

Modernizing Health Care



2009 Summary Annual Report



UnitedHealth Group®

Table of contents

Introduction	1
Letter to Shareholders	2
Responsive, Efficient Service	6
Increasing Access	10
Containing Costs	14
Personalizing the Experience	16
Strengthening the Physician-Patient Relationship	18
Improving Quality	20
Transformative Technology	22
Business Summary	26
Foundations	33
2009 Financial Results	34
Officers and Board Members	38
Forward-Looking Statements	39
Investor Information	40
Mission and Values	inside back cover

The names and health information for individuals included in this report have been used with their express permission.

UnitedHealth Group is a leading health care company, serving more than 70 million people. Our family of companies touches nearly every aspect of health care, helping people live healthier lives.

We help people find and receive the best care possible. We work to provide them with access to the quality care they need at an affordable cost. And we provide information, guidance and tools to help people make more informed decisions about their health, health care and well-being. These decisions have lifelong, sometimes life-defining, consequences. We embrace this position of trust and the critical social responsibility we have to serve people's health care needs in the United States and worldwide. UnitedHealth Group plays a unique role in modernizing the health care system and making it work better for everyone, through innovation, advanced technology and careful stewardship of our unparalleled resources and capabilities.

UnitedHealthcare provides comprehensive commercial health benefits for individuals, small- and medium-sized businesses and large national and international companies. In partnership with AARP, **Ovations** delivers health care services tailored to the needs of people over 50, serving one in five Medicare beneficiaries nationwide. **AmeriChoice** is the largest U.S. company serving low-income families through programs like Medicaid and the Children's Health Insurance Program (CHIP). **OptumHealth** works with health plans, employers and the public sector to bring together information, interventions and holistic solutions that help people make better decisions, achieve their health and well-being goals and finance their health care needs. **Ingenix** develops health information and technology that improve health system performance and streamline administration. Through **Prescription Solutions** we are a leader in the management of pharmacy benefits.

Dear shareholders:

In 2009, the people of UnitedHealth Group delivered a strong performance while advancing our mission to help people live healthier lives, despite a very difficult economy. We demonstrated consistency in effectively managing medical costs and continued to reduce our own operating costs. Our businesses again steadily delivered in service and practical innovation. We continued to combine national scale with local responsiveness and further diversified our products, services and markets. We built stronger relationships with the people we serve across the health care community. Our balance sheet grew stronger — our investments performed well and our leverage decreased.

As a result, we entered 2010 a much stronger enterprise. We are positioned for the next generation of growth, in both health benefits and health services. While we cannot predict what changes ultimately will be introduced to the health care system, we understand that in any setting we must combine consistent fundamental execution with our proven ability to adapt to core market demands and continuously innovate in practical ways across the health care experience.

The extraordinary, national debate over the future of health care in the United States serves to shine a spotlight on a key challenge: How do we modernize the health care system, in a fiscally responsible manner, to make quality health care accessible and affordable for all Americans?

Finding innovative, practical and financially responsible answers to that question has been our objective for more than two decades. This annual

report highlights just a handful of the many ways we are helping create a more modern and effective health care system. We continue to make it easier for people to get the care they need, to personalize and simplify their health care experience, to strengthen the bonds between patients and their physicians, to foster the introduction of modern technology and to find new ways to control the rising costs of health care.

These advances are critically important. As we move into the next decade, we believe positive, competitive pressures and ever-growing demands from individuals and employers, physicians and medical facilities and state and federal governments will open the health care system to even greater change ... change that will accelerate the evolution of new products and services and cost-effective new technologies, spurring even more rapid modernization of our health care system.

Quite simply, we are helping to create the infrastructure and capabilities that will enable a modernized American health care system to take root and function more effectively for all participants.

The changes we envision include:

- Common administrative standards and enabling technology will connect and unify patients, health care providers, health benefit plans and the entire health care sector. Actionable information will be available electronically to help physicians and patients make better decisions together.
- Evidence-based medicine will become widely accepted and consistently practiced, improving care quality and helping to control costs.
- Transparency, performance accountability and comparative effectiveness will be adopted across all care services, just as they are in other sectors of the economy.
- Americans will become better informed consumers of health services, because there will be personalized motivations to be engaged, including financial incentives.
- Better management of care, driven by education, adherence to evidence-based medicine and aligned incentives for patients and health care providers, along with supporting information and technologies, will become ubiquitous to health care, built right into the core of how medicine is practiced rather than existing as a parallel “administrative” function as it is today.
- Health care will adopt a culture of prevention that promotes good health rather than simply treating illnesses as they are presented in the doctor’s office or the emergency room.

- There will be a new focus on the challenges of helping people cope with chronic disease, as well as the importance of health and wellness programs that can prevent the onset of those conditions for many years or a lifetime.
- Health care will be purchased based on the effectiveness of achieving health outcomes, not the volume of services rendered.
- All health care transactions will follow the lead of the financial industry and become totally electronic.
- Public health plans, like Medicare and Medicaid, will be modernized to become more economically viable for the long term and enable better care. The modernization of Medicare is perhaps the greatest area of opportunity to positively influence health care nationally, as well as to improve our financial outlook as a nation.

These changes to our health care system will promote a positive health agenda for our nation and a positive growth agenda for a company with the

range of capabilities, market positions, capital strength and experience of UnitedHealth Group. Our business model and philosophy are designed to align with and help enable this national path into a better health care future.

We are already delivering many of these modernizations to the marketplace.

We have developed and invested in innovative technologies that bring the health care sector into the 21st century.

We pioneered the financial services market for health care. We are a leader in the introduction of consumer-focused benefits and services, and we have more integrated and performance-based care delivery payment relationships than anyone else in health care.

As we have for a decade, we continue to develop and enrich our three core competencies, which are the building blocks of a better health care system:

- Information — to guide and lead;
- Technology — to enable, simplify and modernize; and
- Expertise in clinical access and management — to consistently deliver higher quality, lower cost and consumer affordability in health care.

We leverage these competencies to help the health care system perform to its potential. Quite simply, we are helping to create the infrastructure and capabilities that will enable a modernized American health care system to take root and function more effectively for all participants.

We will remain focused on executing on the fundamentals, prepared to further elevate our performance in medical and operating cost management and deliver an even better experience and value to the markets we serve.

UnitedHealth Group is ready to help make health care more accessible and affordable, and take a leading role in our nation's efforts to modernize health care.

And as we help lead and adapt to change, we are meaningfully deepening our culture as a company to better serve the vital social needs of health care. This is apparent in externally measured satisfaction levels among key stakeholders and in the trust we continue to build with those we touch in the health care community.

Engagement among our employees increased significantly in 2009, on top of substantial gains in 2008. Set against the challenging business and political climate this year, this is a testament to the spirit and commitment of our people to our mission.

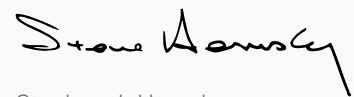
In 2010 we plan to further strengthen and diversify our competitive capabilities to deliver more consistent organic growth and further market expansion across our businesses. We will remain focused on executing on the fundamentals, prepared to further elevate our performance in medical and operating cost management and deliver an even better experience and value to the markets we serve.

Over the next year, you will see our benefits businesses become even more integrated within a more streamlined organization with razor-sharp cost and price sensitivities. Our benefits offerings will become more tightly aligned behind the strong UnitedHealthcare brand name, while the businesses themselves remain distinct, market-facing organizations, dedicated to the differing needs of the benefit markets we serve — commercial, senior and public benefits.

Our health services businesses will fully concentrate on helping the whole health system modernize and perform better. These businesses have been expanding to address the needs of the care delivery side over the past two years. We expect the pace of this expansion will accelerate.

The U.S. health care market will move forward and grow, driven by the need of our society for sustainable care, for even more effective cost controls and for better overall system performance. UnitedHealth Group is ready to help make health care more accessible and affordable, and take a leading role in our nation's efforts to modernize health care. In the years to come, it will be our progressive adaptability that will translate into high performance and distinctive value for our customers and our shareholders.

Sincerely,



Stephen J. Hemsley
President and Chief Executive Officer

Service you can trust—transplant patient says, “One call . . . and I never worried again”

For virtually his entire life, David Reoch suffered from diabetes. Diagnosed at age 7 after he fell into a coma, David has been through more medical procedures than he can remember. His friends jokingly call him the “Bionic Man.”

Several years ago he visited the doctor because he was feeling increasingly fatigued. David says that his physician had him take a cardiac treadmill test. After about 30 seconds the doctor asked if David carried nitroglycerin. David said, “No, why?” The doctor replied, “Well, get off the treadmill and put this pill under your tongue, because you’re about to have a heart attack.”

Subsequent tests showed that David had recently suffered a mild heart attack, and he had more blockages in his heart. He required immediate bypass surgery.

Afterward, his doctors told him his heart problems were primarily caused by complications of diabetes, and referred him for pancreatic transplant surgery to eliminate the diabetes and halt further progression of the many complications he was already experiencing. Because of the seriousness of his condition, he moved quickly through the preparations for possible transplant surgery. But then David switched jobs and his health care coverage changed to UnitedHealthcare. David worried that this change might slow his progress toward, or perhaps even block, the transplant.

He called UnitedHealthcare’s toll-free number to review his coverage with an employee who assists customers with questions about benefits and health coverage. Within a day, he received a call from a registered nurse at UnitedHealthcare who conducted

Within a day, he received a call from a registered nurse at UnitedHealthcare who conducted an interview. She told him everything would be taken care of.





Melissa and David Reoch

an interview. She told him everything would be taken care of. Confused, David sheepishly asked, "I'm not sure I understand you correctly. Am I going to have coverage with UnitedHealthcare?"

"Yes," he was assured. "It'll be fine."

"I thought for sure I'd have a stack of papers in the mail the next day to fill out, but it was pretty much one phone call, a return phone call from UnitedHealthcare and I was done, and I never worried about it again," said David.

When a new pancreas became available, David traveled to a hospital with a program specializing in the procedure and underwent surgery. It was a "life-changing experience," according to David. "Every moment is different now because with a new, functioning pancreas I'm not planning my life around diabetes."

As David recovered, the next year was perhaps the most difficult in his life, but his nurse specialist from UnitedHealthcare was in constant contact with him, asking what she could do to help address his health care needs. David jokes that UnitedHealthcare was checking on his progress almost as frequently as the transplant team.

When people ask David how he got through major transplant surgery, he has a simple answer, "I've had a great insurance company that took care of me. It might sound silly for a guy to say, 'Oh, my health care company is a huge part of my life,' and it might sound like some advertisement that nobody believes when you see it on TV, but it's categorically true."

UnitedHealth Group works hard to earn this kind of trust in the dependability of our service with everyone we touch and who touches us. In 2009, the company continued to enhance service by making it even easier, simpler and more personal.

Consumer call centers continued to deliver excellent results. Call center accuracy remains strong. All UnitedHealthcare customer service call sites are located in the United States. With 14 service sites across the nation, employees can easily support unexpected surges in call volume or site outages. Satisfaction scores in 2009 rose to 92.7 percent with the average time to answer calls remaining below 30 seconds. Employees at call centers can immediately transfer complex benefit questions to experts who have the information and authority to resolve them on the phone.

UnitedHealthcare also offers its health advisor service. Health advisors serve as a person's advocate and single point of contact in helping them understand their health care options and resolve issues across medical, pharmacy and financial products. Each health advisor is responsible for full resolution of a patient's issue and will follow up with that person once resolution is complete. When appropriate, advisors help educate consumers about relevant programs to help them use their benefits most effectively and will even help them in setting up appointments with care providers or with a billing dispute. Health advisors have the highest customer satisfaction rating within UnitedHealthcare at 94.8 percent.

"Every moment is different now because with a new, functioning pancreas I'm not planning my life around diabetes." — **David Reoch**

Claims processing accuracy climbed to 99.6 percent in 2009 with the great majority of claims processed automatically and 96.6 percent of all claims processed within 10 days. UnitedHealthcare also supplies physicians with real-time processing of claims in their offices, delivering accurate results in seconds that provide patients with details of claim benefits and their financial responsibility.

A 2009 survey of health benefit plan consultants who work with large U.S. employers found that their satisfaction with UnitedHealthcare's sales force and client management staff continued to increase. Health and wellness and consumer engagement products directly impacting customers, and the breadth and quality of UnitedHealthcare's network, claims processing and customer service were positively noted by those consultants.

UnitedHealthcare is also making service to brokers, consultants and employer groups easier to access, simpler and more personal with its Service Hotline, United eServices® and Employer eServices® Web sites, and dedicated client service managers who track issues end-to-end, providing updates on progress and ensuring client agreement with resolutions.

Consumer call centers continued to deliver excellent results. Call center accuracy remains strong.



Call center supervisor Shirlee Brown, UnitedHealthcare

2009 call center scores

- 94%**
first call resolution
- 92.7%**
satisfaction scores
- 99.6%**
claims dollar accuracy
- 82.2%**
claims automatically processed

97.9%
CALL ACCURACY

- 96.6%**
claims processed within 10 days
- Under 30 seconds**
average time to answer consumer calls remains below 30 seconds



“21st century house call” delivers care to communities in need

One of the most fundamental ways to increase access to the health care system is making sure people simply have the opportunity to see a doctor when they need to.

Today, millions of people in rural and underserved urban communities do not have adequate access to primary physicians, much less to medical specialists. The nearest doctor may be many hours away and a trip to consult a medical specialist could require a plane flight. The Association of American Medical Colleges estimates that the United States is facing a shortage of 159,000 primary care physicians by 2025, which will compound the problem.

UnitedHealth Group has partnered with Cisco to build the first national telehealth network, which will give patients access to physicians when in-person visits are not possible. This program uses modern

telecommunications and medical technology to deliver a virtual doctor’s visit to patients wherever they are — through mobile units that travel to patients, on-site units in the workplace and in retail locations, and eventually through home-based devices.

Linked via high-definition video conferencing, the doctor “sees” patients in a soundproof office with assistance from an on-site nurse. Physicians can then perform examination procedures remotely, such as taking blood pressure and checking a patient’s ears, nose and throat, and treat a wide variety of acute

159,000

POTENTIAL SHORTAGE OF
PRIMARY CARE PHYSICIANS
BY 2025

Today, millions of people in rural and underserved urban communities do not have adequate access to physicians ...

UnitedHealth Group's collaboration with Project HOPE will provide underserved communities in rural New Mexico access to much needed health services.

and chronic conditions. This advanced telehealth program can provide specialist consultations and checkups for more complicated conditions like diabetes, hypertension and heart disease. Through telehealth technology, doctors are able to consult with their colleagues about specific cases and share critical information and expertise.

UnitedHealth Group launched its first mobile telehealth clinic in 2009 in an 18-wheel tractor trailer, showcasing the technology and connectivity available through the network.

Collaboration with Project HOPE in New Mexico

One of the first telehealth initiatives is an ongoing collaboration with Project HOPE — the world-renowned health education and assistance organization — using UnitedHealth Group's mobile clinic to provide underserved communities in rural New Mexico access to much needed health services and to educate residents about the risks of chronic diseases.

Forty-five percent of New Mexico's population is of Hispanic origin — a group that is highly predisposed toward type 2 diabetes, according to the Centers for Disease Control and Prevention. The mobile clinic will provide health screenings and treatment for diabetes, pre-diabetes and other chronic conditions, such as high blood pressure and heart disease.

Collaboration with Meharry Medical College in Tennessee

AmeriChoice, UnitedHealth Group's business dedicated to state Medicaid and other programs for the underserved, is collaborating with Meharry Medical College in Nashville to provide people in rural and underserved areas of Tennessee access to Meharry Medical Group physicians by using telehealth technology. Individuals seeking adult specialty medical services will be able to consult specialists located in Meharry's Nashville offices, such as a dermatologist or neurologist, through



UnitedHealth Group's mobile telehealth clinic uses modern technology to deliver a virtual doctor's visit to patients wherever they are located.

telehealth technology by visiting one of the approximately 80 community health centers across the state.

Meharry Medical Group is composed of physicians who serve on the faculty of Meharry Medical College, the nation's largest private, independent, historically black academic health education and research center. Dr. Wayne J. Riley, president and CEO of the college, said, "Meharry Medical College has a rich tradition — stretching back over a hundred years — of delivering quality health care to people in poor, minority communities and underserved communities. UnitedHealth Group's telehealth technology will help Meharry physicians provide care to even more who are in need. We take great pride in being on the cutting edge, providing opportunities to people of color and individuals from disadvantaged backgrounds, regardless of race or ethnicity; delivering high quality health services; and conducting research that fosters the elimination of health disparities. Through this innovative telehealth program, we can extend the benefits of our research and medical expertise to more people, more effectively."



Dr. Wayne J. Riley, president and CEO,
Meharry Medical College, Nashville, Tenn.

*“Through this innovative telehealth program,
we can extend the benefits of our research and
medical expertise to more people, more effectively.”*

— Dr. Wayne J. Riley

Changing lives and saving money in the fight against diabetes

In 2009, the United States spent \$2.5 trillion on health care, which is approximately 17 percent of our nation's gross domestic product. By 2019, that number may surpass \$4.5 trillion and is expected to continue to rise. These costs have real world effects: forcing businesses to reduce coverage and placing unneeded hardship on families that lose access to care, while diminishing our nation's global competitiveness in challenging economic times.

UnitedHealthcare studies show the average annual cost for treating individuals with diabetes and pre-diabetes as:

Pre-diabetes	\$ 5,000
Undiagnosed diabetes	\$12,000
Diabetes without complications	\$10,000
Diabetes with complications	\$30,000

\$174B

2007 COST OF DIABETES TO THE U.S. ECONOMY

UnitedHealth Group is focused on finding new and innovative ways to promote better health while controlling costs — saving lives *and* saving money. Modernizing health care by embedding preventive medicine in the system is an important key to this effort.

The company is currently using this approach to combat diabetes, a devastating chronic disease that afflicts an estimated 24 million adults in the United States alone. Another 57 million people are considered pre-diabetic. Though diabetes can often be controlled with effective care, research from the Centers for Disease Control and Prevention shows that 60 percent of people with diabetes do not follow their physicians' advice on how to manage the disease.

In UnitedHealthcare's Diabetes Health Plan, those suffering from diabetes or pre-diabetes, along with their family members, are guided toward physicians who have documented success in treating the disease. Participants are educated about chronic disease, how to manage it and the importance of routine care. Out-of-pocket expenses for individuals are reduced and enhanced benefits are offered in exchange for compliance with preventive care guidelines.

According to Dr. Deneen Vojta, senior vice president, UnitedHealth Group and a leader in the development of the Diabetes Health Plan, "The design of UnitedHealthcare's Diabetes Health Plan meaningfully engages people based on their individual health needs. We're finding that once people have the tools, support and incentives to make simple changes, the response is phenomenal. There is a massive, untapped opportunity for millions of Americans to slow the progression of diabetes and avoid life-threatening complications. The added bonus is that progress in combating diabetes could save U.S. employers billions of dollars in health care costs."

The plan was piloted with General Electric, Hewlett-Packard and Affinia in 2009. All three companies have renewed or expanded their participation in the program and a number of other groups, including the city of New Orleans and the American Postal Workers Union Health Plan, will offer the plan in 2010.

Dr. Robert S. Galvin's work as General Electric's executive director of Health Services and chief medical officer, is focused on keeping 300,000 employees healthy. He is one of the nation's leading proponents of innovation in health care management. Dr. Galvin says that General Electric was interested in participating in the Diabetes Health Plan pilot because it is one of the few new



Dr. Deneen Vojta, senior vice president, UnitedHealth Group and a leader in the development of the Diabetes Health Plan

programs that combines innovation, incentives *and* accountability. As he puts it, the Diabetes Health Plan “really connects the dots.

“Everybody participating in this program has to do something differently. Everybody has to take their share of the responsibility for making it work successfully,” says Dr. Galvin. “The employer has to be willing to waive or lower the copay as incentive for their employees and take the risk on the

company’s investment in the program. To get enhanced benefits, employees have to go see their doctors regularly, make sure they get their lab tests and follow their physicians’ plans for their

treatment. And health care providers must agree to follow evidence-based medicine to receive a performance bonus and an increased volume of patients directed to their practices.”

“We’re finding that once people have the tools, support and incentives to make simple changes, the response is phenomenal.” — Dr. Deneen Vojta

One-on-one: guiding a cancer patient to better care and a brighter future

Cancer is the second most common cause of death in the United States, exceeded only by heart disease. A cancer diagnosis is frightening and the decisions that must be made can seem overwhelming. UnitedHealth Group offers a program that provides a unique service to customers and their families who are facing cancer: the OptumHealth Cancer Support Program, a highly personalized source of information and support.



Patty Migler, RN, BSN, OCN, case manager, Cancer Support Program, OptumHealth

OptumHealth works with cancer centers clinically proven to provide exceptional care for patients with complex cancers. Treatment at these Centers of Excellence can result in a more consistently accurate diagnosis; care that is planned, coordinated and provided by a multi-disciplinary team of experts who specialize in the patient's specific kind of cancer; appropriate therapy; fewer complications and higher survival rates; and shorter hospitalizations and lower costs.

In addition, experienced nurse advocates help patients make informed decisions about their cancer care and navigate the health care system. They help prevent and manage symptoms and side effects to reduce inpatient admissions and emergency room visits. They also collaborate with treating physicians, help manage pharmacy costs and educate patients regarding hospice services and palliative care.

Nancy Mack is a director of project management in UnitedHealth Group's Information Technology department. When she was diagnosed with breast cancer, the news made her and her family fearful and uncertain about the future. She turned to OptumHealth's Cancer Support Program. Nancy was connected to Patty Migler, one of 59 clinicians who staff the program.

"Patty spent a lot of time with me, explaining all the different kinds of breast cancers and what each kind of diagnosis meant," said Nancy. "When I received my pathology reports, Patty reviewed them with me, line by line, to make sure that I understood exactly what I was dealing with."

After undergoing her first round of tests, Nancy was told the cancer had spread — and she was facing a terminal diagnosis. Despite the grim news, Patty encouraged her to stay positive and get a second opinion. She arranged for Nancy to see a cancer specialist at one of the program's Cancer Centers of Excellence.

The second opinion disputed the first diagnosis and Nancy began treatment, which included surgery, radiation and chemotherapy. Patty was there to support Nancy throughout each step, explaining symptoms or often just placing a friendly phone call to see how Nancy was feeling.

Today, Nancy is cancer-free for more than three years and she credits Patty for getting her through the experience.

"Without Patty, I don't think I would be here today. She was the one who encouraged me to get the second opinion. She helped me take control of the situation and fight for my life, so that I'll be around for a long time. I think that she's a great gift to this company and this community."



Nancy Mack

Today, Nancy is cancer-free for more than three years and she credits Patty for getting her through the experience.

Welcome to the Patient Centered Medical Home



Dr. Sam Ho, chief medical officer,
UnitedHealthcare

29%

FEWER EMERGENCY ROOM VISITS

Early results from the Patient Centered Medical Home project are promising

29% fewer emergency room
visits, 11% fewer preventable
hospitalizations and 6% fewer
visits to the doctor's office

In a modernized health care system, everyone should have a strong relationship with his or her primary care physician — a “medical home” where the patient and doctor work together to coordinate comprehensive care with an emphasis on overall wellness and preventing disease, improving the care of chronic conditions, behavioral health support and patient education.

In 2009, UnitedHealthcare launched Patient Centered Medical Home (PCMH) projects in collaboration with select primary care physician practices in Arizona, Colorado, Ohio, Rhode Island and New York.

Dr. Jeffrey I. Selwyn, internist and president of New Pueblo Medicine in Tucson is an enthusiastic participant. “To try to be on the cutting edge of patient-centered awareness and practice is a tough task, but it’s something that has been a passion of mine,” he said. “I’m very pleased to see this passion finally coming to fruition.”

The Patient Centered Medical Home offers a holistic and well-integrated approach to providing patients with safe, effective, comprehensive care — an antidote to what is too often fragmented and episodic care from various health care providers and facilities.

“The medical home model goes beyond simply the diagnosis and treatment of injury and illness,” said Dr. Sam Ho, chief medical officer, UnitedHealthcare. “The Patient Centered Medical Home provides an overarching context for care, strengthening the bond between doctor and patient because the doctor has a better understanding of each patient’s needs and preferences. We believe that moving to this model for the delivery of primary care will result in higher quality, more effective care, while improving medical outcomes and reducing health care costs.”

Dr. Selwyn explained, “It is truly a team-based model where there’s a very significant bond between the patient and the physician. It’s a 50-50 partnership. We engage our patients to really be involved in their own care.”

UnitedHealthcare provides the technology and infrastructure support to improve information systems and adherence to

“The Patient Centered Medical Home will result in higher quality, more effective care ...” — Dr. Sam Ho

evidence-based medicine. Furthermore, physicians also stand to receive enhanced reimbursement in recognition of superior care coordination, improved access, better patient communications, delivery of preventive and chronic care and improvements in patient experience and satisfaction. Increased compensation can be funded by the medical cost savings from improved health outcomes resulting in fewer hospitalizations, better coordination with specialists, fewer emergency room visits and more cost-effective medication use.

“What UnitedHealthcare is doing allows benefits for the private physician, the patient and plan sponsors,” Dr. Selwyn said. “Better health care, better outcomes for patients and less expenditure.”

The PCMH model was developed by primary care physicians in the United States, including the American Academy of Family Physicians, the American College of Physicians, the American Osteopathic Association and the American Academy of Pediatricians. UnitedHealthcare’s pilot program in Arizona is available to customers in employer-sponsored benefit plans and Medicare Advantage and Medicaid health plan customers.

“It is truly a team-based model where there’s a very significant bond between the patient and the physician.” — Dr. Jeffrey I. Selwyn



Dr. Jeffrey I. Selwyn, internist and president, New Pueblo Medicine, Tucson, Ariz.



Safety and support for the most vulnerable in a complex health system

The U.S. health care system's complexity and often fragmented delivery of care can negatively impact quality. UnitedHealth Group uses technology to help organize care and make it safer; and the company provides expert guidance to help individuals navigate a confusing and sometimes contradictory system. Here are two examples of how UnitedHealth Group is modernizing health care to improve quality.

The Drug Interaction Alert Program is an innovative program that specifically identifies potentially dangerous drug interactions.

Tracking prescriptions for dangerous interactions

Many people see more than one doctor or fill prescriptions at more than one pharmacy for a broad range of medical conditions. This is true particularly for patients with multiple medical challenges and the elderly who often are facing a number of common chronic conditions. This can mean that physicians and pharmacists are unaware of all the medications a patient has been prescribed, which may lead to dangerous drug interactions that are harmful to patients, costly for the health care system and largely avoidable.

Prescription Solutions, UnitedHealth Group's pharmacy benefit management business, has developed the Drug Interaction Alert Program (DIAP), an innovative program to specifically identify potentially dangerous drug interactions.

Heidi Lew, Pharm. D., Prescription Solutions vice president, Clinical Programs, explained, "First, we collaborated with an advisory group of physicians to identify drug interactions most likely to result in serious harm to patients. The drug interaction alert system monitors the millions of prescriptions filled by pharmacies for customers every month to identify instances where a person may be receiving multiple medications that could cause them harm. When possible drug interactions are identified,

patient-specific notifications that set out the potentially clinically significant drug-to-drug interactions are sent to alert prescribing physicians promptly, often within 24 hours.”

Physicians report that the drug interaction alert system helps them take better care of their patients. Dr. Alan Nili runs a family practice in Irvine, California. His patients range from 12 to over 90 years of age, with geriatric patients now comprising more than 50 percent of the patients he sees.

Dr. Nili stated, “Some seniors are taking 10 to 12 different medications, so it can be very difficult to keep track of the interactions. My patients could be receiving prescriptions from other specialists, such as cardiologists and orthopedists, without my knowledge. Receiving a notification from Prescription Solutions alerts me to either switch medications to a different group or to let the patient know there might be side effects with specific combinations of medications.”

Research shows that the drug interaction alert system not only reduces the risk of adverse drug reactions and harm to patients, it provides significant savings to the health care system. Depending on the type and severity of drug interaction, the drug interaction alert system can potentially reduce medical costs up to \$13,000 for treatment of a patient at risk.

Guiding a caregiver through the health care maze

Rhonda Burcham, RN, is a care manager in SecureHorizon’s Post Acute Transition Team, a clinical program offered by Ovations to Medicare recipients. She first contacted Richard Radlinger when his wife Mary Jane had just been admitted to an acute care facility after suffering a stroke. Rhonda said that Richard was full of questions and very worried: What did their insurance cover? How would he find the treatments his wife needed? How could he ever take care of her on his own?

As Richard explained, “You walk into that situation and you just don’t know where to turn, and that’s where I was. I’m the only caregiver. We’ve been married 48 years and I’m 73.”

Rhonda went to work immediately, helping to arrange proper speech, occupational and physical therapy in preparation for discharge from the facility. She recommended home care for a time and helped expedite outpatient speech therapy. Rhonda found answers to all their questions related to their insurance. She said, “I spent a lot of time with both of them throughout Ms. Radlinger’s stay, and at discharge he was comfortable with taking her home.” Rhonda admired their courage. “They are a really awesome couple who have been through a very difficult

and challenging time. It was great to have the opportunity to help make a difference in their lives.”

The admiration was mutual, as Richard stated, “I think the world of Rhonda. I’m not trying to unduly put a burden on anybody, but I can’t do all the stuff myself. The mental health of the caregiver is important, because it’s such a dramatic change in our lifestyles. Rhonda was a blessing to us. That’s all I can tell you.”



Rhonda Burcham, RN, care manager, SecureHorizon’s Post Acute Transition Team, helps guide customers through a sometimes confusing health system.

315M

PRESCRIPTIONS
PROCESSED ANNUALLY BY
PRESCRIPTION SOLUTIONS

Information: the lifeblood of health care

Information technology has the power to transform health care. UnitedHealth Group built a \$2 billion business, Ingenix, around that idea. Ingenix is committed to using the power of health information and analytics to help save lives, improve care and modernize the health care system.

To begin to address the inefficiencies plaguing the health care system, Ingenix starts with large and robust resources of health care data, including 32 terabytes of information covering more than 90 million people, and the performance of 600,000 physicians and other health care providers.

Health care information is abundant. Every time a person goes to a doctor's office or a hospital, gets a lab result, orders a prescription or interacts with the health care system in any way, a record is created.

Those kinds of records, combined with information on the activities of other health consumers, allows Ingenix to make important observations about how doctors practice medicine; what happens to the patients in their practice; why some patients get better and some don't; and the correlation of health outcomes to how often physicians and other health care professionals do or do not follow evidence-based guidelines for care.

Ingenix organizes these vast data resources, analyzes the information and puts the results into action throughout the health care system — all while ensuring that the privacy and security of patient information is protected.

Ingenix's Natural History of Disease solution

Ingenix's Natural History of Disease solution and its application to the analyses of diabetes provides one example of how this works. Ingenix looked at data — which had been

Ingenix organizes these vast data resources, analyzes the information and puts the results into action throughout the health care system.







de-identified to protect individual privacy — related to people suffering from diabetes. The company studied treatments that are successful and the results of non-treatment. Ingenix also closely considered the factors leading up to the diagnosis of diabetes: What characteristics did these people share? What early warning signs might there be that would enable health interventions that would help patients in the future to avoid diabetes altogether?

Research indicated an array of symptoms diabetes patients experience long before

their diagnosis. For example, Ingenix discovered that many of these patients suffered either from insomnia or sleep apnea. The company found patients with these symptoms are 30 percent more likely to become diabetic in the future, if nothing changes. Additionally, their chances of developing diabetes increases in the presence of obesity or certain other signals. Ingenix looked at patients from this group who went on to suffer from diabetes and those who did not — and the difference in how these two groups were treated.

Based on a person's health profile, UnitedHealth Group can create a personalized blueprint for healthy living and customized outreach, including by telephone, direct mail, online and mobile device.

With the insights gained from this work, Ingenix moves from being able to identify and suggest treatment for patients with pre-diabetes to helping treat people who are at risk for developing pre-diabetes. Patients can be educated about potential risks to their health much earlier, and helped to take measures to protect themselves, potentially reducing or avoiding the life-changing impacts of chronic disease.

Ingenix can also compare the difference in the cost of caring for these patients. Because untreated diabetes is linked to cardiovascular disease, the cost difference between patients who follow their treatment plan and those who do not can be staggering. Understanding these potential links and consequences

Understanding these potential links and consequences is a powerful way to help improve health and dramatically reduce costs.

is a powerful way to help improve health and dramatically reduce costs.

Based on average costs, the difference in the cost of care for treated and untreated patients for the group Ingenix studied was more than \$340 million per year. Applied across the U.S. population, that bill adds up to billions of dollars.

The eSync PlatformSM

To apply information and analytics capabilities and make them more relevant for individual patients and their care providers, as well as for UnitedHealth Group's clinical engagement teams, OptumHealth worked with Ingenix to launch the eSync Platform.

eSync helps create a holistic view of a patient's medical history by organizing an individual's appropriate health care data, such as laboratory and claims information, prescription drug use and recent medical procedures and behavioral health, plus the information each person wishes to add about himself or herself and basic demographic information.

Then, using each individual's health profile, the eSync Platform creates a practical blueprint for healthy living that allows UnitedHealth Group to offer recommendations, opportunities to improve health and tips for healthy living. Outreach methods can be customized to fit patients' and care providers' needs, including telephone, direct mail, secure

e-mail, personal Web portals, fax and mobile device.

The eSync Platform constantly reviews data to identify opportunities to engage with patients and care providers to help improve health. eSync concentrates on four key areas: choosing the right provider, making decisions about the right care, taking the right medication and engaging in the right lifestyle.

If needed, eSync also informs an OptumHealth personal care consultant

of actionable, high-priority steps that can be taken to help a patient manage his or her health. And at critical junctures in a patient's care or in medical emergencies, eSync's care provider and patient alerts and the integrated personal health information eSync has available online can make a crucial difference in a patient's care.

Today, OptumHealth is using eSync to help deliver personalized health management programs to approximately 22 million consumers.

Information matters

37%

CHANGED
PHYSICIANS

Better Decisions: 37 percent of consumers in the treatment decision support program changed to a quality-rated physician best suited for their health needs.

Better Health: Quality-designated surgeons have a 23 percent lower rate of medical complications and a nearly 20 percent lower cost.

64%

REDUCTION IN
READMISSION RATES

One specific example: UnitedHealth Group has seen a 64 percent reduction in readmission rates when high-risk pregnant moms deliver at a Center of Excellence.

Better Economics: Transplant Centers of Excellence produce a 57 percent lower average cost per transplant.

57%

LOWER AVERAGE COST
PER TRANSPLANT

UnitedHealth Group focuses on improving the nation's health care system, helping to make quality care more accessible and affordable for all Americans. Our family of businesses today provides more than 70 million individuals with a highly diversified and comprehensive array of health and well-being products and services. We are dedicated to helping people live healthier lives.

By developing innovative solutions to the challenges of health care and harnessing the power of modern technology, we create new health care options for customers. Our products and services expand consumer choice, engage people more directly in their own health care and strengthen patient-physician relationships.

We offer health benefits in the commercial market for employer and individual customers, and hold market leading positions in the public and senior sectors. We provide health services to the participants in the health care system itself, ranging from employers and health plans, to physicians and life sciences companies.

We are a valuable partner in supporting the health and financial needs of our customers, and we serve as a trusted source of information for patients as they navigate today's complex health

care landscape and make important health and lifestyle decisions.

Through our extensive network of health care providers and facilities, we purchase more than \$120 billion in health care per year for our customers from roughly 700,000 physicians and other care providers, 5,200 hospitals and all major drug and device companies. We process more than 800 million claims, respond to more than 80 million phone calls, execute more than three quarters of a billion Internet transactions and support more than 24 million electronic personal health records. We maintain the only major chartered health care bank, manage almost \$1 billion in assets, service nearly 2 million consumer health care accounts, and process \$36 billion in electronic payments to providers annually. Our health care data assets are some of the most robust in the nation.

UnitedHealth Group has achieved market leadership by providing value to our customers through:

- A sustained focus on advancing health and well-being;
- A commitment to operational excellence;
- Product and service innovation;
- Advancement of practical technology applications to engage consumers and simplify the health care experience;
- The analytic use of information to enhance service, quality and patient safety;
- Support of science as the cornerstone of optimum health care delivery; and
- Diversification of businesses and product offerings.

At UnitedHealth Group, we value the personal nature of our relationship with our customers, understanding that individuals and families often rely on our services at crucial moments in their lives.

Because health care is delivered and accessed locally by the people we serve, UnitedHealth Group closely aligns our businesses with local communities and markets. This focus, combined with the company's national scale and breadth of resources, provides effective, responsive health care service, greater access and higher quality coast-to-coast.

Fast facts

\$120B
IN HEALTH CARE
PURCHASED PER YEAR

700,000
PHYSICIANS & CARE PROVIDERS
IN NETWORK

5,200
HOSPITALS IN NETWORK

Our strong capital structure and asset base enable us to invest in research and development activities, which in turn stimulate business innovation and opportunity while providing stability and security for customers, business partners and our investors.

UnitedHealth Group performed well in 2009 with just over \$87 billion in revenues — 7 percent year-over-year growth — and earnings of \$3.24 per share. Satisfaction levels improved for every key constituency — consumers, physicians and other care providers; employers and benefit sponsors; and brokers and consultants.

We managed through many unforeseen obstacles to achieve these results, including significantly higher unemployment, anemic short-term investment yields, the H1N1 outbreak, slower buying behaviors in the market for health services, COBRA benefit extensions, unexpected state tax actions on insurance premiums and more.

While cautious about the expected economic recovery and the uncertainty surrounding health reform, we are well positioned to capture the growth opportunities that are likely to accompany the continuing modernization of the U.S. health care system.

We also continue to expand internationally in select markets as other industrialized nations confront challenges similar to those UnitedHealth Group helps resolve for Americans.

Health Benefits

In 2009, revenues in Health Benefits increased \$5.5 billion, or 7 percent, to \$81.3 billion, driven by the addition of nearly 1.1 million customers across the public and senior markets, as well as rate increases reflecting underlying medical cost trends. This growth was offset by a decrease of 1.7 million people served in the commercial benefits market, reflecting the significant decline in U.S. employment in 2009. Health Benefits earnings from operations for the full year were \$4.8 billion.



More than 24 million customers receive a comprehensive array of consumer-oriented health benefit plans and services from UnitedHealthcare, which serves the full spectrum of the commercial benefits market, from individual consumers to Fortune 500 companies.

UnitedHealthcare's national scale allows it to provide employers and consumers innovative, personalized and cost-effective solutions geared toward their changing health care needs. These include:

- Consumer-driven health plans;
- Flexible benefit plans, like the Multi-Choice suite of offerings tailored to meet the needs of small businesses;

- Services that empower consumers to take active control of their health care needs and drive down costs; and
- Meaningful economic discounts and innovative clinical advocacy programs that promote quality care.

In 2009, UnitedHealthcare posted a gain of 115,000 people participating in consumer-driven health plans, strengthening its position as the leader in the consumer-driven health plan market segment.

Initiatives like UnitedHealthcare's Premium® designation program drive better and more efficient health decisions by encouraging use of physicians who meet quality and efficiency standards through benefit design incentives.

Delivering a comprehensive array of consumer-oriented health benefit plans and services to more than 24 million customers.

SimplyEngaged® is a product for mid-sized employers who are seeking to engage employees in their own health care and promote personal accountability. It includes a national biometric screening network and reinforces the value of healthy actions and outcomes through financial incentives and increased consumer awareness.

UnitedHealthcare leverages consumer-centric innovations to integrate clinical, behavioral, financial, administrative and claims data in practical ways.

In 2009, UnitedHealthcare introduced two new programs that illustrate the company's focus on personalized and cost-effective care. The Diabetes Health Plan is a first-of-its-kind benefit program that gives people with diabetes and pre-diabetes tools designed to help them avoid the complications of the disease. The plan focuses on early identification of diabetes and provides incentives for patients to follow a health care plan that lessens its effects.

The second new program is Patient Centered Medical Home, which creates a close partnership between patients and physicians to improve consumer access and quality at lower cost. Patient Centered Medical Homes use the latest health-information technology to ensure people receive comprehensive, coordinated and information-based care from their primary care physicians, rather than fragmented care from a range of providers.



Ovations is the largest business in America dedicated to the health and well-being of individuals over the age of 50 — the fastest growing segment of the health care market.

Through a diversified range of products and services, the company makes it easier for more than 8 million seniors — or one in five Medicare beneficiaries — to manage their health care needs.

Ovations is a market leader in delivering Medicare Advantage health benefits products, serving nearly 1.8 million people across the United States. In association with AARP, the company serves nearly 4 million people with specialized products for the senior health care market, including operating the nation's largest Medicare Supplement business. It also is the nation's largest Medicare Part D prescription drug plan provider, serving 4.3 million individuals on a stand-alone basis and another 1.6 million through Medicare Advantage Part D plans. In addition, the business is a national leader in providing health care planning, coordination and benefits to individuals residing in skilled-nursing facilities.

Ovations' success in the senior market is defined by an intense focus

on customers and affordability. The company has a deep understanding of its customers' needs, and offers health benefit products that ensure predictability, stability and financial protection. Ovations offers its customers access to a broad network of doctors, individualized health and wellness programs, care coordination services and products explained in "plain language" that promote informed decision-making. The business has expanded its retail presence, improved relationships with brokers and bolstered its direct-sales channels. Ovations' relationship with AARP is built not only on providing affordable, quality products, but also on driving innovation and advances in the delivery of senior health services.

Making it easier for more than 8 million seniors — or one in five Medicare beneficiaries — to manage their health care needs.

Ovations delivers affordability through a combination of effective medical management and administrative discipline. It has a 20-year track record of proficient adaptability to market and competitive challenges.

- Revenues grew \$4.1 billion, or 15 percent, to \$32.1 billion in 2009. This strong growth included revenue advances in the Medicare Advantage,

Medicare Supplement and Part D prescription drug businesses. Medicare Advantage enrollment increased 20 percent, or nearly 300,000 seniors, while the number of seniors served by Medicare Supplement products grew by 6 percent or 140,000 individuals. At December 31, 2009, approximately 4.3 million people participated in the company's stand-alone Part D prescription drug plans, including growth of 240,000 people in 2009.



Working with states, municipalities and other government agencies, AmeriChoice provides assistance to those Americans in greatest need — the economically disadvantaged, the medically underserved and those who lack access to employer-funded health care coverage.

This business is focused on supporting and managing the health care needs for nearly 3 million Americans who turn to Medicaid and other public health programs for care.

AmeriChoice programs are specially designed to address the complex set of medical and social needs that confront this population, going beyond the immediate medical issues to focus on the social, behavioral and economic barriers that impede healthier living.

The cornerstone of the company's efforts is the AmeriChoice Personal Care Model™. This Personal Care Model program creates an ongoing relationship between health care professionals and individuals with serious and chronic illnesses, including asthma, diabetes, congestive heart failure, HIV/AIDS, hypertension and high-risk pregnancies. The Personal Care Model provides outreach and education programs to help patients and their families manage these conditions. Other long-term care programs focus on dementia, depression, coronary disease and functional deficiencies.

The company also offers government agencies a broad array of management tools designed to help them effectively administer their distinctive health care delivery systems. These include clinical-care management and consulting, disease and conditions management, and administrative and technological services.

AmeriChoice expanded beyond its traditional focus on mothers and children by differentiating its programs across three other primary groups: low-income families, childless adults and people with

chronic or end-of-life diseases, including the disabled and those living in a long-term care setting.

In 2009, AmeriChoice revenues of \$8.4 billion increased \$2.4 billion, or 40 percent from 2008, driven by strong organic growth as well as the full year benefit of a mid-2008 acquisition. Growth highlights in 2009 included expanding to Hawaii and completing program implementations in Connecticut, Tennessee and New Mexico.

Focusing on supporting and managing the health care needs for nearly 3 million Americans who turn to Medicaid and other public health programs for care.

Health Services

In 2009, Health Services combined revenues increased \$2.5 billion, or 13 percent, to \$21.8 billion. The revenue advance was driven by strong growth in consumers served, particularly through pharmaceutical benefit management programs, as well as higher revenues from public sector specialty benefit offerings and health care technology software and services. Health Services earnings from operations for the full year were \$1.6 billion.



OptumHealth provides essential health information and services to nearly 58 million Americans.

Through its four businesses — Care Solutions, Financial Services, Behavioral Solutions and Specialty Benefits — OptumHealth helps Americans more effectively navigate the health care system, make better informed health decisions, finance their health care needs and access the best health services.

OptumHealth is a recognized leader in:

- Wellness, disease and care management programs;
- Care advocacy and decision support services;

1.9M

CONSUMER ACCOUNTS
SERVED IN 2009

- Complex condition management;
- Physical health networks;
- Mental health and substance abuse management; and
- Employee assistance programs.

Through myoptumhealth.com, as well as more than 1,500 private health portals (serving 36 million consumers), the company is also a leading provider of consumer health information. Every day, thousands of calls are received by OptumHealth's NurseLineSM and employee assistance programs, which provide customers with personalized health and wellness information.

OptumHealth's innovative eSync PlatformSM is a cutting-edge clinical technology capability. It provides a holistic view of a patient's medical history by combining all pertinent data, such as lab and claims information, prescription drug use, recent medical procedures, behavioral information and self-reported information. eSync's analytic software pores through this data and proactively sends out care recommendations, reminders to schedule annual exams and information about upcoming medical procedures. It's an integrated,

synchronized approach that allows OptumHealth to leverage many different types of outreach, including telephonic, fax, text messaging, mail, e-mail and personal Web portals.

OptumHealth Financial Services operates the only major bank dedicated exclusively to the health care industry. OptumHealth is also a leader in the promotion of paperless payment and statement solutions. The company connects almost 500,000 health care providers and electronically transmits more than \$3 billion of claim payments per month.

Providing health information and services through four businesses — Care Solutions, Financial Services, Behavioral Solutions and Specialty Benefits.

In 2009, OptumHealth continued to identify new ways to integrate its robust product offerings, while creating a more personalized patient experience and closely partnering with care providers. The result is a meaningful and powerful consumer franchise that is serving health needs for one out of every five Americans.

In 2009, OptumHealth revenues increased \$303 million, or 6 percent, to \$5.5 billion. The year marked OptumHealth's best overall external growth year in its history.

OptumHealth's public sector business continued to grow strongly in 2009, with significant new sales for services, including five state programs serving a total of nearly 1 million people. OptumHealth Financial Services ended the year serving 1.9 million consumer accounts, up 10 percent from 2008. Assets under management grew 31 percent to \$860 million in 2009.



As one of the largest global health information technology and consulting companies in the world, **Ingenix** is a leading supplier of information-based solutions to the health care market.

Included are those who diagnose and treat patients (doctors and hospitals), those who develop cures for disease (the life sciences industry) and those who pay for care (governments, commercial health plans and employers).

Relying on vast and robust health information resources, including 32 terabytes of information covering the health experiences of more than 90 million people, Ingenix uses the power of health information and

advanced analytics to strengthen clinical decision support, expand the use of health information technology, improve health care administration — and ultimately help to improve health outcomes.

In 2009, Ingenix brought its ability to innovate and its commitment to health privacy and security to an array of opportunities to address major health care outcomes and economics issues for clients. With more than 10,000 knowledge workers in more than 50 countries, Ingenix made an impact in some important arenas, including:

- Administrative simplification;
- Electronic health records and health information exchanges;
- Clinical decision support and analytics;
- Performance management and consumer transparency;
- Risk management, trend forecasting and underwriting;
- Comparative effectiveness research;
- Public health policy analysis; and
- Clinical and information services for life sciences companies, improving clinical effectiveness, safety and outcomes.

Ingenix offers clients software, services, consulting and outsourcing solutions. These solutions are provided to nearly every major participant in the U.S. health care system and a growing number of international systems. Clients include approximately 6,000 hospitals, 245,000 physicians, 2,000 health care payers and other intermediaries, 200 *Fortune 500* companies, 655 life sciences companies,

350 federal and state agencies and 135 United Kingdom government payers.

Over the past decade, revenue growth for Ingenix has averaged approximately 20 percent annually. Market demand for many of Ingenix services is on the rise with innovation driving growth. The American Recovery and Reinvestment Act of 2009 is already accelerating demand for industry-leading health care technology like Ingenix CareTracker, Ingenix's Web-based solution that modernizes and integrates all the functions of a physician practice, including electronic health records.

CareTracker modernizes and integrates all the functions of a physician practice, including electronic health records.

In collaboration with Intuit, a leader in financial software, Ingenix helped develop the Quicken Health Expense TrackerSM, combining Intuit's experience building consumer-friendly financial management tools with innovative Ingenix health care technology and experience. This Web-based tool guides consumers through the process of understanding and managing their health care finances. Quicken Health Expense Tracker will be widely available to UnitedHealthcare customers in 2010 through their personalized myuhc.com Web portals.

In 2009, The Lewin Group® launched its Center for Comparative Effectiveness Research, formed to meet the growing need for fact-based, comparative effectiveness research (CER) for use by policymakers, researchers, health care providers and others to improve patient care and optimize health care resources.

Ingenix's i3 business launched i3Cube™ in March 2009, an award-winning, integrated solution for managing all drug study activities in a centralized location on a single, user-friendly Adobe® platform. i3Cube brought a unique capability to the marketplace and has attracted the attention of clients embarking on projects across all phases of the drug development research cycle.

17%

2009 INGENIX
REVENUE INCREASE

In 2009, Ingenix also made several strategic acquisitions. In June, Ingenix acquired AIM Healthcare Services, Inc., a leading provider of health care payment solutions in all 50 states. In November, Ingenix acquired CareMedic Services, Inc., a company known for its innovation in hospital revenue cycle management.

Ingenix increased revenues by \$271 million, or 17 percent, to \$1.8 billion in 2009. The year included significant investments in new solutions related to payment and revenue cycle management,

comparative effectiveness research, international markets and electronic health records.

Continuing pressure to reduce health care costs and improve care quality is expected to create new demand for Ingenix's solutions.



Prescription Solutions is one of the largest Pharmacy Benefit Managers (PBMs) in the United States offering a comprehensive suite of pharmaceutical programs and consumer health products including retail, mail order, specialty pharmacy and clinical services.

Serving 11 million people nationwide and processing approximately 315 million adjusted prescriptions annually.

Prescription Solutions serves 11 million people nationwide and processes approximately 315 million adjusted prescriptions annually. The company has twice been recognized by J. D. Power

and Associates for its mail-pharmacy service, and is the only PBM to receive all four accreditations from URAC (a leading health care accreditation and education organization): Pharmacy Benefit Management, Drug Therapy Management, Mail Service Pharmacy and Specialty Pharmacy.

Prescription Solutions' mail order facilities provide customers with significant discounts versus typical retail drug stores. Its purchasing scale also allows it to supply customers with cost-effective brand name and generic drugs. Prescription Solutions generic penetration rate is nearly 70 percent, the highest among major PBMs.

A new consumer Web site was launched in 2009 to offer customers enhanced functionality, simplified navigation and up-to-date information on medications, as well as a real-time pricing tool for the growing Medicare Part D population.

In 2009, Prescription Solutions revenues of \$14.5 billion grew \$1.9 billion, or 15 percent, driven by strong growth in consumers served, script volume growth and steady gains in mail service drug fulfillment.

Over the past three years, revenue has increased from \$13.2 billion to \$14.5 billion and the number of customers served grew from 10.3 million to 11 million during the same period.

15%

2009 REVENUE GROWTH



United Health Foundation®

The United Health Foundation is a not for profit, private foundation that provides actionable information to support decisions that lead to better health outcomes and healthier communities. Established by UnitedHealth Group in 1999, the Foundation has committed more than \$170 million to improve health and health care. Following are examples of its program initiatives:

The United Health Foundation's **America's Health Rankings®** is an annual state-by-state assessment of the nation's health. In collaboration with the American Public Health Association and Partnership for Prevention, for nearly two decades *America's Health Rankings* has provided communities and individuals with data that has spurred innovative thinking and action to strengthen our nation's health.

Pictured above: Daughters of Charity Health Center at St. Cecilia (New Orleans, La.) participates in the United Health Foundation's Community Health Centers of Excellence initiative.

(Photo taken as part of a documentary book project on community health centers sponsored by the United Health Foundation.)

To increase access to health care for underserved communities, the Foundation's **Community Health Centers of Excellence** initiative supports community clinics that are part of our nation's health care safety net. Five health centers, in New Orleans, Miami, New York City and Washington, D.C., provide care equal to or better than care available by private-sector health care facilities, despite challenges unique to their locations.

The goal of the Foundation's **Diverse Scholars Initiative** is to increase the number of qualified, yet under-represented, college graduates entering the health workforce. Scholarships support hundreds of low-income minority students pursuing degrees in the health field. The development of health professionals from diverse, multicultural backgrounds will help improve the quality of culturally competent health care and help close the health disparities gap.

The Foundation collaborates with health research agencies, medical specialty societies and others to translate science into practice and helps make reliable medical evidence available to physicians and other care providers. Through **Advancing Clinical Excellence**, the United Health Foundation helps physicians and other health professionals achieve the best possible health outcomes for their patients.

To learn more about the United Health Foundation, go to www.unitedhealthfoundation.org.



Children who have medical needs are sometimes not insured comprehensively for all of their medical treatments. There are few places for families who have gaps in their commercial health benefit plan coverage to turn to for funding medically necessary services for their children. As a result, children may go without necessary treatment, or they receive needed care while their families assume large financial obligations.

That's where the UnitedHealthcare Children's Foundation (UHCCF) helps fill the gap. Established in 1999, UHCCF has provided grants to hundreds of children and their families to offset the cost of medical care.

UHCCF is funded by contributions from UnitedHealth Group and its employees, as well as the generosity of individuals and corporations. To learn more about the UnitedHealthcare Children's Foundation, visit www.uhccf.org.

Pictured above: UnitedHealthcare Children's Foundation grant recipient Liam Wolf and his dad.

2009 Financial Results

UnitedHealth Group Highlights

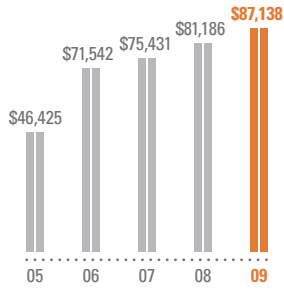
- UnitedHealth Group achieved business growth across each of its reporting segments and generated earnings from operations of \$6.4 billion.
- Diluted net earnings per common share were \$3.24.
- Revenues were \$87.1 billion.
- Cash flows from operations reached \$5.6 billion, representing 147 percent of 2009 net earnings.
- The challenging economic environment in the United States during 2009 exerted pressure on growth, product pricing and margins for UnitedHealth Group.

The 2009 financial results on pages 34 through 37 should be read together with the consolidated financial statements and notes in the 2009 Annual Report on Form 10-K. The 2009 Annual Report on Form 10-K is an integral part of this summary annual report.

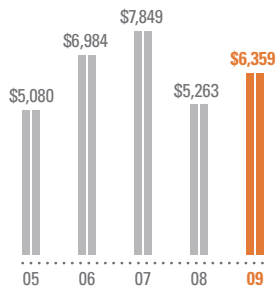
(dollars in millions, except per share data)

Year ended December 31	2009	2008	2007	2006	2005
Consolidated Operating Results					
Revenues	\$87,138	\$81,186	\$75,431	\$71,542	\$46,425
Earnings from operations	\$ 6,359	\$ 5,263	\$ 7,849	\$ 6,984	\$ 5,080
Net earnings	\$ 3,822	\$ 2,977	\$ 4,654	\$ 4,159	\$ 3,083
Return on shareholders' equity	17.3%	14.9%	22.4%	22.2%	25.2%
Basic net earnings per common share	\$ 3.27	\$ 2.45	\$ 3.55	\$ 3.09	\$ 2.44
Diluted net earnings per common share	\$ 3.24	\$ 2.40	\$ 3.42	\$ 2.97	\$ 2.31
Common stock dividends per share	\$.030	\$.030	\$.030	\$.030	\$.015
Consolidated Cash Flows From (Used For)					
Operating activities	\$ 5,625	\$ 4,238	\$ 5,877	\$ 6,526	\$ 4,083
Investing activities	\$ (976)	\$ (5,072)	\$ (4,147)	\$ (2,101)	\$ (3,489)
Financing activities	\$ (2,275)	\$ (605)	\$ (3,185)	\$ 474	\$ 836
Consolidated Financial Condition					
As of December 31					
Cash and investments	\$24,350	\$21,575	\$22,286	\$20,582	\$14,982
Total assets	\$59,045	\$55,815	\$50,899	\$48,320	\$41,288
Total commercial paper and long-term debt	\$11,173	\$12,794	\$11,009	\$ 7,456	\$ 7,095
Shareholders' equity	\$23,606	\$20,780	\$20,063	\$20,810	\$17,815
Debt-to-total-capital ratio	32.1%	38.1%	35.4%	26.4%	28.5%

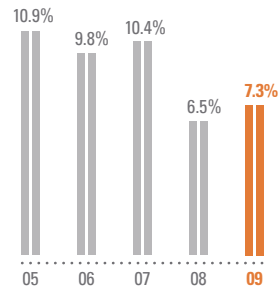
Revenues
(in millions)



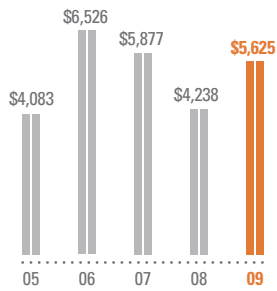
Earnings From Operations
(in millions)



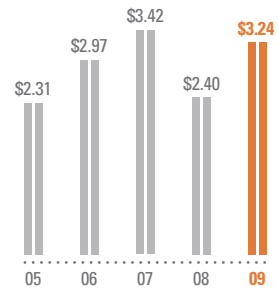
Operating Margin



Cash Flows From Operations
(in millions)



Diluted Earnings Per Share



Health Benefits

(includes UnitedHealthcare, Ovations and AmeriChoice)

- UnitedHealthcare revenues of \$40.8 billion decreased by 2 percent in 2009 primarily due to a 7 percent year-over-year decrease in total people served, partially offset by premium rate increases. Employment attrition at continuing clients contributed 55 percent of the total decrease in people served during the year.
- Ovations revenues were \$32.1 billion, an increase of \$4.1 billion, or 15 percent, compared to 2008 driven by an increase in individuals served across each major senior health care product category including Medicare Advantage, standardized Medicare Supplement offerings and Medicare Part D, as well as premium rate increases. In total, Ovations brought services to an additional 675,000 seniors in 2009.
- AmeriChoice revenues of \$8.4 billion in 2009 increased by \$2.4 billion, or 40 percent, year-over-year primarily due to organic growth in individuals served. Risk-based Medicaid programs organically grew by 24 percent or 565,000 individuals during the year to 2.9 million people.

Health Services

OptumHealth

- OptumHealth revenues of \$5.5 billion increased \$303 million, or 6 percent, over 2008 primarily due to new business development in large-scale public sector care management and behavioral health programs for state clients, partially offset by a decline in people served in commercial products.
- Growth in public sector business included new sales for services commencing in 2009 or 2010 to five state programs serving a total of nearly 1 million people.
- OptumHealth Financial Services grew its connectivity network to more than 500,000 physicians and care providers in 2009 and electronically transmitted \$36 billion in medical payments to them, a year-over-year increase of 36 percent. Assets under management in health-linked savings and investment accounts reached \$860 million, an increase of 31 percent over 2008.

Ingenix

- Ingenix provides services in more than 50 countries and serves virtually every category of participant in the U.S. health system.
- Revenues for Ingenix increased \$271 million, or 17 percent, during 2009 to \$1.8 billion primarily due to organic growth in new payer business and new internal service offerings.
- The Ingenix contract revenue backlog grew \$380 million, or 21 percent, during 2009 to \$2.2 billion, led by growth in the government and payer sectors.

Prescription Solutions

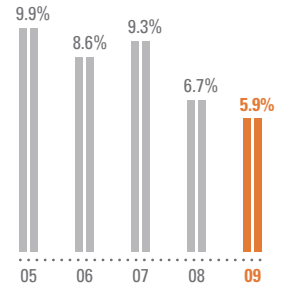
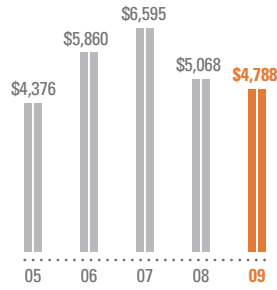
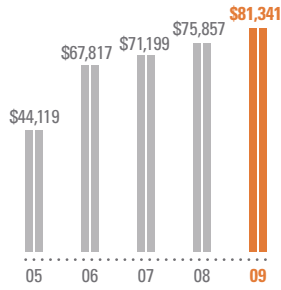
- Prescription Solutions 2009 revenues of \$14.5 billion grew \$1.9 billion, or 15 percent, year-over-year due to strong growth in consumers served through Medicare Part D prescription drug plans.
- During the year, Prescription Solutions processed approximately 315 million adjusted scripts for 11 million individuals.
- Generic prescriptions reached nearly 70 percent of all scripts filled by Prescription Solutions by the fourth quarter 2009, an increase of 160 basis points year-over-year. The expanded use of generics increases the affordability of health care and also increases earnings from operations at Prescription Solutions.

Revenues
(in millions)

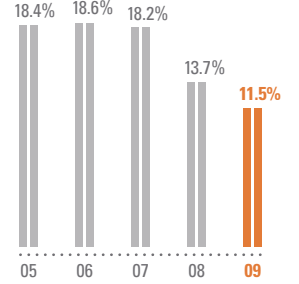
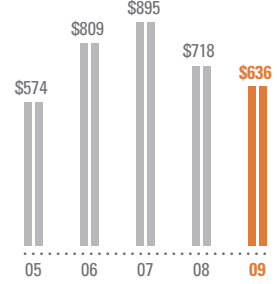
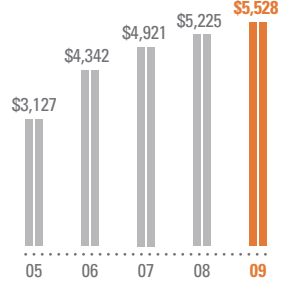
Earnings From Operations
(in millions)

Operating Margin

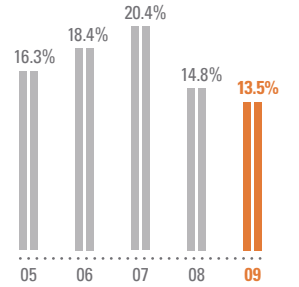
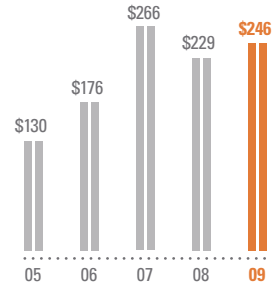
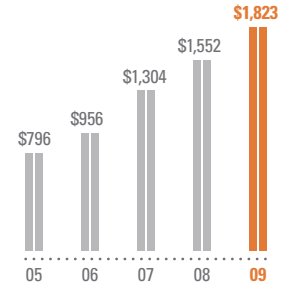
Health Benefits



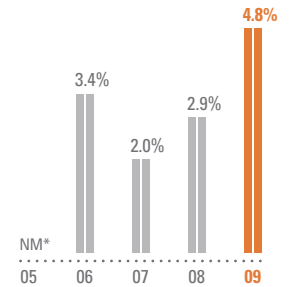
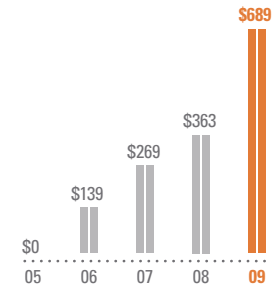
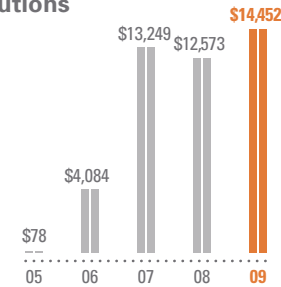
OptumHealth



Ingenix



Prescription Solutions



*Not Meaningful

Officers and Board Members

Officers and Leaders

Stephen J. Hemsley

President and
Chief Executive Officer

Gail K. Boudreaux

Executive Vice President
and President,
UnitedHealthcare

G. Mike Mikan

Executive Vice President
and Chief Financial Officer

William A. Munsell

Executive Vice President
and President,
Enterprise Services Group

Don Nathan

Senior Vice President and
Chief Communications Officer

John S. Penshorn

Senior Vice President,
Capital Markets Communications
and Strategy

Eric S. Rangen

Senior Vice President
and Chief Accounting Officer

Larry C. Renfro

Executive Vice President
and Chief Executive Officer,
Public and Senior Markets Group

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Executive Vice President

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Executive Vice President
and President,
Global Health

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Executive Vice President,
Human Capital

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Executive Vice President
and Chief of Medical Affairs

Christopher J. Walsh

Executive Vice President
and General Counsel

Anthony Welters

Executive Vice President
and President,
Public and Senior Markets Group

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Executive Vice President
and President,
UnitedHealth Group Operations

Mitchell E. Zamoff

Executive Vice President
and General Counsel

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Greenebaum Doll & McDonald PLLC

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UnitedHealth Group

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and Chief Financial Officer,
Johnson & Johnson

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President and
Chief Executive Officer,
UnitedHealth Group

Michele J. Hooper

President and
Chief Executive Officer,
The Directors' Council

Douglas W. Leatherdale

Retired Chairman
and Chief Executive Officer,
The St. Paul Companies, Inc.

Glenn M. Renwick

President and
Chief Executive Officer,
The Progressive Corporation

Kenneth I. Shine, M.D.

Executive Vice Chancellor
for Health Affairs,
The University of Texas System

Gail R. Wilensky, Ph.D.

Senior Fellow,
Project HOPE

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Robert J. Darretta

Glenn M. Renwick

Nominating and

Corporate Governance Committee

Michele J. Hooper, Chair

William C. Ballard, Jr.

Douglas W. Leatherdale

Compensation and

Human Resources Committee

Douglas W. Leatherdale, Chair

Robert J. Darretta

Gail R. Wilensky, Ph.D.

Public Policy Strategies

and Responsibility Committee

Gail R. Wilensky, Ph.D., Chair

Michele J. Hooper

Kenneth I. Shine, M.D.

This Summary Annual Report may contain statements, estimates, projections, guidance or outlook that constitute “forward-looking” statements as defined under U.S. federal securities laws. Generally the words “believe,” “expect,” “intend,” “estimate,” “anticipate,” “plan,” “project,” “should” and similar expressions identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions, trends and uncertainties and involve risks and uncertainties. We caution that actual results could differ materially from those that management expects, depending on the outcome of certain factors. Some factors that could cause results to differ materially from the forward-looking statements include: the outcome of proposed health care reform, which could materially adversely affect our revenues, financial position and results of operations, including increasing our costs, subjecting us to new and potentially significant taxes, exposing us to expanded liability, requiring us to revise the ways in which we conduct business or putting us at risk for loss of business (our financial outlook does not account for any potential impact of health care reform on our businesses); our ability to effectively estimate, price for and manage our medical costs, including the impact of any new coverage requirements; the potential impact that new laws or regulations or changes in existing laws or regulations or their enforcement could have on our results of operations, financial position and cash flows, including as a result of increases in medical, administrative, technology or other costs resulting from federal and state regulations affecting the health care industry; the potential impact of adverse economic conditions on our revenues (including decreases in enrollment resulting from increases in the unemployment rate and commercial attrition) and results of operations; regulatory and other risks and uncertainties associated with the pharmacy benefits management industry; competitive pressures, which could affect our ability to maintain or increase our market share; uncertainties regarding

changes in Medicare; potential reductions in revenue received from Medicare and Medicaid programs, including as a result of reduced payments to private plans offering Medicare Advantage; our ability to execute contracts on competitive terms with physicians, hospitals and other service professionals; our ability to attract, retain and provide support to a network of independent third party brokers, consultants and agents; failure to comply with restrictions on patient privacy and data security regulations; events that may negatively affect our contracts with AARP; increases in costs and other liabilities associated with increased litigation; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and intangible assets recorded for businesses that we acquire; increases in health care costs resulting from large-scale medical emergencies; failure to maintain effective and efficient information systems; misappropriation of our proprietary technology; our ability to obtain sufficient funds from our regulated subsidiaries to fund our obligations; failure to complete or receive anticipated benefits of acquisitions; potential downgrades in our credit ratings; and failure to achieve targeted operating cost productivity improvements, including savings resulting from technology enhancement and administrative modernization.

This list of important factors is not intended to be exhaustive. A further list and description of some of these risks and uncertainties can be found in our reports filed with the Securities and Exchange Commission from time to time, including the cautionary statements in our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. Any or all forward-looking statements we make may turn out to be wrong. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. We do not undertake to update or revise any forward-looking statements.

Market price of common stock

The following table shows the range of high and low sales prices for the company's common stock as reported by the New York Stock Exchange, where it trades under the symbol UNH. These prices do not include commissions or fees associated with purchasing or selling this security.

	<i>high</i>	<i>low</i>
2010		
First Quarter thru February 3, 2010	\$36.07	\$30.97
2009		
First Quarter	\$30.25	\$16.18
Second Quarter	\$29.69	\$19.85
Third Quarter	\$30.00	\$23.69
Fourth Quarter	\$33.25	\$23.50
2008		
First Quarter	\$57.86	\$33.57
Second Quarter	\$38.33	\$25.50
Third Quarter	\$33.49	\$21.00
Fourth Quarter	\$27.31	\$14.51

As of February 3, 2010, the company had 18,145 shareholders of record.

Shareholder account questions

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including:

- Change of address
- Lost stock certificates
- Transfer of stock to another person
- Additional administrative services

You can write to them at:

Wells Fargo Shareowner Services
P.O. Box 64854
St. Paul, Minnesota 55164-0854

Or you can call our transfer agent toll free at (800) 468-9716 or locally at (651) 450-4064.

You can e-mail our transfer agent at:

stocktransfer@wellsfargo.com

Investor relations

You can contact UnitedHealth Group Investor Relations to order, without charge, financial documents such as the Annual Report on Form 10-K and the Summary Annual Report.

You can write to us at:

Investor Relations, MN008-T930
UnitedHealth Group
P.O. Box 1459
Minneapolis, Minnesota 55440-1459

You can also obtain information about UnitedHealth Group and its businesses, including financial documents, online at www.unitedhealthgroup.com.

Annual meeting

We invite UnitedHealth Group shareholders to attend our annual meeting, which will be held on Monday, May 24, 2010, 12:00 p.m. Central Time at the Sheraton Overland Park Hotel at the Convention Center, 6100 College Boulevard, Overland Park, Kansas. You will need to bring your admission card with you to the annual meeting in order to be admitted.

Common stock dividends

UnitedHealth Group's Board of Directors regularly reviews the company's financial statements and decides whether it is advisable to declare a dividend on the outstanding shares of common stock. The Board of Directors has declared the following dividends in 2009 and 2010: Shareholders of record on April 2, 2009, received an annual dividend for 2009 of \$0.03 per share, which was paid on April 16, 2009; shareholders of record on April 6, 2010, received an annual dividend of \$0.03 per share, which will be paid on April 20, 2010.

Our mission is to help people live healthier lives.

Mission statement

We seek to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities.

We work with health care professionals and other key partners to expand access to quality health care so people get the care they need at an affordable price.

We support the physician/patient relationship and empower people with the information, guidance and tools they need to make personal health choices and decisions.

Our values

We serve people through a value and performance culture based on integrity, quality, innovation, diversity and social responsibility. The best way we can satisfy the millions of people we serve — our customers and members, employees, shareholders and partners — is to execute on the fundamentals of our business to the very best of our abilities, each and every day. That means as an organization, we are accountable for adding value to the health care system.

For more information on how our 80,000 people work to fulfill our mission every day, please see our Social Responsibility Report at www.unitedhealthgroup.com/2009-social-responsibility-report



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UnitedHealth Group®

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