutting down on the number of unnecessary treatments and the harms associated with them, lowering health care costs, and enhancing the patient's experience and wellness.
- Medicare Advantage plans are critical to the health system's shift to value-based care. These plans, offered by private insurers, cover all traditional Medicare benefits — plus additional benefits like dental coverage and gym memberships.

Is VBC working

- Multiple peer-reviewed studies published this year show value-based care leads to better outcomes for Medicare Advantage patients compared to traditional fee-for-service Medicare.
- The most recent study, published in the *American Journal of Managed Care,* shows MA patients cared for in full-risk arrangements have dramatically better outcomes than those in traditional Medicare:
    - 36%-43% percent less likely to be hospitalized for acute and chronic conditions;
    - 39% less likely to be readmitted to a hospital within 30 days of being discharged;
    - 19% less likely to undergo avoidable hospital emergency department care;
    - 23% less likely to use high-risk medications that can be harmful or fatal if used incorrectly
- The $5 trillion U.S. health system remains deeply fragmented and rooted in fee-for-service models that put the burden of finding and navigating care squarely on the shoulders of the people who need help the most.
- Value-based care is a better way. A way that enables doctors and nurses to genuinely care for their patients, saves taxpayers money, and currently provides better health outcomes for millions of Americans.
- UnitedHealth Group's value-based care model better supports people with complex care needs, many of whom come from diverse and disadvantaged backgrounds. Also, value-based care models allow doctors to spend as much time with a patient as they need — leading to lower levels of burnout and a better experience.
- Optum's history of aligning with and employing physician practices is focused on advancing solutions to expand access to care, improve affordability, enhance the care experience, combat health care inequity and achieve better health outcomes.
- Medicare Advantage patients served by the Optum fully accountable value-based care model have better outcomes than those in Medicare fee-for-service.

PBMs

Scrutiny of PBMs

- PBMs are the only participants in the drug supply chain focused on lowering the egregious prices of prescription drugs set by manufacturers. PBMs work every day to secure savings, enable better health outcomes, and support access to quality prescription drug coverage.
- Any examination of the prescription drug supply chain has to start with manufacturers — who set prices for their products. We welcome the opportunity to engage with policy makers on our role in holding down high drug prices for the customers and individual consumers we serve.
- Overall, we deliver on average $1,600 in annual drug savings per person to our customers.
- Ninety-eight percent (98%) of our negotiated discounts pass directly to our customers. They use these discounts to help reduce premiums, provide point-of-sale savings, and invest in health and wellness programs.
- Ninety-seven percent (97%) of employers that contract directly for pharmacy benefit services are satisfied with their PBM. OptumRx has offered $35 insulin since 2020 as part of its Critical Drug Affordability list, which today includes 290 brand and generic medicines with low or $0 cost sharing.

Reaction to Executive Order on PBMs

- We applaud the administration's acknowledgement of the root cause of high drug prices — pharma's egregious pricing practices.
- We have publicly called on pharma manufacturers to lower their list prices while taking industry-leading actions — including committing to 100% pass-through of rebates to clients and moving to cost-based reimbursement for pharmacies — to help lower drug costs and increase transparency for clients and consumers.
- In addition, we continue to aggressively negotiate directly with pharma manufacturers to get them to lower their prices.
- We will continue to work across the health care system to ensure Americans have access to affordable medications.
- We have always been an adaptable enterprise that is able to collaborate with all presidential administrations, government officials and regulatory agencies. We plan strategically for a range of possible scenarios.

Arkansas PBM bill

- Proposals requiring pharmacy and PBM separation will have significant, unintended negative consequences on patients with serious mental illness or complex and rare conditions.
- Patients, including those covered by Medicare and Medicaid, will lose access to the high-quality specialized care from the specially trained pharmacists who they rely on through Optum pharmacies.
- Our specially trained pharmacists and nurses care for patients struggling with cancer, HIV, Crohn's disease, bipolar disorder, hemophilia, and other conditions. Given the complexity of the medications and patient populations we serve, if governments force us to cease pharmacy operations, other entities — particularly private equity — will fill the void.

TFAP

Recoupment efforts

- The company extended more than $9 billion in temporary financial assistance to more than 10,000 provider Tax ID numbers.
- We were pleased to be able to provide support to providers after an incident that took place over a year ago.
- Optum has and will continue to actively work with providers to develop flexible repayment plans based on the individual circumstances of providers and their practices.

- We have also worked with UnitedHealthcare to ensure the claims it receives are reviewed in light of the challenges providers experienced, including waiving timely filing requirements for the plans under its control.
- We have begun the process of recouping the interest-free funding we provided to providers — as HHS itself did when it began recouping payments it provided under its own cyberattack lending program in July 2024.
- We continue to work with providers on repayment and continue to reach out to those providers that have not responded to previous calls or email requests for more information. We have asked the AMA to join us in encouraging flexibility from all payers and plan sponsors.

General Compensation

Employee compensation

- Fair and equitable compensation practices within a pay-for-performance framework are core to our culture and key to achieving our mission. Skilled and diverse teams generate new ideas, produce better solutions and help us to better serve our diverse customer base across the health care community.
- We are committed to pay equity at all levels of our organization. Compensation at UnitedHealth Group is based on required skills, experience, market rate for the position, and employee performance. It also considers the performance of the team and the company overall. For both executives and employees, we also look at what the market pays for similar jobs at similar companies.
- Pay is the same between females and males performing similar work at similar levels for our global integrated workforce. In addition, pay is the same between people of color and white employees in the U.S. performing similar work at similar levels.

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

- We review and monitor market conditions throughout the year. Key variables we consider when making additional allocation decisions are business goals, employee feedback, talent attraction and retention strategies, macroeconomic trends, and market benchmarking across our diverse portfolio of businesses and employee populations.
- For example, in 2024 we made contributions outside of our normal annual review cycle, including salary adjustments, stock awards and benefits enhancements.
- In 2025, UHG will continue to regularly review and prioritize areas of opportunity and ensure UnitedHealth Group attracts and retains the talent it needs to achieve its business goals and priorities. Overall, UHG's Total Rewards program is positioned in the competitive range in the U.S. and globally.

U.S. employees below the UHG median salary

- Less than one-third of UnitedHealth Group's U.S. employees are below the calculated median employee pay ($75,778).
- The calculation for median employee pay for UnitedHealth Group considers the annual compensation of all UnitedHealth Group employees globally, including part-time and per diem employees (excluding employees in Colombia and Peru, representing approximately 3.3% of the total workforce).

Males and females, minorities and non-minorities' pay

- UnitedHealth Group is committed to and continues to prioritize pay equity for all employees. Fair and equitable compensation practices within a pay-for-performance framework support our inclusive culture and are critical to achieving our mission.
- Compensation at UnitedHealth Group is based on required skills, experience, market rate for the position, and employee performance.

Say on Pay

Voting results for the say on executive compensation philosophy and practices

- The final vote showed our executive compensation philosophy and practices through an advisory vote passed with more than 60 percent of shareholders voting for the proposal. Our board and management team will continue to engage with shareholders to understand their perspectives as part of our ongoing evaluation of the effectiveness of our executive compensation programs.

Other Shareholder Resolutions

Board recommending that shareholders vote against the proposal regarding excessive golden parachutes

- We have carefully considered this proposal and have concluded it is unnecessary and not in the best interests of the company and its shareholders.
- Our Compensation and Human Resources Committee has adopted a policy which sets forth that we will not pay cash severance exceeding 2.99x the sum of base salary and bonus to executive officers, rendering the adoption of the proposal unnecessary. For purposes of clarity, we have never provided cash severance above this threshold. The policy is already set forth in our Principles of Governance, which are publicly available on our website.
- Our shareholders are already able to effectively express their views on our executive compensation through our annual Say-on-Pay advisory vote and NYSE's requirement to seek shareholder approval of equity compensation plans. Last year's Say-on-Pay advisory vote received 96% support and for 2025, we received 60% support.
- The proposal's request for a shareholder vote on a specific component of our executive compensation program is duplicative of these opportunities and goes beyond what is already required by SEC and NYSE rules. As a result, this proposal is unnecessary.

Voting results for say on shareholder proposal requesting a shareholder vote regarding excessive golden parachutes

- The final vote showed the shareholder proposal requesting a shareholder vote regarding excessive golden parachute payments received approximately 12 percent of shareholders voting for the proposal. Our board and compensation and human resources committee will continue to engage with shareholders to understand their perspectives as part of our ongoing evaluation of our executive compensation programs.

Dividend strategy

- The dividend was increased to $2.21.
- 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 health care industry, broadly defined
    - Other considerations that impact available capital, such as regulations and tax law

Deloitte as independent auditor

- The Audit and Finance Committee periodically considers whether there should be a rotation of our independent registered public accounting firm.
- The Board also evaluates the company's independent auditor, Deloitte, on an annual basis, and this year recommended that shareholders approve Deloitte as the company's auditor for the next year.

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 and 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 health care 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 9.21% of our common stock as of April 4, 2025. The company paid BlackRock $10.2 million for investment management fees and $129,413 for medical/pharmacy rebates in 2024. BlackRock maintains a self-funded health insurance plan through the company and paid the company $3.1 million for administrative services in 2024.
    - The Vanguard Group beneficially owned approximately 7.98% of our common stock as of April 4, 2025. The company and its employees paid Vanguard approximately $7.8 million for benefits program management fees in 2024.

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

- No. 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 our capital partners. As in other industries, passive investing has been growing in health care, including passive ownership of UNH shares.

Executive Security

- We, and others, are unfortunately in a position of having to take additional steps to ensure the safety and security of our employees. 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.

Cybersecurity

Oversight by audit committee

- Last year, we added a Mandiant cyber expert to advise our Board's Audit Committee. They have a deep knowledge of the company, along with broad knowledge and visibility of threats facing the health care industry.
- The Audit and Finance Committee of the board has oversight of our cybersecurity program and is responsible for reviewing and assessing the company's cybersecurity and data protection policies, procedures and resource commitment, including key risk areas and mitigation strategies.
- We have a robust information security program, with over 1,300 people. We repel an attempted intrusion every 70 seconds — equal to more than 450,000 thwarted intrusions per year.

MFA

- UHG policy requires MFAs on external-facing applications. We acquired Change in an acquisition in late 2022. This server was a legacy Change system, and our team was working to bring this server up to UHG's standards.
- We directed our teams to redouble efforts and ensure that MFA is in place on all external-facing UHG applications. We are not aware of any exception to this — but one of the lessons learned from this incident is that continued vigilance is required on this front, especially as new applications or environments are added.

Change Healthcare investigation

- In January, Change Healthcare determined the estimated total number of individuals impacted by the cyberattack is approximately 190 million.
- Change Healthcare has been in regular communication with the U.S. Department of Health and Human Services Office for Civil Rights and other regulators regarding our notification process. As a vendor, Change Healthcare continues to follow the HIPAA Breach Notification Rule. The final number, which likely includes some duplicate individuals, will be confirmed and filed with the Office for Civil Rights.
- Change Healthcare is not aware of any misuse of individuals' information as a result of this incident and has not seen electronic medical record databases appear in the data during the analysis.

M&A policies and cybersecurity considerations around acquisitions

- As part of UnitedHealth Group's M&A protocols, a dedicated Optum Technology M&A team conducts extensive due diligence on each potential acquisition partner. Each potential acquisition partner is measured against UnitedHealth Group's standards for cybersecurity.
- The Optum Technology team conducts a comprehensive assessment of the potential acquisition partner's information technology practices.
- In addition, the Technology team evaluates each potential partner's cybersecurity processes, controls, and tools through adequacy assessments of the potential partner's identity management and password policies, cybersecurity training programs, remote access technologies, auditing practices, remediation programs, data protection policies and controls, incident management processes, prior incidents, and whether cybersecurity requirements, as defined by relevant regulatory agencies, are met.

Board Composition

Board independence

- Our Board of Directors has adopted the Company's Standards for Director Independence. The Standards for Director Independence align with the independence standards set by the NYSE.
- Our board has determined director nominees Charles Baker, Timothy Flynn, Paul Garcia, Kristen Gil, Michele Hooper, F. William McNabb III, Valerie Montgomery Rice, M.D., and John Noseworthy, M.D., are each independent under the NYSE rules and the Company's Standards for Director Independence and have no material relationships with the company that would prevent the directors from being considered independent.

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. Upon the election of our 2025 director nominees, the average tenure of our board members will be approximately 8.5 years.

Removal of director diversity table or individual director diversity attributes

- We revised and updated our disclosures to reflect the Board's belief that an effective board consists of a group of individuals who bring diverse professional experiences, perspectives, skills and backgrounds to their positions. Each director has specialized experience in the areas relevant to our businesses.

Succession Planning

Executive succession and talent development

- Talent development and succession planning are a high priority for our board and have been identified as a focus area through the board evaluation process.
- As a company, our talent philosophy is centered on continually developing our leaders and putting the right people in the right positions to advance our goals of growth, quality of service, and support of our colleagues in doing their very best work for the millions of people we serve.
- The Governance Committee reviews the CEO succession plan on an annual basis. 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 in executive session.

Recruiting new leaders

- We are continuing to work aggressively both to develop leaders internally and bring in talented people from outside, and then to provide them with the experiences necessary to succeed in the complex arena of American health care.

Succeeding Hemsley as CEO

- Steve is staying for a minimum of three years as the CEO.
- The Governance Committee reviews the CEO succession plan on an annual basis. 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. We have a deep bench of leadership talent and are well positioned for the future.

DEI

DEI policy

- We continue to comply with existing and emerging regulations while striving to support what is best for the communities we serve. Our values of supporting a collaborative environment where we treat each other with mutual respect continue to be part of our culture and fundamental to expanding access to health care services.
- We are continuously monitoring the changing laws and regulations around diversity, equity and inclusion initiatives and adjusting our programs and policies accordingly to comply with the changing environment and better articulate the objectives of our offices, practices and programs.
- **Comment about board composition:**
    - We believe an effective board consists of a group of individuals who bring diverse professional experiences, perspectives, skills and backgrounds to their positions. Each director has specialized experience in the areas relevant to our businesses.

Miscellaneous

Potential for layoffs

- Our key priorities are to continue to meet the health care needs of our customers and members and to provide 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, and we continue to grow our workforce.
- Support for any potentially impacted individuals is offered, and we would assist individuals in applying for positions within our growing organizations. Currently we have more than 3,000 job opportunities across the country, with many available for telecommuting or work from home opportunities.

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 the majority 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.
- In our last employee listening survey, 81.4% of respondents said they are likely to recommend us as a great place to work and 81.1% said they are proud to work for our company. These are great indicators that we will continue to be able to attract and retain top talent.

Political contributions

- We participate in the political process to inform health care 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.

UnitedHealth Group's relationship with AARP

- For more than 25 years, UnitedHealth Group and AARP have shared a common mission to help ensure America's seniors have access to affordable, high-quality health care. UnitedHealthcare offers AARP-branded Medicare-related and indemnity insurance products, including Medicare Advantage, Medicare Part D, and Medicare Supplement plans. UnitedHealthcare pays royalty fees to AARP for the use of its intellectual property. AARP and its affiliates are not insurers.

Provider network relationship

- We offer access to the broadest network of providers — over 7,000 hospitals and 1.7 million physicians and health care professionals.
- We are grateful for and rely on our providers to deliver quality, affordable care to more than 50 million people and give almost all of them great marks. This is really important to our customers who count on us to have great quality at affordable costs, given they are often paying the cost of care themselves.
- We negotiate approximately 2,000 provider contracts on average per year, and the vast majority go unnoticed by our members and the general public as they are resolved prior to a contract's expiration date. We occasionally encounter a provider that is looking for rates that are not supported by the market and we can't come to terms with, so they go out of network, but this is rare.

Health equity

- We believe every person deserves the opportunity to live their healthiest life. This means closing gaps in care and connecting people to the resources and support they need to stay healthy.
- It means collaborating with our partners to identify and address the social drivers of health, such as food security, housing stability and access to health care. And it means building a capable and compassionate healthy workforce to support the communities we serve.
- Since 2011, we have invested more than $1.2 billion to create 33,000 new homes, while targeted investments like Invest Appalachia are focused on supporting community-specific issues related to housing, poverty and food insecurity.

Net-zero commitment

- We are working to build a more resilient health system, one that can address the growing environmental challenges facing our members and their communities. This includes near-term adaptive solutions like offering telehealth behavioral health consultations, as well as long-term commitments to help mitigate the impact of our carbon emissions.
- UnitedHealth Group is committed to reducing our emissions, including achieving operational net zero by 2035 and net zero across our value chain by 2050.

Appendix

NEWS RELEASE

UNITEDHEALTH GROUP®

UnitedHealth Group Updates on Annual Shareholder Meeting, Board Actions

(June 4, 2025) – UnitedHealth Group (NYSE: UNH) provided updates on its 2025 annual shareholder meeting and actions taken by its Board of Directors.

Shareholders re-elected all current directors: Charles Baker, Timothy Flynn, Paul Garcia, Kristen Gil, Stephen Hemsley, Michele Hooper, F. William McNabb III, Valerie Montgomery Rice, M.D. and John Noseworthy, M.D.

Shareholders also:

- Approved the advisory resolution on the Company's executive compensation.
- Ratified Deloitte & Touche LLP as the Company's independent registered public accounting firm.
- Voted against the shareholder proposal requesting a shareholder vote regarding excessive golden parachutes.

At its regular quarterly meeting, the Board authorized payment of a cash dividend of $2.21 per share, to be paid June 24, 2025, to common stock shareholders of record as of the close of business June 16, 2025.

About UnitedHealth Group

UnitedHealth Group is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone through two distinct and complementary businesses. Optum delivers care aided by technology and data, empowering people, partners and providers with the guidance and tools they need to achieve better health. UnitedHealthcare offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. Visit UnitedHealth Group at www.unitedhealthgroup.com and follow UnitedHealth Group on LinkedIn.

# # #

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