UnitedHealth Group 2005 Summary Annual Report

REAL NEEDS. REAL SOLUTIONS.

COMMITTED TO:

- > AFFORDABILITY
- > ACCESS
- > QUALITY AND
- > SIMPLICITY

Chairman's Letter

IN THE AMERICAN HEALTH CARE SYSTEM

As I write this letter, our nation continues its decades-long struggle to ensure that affordable and appropriate health care is available to all people.

America's health care system, which has long been recognized for its achievement in addressing complex disease, is also marked by embarrassing shortcomings relative to the efficiency of the health system, the availability of needed care interventions for all people, and the economic costs it carries. And even as our nation works to correct these deficiencies, new challenges have emerged — such as accelerating demographic changes, the escalating cost of new technologies, clinical interventions and research, and increasing complexities around medical decision-making — which make our goals even more complicated and difficult to realize.

Although it seems that few economically developed countries struggle as much as our society with the entire range of issues surrounding health care, most nations today face some or all of the same health-care-related issues that we do in the United States. Research to identify the optimum and appropriate health care system, when unencumbered by anecdote and political bias, reveals that virtually all societies grapple with cost, access and resource availability — issues that are essential to providing timely health care interventions to all of their people, whether their health systems are government-run and sponsored, private or hybrids of the two.

This leads us back to a fundamental and long-standing reality: How health care is organized and how it performs is more critical to realizing optimum results than is the funding structure for the system…and at some level even the funding amount. It is clear that simply spending more money on the traditional approaches, with their inherent inefficiencies and shortcomings, will not address the issues that impede our nation's ability to make health care services more available and affordable for all people. Fundamental changes are required in how health care is organized, delivered and administered.

Today, UnitedHealth Group is better equipped than at any time in its history to advance changes that will serve as catalysts for meaningful improvement in the health care system. Driven by a fundamental belief that our health care system is neither what it could be nor what it should be, and supported by a culture within our company that unequivocally embraces this belief and demonstrates passion for change, we are building upon years of strategic asset development, operating focus and establishment of proven capabilities, along with the diverse experiences of our employees, to advance on the imperatives of access, quality, ease of use and affordability in health care.

We are positioned — through the diversification of businesses and the cultivation of competencies such as enabling technology, sophisticated analytical applications of large-scale clinical data, and the value of optimally effective care procurement and its management and coordination — to respond quickly and effectively to the expanding set of health-care-related changes on behalf of our diverse customer base. The reality of this ability is manifest even today in our business, our results and our positive impact on those we serve.

Exemplifying this is Ovations, the dedicated business created by UnitedHealth Group to serve the diverse health and well-being needs of older Americans. With its broad array of service offerings, Ovations addresses the needs of a group of people who today account for nearly $700 billion of annual health care expenditures, who in the next decade will increase in number by nearly 25 percent — or 10 million individuals — and whose health care needs and interests are complex and compounding dramatically. For them, an enterprise such as Ovations is critical to providing innovative and responsive solutions for their unique needs.

That is demonstrated by the issues surrounding the availability of affordable prescription drugs and the new Medicare Part D prescription drug program. While no one would deny the challenges produced by meaningful start-up problems in this huge new federal initiative, Ovations responded effectively on behalf of enrolled seniors and expects to serve nearly 6 million people through this program by year-end. The savings on prescriptions for the first 3 million of Ovations' enrollees, when compared to retail pricing, amounted to more than $900 million in just the initial six weeks of the program. That is an indisputable positive for American seniors, and a demonstration of how an entirely new and innovative program can address meaningful ongoing needs of our society — even with short-term start-up challenges.

Similarly, the significant investments we have made in R&D, technology and business process improvements — now approaching $3 billion in the past five years — have produced modernized and broad applications that scale across the entire health care services arena. Our unique, fully integrated, efficient and highly interactive infrastructure for administrative services is one of the outputs of this effort. Leveraged across multiple business and customer needs, such an operating platform advances the creation of a simpler, more usable and infinitely more affordable health care system. And with the implementation of such a system, and the impact on cost and effectiveness it provides, key challenges for our nation — such as global competitiveness and lowering the numbers of underinsured and uninsured people — can be at least partially addressed.

We also believe the creation of robust longitudinal data sets and the tools to intelligently sort and analyze that data is integral to any effort to improve health care quality, appropriateness and safety. This is another area where resources are now at hand and can make meaningful contributions if we use them more innovatively. Such capabilities address pervasive needs in all that is done around health care — from the development of effective drug therapies, to the making of health-related decisions, to identifying the best care providers who can handle specific clinical needs of individual patients. Ingenix, a UnitedHealth Group company dedicated to the data and information marketplace, has emerged as a leader in these efforts. A recent contract with the U.S. Food and Drug Administration to use these capabilities for post-marketing surveillance and drug safety assessment, as well as similar decisions by major drug development and medical device companies, provide examples of how such innovative approaches can be used and, in so doing, address fundamental needs in health care.

There is much, much more to do, and it must be done with an urgency and conviction that recognizes the human needs to which each of us and our nation are committed. In this pursuit, UnitedHealth Group is ideally positioned to respond and lead.

Clearly, UnitedHealth Group is not unique in its ability to drive change in health care, nor is this a newly conceived position for us. A commitment to changing how the health care system works has long been part of us, and this agenda has been at the foundation of building this company to our current position. Importantly, today we know that our assets and capabilities are more advanced than ever before and our resolve more entrenched…and such resolve is ultimately essential for success. In fact, when addressing the complex and challenging issues in health care, our resolve may transcend in importance the assets we possess.

Access, affordability, quality and ease of use: These imperatives shape our actions. They do not exist in isolation, but are closely intertwined; realization of one demands resolution of another. But they must each be addressed to achieve the health system we desire…and the health care and outcomes we demand. To do this, we must act together and in ways heretofore ignored or stymied. Our society no longer has the luxury of prolonged debate and discussion, of further study and delay, of imbalanced ideology or self-interest. The costs by any measure — human suffering, economic waste, public accountability — are too great to continue as we have.

The resources and tools are available. The time to act is now.

I have had the privilege of writing this annual letter to shareholders of UnitedHealth Group for 15 years and to have worked as both a medical researcher and practicing physician for more than a dozen years. Those perspectives and that time frame have allowed me to observe how our nation responds to its health care needs and to make a longer-term assessment of what UnitedHealth Group has accomplished and what it is capable of accomplishing. During that span, our nation has meaningfully advanced its agenda, yet it remains well short of the sustainable changes needed to realize its goals for our society. And during that time, this company has demonstrated a commitment to improving and thus changing the health care system, an unwillingness to be satisfied with what has been accomplished, and a realization that much more is possible. This has served us well, but our larger aspirations remain unfulfilled.

Based on financial measures — traditionally the principal value measurement for Wall Street — we have provided a continuum of growth and strongly positive results. Without question, our shareholders have seen success emerge from a clear and consistent vision, innovation, execution and the resolve to change how health care works in order to improve what it achieves. We are proud of this performance for shareholders, including our 15-year compound annual growth rate of 32 percent for earnings per share and projected 2006 revenues that will likely place us among the *Fortune* 20. We will work to continue the same level of performance in the future. But financial measurement alone is not enough to gauge success.

Ultimate success requires another measure — one that rates performance based on the effectiveness in meeting customer needs, advancement of a critical social good, and the realization of one's full potential. By that measure, we are yet incomplete. There is much, much more to do, and it must be done with an urgency and conviction that

William W. McGuire, M.D.
Chairman and Chief Executive Officer

recognizes the human needs to which each of us and our nation are committed. In this pursuit, UnitedHealth Group is ideally positioned to respond and lead.

2005 was an outstanding year for UnitedHealth Group. It was a period of advancement and innovation that saw us help improve the health and well-being of tens of millions of people, both here and abroad, and further expand the breadth and scope of our capabilities to more effectively address the challenges we all share.

Actions we have long pursued — promoting greater use of scientifically based evidence to inform and guide the consumption of health care resources, applying advanced technologies to modernize and streamline health care administration and forging stronger partnerships between private and public entities to address health care needs of vulnerable populations — have become even more relevant today as new medical interventions emerge, our population ages and individuals assume more responsibility for their health care. It is encouraging to see these concepts integrated as meaningful elements of our health care system. Going forward, our efforts will reflect other evolving issues and will thus be marked by significant further expansion in areas such as consumerism, services for care providers, financial services as they apply to health care needs, technology applications and services for uninsured and economically disadvantaged individuals, as well as older Americans and discrete groups with unique needs.

We remain steadfast in our belief that basic health care can — and must — be made available to all Americans, and we recognize that achievement of this goal will require the collective efforts of all parties involved in the health care system. As a nation, we must truly commit to, rather than simply debate, this goal of essential health care benefits for all people. Authorities from medical science must step forward as leaders in addressing what is truly essential in health care, even as they help establish the standards of appropriate interventions for care providers. In turn, our nation must use this information to create a rational standard for what constitutes essential health care, and our legislators must replace current mandates, which have been driven too frequently by special interests rather than science, with statutes that support the provision of such essential health care benefits through private and public means. And for our part, UnitedHealth Group will move forward with urgency to deliver innovative and sustainable solutions that will make that health care system work better, replacing outdated tools and ways of administrating benefits with more efficient, lower cost processes and technologies, providing data and information that drive better health care decisions, and organizing access to optimize the use of precious health care resources.

The emerging trends brought about by aging populations, greater consumer accountability, the use of data and the application of technology are undeniable. The imperatives of affordability, quality, access and simplification are clear. We recognize our responsibility to help address these critical issues, and we are committed to act.

Sincerely,

William W. McGuire

William W. McGuire, M.D.
Chairman and Chief Executive Officer

At UnitedHealth Group, we envision a health care system in which individuals can easily determine who to see and where to go for services that best meet their needs; where physicians, hospitals and care professionals deliver consistent, high-quality care based on scientific evidence of what works; where prescription drugs, medical devices and new therapies are developed safely and efficiently and used appropriately to address illness; and individuals and businesses alike are supported by an advanced technology infrastructure that provides simple, integrated service.

Through our family of businesses, we are turning commitment into action — leveraging established strengths in organizing resources, applying technology and analyzing data to create real solutions that expand access, promote quality, simplify service and make health care more affordable.

TURNING COMMITMENT INTO ACTION

Uniprise

REAL NEEDS

Uniprise serves large employers, insurers and other health care intermediaries, helping them deliver affordable, high-quality health benefits by providing highly integrated information, technology, health care benefits management and financial solutions.

Using an informed and consultative approach, Uniprise designs customized benefit solutions to meet the unique needs of each customer and the individuals they represent. Combining innovative benefit designs with exceptional administrative services and individualized interactions allows Uniprise to offer accessible health care services that are both affordable and personal.

Uniprise benefit strategies engage consumers directly in their health care decisions. Plan designs feature decision-support vehicles that give people credible information they can use to help optimize their health care provider and treatment decisions, personalized communications and coaching services that encourage healthy behaviors, and care support services that help people with chronic illnesses manage their conditions more effectively.

Uniprise offers integrated personal financial services and payment capabilities through Exante Bank, a financial institution chartered by UnitedHealth Group. Electronic ID cards streamline service, enabling physicians to verify patient benefit eligibility using electronic connectivity and existing payment networks. Exante Bank cards let consumers pay for qualified medical expenses directly from a full spectrum of personal health account options, including health savings accounts, health reimbursement accounts or flexible spending accounts. Exante offers turnkey financial services products to other insurers, administrators and care providers and serves as a platform for ongoing product innovation and growth.

A single, highly scalable operating environment is used by Uniprise to support efficient, high-quality health benefit administration services. Uniprise responds to approximately 300 million transactions annually, and processes more than 85 percent of all claim and customer care transactions automatically. Its intelligently designed technology platform removes administrative complexity, improves payment accuracy and lowers costs. Sophisticated new capabilities are being used to improve service response and outcomes for consumers with the most complex claim or benefit issues.

Integral to these customer-responsive technology advances are robust and convenient Internet self-service portals, which today enable 5 million households, 660,000 physician and care provider user sites, 220,000 employers and 50,000 brokers to conduct more than 440 million transactions on an annualized basis. Online personal health records feature a continuously updated Personal Health Summary that is accessible to the consumer through myuhc.com®, and to their physicians via a unique physician portal, UnitedHealthcare Online®. This tool is a tangible advancement providing both patients and physicians with timely medical information. Online personal financial statements enable consumers to track their health care expenses and account balances.

Today, Uniprise is the nation's largest and fastest-growing health benefits business for the national employer health services market, with more than 5 million new individuals joining its customer base over the past seven years. And while focused on fully meeting the needs of that group of clients, Uniprise is expanding its market scope into new areas. These include greater emphasis on retiree health care solutions and new ways to help plan sponsors improve program effectiveness and performance for the benefit of their employees.

REAL SOLUTIONS

- Consumer-driven health plans, health coaching and personalized communication services from Uniprise's Definity Health® business that help individuals engage more directly in their health care decisions
- Personal financial services from Exante Bank, which give consumers financial control over their health care dollars and spending decisions
- Online personal health records that help consumers maintain a personal health history and summary of conditions, procedures, medications and lab tests
- Online personal financial statements that provide consumers with an overview of health-related expenses and account balances
- Internet service portals, which enable individuals, households, physician and care providers and employers to conduct transactions and access information quickly and efficiently
- Affordable benefit solutions that extend health care coverage to uninsured and underinsured workers
- Customized benefit solutions, which provide access to quality, affordable health and well-being services for 10.5 million people
- Efficient, comprehensive operational services that support health plans and intermediaries representing more than 24 million individuals
- More than 20 million electronic medical ID cards issued, which let physicians and care providers instantly check patient benefits eligibility
- The UnitedHealth Allies℠ discount program, which helps consumers lower out-of-pocket costs on a broad spectrum of products and services

UnitedHealthcare

REAL NEEDS

UnitedHealthcare advances affordable, consumer-oriented health benefits that provide access to an extensive, nationwide network of high-quality physicians and hospitals, as well as the tools needed to support appropriate and efficient use of their capabilities.

Approximately 135 million Americans secure individual health coverage or are affiliated with small, mid-sized or public sector employers. UnitedHealthcare offers a full range of health solutions to meet their varying needs, including benefit plans specifically designed to help employers extend benefit coverage to uninsured or underinsured part-time, hourly and full-time workers.

UnitedHealthcare benefit plans provide convenient access to physicians, hospitals and health professionals from coast to coast, as well as coordinated delivery of care support, education and wellness services through online tools and personalized interventions. All UnitedHealthcare benefit plans can be combined with flexible spending accounts, health reimbursement accounts or health savings accounts to support greater individual participation in health care decisions.

Programs around quality, safety and affordability are central to UnitedHealthcare's mission. The UnitedHealth Premium℠ program offers quality and efficiency information consumers can use to help identify specialists and hospitals that best meet their needs, and provides people with critical or complex medical conditions access to care through nationally recognized centers of excellence. A discount buying program, UnitedHealth Allies℠, offers consumers savings of 10 percent to 50 percent on many health-related products and services. Pharmacy benefit programs from UnitedHealth Pharmaceutical Solutions provide opportunities for people to select drugs that are proven to meet clinical needs and offer the best total value, whether they are brand-name or generic drugs.

Through Internet portals and electronic service channels, UnitedHealthcare seeks to simplify administrative aspects of health care and lower costs. The UnitedHealthcare consumer Web site, myuhc.com®, provides 24/7 access to information resources and tools that support better decisions. Online personal health record and personal financial statement capabilities are coupled with this, enabling consumers to maintain both a personal health record and personal financial record related to their health benefits program, and a summary of conditions, procedures, medications and lab tests. This information can be accessed through proprietary, privacy-protected channels, and the summary can be printed and taken to appointments, allowing physicians to spend less time gathering routine health information and more time on assessment and treatment planning.

Moving to improve access to optimal care, strategic alliances have been created between UnitedHealthcare and some of the nation's most highly regarded regional not-for-profit health plans, including Medica Health Plans in the Upper Midwest and Harvard Pilgrim Health Care in New England. These alliances, which are unique in the marketplace, improve service to customers of each participating organization. In addition, they help not-for-profit health plans access advanced technology investments and achieve economies of scale, which strengthen them competitively and help them advance their missions.

Today, UnitedHealthcare serves more than 14 million Americans nationwide, offering the most comprehensive range of products and services available.

REAL SOLUTIONS

- An integrated network of care professionals, providing direct access to more than 500,000 physicians and other care providers, and 4,600 hospitals nationwide
- The UnitedHealth Premium℠ program, which provides quality and cost information about physicians and hospitals in 19 medical and surgical subspecialties
- Integrated clinical outreach programs and disease and care management programs that help individuals with complex and chronic conditions access services and maintain optimal health
- Unique partnerships with leading medical specialty organizations, such as The Society of Thoracic Surgeons and American College of Cardiology, which draw upon their leadership and knowledge to drive the use of evidence-based clinical outcomes data to improve decisions
- Unique market alliances with regional not-for-profit health plans, which help expand customer access to affordable care services regionally and throughout the United States
- UnitedHealth Basics℠, health benefit plans designed to help employers extend basic coverage to their workers at a more affordable cost
- Pharmacy benefit programs, which help people access appropriate drugs at the best total value and allow employers and payers to achieve pharmacy cost trends well below national trends
- The use of proprietary Internet portals that help streamline service for consumers, brokers, physicians and employers and lower related administrative costs
- Online personal health capabilities that allow consumers to maintain personal health records and health-related financial records, and print a summary of conditions, procedures, medications and lab tests

Ovations

REAL NEEDS

Ovations is dedicated to the growing need for affordable health care solutions for Americans age 50 and older.

Each day, more than 12,000 Americans turn 50. Over the next decade, Medicare expenditures are expected to rise by 150 percent. These simple statistics underlie one of the most significant challenges for the nation, and also define an enormous opportunity for companies that can deliver simple, affordable, effective health care solutions shaped to meet the needs of older Americans.

Ovations responds to a full range of health and well-being needs for people over age 50. Its diverse and comprehensive array of products and services includes Medicare Advantage plans and Medigap offerings, private fee-for-service plans, independent living services, special need and hospice services, prescription drug coverage, medical supply services, and group retiree solutions and insurance plans for pre-Medicare retirees ages 50 to 64.

Ovations works with national and local institutions, including AARP, the Centers for Medicare & Medicaid Services, large employers, state governments and health care facilities, to help meet the needs of older Americans. The launch of the Ovations Medicare Part D prescription drug benefit plan in 2005 demonstrates the important role these relationships play in serving the needs of seniors. The Ovations Medicare Part D prescription drug benefit plan is exclusively endorsed by AARP. Through relationships with premier drugstores, the Ovations plan provides seniors with convenient access to retail pharmacy locations as well as mail order services for their prescription drugs. Built around this strong set of resources, Ovations expects to enroll nearly 6 million individuals in Medicare Part D prescription drug plans for 2006, helping seniors achieve a projected $5 billion in savings on their prescriptions compared to retail costs for the first year alone.

Among our nation's most important issues are chronic health problems. Today they account for about 70 percent of the medical costs for Medicare and long-term-care Medicaid programs. Through its Evercare senior services offerings, Ovations provides a proprietary set of health and well-being services for chronically ill and frail elderly individuals. Launched more than 15 years ago, Evercare now offers services in 23 states. Continued growth in Evercare is expected as it further expands programs for nursing home residents in existing and new markets, participates in additional special needs plans and expands end-of-life care services.

With extensive assets, proven capabilities and a dedicated focus on seniors, Ovations is in a unique position to respond to the needs of this important segment of our society and the vast and growing market they represent. Ovations expects accelerating growth to advance revenue to $25 billion in 2006 and is poised to sustain exceptional growth over the years to come.

REAL SOLUTIONS

- Affordable health insurance plans and related services dedicated to AARP members using Medicare programs and services
- Pre-Medicare insurance plans, which help AARP members between 50 and 64 years of age access more affordable health care services
- Prescription drug benefit programs that will help nearly 6 million older Americans achieve a projected $5 billion in savings compared to retail prescription costs in 2006 alone
- Medicare Advantage plans, which improve access to health care services for older Americans in 35 states nationwide
- Private fee-for-service programs that help seniors in 24 states access health care services
- Newly created Special Needs Plans in 33 markets that help people eligible for both Medicare and Medicaid access health care services easily and more effectively
- Health care planning and complex care management services, which improve quality of care for chronically ill, frail or elderly individuals
- Proprietary clinical software that supports and, in turn, improves complex care management for patients in nursing homes, hospitals and home care settings
- End-of-life programs that address palliative care needs in a timely and compassionate manner

AmeriChoice

REAL NEEDS

AmeriChoice works to improve health care for underserved, economically disadvantaged and vulnerable individuals.

Health care represents nearly one-third of all state expenditures and, without question, remains the most rapidly growing element of state budgets. The vast majority of these expenditures are directed at the health care needs of lower income and vulnerable populations. AmeriChoice is committed to addressing these needs by partnering with states to deliver effective, affordable services to those in need.

AmeriChoice today provides access to health care services for 1.3 million members of state-sponsored health care programs in 13 states, including 10 in which the company operates full-service health plans. In addition to community-oriented networks, AmeriChoice offers its members wellness and disease management programs targeted to their specific needs, and offers government agencies a comprehensive menu of distinctive management services — including clinical consulting and management, pharmacy benefit design services, and benefit administration and technology services — to help each one optimize its health care program in response to its unique situation and resource availability.

Using an insightful and sensitive clinical care approach called its Personal Care Model, AmeriChoice works proactively to address the particular health care needs of the individuals served. In this setting, sophisticated data tools identify individuals who may need immediate care management services or social service resources so that AmeriChoice medical professionals can provide hands-on clinical and social case management. They work directly with family members and primary care physicians to determine the most effective clinical interventions and help individuals and their families better manage medical conditions to realize optimal health outcomes.

Of particular importance are chronic and acute conditions that are prevalent among this vulnerable population. AmeriChoice targets these conditions through specialized disease management programs for people with asthma, diabetes, congestive heart failure, sickle cell disease, chronic obstructive pulmonary disease, pneumonia, special needs, lead poisoning, HIV and high-risk obstetrical and maternal management. The Healthy First Steps program is a prime example: It supports women with high-risk pregnancies and coordinates care through an obstetrician and outreach personnel to help minimize premature deliveries and related medical complications. The company takes a proactive engagement approach toward preventive health services and screenings for children of all ages.

In addition to supporting appropriate clinical care, AmeriChoice further addresses the issues of cost by drawing on the expertise of UnitedHealthcare contracting and network servicing functions to leverage the full purchasing power of UnitedHealth Group on behalf of the Medicaid population. AmeriChoice, equipped with an outstanding and, in many ways, unique set of assets and an unwavering commitment to advancing the health of disadvantaged populations, is well positioned to expand further as legislators search for new and more effective ways to extend health care services to their most vulnerable citizens.

REAL SOLUTIONS

- Access to care for 1.3 million Medicaid beneficiaries in 13 states
- Clinical, operational and technology services that help states optimize health care programs
- Care management services that help individuals with serious and chronic health conditions maintain optimal health
- Disease management, education and outreach programs that target the most prevalent chronic conditions to affect Medicaid beneficiaries, including hypertension, cardiovascular disease, asthma, sickle cell disease, diabetes and high-risk pregnancies
- Widely used telemedicine tools that enable nurses and physicians to monitor vital signs, check medication usage, assess patient status and facilitate overall care, particularly in settings with limited access to needed services
- Comprehensive pharmacy services, including benefit design, programs that facilitate use of appropriate drugs, including generic drugs, and drug utilization review and preferred drug list development, which optimize pharmaceutical use and help contain rising costs
- Advanced technology applications that support efficient, reliable and scalable business processes

Specialized Care Services

REAL NEEDS

Specialized Care Services offers a diverse array of specialty health and wellness services that can work alone or be easily integrated with medical benefits to provide an effective response to unique and ancillary health and well-being needs.

In a marketplace generally characterized by inconsistent and highly fragmented services, Specialized Care Services helps employers and insurers gain access to a comprehensive array of specialty health and well-being services nationwide. Specialized Care Services responds to needs in three broad areas: specialized health solutions, dental and vision services and group insurance solutions.

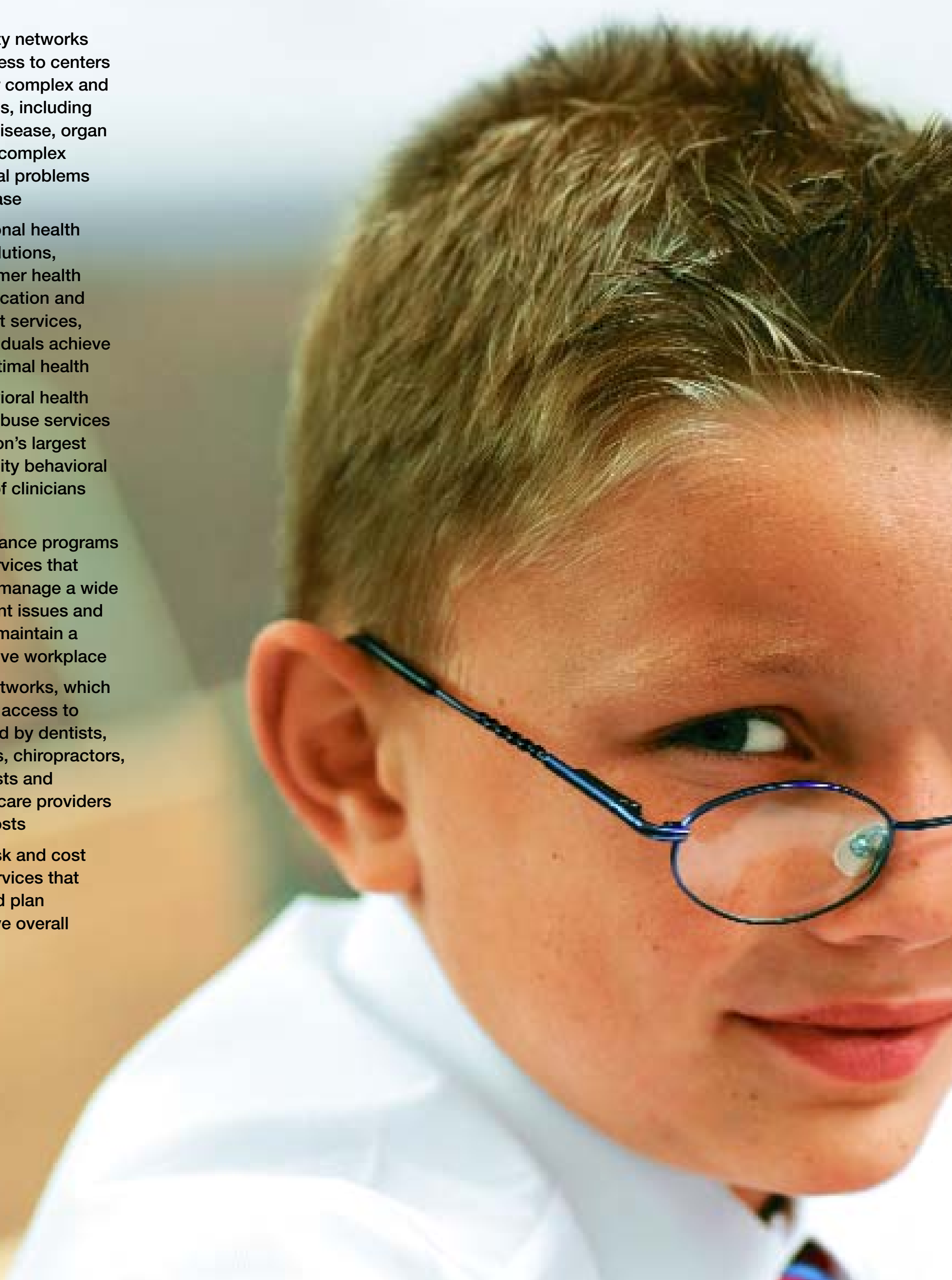
The largest component of Specialized Care Services offers behavioral health and substance abuse interventions and network services, as well as employee assistance and work/life programs. Equally important and even larger in terms of consumer health and well-being are national “centers of excellence” networks for complex medical conditions. First organized by UnitedHealth Group in the late 1980s, today these networks are the largest, deepest and most effective in the health care marketplace, addressing organ transplantation, complex cancers, end-stage renal disease, neonatal problems and cardiovascular disease. Related disease management programs, care support services and consumer health information services are also very effective programs, which can stand alone or be integrated with medical benefit plans to help individuals achieve and maintain optimal health.

Specialized Care Services offers national capabilities in the areas of chiropractic, complementary and alternative care services, dental and vision services, and life and group insurance products. The growing demand for ancillary services responds to the rising trend among employers to offer consumer-driven, high-deductible health plans, which typically cover medical services only. Such health plans are enhanced by offering benefits that help employees offset out-of-pocket expenses. Specialized Care Services is well suited to meet this need as virtually all of its products qualify for reimbursement from medical spending accounts.

Specialized Care Services provides its product solutions through UnitedHealth Group businesses, as well as through employer groups, public sector programs and labor and government employee groups, and nonaffiliated health plans, insurance companies, third-party administrators and similar institutions that deliver their own branded products to their customers. Today, 54 million Americans have access to specialty services through the businesses of Specialized Care Services.

Specialized Care Services is still quite modest in size, relative to the potential market it serves. With more than $220 billion in specialty services consumed by Americans each year, Specialized Care Services is positioned to achieve dramatic growth as it continues to diversify and innovate to meet the increasing needs of the specialty services markets.

REAL SOLUTIONS



- > Modular product and service designs that easily integrate to meet the varying needs of health plans, employers and individuals
- > National specialty networks that provide access to centers of excellence for complex and critical conditions, including cardiovascular disease, organ transplantation, complex cancers, neonatal problems and kidney disease
- > Integrated personal health management solutions, including consumer health information, education and decision-support services, which help individuals achieve and maintain optimal health
- > Access to behavioral health and substance abuse services through the nation's largest and highest quality behavioral health network of clinicians and counselors
- > Employee assistance programs and work/life services that help individuals manage a wide range of life-event issues and help employers maintain a healthy, productive workplace
- > Ancillary care networks, which offer nationwide access to services provided by dentists, vision specialists, chiropractors, physical therapists and complementary care providers at discounted costs
- > Sophisticated risk and cost management services that help insurers and plan sponsors improve overall affordability

Ingenix

REAL NEEDS

Ingenix provides innovative data, analytics, research and consulting products and services to meet the growing needs and demands of all sectors of the health care marketplace.

The need for information and technology-based applications to improve health care is clear; political, economic and consumer-driven pressures make this need even more acute. Today, more than 3,000 hospitals, 250,000 physicians, 2,000 health care payers and intermediaries, 150 *Fortune* 500 companies and 180 pharmaceutical and biotechnology companies use products and services from Ingenix to improve health care quality, affordability, usability and accessibility. Ingenix products are widely adopted in the markets it serves, and its clinical encounter database, which provides the foundation for software solutions that improve decision-making, is unparalleled in size and scope.

Ingenix solutions are designed to help advance clinical quality and cost appropriateness. Its decision management services, actuarial services, clinical cost trend reporting and forecasting, and predictive modeling tools help users analyze and understand medical cost trends, quality measures, utilization rates and the efficacy of new therapies and compounds, and its benchmarking tools enable customers to compare and contrast costs, develop risk-based intervention strategies and drive performance improvement. Ingenix claim management and coding tools help physicians and health care providers bill accurately and improve payment efficiency, while its editing and compliance solutions streamline and improve administrative processes for health care payers.

In the areas of oncology, the central nervous system, and infectious and pulmonary diseases, Ingenix helps pharmaceutical and biotechnology companies effectively and efficiently get drugs to market and, in turn, support improved health outcomes. No other clinical research enterprise has the clinical data sets available to Ingenix — capabilities that can be rapidly deployed to identify physicians who are treating patients with specific conditions and may be invaluable for a particular research project. Nor do any other clinical research enterprises offer post-approval data and analytic services to promptly track drug safety. These unparalleled data and analytics assets give Ingenix a unique competitive advantage.

The i3 Aperio™ drug experience registry is an example of this capability. It integrates Ingenix technology, epidemiological expertise and clinical data capabilities to provide continuous and contemporary real-world health care experience data on millions of patients. The U.S. Food and Drug Administration uses Aperio to review health care data relating to new prescription drug experiences and identify data signals that may indicate potential drug safety issues.

The outlook for Ingenix — both near and long term — is excellent as physicians, hospitals, employers, government agencies, pharmaceutical companies and other health care participants strive to improve the affordability, accessibility, quality and efficiency of health care.

REAL SOLUTIONS

- More than 100 proprietary software applications that streamline and enhance the quality of key business processes on behalf of payers, care providers, employers, property and casualty insurers and life sciences companies
- Integrated clinical, laboratory and pharmacy databases, which enable comprehensive analyses of clinical quality and efficiency measures
- Directory databases integrated with performance assessment tools that help consumers identify physicians and care providers based on quality and cost effectiveness as well as location
- Integrated consumer decision-support tools, which offer clinical quality and cost information to support more informed health care decisions
- Predictive modeling solutions that help clients detect high-risk medical cases and repetitive health care patterns, so they can implement effective care management strategies
- Clinical research services, which help pharmaceutical and biotechnology companies evaluate new therapeutic compounds and get them to market more quickly and cost-effectively
- Data and analytics services that enable hospitals, physicians, health professionals, employers, payers, pharmaceutical companies and researchers to compare, contrast and model performance data
- Decision-support tools that help employers, payers and insurers design and manage health benefit plans, focus spending and allocate resources effectively and efficiently
- Data and analytic services that help pharmaceutical, biotechnology and device manufacturers, as well as regulators, assess the safety and efficacy of newly introduced interventions

2005 Financial Results

UNITEDHEALTH GROUP HIGHLIGHTS

> UnitedHealth Group realized diversified growth across its business segments and generated net earnings of $3.3 billion, representing an increase of 28 percent over 2004.

> Revenues reached $45.4 billion, a 22 percent increase over 2004.

> Earnings from operations were $5.4 billion, up 31 percent over 2004.

> Operating margins increased to 11.8 percent, up from 11.0 percent in 2004.

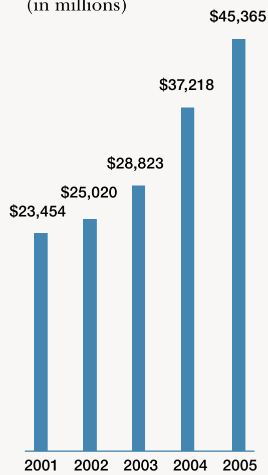
> Earnings per common share were $2.48, an increase of 26 percent over 2004.

	For the Year Ended December 31,				
(in millions, except per share data)	**2005**	**2004**	**2003**	**2002**	**2001**
CONSOLIDATED OPERATING RESULTS					
Revenues	**$45,365**	$37,218	$28,823	$25,020	$23,454
Earnings From Operations	**$ 5,373**	$ 4,101	$ 2,935	$ 2,186	$ 1,566
Net Earnings	**$ 3,300**	$ 2,587	$ 1,825	$ 1,352	$ 913
Return on Shareholders' Equity	**27.2%**	31.4%	39.0%	33.0%	24.5%
Basic Net Earnings per Common Share	**$ 2.61**	$ 2.07	$ 1.55	$ 1.12	$ 0.73
Diluted Net Earnings per Common Share	**$ 2.48**	$ 1.97	$ 1.48	$ 1.06	$ 0.70
Common Stock Dividends per Share	**$ 0.015**	$ 0.015	$ 0.008	$ 0.008	$ 0.008
CONSOLIDATED CASH FLOWS FROM (USED FOR)					
Operating Activities	**$ 4,326**	$ 4,135	$ 3,003	$ 2,423	$ 1,844
Investing Activities	**$ (3,489)**	$ (1,644)	$ (745)	$ (1,391)	$ (1,138)
Financing Activities	**$ 593**	$ (762)	$ (1,126)	$ (1,442)	$ (585)
CONSOLIDATED FINANCIAL CONDITION (As of December 31)					
Cash and Investments	**$14,982**	$ 12,253	$ 9,477	$ 6,329	$ 5,698
Total Assets	**$41,374**	$ 27,879	$17,634	$14,164	$12,486
Debt	**$ 7,111**	$ 4,023	$ 1,979	$ 1,761	$ 1,584
Shareholders' Equity	**$17,733**	$ 10,717	$ 5,128	$ 4,428	$ 3,891
Debt-to-Total-Capital Ratio	**28.6%**	27.3%	27.8%	28.5%	28.9%

Financial Highlights should be read together with the Consolidated Financial Statements and Notes in the Annual Report on Form 10-K.

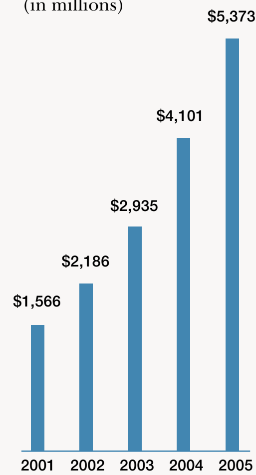
REVENUE

(in millions)

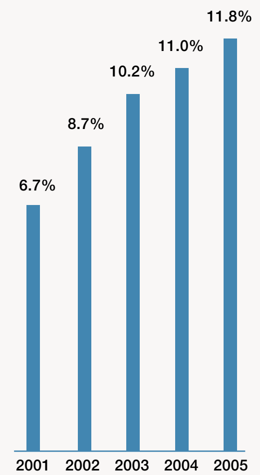


EARNINGS FROM OPERATIONS

(in millions)

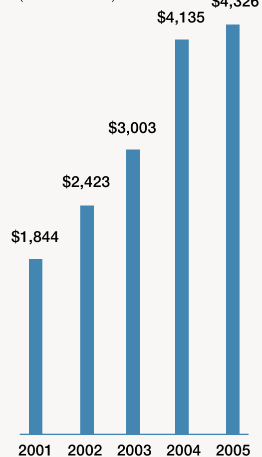


OPERATING MARGIN

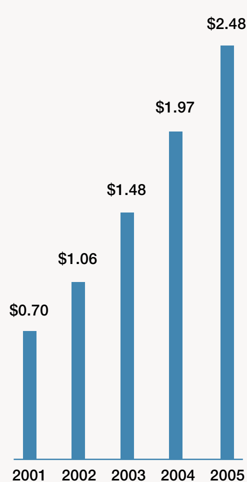


CASH FLOWS FROM OPERATIONS

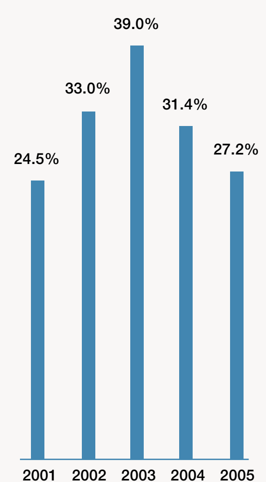
(in millions)



EARNINGS PER SHARE



RETURN ON EQUITY



2005 Financial Results

BUSINESS SEGMENT HIGHLIGHTS

Uniprise

- Uniprise revenue increased 14 percent in 2005, reaching $3.85 billion.
- The number of consumers affiliated with large employers served by Uniprise increased to 10.5 million.
- The full-year operating margin of 20.8 percent reflected 70 basis points in year-over-year gain, driven largely by improving productivity through the application of advanced technology to basic business processes.
- Earnings from operations grew $122 million, or 18 percent, year over year to $799 million in 2005.

Health Care Services

(includes UnitedHealthcare, Ovations and AmeriChoice)

- UnitedHealthcare reported 2005 revenue of $27.2 billion, up more than $5.2 billion or 24 percent year over year.
- Ovations revenue was $9.4 billion in 2005, an increase of more than $1.8 billion or 24 percent over 2004.
- AmeriChoice revenue for 2005 was $3.4 billion, up 9 percent year over year.
- UnitedHealthcare increased the number of consumers served by approximately 700,000 over 2004, to more than 14 million.
- Ovations saw significant positive response to early marketing efforts and enrolled 4.4 million seniors in Medicare Part D prescription drug benefit plans, including members of Medicare Advantage health plan programs with Part D benefits, as of mid-February 2006.
- Earnings from operations increased $1.0 billion, or 36 percent, to $3.8 billion in 2005.

Specialized Care Services

- 2005 revenue increased 22 percent, year over year, to $2.8 billion, driven by an 11 percent increase in consumers served by its specialty benefits businesses. Today, Specialized Care Services offers services to 54 million people.
- Reflecting the strength of customer diversification and external growth, more than 55 percent of the consumers served by Specialized Care Services receive their major medical health benefits from a company outside of UnitedHealth Group.
- The Specialized Care Services full-year operating margin of 20.7 percent decreased 40 basis points year over year, reflecting its evolving business mix, which favors lower margin products.
- Earnings from operations grew $97 million to $582 million, a 20 percent year-over-year increase.

Ingenix

- Ingenix 2005 revenue grew by $124 million, or 19 percent, from year-end 2004.
- Strong sales performance resulted in an Ingenix contract revenue backlog of more than $850 million on December 31, 2005, the strongest position in its history and a year-over-year increase of 28 percent.
- Earnings from operations increased $48 million, or 37 percent, to $177 million in 2005.
- Exceptional earnings leverage — particularly from data, software and informatics products — helped expand the 2005 operating margin to 22.3 percent.

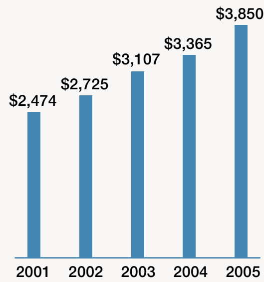
REVENUE

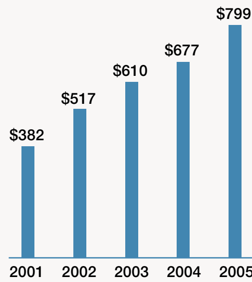
EARNINGS FROM OPERATIONS

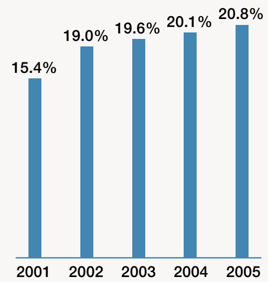
OPERATING MARGIN

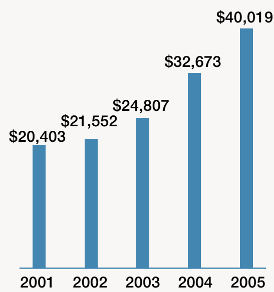
(in millions)

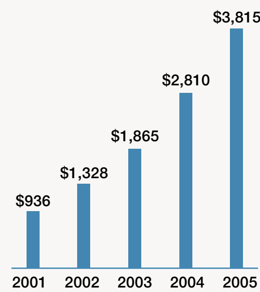
(in millions)

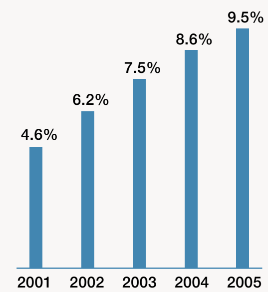


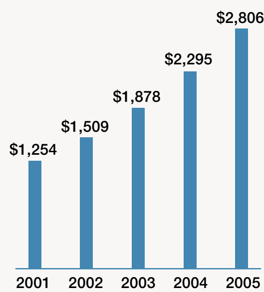


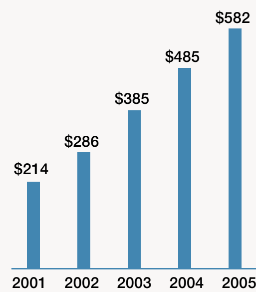


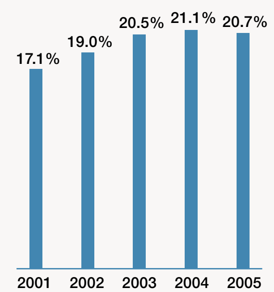


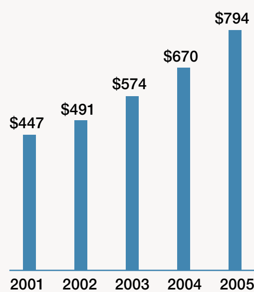


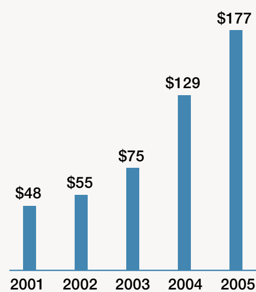


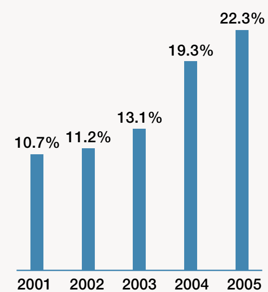












Corporate and Business Leaders

William W. McGuire, MD
Chairman and
Chief Executive Officer

Stephen J. Hemsley
President and
Chief Operating Officer

Patrick J. Erlandson
Chief Financial Officer

David J. Lubben
General Counsel and Secretary

Howard G. Phanstiel
Executive Vice President,
UnitedHealth Group, and
Chief Executive Officer, PacifiCare

Jeannine M. Rivet
Executive Vice President

Reed V. Tuckson, MD
Senior Vice President
Consumer Health and
Medical Care Advancement

L. Robert Dapper
Senior Vice President
Human Capital

John S. Penshorn
Senior Vice President and
Director, Capital Markets
Communications and Strategy

Richard H. Anderson
Executive Vice President,
UnitedHealth Group, and
Chief Executive Officer, Ingenix

Tracy L. Bahl
Chief Executive Officer
Uniprise

William A. Munsell
Chief Executive Officer
Specialized Care Services

Lois Quam
Chief Executive Officer
Ovations

Robert J. Sheehy
Chief Executive Officer
UnitedHealthcare

Anthony Welters
Chief Executive Officer
AmeriChoice

Board of Directors

William C. Ballard, Jr.
Of Counsel
Greenebaum Doll & McDonald PLLC

Richard T. Burke
Director of
Meritage Homes Corporation and
First Cash Financial Services, Inc.

Stephen J. Hemsley
President and
Chief Operating Officer
UnitedHealth Group

James A. Johnson
Vice Chairman
Perseus, LLC

Thomas H. Kean
Former President of
Drew University
Former Governor of New Jersey

Douglas W. Leatherdale
Former Chairman and
Chief Executive Officer
The St. Paul Companies, Inc.

William W. McGuire, MD
Chairman and
Chief Executive Officer
UnitedHealth Group

Mary O. Mundinger, DrPH, RN
Dean, School of Nursing and
Centennial Professor in Health
Policy, and Associate Dean,
Faculty of Medicine
Columbia University

Robert L. Ryan
Former Senior Vice President and
Chief Financial Officer
Medtronic, Inc.

Donna E. Shalala, PhD
President of
University of Miami

William G. Spears
Senior Principal
Spears Grisanti & Brown LLC

Gail R. Wilensky, PhD
Senior Fellow
Project HOPE

AUDIT COMMITTEE
William C. Ballard, Jr.
Thomas H. Kean
Douglas W. Leatherdale

COMPENSATION AND HUMAN RESOURCES COMMITTEE
James A. Johnson
Mary O. Mundinger
William G. Spears

COMPLIANCE AND GOVERNMENT AFFAIRS COMMITTEE
Donna E. Shalala
Gail R. Wilensky

NOMINATING COMMITTEE
William C. Ballard, Jr.
Thomas H. Kean
Douglas W. Leatherdale
William G. Spears

EXECUTIVE COMMITTEE
William C. Ballard, Jr.
Douglas W. Leatherdale
William W. McGuire
William G. Spears

Investor Information

MARKET PRICE OF COMMON STOCK

The following table shows the range of high and low sales prices for the company's stock as reported on the New York Stock Exchange for the calendar periods shown through February 15, 2006. These prices do not include commissions or fees associated with purchasing or selling this security.

	High	Low
2006		
First Quarter through February 15, 2006	$ 62.93	$ 56.00
2005		
First Quarter	$ 48.33	$ 42.63
Second Quarter	$ 53.64	$ 44.30
Third Quarter	$ 56.66	$ 47.75
Fourth Quarter	$ 64.61	$ 53.84
2004		
First Quarter	$ 32.25	$ 27.73
Second Quarter	$ 34.25	$ 29.31
Third Quarter	$ 37.38	$ 29.67
Fourth Quarter	$ 44.38	$ 32.31

As of February 15, 2006, the company had 14,741 shareholders of record.

ACCOUNT QUESTIONS

Our transfer agent, Wells Fargo, 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 call our transfer agent toll free at:
(800) 468-9716 or locally at (651) 450-4064

You can write them at:
Wells Fargo Shareowner Services
P.O. Box 64854
Saint Paul, Minnesota 55164-0854

Or 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 (which is the UnitedHealth Group Annual Report to Shareholders) and 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 Tuesday, May 2, 2006, at 10 a.m. CDT, at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota.

DIVIDEND POLICY

UnitedHealth Group's board of directors established the company's dividend policy in August 1990. The policy requires the board to review the company's financial statements following the end of each fiscal year and decide whether it is advisable to declare a dividend on the outstanding shares of common stock.

Shareholders of record on April 1, 2005, received an annual dividend for 2005 of $0.015 per share. On January 31, 2006, the board approved an annual dividend for 2006 of $0.03 per share. The dividend will be paid on April 17, 2006, to shareholders of record at the close of business on April 3, 2006.

NEW YORK STOCK EXCHANGE — STOCK LISTING AND CORPORATE GOVERNANCE

The company's common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. As required by the NYSE, the company submitted an unqualified certification of its Chief Executive Officer to the NYSE in 2005. The company has also filed as exhibits to its Annual Report on Form 10-K for the year ended December 31, 2005, the Chief Executive Officer and Chief Financial Officer certifications required under the Sarbanes-Oxley Act.

FORWARD-LOOKING STATEMENTS

This Summary Annual Report contains statements, estimates or projections that constitute "forward-looking" statements as defined under U.S. federal securities laws. Generally the words "believe," "expect," "intend," "estimate," "anticipate," "project," "will" and similar expressions identify forward-looking statements, which generally are not historical in nature. By their nature, forward-looking statements are subject to risks and uncertainties that could cause actual results to differ materially from our historical experience and our present expectations or projections. A list and description of some of the risks and uncertainties can be found in our reports filed with the Securities and Exchange Commission from time to time, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. Except to the extent otherwise required by federal securities laws, we do not undertake to publicly update or revise any forward-looking statements.

UnitedHealth Group
UnitedHealth Group Center
9900 Bren Road East
Minnetonka, Minnesota 55343

www.unitedhealthgroup.com

UnitedHealth Group®

100-7153

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2005**

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission file number: 1-10864

UNITEDHEALTH GROUP INCORPORATED
(Exact name of registrant as specified in its charter)

MINNESOTA	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UNITEDHEALTH GROUP CENTER 9900 BREN ROAD EAST MINNETONKA, MINNESOTA	**55343**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (952) 936-1300

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by checkmark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2005, was approximately $65,178,318,867 (based on the last reported sale price of $52.14 per share on June 30, 2005, on the New York Stock Exchange).*

As of February 15, 2006, there were 1,356,292,073 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

Note that in Part III of this report on Form 10-K, we "incorporate by reference" certain information from our Definitive Proxy Statement for the Annual Meeting of Shareholders to be held on May 2, 2006. This document will be filed with the Securities and Exchange Commission (SEC) within the time period permitted by the SEC. The SEC allows us to disclose important information by referring to it in that manner. Please refer to such information.

* Only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the company have been excluded in determining this number.

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PART I

ITEM 1. BUSINESS

INTRODUCTION

UnitedHealth Group is a diversified health and well-being company, serving approximately 65 million Americans. We are focused on improving the American health care system and how it works for multiple, distinct constituencies. We provide individuals with access to quality, cost-effective health care services and resources through more than 500,000 physicians and other care providers and 4,600 hospitals across the United States. During 2005, we managed approximately $68 billion in aggregate annual health care spending on behalf of the constituents and consumers we served. Our primary focus is on improving health care systems by simplifying the administrative components of health care delivery, promoting evidence-based medicine as the standard for care, and providing relevant, actionable data that physicians, health care providers, consumers, employers and other participants in health care can use to make better, more informed decisions. Through our diversified family of businesses, we leverage core competencies in advanced technology-based transactional capabilities; health care data, knowledge and information; and health care resource organization and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable.

Our revenues are derived from premium revenues on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and, investment and other income. We conduct our business primarily through operating divisions in the following business segments:

- Uniprise;
- Health Care Services, which includes our UnitedHealthcare, Ovations and AmeriChoice businesses;
- Specialized Care Services; and
- Ingenix.

For a discussion of our financial results by segment see Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

On December 20, 2005 we acquired PacifiCare Health Systems, Inc. PacifiCare offers managed care and other health insurance products to employer groups, individuals and Medicare beneficiaries, with approximately 3.1 million health plan members, including 2.4 million commercial members and 750,000 senior members, and approximately 12 million specialty plan members nationwide. PacifiCare's commercial and senior plans are primarily offered in the Western United States and are designed to deliver quality health care and customer service cost effectively. PacifiCare operates one of the largest Medicare Advantage programs in the United States as measured by membership under its Secure Horizons brand. PacifiCare's specialty plan operations include behavioral health, dental, vision and complete pharmacy benefit management (PBM) services, through its subsidiary Prescription Solutions.

UnitedHealth Group Incorporated is a Minnesota corporation incorporated in January 1977. The terms "we," "our" or the "company" refer to UnitedHealth Group Incorporated and our subsidiaries. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300. You can access our Web site at www.unitedhealthgroup.com to learn more about our company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, along with amendments to

those reports. You can also download from our Web site our Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our Web site free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary.

Our transfer agent, Wells Fargo, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email stocktransfer@wellsfargo.com, or telephone (800) 468-9716 or (651) 450-4064.

UNIPRISE

Uniprise delivers health care and well-being services nationwide to large national employers, individual consumers and other health care organizations through three related business units: Uniprise Strategic Solutions (USS), Definity Health and Exante Financial Services (Exante). Each business unit works with other UnitedHealth Group businesses to deliver a complementary and integrated array of services. USS delivers strategic health and well-being solutions to large national employers. Definity Health provides consumer-driven health plans and services to employers and their employees. As of December 31, 2005, USS and Definity Health served approximately 10.5 million individuals. Exante delivers health-care-focused financial services for consumers, employers and providers. Most Uniprise products and services are delivered through its affiliates. Uniprise provides administrative and customer care services for certain other businesses of UnitedHealth Group. Uniprise also offers transactional processing services to various intermediaries and health care entities.

Uniprise specializes in large-volume transaction management, large-scale benefit design and innovative technology solutions that simplify complex administrative processes and promote improved health outcomes. Uniprise processes approximately 240 million medical benefit claims each year and responds to approximately 50 million service calls annually. Uniprise provides comprehensive operational services for independent health plans and third-party administrators, as well as the majority of the commercial health plan consumers served by UnitedHealthcare. Uniprise maintains Internet-based administrative and financial applications for physician inquiries and transactions, customer-specific data analysis for employers, and consumer access to personal health care information and services.

USS

USS provides comprehensive and customized administrative, benefits and service solutions for large employers and other organizations with more than 5,000 employees in multiple locations. USS customers generally retain the risk of financing the medical benefits of their employees and their dependents and USS provides coordination and facilitation of medical services; transaction processing; consumer and care provider services; and access to contracted networks of physicians, hospitals and other health care professionals for a fixed service fee per individual served. As of December 31, 2005, USS served approximately 380 employers, including approximately 160 of the *Fortune* 500 companies.

Definity Health

Definity Health provides innovative consumer health care solutions that enable consumers to take ownership and control of their health care benefits. Definity Health's products include high-deductible consumer-driven benefit plans coupled with health reimbursement accounts (HRAs) or health savings accounts (HSAs), and discount cards for services generally not covered by high-deductible health plans. Definity Health is a national leader in consumer-driven health benefit programs. As of December 31, 2005, Definity Health provided health benefits to 83 employers, including 23 of the *Fortune* 500, under self-funded benefit plan arrangements.

Exante

Exante Financial Services provides health-based financial services for consumers, employers and providers. These financial services are delivered through Exante Bank, a Utah-chartered industrial bank. These financial services include HSAs that consumers can access using a debit card. Exante's health benefit card programs

include electronic systems for verification of benefit coverage and eligibility and administration of Flexible Spending Accounts (FSAs) and HRAs. Exante also provides extensive electronic payment and statement services for health care providers and payers.

HEALTH CARE SERVICES

Our Health Care Services segment consists of our UnitedHealthcare, Ovations and AmeriChoice businesses.

UnitedHealthcare

UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for small and mid-sized employers, and individuals nationwide. UnitedHealthcare provides health care services on behalf of more than 14 million Americans as of December 31, 2005. With its risk-based product offerings, UnitedHealthcare assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically at a fixed rate for a one-year period. UnitedHealthcare also provides administrative and other management services to customers that self-insure the medical costs of their employees and their dependents, for which UnitedHealthcare receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and their dependents, while UnitedHealthcare provides coordination and facilitation of medical services, customer and care provider services and access to a contracted network of physicians, hospitals and other health care professionals. Small employer groups are more likely to purchase risk-based products because they are generally unable or unwilling to bear a greater potential liability for health care expenditures.

UnitedHealthcare offers its products through affiliates that are usually licensed as insurance companies or as health maintenance organizations, depending upon a variety of factors, including state regulations. UnitedHealthcare's product strategy centers on several fundamentals: consumer choice, broad access to health professionals, actionable information, better outcomes, quality service and greater affordability. Integrated wellness programs and services help individuals make informed decisions, maintain a healthy lifestyle and optimize health outcomes by coordinating access to care services and providing personalized, targeted education and information services.

UnitedHealthcare arranges for discounted access to care through more than 500,000 physicians and other care providers, and 4,600 hospitals across the United States. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare to contract for cost-effective access to a large number of conveniently located care providers. Directly or through UnitedHealth Group's family of companies, UnitedHealthcare offers:

- A broad range of benefit plans integrating medical, ancillary and alternative care products so customers can choose benefits that are right for them;
- Affordability through a broad product line from basic benefit plans to full benefit plans, all of which offer access to our broad-based proprietary network with economic benefits reflective of the aggregate purchasing capacity of tens of millions of people;
- Access to broad and diverse numbers of physicians and other care providers;
- Innovative clinical outreach programs—built around an extensive longitudinal clinical data set and the principles of evidence-based medicine—that promote care quality and patient safety and provide incentives for physicians who demonstrate consistency of clinical care against best practice standards;
- Access to quality and cost information for physicians and hospitals in a variety of specialties through the UnitedHealth Premium program;

- Care facilitation services that use proprietary predictive technology to identify individuals with significant gaps in care and unmet needs or risk for potential health problems and then facilitate timely and appropriate interventions;
- Unique disease and condition management programs to help individuals address significant, complex disease states;
- Convenient self-service for customer transactions, pharmacy services and health information; and
- Clinical information that physicians can use to better serve their patients as well as improve their practices.

UnitedHealthcare's regional and national access to broad, affordable and quality networks of care has advanced significantly in the past 24 months with acquisitions and/or expansions enhancing services throughout the United States, including California, Oregon, Washington, Oklahoma, Texas, Arizona, Colorado, Nevada, Indiana, Florida, Connecticut, Delaware, Maryland, New Jersey, New York, Pennsylvania and Wisconsin. UnitedHealthcare has also organized health care alliances with select regional not-for-profit health plans to facilitate greater customer access and affordability.

We believe that UnitedHealthcare's innovation distinguishes its product offerings from the competition. Its consumer-oriented health benefits and services value individual choice and control in accessing health care. UnitedHealthcare has programs that provide health education, admission counseling before hospital stays, care advocacy to help avoid delays in patients' stays in the hospital, support for individuals at risk of needing intensive treatment and coordination of care for people with chronic conditions. UnitedHealthcare offers comprehensive and integrated pharmaceutical management services that achieve lower costs by using formulary programs that drive better unit costs for drugs, benefit designs that encourage consumers to use drugs that offer the best value and outcomes, and physician and consumer programs that support the appropriate use of drugs based on clinical evidence.

UnitedHealthcare's distribution system consists primarily of insurance producers in the small employer group market and producers and other consultant-based or direct sales for large employer and public sector groups. UnitedHealthcare's direct distribution operations are relatively limited and apply only in the Maryland, Washington, D.C. and Virginia markets, as well as to portions of the large employer commercial market (which is generally self-funded) and to cross-selling of specialty products to existing customers. UnitedHealthcare's external distribution network includes national benefits consultants and local insurance producers.

Ovations

Ovations provides health and well-being services for individuals age 50 and older, addressing their unique needs for preventative and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. Ovations is one of few enterprises fully dedicated to this market segment, providing products and services in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and the Northern Mariana Islands through affiliates. Ovations' wide array of products and services includes Medicare Supplement and Medicare Advantage health benefit coverage, and stand-alone prescription drug coverage and prescription drug discount cards, as well as disease management and chronic care programs.

Ovations has extensive capabilities and experience with distribution, including direct marketing to consumers on behalf of its key clients—AARP, state and U.S. government agencies and employer groups. Ovations also has distinct marketing, pricing, underwriting and clinical program management, and marketing capabilities dedicated to senior and geriatric risk-based health products and services.

Medicare Reform Legislation

The Medicare Modernization Act represents a significant change to the Medicare program. The Centers for Medicare & Medicaid Services (CMS) is overseeing a multiyear implementation of these changes, including the recent introduction of a prescription drug benefit (Part D) and a greater diversity in Medicare's product offerings. We believe that these changes create and expand opportunities for well-organized and focused companies to better serve older Americans. We believe that Ovations is well-positioned to respond to these opportunities.

In November 2005, Ovations began enrollment into its Medicare Part D program, in preparation for offering prescription drug coverage to Medicare beneficiaries nationwide. Ovations provides the only Medicare prescription drug coverage plan branded by AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over. Ovations is also offering Part D drug coverage through its Medicare Advantage program and Special Needs Plans.

Ovations participates nationally in the Medicare program across the broad spectrum of Medicare products—offering Medigap products that supplement traditional fee-for-service coverage, more traditional health plan-type programs under Medicare Advantage, prescription drug coverage and discount card offerings, and special offerings for chronically ill and Medicare and Medicaid dual-eligible beneficiaries. Ovations will continue to explore new market opportunities in a disciplined manner.

Ovations Insurance Solutions

Ovations offers a range of health insurance products and services to AARP members, and has expanded the scope of services and programs offered over the past several years. Ovations operates the nation's largest Medicare Supplement business, providing Medicare supplement and hospital indemnity insurance from its insurance company affiliates to approximately 3.8 million AARP members. Additional Ovations' services include an expanded AARP Nurse Healthline service, which provides 24-hour access to health information from nurses for certain lines of business. Ovations also developed a lower cost Medicare Supplement offering that provides consumers with a hospital network and 24-hour access to health care information. Ovations also offers an AARP-branded health insurance program focused on persons between 50 and 64 years of age.

Ovations Pharmacy Solutions

Ovations Pharmacy Solutions addresses one of the most significant cost problems facing older Americans—prescription drug costs. With approximately 1.9 million users on December 31, 2005, Ovations' discount card and pharmacy services programs provide access to discounted retail and mail order pharmacy services, and a complimentary health and well-being catalog offering. Ovations also offers three different Medicare-endorsed discount drug cards under the Medicare Modernization Act. These cards offer cost savings for retail and mail order prescription drugs. The Medicare endorsed card programs end on May 15, 2006.

In November 2005, Ovations began enrollment into its Medicare Part D program. As of December 31, 2005**,** including PacifiCare, Ovations had enrolled 3.9 million members in the Part D program, including 2.8 million in the stand-alone prescription drug plans and 1.1 million in Medicare Advantage plans incorporating Part D coverage.

Prescription Solutions®

Prescription Solutions, a subsidiary of PacifiCare, offers integrated PBM services (including mail order pharmacy services) to approximately 6.0 million people, including approximately 800,000 seniors, as of December 31, 2005. Prescription Solutions offers a broad range of innovative programs, products and services designed to enhance clinical outcomes with appropriate financial results for employers and members. The fulfillment capabilities of Prescription Solutions are an important strategic component in serving PacifiCare's legacy commercial and senior business, as well as PacifiCare's Part D enrollees.

Ovations Secure Horizons

The Ovations Secure Horizons division provides health care coverage for the seniors market primarily through the Medicare Advantage program administered by CMS. Ovations offers Medicare Advantage HMO, PPO, Special Needs Plans and Private-Fee-for-Service plans. Under the Medicare Advantage programs, Ovations provides health insurance coverage to eligible Medicare beneficiaries in exchange for a fixed monthly premium per member from CMS that varies based on the geographic areas in which members reside. Products are offered under the Secure Horizons and UnitedHealthcare Medicare Complete brand names. In 2005, Ovations Secure Horizons expanded its program to 16 new regional markets and offered Medicare Advantage in 35 markets nationwide. In addition, Ovations Secure Horizons offers Private-Fee-for-Service plans in 24 states. As of December 31, 2005, Ovations had more than 1.1 million enrolled individuals in its Medicare Advantage products. Beginning January 1, 2006, Secure Horizons will offer a regional PPO in 3 markets.

Evercare

Through its Evercare division, Ovations is one of the nation's leaders in offering complete, individualized care planning and care benefits for aging, disabled and chronically ill individuals. Evercare serves approximately 80,000 people across the nation in long-term care settings including nursing homes, community-based settings and private homes, as well as through hospice and palliative care. Evercare offers services through innovative care management and clinical programs. In 2005, Evercare expanded its programs and now offers services in 23 states.

Evercare offers a variety of federally sponsored products that provide enhanced medical coverage to frail, elderly and chronically ill populations in both nursing homes and community settings. These services are provided primarily through nurse practitioners, nurses and care managers. Evercare also offers a Medicaid long-term health care product for elderly, physically disabled and other vulnerable individuals in five states. Evercare Connections is a comprehensive eldercare service program providing service coordination, consultation, claim management and information resources nationwide. Proprietary, automated medical record software enables Evercare geriatric care teams to capture and track patient data and clinical encounters in nursing home, hospital and home care settings. Evercare has begun extending its complex care management services to end-of-life situations and now offers community-based hospice programs in four states.

AmeriChoice

AmeriChoice provides network-based health and well-being services to beneficiaries of state Medicaid, Children's Health Insurance Programs (CHIP), and other government-sponsored health care programs through its affiliates. AmeriChoice provides health insurance coverage to eligible Medicaid beneficiaries in exchange for a fixed monthly premium per member from the applicable state. AmeriChoice provides services to nearly 1.3 million individuals in 13 states across the country. The individuals AmeriChoice serves generally live in areas that are medically underserved and where a consistent relationship with the medical community or a care provider is less likely. The population served by AmeriChoice also tends to face significant social and economic challenges. AmeriChoice offers government agencies a broad menu of separate management services—including clinical care, consulting and management, pharmacy benefit services and administrative and technology services—to help them effectively administer their distinct health care delivery systems for individuals in these programs.

AmeriChoice's approach is grounded in its belief that health care cannot be provided effectively without consideration of all of the factors—social, economic and environmental, as well as physical—that affect a person's life. AmeriChoice coordinates resources among family members, physicians, other health care providers and government and community-based agencies and organizations to provide continuous and effective care. For members, this means that the AmeriChoice Personal Care Model offers them a holistic approach to health care, emphasizing practical programs to improve their living circumstances as well as quality medical care and treatment in accessible, culturally sensitive, community-oriented settings. AmeriChoice's disease management and outreach programs focus on high-prevalence and debilitating illnesses such as hypertension and

cardiovascular disease, asthma, sickle cell disease, diabetes, cancer and high-risk pregnancy. Several of these programs have been developed by AmeriChoice with the help of leading researchers and clinicians at academic medical centers and medical schools.

For physicians, the AmeriChoice Personal Care Model means assistance with coordination of their patients' care. AmeriChoice utilizes sophisticated technology to monitor preventive care interventions and evidence-based treatment protocols to support care management. AmeriChoice uses state-of-the-art telemedicine tools that enable nurses and physicians to monitor vital signs, check medication use, assess patient status and facilitate overall care. AmeriChoice utilizes advanced and unique pharmacy services—including benefit design, generic drug incentive programs, drug utilization review and preferred drug list development—to help optimize the use of pharmaceuticals and concurrently contain pharmacy expenditures to levels appropriate to the specific clinical situations. For state customers, the AmeriChoice Personal Care Model means increased access to care and improved quality, in a measurable system that reduces their administrative burden and lowers their costs.

AmeriChoice considers a variety of factors in determining in which state programs to participate, including the state's experience and consistency of support for its Medicaid program in terms of service innovation and funding, the population base in the state, the willingness of the physician/provider community to participate with the AmeriChoice Personal Care Model, and the presence of community-based organizations that can partner with AmeriChoice to meet the needs of its members. Using these criteria, AmeriChoice entered one new market in 2005, signed an agreement to enter another new market in 2006, and is examining several others. Conversely, during the past three years, AmeriChoice has exited several markets because of reimbursement issues or lack of consistent direction and support from the sponsoring states.

SPECIALIZED CARE SERVICES

The Specialized Care Services (SCS) companies offer a comprehensive platform of specialty health and wellness and ancillary benefits, services and resources to specific customer markets nationwide. These products and services include employee benefit offerings, provider networks and related resources focusing on behavioral health and substance abuse, dental, vision, disease management, complex and chronic illness and care facilitation. The SCS companies also offer solutions in the areas of complementary and alternative care, employee assistance, short-term and long term disability, life insurance, work/life balance and health-related information. These services are designed to simplify the consumer health care experience and facilitate efficient health care delivery.

Specialized Care Services' products are marketed under several different brands to employers, government programs, health insurers and other intermediaries, and individual consumers, and through affiliates such as Ovations, UnitedHealthcare, AmeriChoice and Uniprise. SCS also distributes products on a private-label basis, allowing unaffiliated health plans, insurance companies, third-party administrators and similar institutions to deliver products and services to their customers under their brands. Specialized Care Services offers its products both on an administrative fee basis, where it manages and administers benefit claims for self-insured customers in exchange for a fixed service fee per individual served, and a risk-based basis, where Specialized Care Services assumes responsibility for health care and income replacement costs in exchange for a fixed monthly premium per individual served. Specialized Care Services' simple, modular service designs can be easily integrated to meet varying health plan, employer and consumer needs at a wide range of price points. Approximately 55% of consumers served by Specialized Care Services receive their major medical health benefits from a source other than a UnitedHealth Group affiliate.

The SCS companies are divided into three operating groups: Specialized Health Solutions; Dental and Vision; and Group Insurance Services.

Specialized Health Solutions

The Specialized Health Solutions operating group provides services and products for benefits commonly found in comprehensive medical benefit plans, as well as a continuum of individualized specialty health and wellness solutions from health information to case and disease management for complex, chronic and rare medical conditions.

United Behavioral Health (UBH) and its subsidiaries provide behavioral health care, substance abuse programs and psychiatric disability benefit management services. UBH's customers buy its care management services and access its large national network of 77,000 clinicians and counselors. UBH serves 29 million individuals.

LifeEra offers employee assistance, work life and other products to assist individuals in managing personal issues while seeking to increase employee productivity. LifeEra serves nearly 16 million consumers through programs developed in consultation with employers, government agencies and other affinity plans.

ACN Group (ACN) and its affiliates provide benefit administration, and clinical and network management for chiropractic, physical therapy, occupational therapy and other complementary and alternative care services. ACN's national networks of contracted health professionals serves more than 22 million consumers.

Through Optum, Specialized Care Services delivers personalized care and condition management, health assessments, longitudinal care management, disease management, and health information assistance, support and related services including wellness services. Utilizing evidence-based medicine, technology and specially trained nurses, Optum facilitates effective and efficient health care delivery by helping its 28 million consumers address daily living concerns, make informed health care decisions, and become more effective health care purchasers.

United Resource Networks (URN) provides support services and access to "Centers of Excellence" networks for individuals in need of organ transplantation and those diagnosed with complex cancer, congenital heart disease, kidney disease, infertility and neonatal care issues. URN provides these services to approximately 48 million individuals through more than 3,000 payers. United Resource Networks negotiates competitive rates with medical centers that have been designated as "Centers of Excellence" based on satisfaction of clinical standards, including patient volumes and outcomes, medical team credentials and experience, and support services.

Dental and Vision

Spectera and its affiliates administer vision benefits for 11 million people enrolled in employer-sponsored benefit plans. Spectera works to build productive relationships with vision care professionals, retailers, employer groups and benefit consultants. Spectera's national network includes approximately 31,000 vision professionals.

UnitedHealth Dental (UHD) and its affiliates provide dental benefit management and related services to 6 million individuals through a network of approximately 90,000 dentists. UHD's products are distributed to commercial and government markets, both directly and through unaffiliated insurers and its UnitedHealth Group affiliates.

Group Insurance Services

Group Insurance Services distributes life, critical illness, and short-term and long-term disability insurance, along with cost management products and services for health plans and employers through its affiliates. Unimerica Workplace Benefits provides integrated short-term disability, critical illness and group life insurance products to employers' benefit programs. National Benefit Resources (NBR) distributes and administers medical stop-loss insurance covering self-funded employer benefit plans. Through a network of third-party administrators, brokers and consultants, NBR markets stop-loss insurance throughout the United States. NBR also distributes products and services on behalf of its SCS affiliates, URN and Optum.

INGENIX

Ingenix offers database and data management services, software products, publications, consulting services, outsourced services and pharmaceutical development and consulting services on a nationwide and international

basis. Ingenix's customers include more than 3,000 hospitals, 250,000 physicians, 2,000 payers and intermediaries, more than 150 *Fortune* 500 companies, and more than 180 pharmaceutical and biotechnology companies, as well as other UnitedHealth Group businesses. Ingenix is engaged in the simplification of health care administration by providing products and services that help customers accurately and efficiently document, code and bill for reimbursement for the delivery of care services. Ingenix is a leader in contract research services, medical education services, publications, and pharmacoeconomics, outcomes, safety and epidemiology research through its i3 businesses.

Ingenix's products and services are sold primarily through a direct sales force focused on specific customers and market segments across the pharmaceutical, biotechnology, employer, government, hospital, physician and payer market segments. Ingenix's products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface its products with their applications.

The Ingenix companies are divided into two operating groups: information services and pharmaceutical services.

Information Services

Ingenix's diverse product offerings help clients strengthen health care administration and advance health care outcomes. These products include health care utilization reporting and analytics, physician clinical performance benchmarking, clinical data warehousing, analysis and management responses for medical cost trends, decision-support portals for evaluation of health benefits and treatment options and claims management tools for administrative error and cost reduction. Ingenix uses proprietary software applications that manage clinical and administrative data across diverse information technology environments. Ingenix also uses proprietary predictive algorithmic applications to help clients detect and act on repetitive health care patterns in large data sets.

Ingenix provides other services on an outsourced basis, such as physician credentialing, provider directories, HEDIS reporting, and fraud and abuse detection and prevention services. Ingenix also offers consulting services, including actuarial and financial advisory work through its Reden & Anders division, as well as product development, provider contracting and medical policy management. Ingenix publishes print and electronic media products that provide customers with information regarding medical claims coding, reimbursement, billing and compliance issues.

Pharmaceutical Services

Ingenix's i3 division helps to coordinate and manage clinical trials for pharmaceutical products in development for pharmaceutical, biotechnology and medical device manufacturers. Ingenix's focus is to help pharmaceutical and biotechnology customers effectively and efficiently get drug and medical device data to appropriate regulatory bodies and to improve health outcomes through integrated information, analysis and technology. Ingenix capabilities and efforts focus on the entire range of product assessment, through commercialization of life-cycle management services—pipeline assessment, market access and product positioning, clinical trials, economic, epidemiology, safety and outcomes research, and medical education. Ingenix services include global contract research services, protocol development, investigator identification and training, regulatory assistance, project management, data management, biostatistical analysis, quality assurance, medical writing and staffing resource services. Ingenix's pharmaceutical contract research operations are in 45 countries and are therapeutically focused on oncology, the central nervous system, and respiratory and infectious diseases. Ingenix uses comprehensive, science-based evaluation and analysis and benchmarking services to support pharmaceutical, biotechnology and medical device development. Ingenix has developed an advanced drug registry tool, i3 Aperio, that utilizes Ingenix's proprietary research database to assist pharmaceutical manufacturers and regulatory agencies in detecting potential safety issues from newly marketed drugs earlier than other available surveillance methods. Ingenix also helps educate providers about pharmaceutical products through medical symposia, product communications and scientific publications.

GOVERNMENT REGULATION

Most of our health and well-being services are regulated. This regulation can vary significantly from jurisdiction to jurisdiction. Federal and state regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and regulations are continually being considered, and the interpretation of existing laws and rules also may change periodically.

Federal Regulation

Our Health Care Services segment, which includes UnitedHealthcare, Ovations and AmeriChoice, is subject to federal regulation. Ovations' Medicare business is regulated by CMS. CMS has the right to audit performance to determine compliance with CMS contracts and regulations and the quality of care being given to Medicare beneficiaries. Our Health Care Services segment also has Medicaid and State Children's Health Insurance Program contracts that are subject to federal and state regulations regarding services to be provided to Medicaid enrollees, payment for those services, and other aspects of these programs. There are many regulations surrounding Medicare and Medicaid compliance. In addition, because a portion of Ingenix's business includes clinical research, it is subject to regulation by the Food and Drug Administration. We believe we are in compliance in all material respects with the applicable laws and regulations.

State Regulation

All of the states in which our subsidiaries offer insurance and health maintenance organization products regulate those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state Departments of Insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. In addition, some of our business and related activities may be subject to preferred provider organization (PPO), managed care organization (MCO) or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, but may contain network, contracting, product and rate, financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, payment of claims, fraud prevention, protection of consumer health information and covered benefits and services. We believe we are in compliance in all material respects with the applicable laws and regulations.

As typically occurs in connection with a transaction of this size, in connection with the PacifiCare transaction, certain of our subsidiaries entered into various commitments with state regulatory departments, principally in California. We believe that none of these commitments will materially affect our operations.

HIPAA

The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations promulgated pursuant to HIPAA include minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. We believe that we are in compliance in all material respects with these regulations. New standards for national provider and employer identifiers are currently being implemented by regulators. We have been and intend to remain in compliance in all material respects with these regulations. Additionally, different approaches to HIPAA's provisions and varying enforcement philosophies in the different states may adversely affect our ability to standardize our products and services across state lines.

ERISA

The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and

regulations subject to periodic interpretation by the United States Department of Labor as well as the federal courts. ERISA places controls on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. We believe that we are in compliance in all material respects with applicable ERISA regulations.

Audits and Investigations

We typically have and are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits, and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Department of Justice and U.S. Attorneys. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs. We do not believe the results of any of the current investigations, audits or reviews, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or results of operations.

International Regulation

Some of our business units have limited international operations. These international operations are subject to different legal and regulatory requirements in different jurisdictions, including various tax, tariff and trade regulations, as well as employment, intellectual property and investment rules and laws. We believe we are in compliance in all material respects with applicable laws.

COMPETITION

As a diversified health and well-being services company we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, third-party administrators and business services outsourcing companies, health care providers that have formed networks to directly contract with employers, specialty benefit providers, government entities, and various health information and consulting companies. For our Uniprise and Health Care Services businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc., and WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises concentrated in more limited geographic areas. Our Specialized Care Services and Ingenix business segments also compete with a number of other businesses. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We believe the principal competitive factors that can impact our businesses relate to the sales and pricing of our products and services; product innovation; consumer satisfaction; the level and quality of products and services; care delivery; network capabilities; market share; product distribution systems; efficiency of administration operations; financial strength and marketplace reputation.

EMPLOYEES

As of December 31, 2005, we employed approximately 55,000 individuals. We believe our employee relations are positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

Name	Age	Position	First Elected as Executive Officer
William W. McGuire, M.D.	57	Chairman of the Board and Chief Executive Officer	1988
Stephen J. Hemsley	53	President, Chief Operating Officer and Director	1997
Patrick J. Erlandson	46	Chief Financial Officer	2001
David J. Lubben	54	General Counsel and Secretary	1996
Richard H. Anderson	50	Executive Vice President, UnitedHealth Group and Chief Executive Officer, Ingenix	2005
Tracy L. Bahl	43	Chief Executive Officer, Uniprise	2004
William A. Munsell	54	Chief Executive Officer, Specialized Care Services	2004
Lois E. Quam	44	Chief Executive Officer, Ovations	1998
Robert J. Sheehy	48	Chief Executive Officer, UnitedHealthcare	2001
David S. Wichmann	43	President and Chief Operating Officer, UnitedHealthcare, and Senior Vice President, UnitedHealth Group	2004

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified.

Dr. McGuire is the Chairman of the Board of Directors and Chief Executive Officer of UnitedHealth Group. Dr. McGuire joined UnitedHealth Group as Executive Vice President in November 1988 and became its Chairman and Chief Executive Officer in 1991. Dr. McGuire also served as UnitedHealth Group's Chief Operating Officer from May 1989 to June 1995 and as its President from November 1989 until May 1999.

Mr. Hemsley is the President and Chief Operating Officer of UnitedHealth Group and has been a member of the Board of Directors since February 2000. Mr. Hemsley joined UnitedHealth Group in May 1997 as Senior Executive Vice President. He became Chief Operating Officer in September 1998 and was named President in May 1999.

Mr. Erlandson joined UnitedHealth Group in 1997 as Vice President of Process, Planning and Information Channels. He became Controller and Chief Accounting Officer in September 1998 and was named Chief Financial Officer in January 2001.

Mr. Lubben joined UnitedHealth Group in October 1996 as General Counsel and Secretary. Prior to joining UnitedHealth Group, he was a partner in the law firm of Dorsey & Whitney LLP.

Mr. Anderson joined UnitedHealth Group in November 2004 as Executive Vice President and was named Chief Executive Officer, Ingenix in January 2005. From April 2001 until November 2004, Mr. Anderson served as the Chief Executive Officer of Northwest Airlines Corporation. Mr. Anderson served in various other capacities at Northwest Airlines from 1990 until April 2001.

Mr. Bahl joined UnitedHealth Group in August 1998 and was named Chief Executive Officer, Uniprise in March 2004. From January 2003 until March 2004, Mr. Bahl was UnitedHealth Group's Chief Marketing Officer, and from August 1998 until December 2002, he was the President of Uniprise Strategic Solutions.

Mr. Munsell joined UnitedHealth Group in 1997 and was named Chief Executive Officer, Specialized Care Services in November 2004. From February 2003 to June 2004, Mr. Munsell served as the Chief Administrative Officer, UnitedHealthcare, after serving as Chief Operating Officer, UnitedHealthcare since February 2000. From August 1997 to January 2000, Mr. Munsell served as Chief Financial Officer, UnitedHealthcare.

Ms. Quam joined UnitedHealth Group in 1989 and became the Chief Executive Officer of Ovations in April 1998. Prior to April 1998, Ms. Quam served in various capacities with UnitedHealth Group.

Mr. Sheehy joined UnitedHealth Group in 1992 and became Chief Executive Officer of UnitedHealthcare in January 2001. From April 1998 to December 2000, he was President of UnitedHealthcare. Prior to April 1998, Mr. Sheehy served in various capacities with UnitedHealth Group.

Mr. Wichmann joined UnitedHealth Group in 1998 and became President and Chief Operating Officer, UnitedHealthcare in July 2004. From June 2003 to July 2004, Mr. Wichmann served as the Chief Executive Officer, Specialized Care Services. From 2001 to June 2003, he was President and Chief Operating Officer, Specialized Care Services. From March 1998 to July 2004, Mr. Wichmann also served as Senior Vice President of Corporate Development.

ITEM 1A. RISK FACTORS

See Item 7—"Cautionary Statements," which is incorporated by reference herein.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

As of December 31, 2005, we leased approximately 10.1 million aggregate square feet of space and owned approximately 1.9 million aggregate square feet of space in the United States and Europe. Our leases expire at various dates through May 31, 2025. Our various segments use this space exclusively for their respective business purposes and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

See Item 7—"Legal Matters" and Item 8—Note 12 "Commitments and Contingencies"— "Government Regulation," which are incorporated by reference herein.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

None.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Prices

Our common stock is traded on the New York Stock Exchange under the symbol UNH. On February 15, 2006, there were 14,741 registered holders of record of our common stock. The high and low common stock prices per share were as follows:

	High	Low
2006		
First quarter (through 2/15/06)	$62.93	$56.00
2005		
First quarter	$48.33	$42.63
Second quarter	$53.64	$44.30
Third quarter	$56.66	$47.75
Fourth quarter	$64.61	$53.84
2004		
First quarter	$32.25	$27.73
Second quarter	$34.25	$29.31
Third quarter	$37.38	$29.67
Fourth quarter	$44.38	$32.31

Dividend Policy

Our Board of Directors established our dividend policy in August 1990. Pursuant to our dividend policy, the Board reviews our financial statements following the end of each fiscal year and decides whether to declare a dividend on the outstanding shares of common stock. Shareholders of record on April 1, 2005 received an annual dividend for 2005 of $0.015 per share and shareholders of record on April 1, 2004 received an annual dividend for 2004 of $0.008 per share. On January 31, 2006, the Board approved an annual dividend of $0.03 per share, which will be paid on April 17, 2006 to shareholders of record on April 3, 2006.

Issuer Purchases of Equity Securities

Issuer Purchases of Equity Securities (1)
Fourth Quarter 2005

For the Month Ended	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that may yet be purchased under the plans or programs
October 31, 2005	250,000	$56.50	250,000	59,545,100
November 30, 2005	200,000	$60.40	200,000	59,345,100
December 31, 2005	3,800,000	$63.31	3,800,000	55,545,100
TOTAL	4,250,000	$62.77	4,250,000	

(1) In November 1997, the company's Board of Directors adopted a share repurchase program, which the Board evaluates periodically and renews as necessary. The company announced renewals of the program on November 5, 1998, October 27, 1999, February 14, 2002, October 25, 2002, July 30, 2003, and November 4, 2004. On November 4, 2004, the Board renewed the share repurchase program and authorized the company to repurchase up to 65 million shares of the Company's common stock at prevailing market prices. There is no established expiration date for the program. During the year ended December 31, 2005, the company did not repurchase any shares other than through this publicly announced program.

ITEM 6. SELECTED FINANCIAL DATA

Financial Highlights

(in millions, except per share data)	For the Year Ended December 31,				
	2005[1]	**2004[1]**	**2003**	**2002**	**2001**
Consolidated Operating Results					
Revenues	**$45,365**	$37,218	$28,823	$25,020	$23,454
Earnings From Operations	**$ 5,373**	$ 4,101	$ 2,935	$ 2,186	$ 1,566
Net Earnings	**$ 3,300**	$ 2,587	$ 1,825	$ 1,352	$ 913
Return on Shareholders' Equity	**27.2%**	31.4%	39.0%	33.0%	24.5%
Basic Net Earnings per Common Share[2]	**$ 2.61**	$ 2.07	$ 1.55	$ 1.12	$ 0.73
Diluted Net Earnings per Common Share[2]	**$ 2.48**	$ 1.97	$ 1.48	$ 1.06	$ 0.70
Common Stock Dividends per Share[2]	**$ 0.015**	$ 0.015	$ 0.008	$ 0.008	$ 0.008
Consolidated Cash Flows From (Used For)					
Operating Activities	**$ 4,326**	$ 4,135	$ 3,003	$ 2,423	$ 1,844
Investing Activities	**$ (3,489)**	$ (1,644)	$ (745)	$ (1,391)	$ (1,138)
Financing Activities	**$ 593**	$ (762)	$ (1,126)	$ (1,442)	$ (585)
Consolidated Financial Condition					
(As of December 31)					
Cash and Investments	**$14,982**	$12,253	$ 9,477	$ 6,329	$ 5,698
Total Assets	**$41,374**	$27,879	$17,634	$14,164	$12,486
Debt	**$ 7,111**	$ 4,023	$ 1,979	$ 1,761	$ 1,584
Shareholders' Equity	**$17,733**	$10,717	$ 5,128	$ 4,428	$ 3,891
Debt-to-Total-Capital Ratio	**28.6%**	27.3%	27.8%	28.5%	28.9%

Financial Highlights and Management's Discussion and Analysis of Financial Condition and Results of Operations should be read together with the accompanying Consolidated Financial Statements and Notes.

[1] UnitedHealth Group acquired PacifiCare Health Systems, Inc. (PacifiCare) in December 2005 for total consideration of approximately $8.8 billion, Oxford Health Plans, Inc. (Oxford) in July 2004 for total consideration of approximately $5.0 billion and Mid Atlantic Medical Services, Inc. (MAMSI) in February 2004 for total consideration of approximately $2.7 billion. These acquisitions affect the comparability of 2005 and 2004 financial information to prior fiscal years. The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in UnitedHealth Group's consolidated financial statements since the respective acquisition dates. See Note 3 to the consolidated financial statements for a detailed discussion of these acquisitions.

[2] In May 2005, our board of directors declared a two-for-one stock split. All share and per share amounts have been restated to reflect the stock split.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Business Overview

UnitedHealth Group is a diversified health and well-being company, serving approximately 65 million Americans. Our focus is on improving the American health care system by simplifying the administrative components of health care delivery; promoting evidence-based medicine as the standard for care; and providing relevant, actionable data that physicians, health care providers, consumers, employers and other participants in health care can use to make better, more informed decisions.

Through our diversified family of businesses, we leverage core competencies in advanced technology-based transactional capabilities; health care data, knowledge and informatics; and health care resource organization and care facilitation to make health care work better. We provide individuals with access to quality, cost-effective health care services and resources. We promote the delivery of care, consistent with the best available evidence for effective health care. We provide employers and consumers with superb value, service, and support, and we deliver value to our shareholders by executing a business strategy founded upon a commitment to balanced growth, profitability and capital discipline.

2005 Financial Performance Highlights

UnitedHealth Group had a very strong year in 2005. The company achieved diversified growth across its business segments and generated net earnings of $3.3 billion, representing an increase of 28% over 2004. Other financial performance highlights include:

- Diluted net earnings per common share of $2.48, an increase of 26% over 2004.
- Revenues of $45.4 billion, a 22% increase over 2004. Excluding the impact of acquisitions, revenues increased 11% over 2004.
- Earnings from operations of $5.4 billion, up 31% over 2004.
- Operating margin of 11.8%, up from 11.0% in 2004.

UnitedHealth Group acquired PacifiCare Health Plans, Inc. (PacifiCare) in December 2005 for total consideration of approximately $8.8 billion, Oxford Health Plans, Inc. (Oxford) in July 2004 for total consideration of approximately $5.0 billion and Mid Atlantic Medical Services, Inc. (MAMSI) in February 2004 for total consideration of approximately $2.7 billion. The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in UnitedHealth Group's consolidated financial statements since the respective acquisition dates.

2005 Results Compared to 2004 Results

Consolidated Financial Results

Revenues

Revenues consist of premium revenues from risk-based products; service revenues, which primarily include fees for management, administrative and consulting services; and investment and other income.

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is fixed, typically for a one-year period, and we assume the economic risk of funding our customers' health care services and related administrative costs. Service revenues consist primarily of fees derived from services performed for customers that self-insure the medical costs of their employees and their dependents. For both

premium risk-based and fee-based customer arrangements, we provide coordination and facilitation of medical services; transaction processing; customer, consumer and care provider services; and access to contracted networks of physicians, hospitals and other health care professionals.

Consolidated revenues in 2005 increased by $8.1 billion, or 22%, to $45.4 billion. Excluding the impact of businesses acquired since the beginning of 2004, consolidated revenues increased by approximately 11% in 2005 primarily as a result of rate increases on premium-based and fee-based services and growth in individuals served across business segments. Following is a discussion of 2005 consolidated revenue trends for each of our three revenue components.

Premium Revenues Consolidated premium revenues totaled $41.1 billion in 2005, an increase of $7.6 billion, or 23%, over 2004. Excluding the impact of acquisitions, consolidated premium revenues increased by approximately 11% over 2004. This increase was primarily driven by premium rate increases and a modest increase in the number of individuals served by our risk-based products.

UnitedHealthcare premium revenues increased by $5.1 billion, or 24%, over 2004. Excluding premium revenues from businesses acquired since the beginning of 2004, UnitedHealthcare premium revenues increased by approximately 9% over 2004. This increase was primarily due to average net premium rate increases of approximately 8% to 9% on UnitedHealthcare's renewing commercial risk-based products. In addition, Ovations premium revenues increased by $1.8 billion, or 24%, over 2004. Excluding the impact of acquisitions, Ovations premium revenues increased by approximately 20% over 2004, driven primarily by an increase in the number of individuals served by Medicare Advantage products and by Medicare supplement products provided to AARP members, as well as rate increases on these products. Premium revenues from AmeriChoice's Medicaid programs increased by approximately $270 million, or 9%, over 2004 driven primarily by premium rate increases. The remaining premium revenue increase is due mainly to strong growth in the number of individuals served by several Specialized Care Services businesses under premium-based arrangements.

Service Revenues Service revenues in 2005 totaled $3.8 billion, an increase of $473 million, or 14%, over 2004. The increase in service revenues was driven primarily by aggregate growth of 8% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements during 2005, excluding the impact of acquisitions, as well as annual rate increases. In addition, Ingenix service revenues increased by more than 20% due to growth in the health information and clinical research businesses as well as businesses acquired since the beginning of 2004.

Investment and Other Income Investment and other income totaled $499 million, representing an increase of $111 million over 2004. Interest income increased by $126 million in 2005, principally due to the impact of increased levels of cash and fixed-income investments during the year due to the acquisitions of Oxford and MAMSI as well as higher yields on fixed-income investments. Net capital gains on sales of investments were $4 million in 2005, a decrease of $15 million from 2004.

Medical Costs

The combination of pricing, benefit designs, consumer health care utilization and comprehensive care facilitation efforts is reflected in the medical care ratio (medical costs as a percentage of premium revenues). The consolidated medical care ratio decreased from 80.6% in 2004 to 79.7% in 2005. Excluding the AARP business[1],

[1] Management believes disclosure of the medical care ratio excluding the AARP business is meaningful since underwriting gains or losses related to the AARP business accrue to the overall benefit of the AARP policyholders through a rate stabilization fund (RSF). Although the company is at risk for underwriting losses to the extent cumulative net losses exceed the balance in the RSF, we have not been required to fund any underwriting deficits to date, and management believes the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract during the foreseeable future.

the medical care ratio decreased from 79.5% in 2004 to 78.6% in 2005. These medical care ratio decreases resulted primarily from changes in product, business and customer mix and an increase in favorable medical cost development related to prior periods.

Each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to prior fiscal years, resulting from more complete claim information, identified in the current year are included in total medical costs reported for the current fiscal year. Medical costs for 2005 include approximately $400 million of favorable medical cost development related to prior fiscal years. Medical costs for 2004 include approximately $210 million of favorable medical cost development related to prior fiscal years. The increase in favorable medical cost development in 2005 was driven primarily by lower than anticipated medical costs as well as growth in the size of the medical cost base and related medical payables due to organic growth and businesses acquired since the beginning of 2004.

On an absolute dollar basis, 2005 medical costs increased $5.7 billion, or 21%, over 2004. Excluding the impact of acquisitions, medical costs increased by approximately 9% driven primarily by a 7% to 8% increase in medical cost trend due to both inflation and a slight increase in health care consumption as well as organic growth.

Operating Costs

The operating cost ratio (operating costs as a percentage of total revenues) for 2005 was 15.0%, down from 15.4% in 2004. This decrease was primarily driven by revenue mix changes, with premium revenues growing at a faster rate than service revenues largely due to recent acquisitions. Operating costs as a percentage of premium revenues are generally considerably lower than operating costs as a percentage of fee-based revenues. Additionally, the decrease in the operating cost ratio reflects productivity gains from technology deployment and other cost management initiatives.

On an absolute dollar basis, operating costs for 2005 increased $1.1 billion, or 19%, over 2004. Excluding the impact of acquisitions, operating costs increased by approximately 11%. This increase was driven by an 8% increase in total individuals served by Health Care Services and Uniprise during 2005, excluding the impact of acquisitions, growth in Specialized Care Services and Ingenix and general operating cost inflation, partially offset by productivity gains from technology deployment and other cost management initiatives.

Depreciation and Amortization

Depreciation and amortization in 2005 was $453 million, an increase of $79 million, or 21%, over 2004. Approximately $32 million of this increase was related to intangible assets acquired in business acquisitions since the beginning of 2004. The remaining increase is primarily due to additional depreciation and amortization from higher levels of computer equipment and capitalized software as a result of technology enhancements, business growth and businesses acquired since the beginning of 2004.

Income Taxes

Our effective income tax rate was 35.7% in 2005, compared to 34.9% in 2004. The increase was mainly driven by favorable settlements of prior year tax returns during 2004. Excluding these settlements, the 2004 effective tax rate would have been approximately the same as the 2005 effective tax rate.

Business Segments

The following summarizes the operating results of our business segments for the years ended December 31 (in millions):

Revenues	2005	2004	Percent Change
Health Care Services	**$40,019**	$32,673	22%
Uniprise	**3,850**	3,365	14%
Specialized Care Services	**2,806**	2,295	22%
Ingenix	**794**	670	19%
Intersegment Eliminations	**(2,104)**	(1,785)	nm
Consolidated Revenues	**$45,365**	$37,218	22%

Earnings From Operations	2005	2004	Percent Change
Health Care Services	**$ 3,815**	$ 2,810	36%
Uniprise	**799**	677	18%
Specialized Care Services	**582**	485	20%
Ingenix	**177**	129	37%
Consolidated Earnings From Operations	**$ 5,373**	$ 4,101	31%

nm - not meaningful

Health Care Services

The Health Care Services segment is composed of the UnitedHealthcare, Ovations and AmeriChoice businesses. UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for local, small and mid-sized employers and individuals nationwide. Ovations provides health and well-being services to individuals age 50 and older, including the administration of supplemental health insurance coverage on behalf of AARP. AmeriChoice provides network-based health and well-being services to state Medicaid, Children's Health Insurance Program and other government-sponsored health care programs and the beneficiaries of those programs.

Health Care Services had revenues of $40.0 billion in 2005, representing an increase of $7.3 billion, or 22%, over 2004. Excluding the impact of acquisitions, Health Care Services revenues increased by approximately $3.0 billion, or 11%, over 2004. UnitedHealthcare accounted for approximately $1.6 billion of this increase, driven by average premium rate increases of approximately 8% to 9% on UnitedHealthcare's renewing commercial risk-based products. Ovations contributed approximately $1.2 billion to the revenue advance over 2004 largely attributable to growth in the number of individuals served by Ovations' Medicare supplement products provided to AARP members and by its Medicare Advantage products as well as rate increases on these products. The remaining increase in Health Care Services revenues is attributable to an 8% increase in AmeriChoice's revenues, excluding the impact of acquisitions, driven primarily by premium revenue rate increases on Medicaid products.

Health Care Services earnings from operations in 2005 were $3.8 billion, representing an increase of $1.0 billion, or 36%, over 2004. This increase primarily resulted from revenue growth and improved gross margins on UnitedHealthcare's risk-based products, increases in the number of individuals served by UnitedHealthcare's commercial fee-based products, and the acquisitions of Oxford and MAMSI during 2004. UnitedHealthcare's commercial medical care ratio decreased to 78.2% in 2005 from 79.0% in 2004 mainly due to changes in product, business and customer mix. Health Care Services' 2005 operating margin was 9.5%, an

increase from 8.6% in 2004. This increase was driven mainly by the lower commercial medical care ratio as well as changes in business and customer mix.

The following table summarizes the number of individuals served by Health Care Services, by major market segment and funding arrangement, as of December 31[1]:

(in thousands)	2005[2]	2004
Commercial		
Risk-based	**7,765**	7,655
Fee-based	**3,895**	3,305
Total Commercial	**11,660**	10,960
Medicare	**395**	330
Medicaid	**1,250**	1,260
Total Health Care Services	**13,305**	12,550

1 Excludes individuals served by Ovations' Medicare supplement products provided to AARP members.

2 Excludes commercial risk-based membership of approximately 2.3 million, commercial fee-based membership of approximately 100,000 and Medicare membership of approximately 750,000 related to the December 2005 acquisition of PacifiCare. These amounts have been excluded since the impact of PacifiCare on our 2005 consolidated financial results is not significant.

The number of individuals served by UnitedHealthcare's commercial business as of December 31, 2005, excluding the PacifiCare acquisition, increased by approximately 700,000 over the prior year. This included an increase of 590,000 in the number of individuals served with fee-based products driven by the addition of approximately 335,000 individuals served resulting from new customer relationships and customers converting from risk-based products to fee-based products as well as approximately 255,000 individuals served by a benefits administrative services company acquired in December 2005. In addition, the number of individuals served with commercial risk-based products increased by 110,000 driven primarily by the addition of approximately 130,000 individuals served by Neighborhood Health Partnership, acquired in September 2005, and a slight increase in net new customer relationships offset by customers converting from risk-based products to fee-based products.

Excluding the PacifiCare acquisition, the number of individuals served by Ovations' Medicare Advantage products increased by 65,000, or 20%, over 2004 due primarily to new customer relationships. AmeriChoice's Medicaid enrollment decreased by 10,000 from 2004 due primarily to the withdrawal of participation in one market during the third quarter of 2005 partially offset by new customer relationships since 2004.

Uniprise

Uniprise provides network-based health and well-being services, business-to-business transaction processing services, consumer connectivity and technology support services nationwide to large employers and health plans, and provides health-related consumer and financial transaction products and services. Uniprise revenues in 2005 were $3.9 billion, representing an increase of $485 million, or 14%, over 2004. Excluding the impact of acquisitions, Uniprise revenues increased approximately 12% over 2004. This increase was driven primarily by growth of 7% in the number of individuals served by Uniprise, excluding the impact of acquisitions, and annual service fee rate increases for self-insured customers. Uniprise served 10.5 million individuals and 9.9 million individuals as of December 31, 2005 and 2004, respectively.

Uniprise earnings from operations in 2005 were $799 million, representing an increase of $122 million, or 18%, over 2004. Operating margin for 2005 improved to 20.8% from 20.1% in 2004. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that have reduced labor and occupancy costs in its transaction

processing and customer service, billing and enrollment functions. Additionally, Uniprise's infrastructure can be scaled efficiently, allowing its business to grow revenues at a proportionately higher rate than the associated growth in operating expenses.

Specialized Care Services

Specialized Care Services offers a comprehensive platform of specialty health, wellness and ancillary benefits, networks, services and resources to specific customer markets nationwide. Specialized Care Services revenues of $2.8 billion increased by $511 million, or 22%, over 2004. This increase was principally driven by an 11% increase in the number of individuals served by its specialty benefit businesses, excluding the impact of acquisitions, and rate increases related to these businesses as well as businesses acquired since the beginning of 2004.

Earnings from operations in 2005 of $582 million increased $97 million, or 20%, over 2004. Specialized Care Services' operating margin was 20.7% in 2005, down from 21.1% in 2004. This decrease was due to a business mix shift toward higher revenue, lower margin products, partially offset by continued gains in quality initiatives and operating cost efficiencies.

Ingenix

Ingenix offers database and data management services, software products, publications, consulting services, outsourced services and pharmaceutical development and consulting services on a national and international basis. Ingenix 2005 revenues of $794 million increased by $124 million, or 19%, over 2004. This was driven primarily by growth in the health information and contract research businesses as well as businesses acquired since the beginning of 2004.

Earnings from operations in 2005 were $177 million, up $48 million, or 37%, from 2004. Operating margin was 22.3% in 2005, up from 19.3% in 2004. The increase in earnings from operations and operating margin was primarily due to growth in the health information and contract research businesses, improving gross margins due to effective cost management and businesses acquired since the beginning of 2004.

2004 Results Compared to 2003 Results

Consolidated Financial Results

Revenues

Consolidated revenues increased by $8.4 billion, or 29%, in 2004 to $37.2 billion, primarily as a result of revenues from businesses acquired since the beginning of 2003. Excluding the impact of these acquisitions, consolidated revenues increased by approximately 8% in 2004 as a result of rate increases on premium-based and fee-based services and growth across business segments. Following is a discussion of 2004 consolidated revenue trends for each of our three revenue components.

Premium Revenues Consolidated premium revenues in 2004 totaled $33.5 billion, an increase of $8.0 billion, or 32%, over 2003. Excluding the impact of acquisitions, premium revenues increased by approximately 8% in 2004. This increase was due in part to average net premium rate increases of approximately 9% on UnitedHealthcare's renewing commercial risk-based business, partially offset by a slight decrease in the number of individuals served by UnitedHealthcare's commercial risk-based products and changes in the commercial product benefit and customer mix. In addition, Ovations' premium revenues increased largely due to increases in the number of individuals it serves through Medicare Advantage products and changes in product mix related to Medicare supplement products, as well as rate increases on all of these products. Premium revenues from AmeriChoice's Medicaid programs and Specialized Care Services' businesses also increased due to advances in the number of individuals served by those businesses.

Service Revenues Service revenues in 2004 totaled $3.3 billion, an increase of $217 million, or 7%, over 2003. The increase in service revenues was driven primarily by aggregate growth of 4% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements during 2004, excluding the impact of acquisitions, as well as annual rate increases. In addition, Ingenix service revenues increased due to new business growth in the health information and clinical research businesses.

Investment and Other Income Investment and other income totaled $388 million, representing an increase of $131 million over 2003. Interest income increased by $134 million in 2004, principally due to the impact of increased levels of cash and fixed-income investments during the year from the acquisitions of Oxford, MAMSI and Golden Rule Financial Corporation (Golden Rule), which was acquired in November 2003. Net capital gains on sales of investments were $19 million in 2004, a decrease of $3 million from 2003.

Medical Costs

The consolidated medical care ratio decreased from 81.4% in 2003 to 80.6% in 2004. Excluding the AARP business, the medical care ratio decreased from 80.0% in 2003 to 79.5% in 2004. The medical care ratio decrease resulted primarily from net premium rate increases that slightly exceeded overall medical benefit cost increases and changes in product, business and customer mix.

Each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to prior fiscal years that are identified in the current year are included in total medical costs reported for the current fiscal year. Medical costs for 2004 include approximately $210 million of favorable medical cost development related to prior fiscal years. Medical costs for 2003 include approximately $150 million of favorable medical cost development related to prior fiscal years.

On an absolute dollar basis, 2004 medical costs increased $6.3 billion, or 30%, over 2003 principally due to the impact of the acquisitions of Oxford, MAMSI and Golden Rule. Excluding the impact of acquisitions, medical costs increased by approximately 8% driven primarily by medical cost inflation and a moderate increase in health care consumption.

Operating Costs

The operating cost ratio for 2004 was 15.4%, down from 16.9% in 2003. This decrease was driven by revenue mix changes, with premium revenues growing at a faster rate than service revenues largely due to recent acquisitions. The existence of premium revenues within our risk-based products cause them to have lower operating cost ratios than fee-based products, which have no premium revenues. Additionally, the decrease in the operating cost ratio reflects productivity gains from technology deployment and other cost management initiatives.

On an absolute dollar basis, operating costs for 2004 increased $868 million, or 18%, over 2003 primarily due to the acquisitions of Oxford, MAMSI and Golden Rule. Excluding the impact of acquisitions, operating costs increased by approximately 3%. This increase was driven by a more than 3% increase in the total number of individuals served by Health Care Services and Uniprise in 2004, excluding the impact of acquisitions, and general operating cost inflation, partially offset by productivity gains from technology deployment and other cost management initiatives.

Depreciation and Amortization

Depreciation and amortization in 2004 was $374 million, an increase of $75 million, or 25%, over 2003. Approximately $42 million of this increase is related to intangible assets acquired in business acquisitions in 2004. The remaining increase is due primarily to additional depreciation and amortization from higher levels of computer equipment and capitalized software as a result of technology enhancements, business growth and businesses acquired since the beginning of 2003.

Income Taxes

Our effective income tax rate was 34.9% in 2004, compared to 35.7% in 2003. The decrease was driven mainly by favorable settlements of prior year income tax returns during 2004.

Business Segments

The following summarizes the operating results of our business segments for the years ended December 31 (in millions):

Revenues	2004	2003	Percent Change
Health Care Services	**$32,673**	$24,807	32%
Uniprise	**3,365**	3,107	8%
Specialized Care Services	**2,295**	1,878	22%
Ingenix	**670**	574	17%
Intersegment Eliminations	**(1,785)**	(1,543)	nm
Consolidated Revenues	**$37,218**	$28,823	29%

Earnings From Operations	2004	2003	Percent Change
Health Care Services	**$ 2,810**	$ 1,865	51%
Uniprise	**677**	610	11%
Specialized Care Services	**485**	385	26%
Ingenix	**129**	75	72%
Consolidated Earnings From Operations	**$ 4,101**	$ 2,935	40%

nm - not meaningful

Health Care Services

Health Care Services had revenues of $32.7 billion in 2004, representing an increase of $7.9 billion, or 32%, over 2003, driven primarily by acquisitions since the beginning of 2003. Excluding the impact of acquisitions, Health Care Services revenues increased by approximately $1.9 billion, or 8%, over 2003. UnitedHealthcare accounted for approximately $850 million of this increase, driven by average premium rate increases of approximately 9% on renewing commercial risk-based business and growth in the number of individuals served by fee-based products, partially offset by a slight decrease in the number of individuals served by UnitedHealthcare's commercial risk-based products. Ovations contributed approximately $770 million to the revenue advance over 2003 driven by growth in the number of individuals served by Ovations' Medicare Advantage products and changes in product mix related to Medicare supplement products it provides to AARP members, as well as rate increases on all of these products. The remaining increase in Health Care Services revenues is attributable to growth in the number of individuals served by AmeriChoice's Medicaid programs and Medicaid premium rate increases.

Health Care Services earnings from operations in 2004 were $2.8 billion, representing an increase of $945 million, or 51%, over 2003. This increase primarily resulted from Ovations' and UnitedHealthcare's revenue growth, improved gross margins on UnitedHealthcare's commercial risk-based products and the impact of the acquisitions of Oxford, MAMSI and Golden Rule. UnitedHealthcare's commercial medical care ratio decreased to 79.0% in 2004 from 80.0% in 2003. The decrease in the commercial medical care ratio was primarily driven by net premium rate increases that slightly exceeded overall medical benefit cost increases and changes in business and customer mix. Health Care Services' 2004 operating margin was 8.6%, an increase of 110 basis

points over 2003. This increase was principally driven by a combination of the improved commercial medical care ratio and changes in business and customer mix.

The following table summarizes the number of individuals served by Health Care Services, by major market segment and funding arrangement, as of December 31[1]:

(in thousands)	2004	2003
Commercial		
Risk-based	**7,655**	5,400
Fee-based	**3,305**	2,895
Total Commercial	**10,960**	8,295
Medicare	**330**	230
Medicaid	**1,260**	1,105
Total Health Care Services	**12,550**	9,630

[1] Excludes individuals served by Ovations' Medicare supplement products provided to AARP members.

The number of individuals served by UnitedHealthcare's commercial business as of December 31, 2004, increased by nearly 2.7 million, or 32%, over the prior year. Excluding the 2004 acquisitions of Oxford, MAMSI and a smaller regional health plan, the number of individuals served by UnitedHealthcare's commercial business increased by 245,000. This included an increase of 285,000 in the number of individuals served with fee-based products, driven by new customer relationships and existing customers converting from risk-based products to fee-based products, partially offset by a decrease of 40,000 in the number of individuals served with risk-based products resulting primarily from customers converting to self-funded, fee-based arrangements and a competitive commercial risk-based pricing environment.

Excluding the impact of the Oxford acquisition, the number of individuals served by Ovations' Medicare Advantage products increased by 30,000, or 13%, from 2003. AmeriChoice's Medicaid enrollment increased by 155,000, or 14%, due to organic growth in the number of individuals served and the acquisition of a Medicaid health plan in Michigan in February 2004, resulting in the addition of approximately 95,000 individuals served.

Uniprise

Uniprise revenues in 2004 were $3.4 billion, representing an increase of 8% over 2003. This increase was driven primarily by growth of 4% in the number of individuals served by Uniprise, excluding the impact of acquisitions, and annual service fee rate increases for self-insured customers. Uniprise served 9.9 million individuals and 9.1 million individuals as of December 31, 2004 and 2003, respectively.

Uniprise earnings from operations in 2004 were $677 million, representing an increase of 11% over 2003. Operating margin for 2004 improved to 20.1% from 19.6% in 2003. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that have reduced labor and occupancy costs in its transaction processing and customer service, billing and enrollment functions.

Specialized Care Services

Specialized Care Services revenues during 2004 of $2.3 billion increased by $417 million, or 22%, over 2003. This increase was principally driven by an increase in the number of individuals served by its behavioral health benefits business, its dental services business and its vision care benefits business; rate increases related to these businesses; and incremental revenues related to businesses acquired since the beginning of 2003 of approximately $100 million.

Earnings from operations in 2004 of $485 million increased $100 million, or 26%, over 2003. Specialized Care Services' operating margin increased to 21.1% in 2004, up from 20.5% in 2003. This increase was driven primarily by operational and productivity improvements within Specialized Care Services' businesses and consolidation of the production and service operation infrastructure to enhance productivity and efficiency and to improve the quality and consistency of service, partially offset by a business mix shift toward higher revenue, lower margin products.

Ingenix

Ingenix revenues in 2004 of $670 million increased by $96 million, or 17%, over 2003. This was driven primarily by new business growth in the health information and contract research businesses. Earnings from operations in 2004 were $129 million, up $54 million, or 72%, from 2003. Operating margin was 19.3% in 2004, up from 13.1% in 2003. The increase in earnings from operations and operating margin was primarily due to growth and improving gross margins in the health information and clinical research businesses.

Financial Condition, Liquidity and Capital Resources at December 31, 2005

Liquidity and Capital Resources

We manage our cash, investments and capital structure so we are able to meet the short- and long-term obligations of our business while maintaining strong financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from operations. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceed our short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. Factors we consider in making these investment decisions include our board of directors' approved investment policy, regulatory limitations, return objectives, tax implications, risk tolerance and maturity dates. Our long-term investments are also available for sale to meet short-term liquidity and other needs. Cash in excess of the capital needs of our regulated entities are paid to their non-regulated parent companies, typically in the form of dividends, for general corporate use, when and as permitted by applicable regulations.

Our non-regulated businesses also generate significant cash from operations for general corporate use. Cash flows generated by these entities, combined with the issuance of commercial paper, long-term debt and the availability of committed credit facilities, further strengthen our operating and financial flexibility. We generally use these cash flows to reinvest in our businesses in the form of capital expenditures, to expand the depth and breadth of our services through business acquisitions, and to repurchase shares of our common stock, depending on market conditions.

Cash flows generated from operating activities, our primary source of liquidity, are principally from net earnings, prior to depreciation and amortization. As a result, any future decline in our profitability may have a negative impact on our liquidity. The level of profitability of our risk-based insured business depends in large part on our ability to accurately predict and price for health care and operating cost increases. This risk is partially mitigated by the diversity of our other businesses, the geographic diversity of our risk-based business and our disciplined underwriting and pricing processes, which seek to match premium rate increases with future health care costs. In 2005, a hypothetical unexpected 1% increase in commercial insured medical costs would have reduced net earnings by approximately $130 million.

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, debt covenants and other contractual restrictions, regulatory requirements and market conditions. We believe that our strategies and actions toward maintaining financial flexibility mitigate much of this risk.

Cash and Investments

Cash flows from operating activities were $4.3 billion in 2005, an increase over $4.1 billion in 2004. The increase in operating cash flows resulted primarily from an increase of $834 million in net income prior to depreciation, amortization and other noncash items partially offset by a decrease of $643 million in cash flows generated from working capital changes. We generated operating cash flows from working capital changes of $406 million in 2005 and $1,049 million in 2004. The year-over-year decrease primarily resulted from the Company receiving only eleven monthly Medicare premium payments during 2005 from the Centers for Medicare and Medicaid Services (CMS) rather than the twelve monthly payments received in 2004, negatively impacting the change in reported operating cash flows by $375 million. Additionally, there was reduced growth in medical payables during 2005 compared to 2004 due in part to an increase in electronic claim submissions and other disbursement process efficiencies.

We maintained a strong financial condition and liquidity position, with cash and investments of $15.0 billion at December 31, 2005. Total cash and investments increased by $2.7 billion since December 31, 2004, primarily due to cash and investments acquired through businesses acquired since the beginning of 2005, strong operating cash flows and cash received from debt issuances, partially offset by common stock repurchases, cash paid for business acquisitions and capital expenditures.

As further described under Regulatory Capital and Dividend Restrictions, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. At December 31, 2005, approximately $270 million of our $15.0 billion of cash and investments was held by non-regulated subsidiaries and available for general corporate use, including acquisitions and share repurchases.

Financing and Investing Activities

In addition to our strong cash flows generated by operating activities, we use commercial paper and debt to maintain adequate operating and financial flexibility. As of December 31, 2005 and 2004, we had commercial paper and debt outstanding of approximately $7.1 billion and $4.0 billion, respectively. Our debt-to-total-capital ratio was 28.6% and 27.3% as of December 31, 2005 and December 31, 2004, respectively. We believe the prudent use of debt leverage optimizes our cost of capital and return on shareholders' equity, while maintaining appropriate liquidity.

On December 20, 2005, the company acquired PacifiCare. Under the terms of the agreement, PacifiCare shareholders received 1.1 shares of UnitedHealth Group common stock and $21.50 in cash for each share of PacifiCare common stock they owned. Total consideration issued for the transaction was approximately $8.8 billion, composed of approximately 99.2 million shares of UnitedHealth Group common stock (valued at approximately $5.3 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of July 6, 2005), approximately $2.1 billion in cash, $960 million cash paid to retire PacifiCare's existing debt and UnitedHealth Group vested common stock options with an estimated fair value of approximately $420 million issued in exchange for PacifiCare's outstanding vested common stock options.

On February 24, 2006, our Health Care Services business segment acquired John Deere Health Care, Inc. (John Deere Health). Under the terms of the purchase agreement, we paid approximately $500 million in cash in exchange for all of the outstanding equity of John Deere Health. We issued commercial paper to finance the John Deere Health purchase price.

On September 19, 2005, our Health Care Services business segment acquired Neighborhood Health Partnership (NHP). Under the terms of the purchase agreement, we paid approximately $185 million in cash in exchange for all of the outstanding equity of NHP. We issued commercial paper to finance the NHP purchase price.

On December 10, 2004, our Uniprise business segment acquired Definity Health Corporation (Definity). Under the terms of the purchase agreement, we paid $305 million in cash in exchange for all of the outstanding stock of Definity. We used available cash and issued commercial paper to finance the Definity purchase price.

On July 29, 2004, our Health Care Services business segment acquired Oxford. Under the terms of the purchase agreement, Oxford shareholders received 1.2714 shares of UnitedHealth Group common stock and $16.17 in cash for each share of Oxford common stock they owned. Total consideration issued was approximately $5.0 billion, composed of approximately 104.4 million shares of UnitedHealth Group common stock (valued at approximately $3.4 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of April 26, 2004), approximately $1.3 billion in cash and UnitedHealth Group vested common stock options with an estimated fair value of $240 million issued in exchange for Oxford's outstanding vested common stock options.

On February 10, 2004, our Health Care Services business segment acquired MAMSI. Under the terms of the purchase agreement, MAMSI shareholders received 1.64 shares of UnitedHealth Group common stock and $18 in cash for each share of MAMSI common stock they owned. Total consideration issued was approximately $2.7 billion, composed of 72.8 million shares of UnitedHealth Group common stock (valued at $1.9 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of October 27, 2003) and approximately $800 million in cash.

In November and December 2005, we issued $2.6 billion of commercial paper primarily to finance the cash portion of the purchase price of the PacifiCare acquisition described above and to retire a portion of the PacifiCare debt at the closing of the acquisition, as well as to refinance current maturities of long-term debt. As of December 31, 2005, our outstanding commercial paper had interest rates ranging from 4.2% to 4.4%.

In March 2005, we issued $500 million of 4.9% fixed-rate notes due March 2015. We used the proceeds from this borrowing for general corporate purposes including repayment of commercial paper, capital expenditures, working capital and share repurchases.

In July 2004, we issued $1.2 billion of commercial paper to fund the cash portion of the Oxford purchase price. In August 2004, we refinanced the commercial paper by issuing $550 million of 3.4% fixed-rate notes due August 2007, $450 million of 4.1% fixed-rate notes due August 2009 and $500 million of 5.0% fixed-rate notes due August 2014.

In February 2004, we issued $250 million of 3.8% fixed-rate notes due February 2009 and $250 million of 4.8% fixed-rate notes due February 2014. We used the proceeds from the February 2004 borrowings to finance a majority of the cash portion of the MAMSI purchase price as described above.

To more closely align interest costs with the floating interest rate received on our cash and cash equivalent balances, we have entered into interest rate swap agreements to convert the majority of our interest rate exposure from a fixed rate to a variable rate. These interest rate swap agreements qualify as fair value hedges. The interest rate swap agreements have aggregate notional amounts of $3.4 billion with variable rates that are benchmarked to the London Interbank Offered Rate (LIBOR). At December 31, 2005, the rate used to accrue interest expense on these agreements ranged from 4.3% to 5.0%. The differential between the fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as an adjustment to interest expense in the Consolidated Statements of Operations.

In December 2005, we amended and restated our $1.0 billion five-year revolving credit facility supporting our commercial paper program. We increased the capacity to $1.3 billion and extended the maturity date to December 2010. In October 2005, we executed a $3.0 billion 364-day revolving credit facility to support a $3.0 billion increase in our commercial paper program. As of December 31, 2005, we had no amounts outstanding under either of these credit facilities.

PacifiCare had approximately $100 million par value of 3% convertible subordinated debentures (convertible notes) which were convertible into approximately 5.2 million shares of UnitedHealth Group's common stock and $102 million of cash as of December 31, 2005. In December 2005, we initiated a consent solicitation to all of the holders of outstanding convertible notes pursuant to which we offered to compensate all holders who elected to convert their notes in accordance with existing terms and consent to an amendment to a covenant in the indenture

governing the convertible notes. The compensation consisted of the present value of interest through October 18, 2007, the earliest mandatory redemption date, plus a pro rata share of $1 million. On January 31, 2006, approximately 91% of the convertible notes were tendered pursuant to the offer, for which we issued 4.8 million shares of UnitedHealth Group common stock and cash of $99 million.

Our debt arrangements and credit facilities contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio (calculated as the sum of commercial paper and debt divided by the sum of commercial paper, debt and shareholders' equity) below 45% and to exceed specified minimum interest coverage levels. We are in compliance with the requirements of all debt covenants.

Our senior debt is rated "A" by Standard & Poor's (S&P) and Fitch, and "A2" by Moody's. Our commercial paper is rated "A-1" by S&P, "F-1" by Fitch, and "P-1" by Moody's. Consistent with our intention of maintaining our senior debt ratings in the "A" range, we currently intend to maintain our debt-to-total-capital ratio at approximately 30% or less. A significant downgrade in our debt or commercial paper ratings could adversely affect our borrowing capacity and costs.

Under our board of directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. During the year ended December 31, 2005, we repurchased 53.6 million shares at an average price of approximately $48 per share and an aggregate cost of approximately $2.6 billion. As of December 31, 2005, we had board of directors' authorization to purchase up to an additional 55.5 million shares of our common stock. Our common stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares because we believe it is a prudent use of capital. A decision by the company to discontinue share repurchases would significantly increase our liquidity and financial flexibility.

We currently have a $4.0 billion universal S-3 shelf registration statement (for common stock, preferred stock, debt securities and other securities) which has been declared effective by the SEC. In addition, we are considered a "well known seasoned issuer" under the Securities Offering Reform Act that became effective in December 2005. We have not yet issued any securities under this shelf registration statement. We may publicly offer securities from time to time at prices and terms to be determined at the time of offering. We intend to issue debt securities during the first quarter of 2006 to refinance some or all of the commercial paper currently outstanding. Under our S-4 acquisition shelf registration statement, we have remaining issuing capacity of 48.6 million shares of our common stock in connection with acquisition activities. We filed separate S-4 registration statements for the 72.8 million shares issued in connection with the February 2004 acquisition of MAMSI, the 104.4 million shares issued in connection with the July 2004 acquisition of Oxford and the 99.2 million shares issued in connection with the December 2005 acquisition of PacifiCare described previously.

Contractual Obligations, Off-Balance Sheet Arrangements And Commitments

The following table summarizes future obligations due by period as of December 31, 2005, under our various contractual obligations, off-balance sheet arrangements and commitments (in millions):

	2006	2007 to 2008	2009 to 2010	Thereafter	Total
Debt and Commercial Paper[1]	$3,261	$1,450	$ 700	$1,700	$ 7,111
Interest on Debt and Commercial Paper[2]	194	299	191	302	986
Operating Leases	167	287	183	172	809
Purchase Obligations[3]	151	45	6	—	202
Future Policy Benefits[4]	120	305	280	1,176	1,881
Other Long-Term Obligations[5]	—	56	—	302	358
Total Contractual Obligations	$3,893	$2,442	$1,360	$3,652	$11,347

1 Debt payments could be accelerated upon violation of debt covenants. We believe the likelihood of a debt covenant violation is remote.

2 Calculated using stated rates from the debt agreements and related interest rate swap agreements and assuming amounts are outstanding through their contractual term. For variable-rate obligations, we used the rates in place as of December 31, 2005 to estimate all remaining contractual payments.

3 Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements which are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and also excludes liabilities to the extent recorded on the Consolidated Balance Sheet at December 31, 2005.

4 Estimated payments required under life and annuity contracts. Under our reinsurance arrangement with OneAmerica Financial Partners, Inc. (OneAmerica) these amounts are payable by OneAmerica but we remain primarily liable to the policyholders if they are unable to pay (see Note 3 of the consolidated financial statements).

5 Includes obligations associated with certain employee benefit programs and minority interest purchase commitments.

Currently, we do not have any other material contractual obligations, off-balance sheet arrangements or commitments that require cash resources; however, we continually evaluate opportunities to expand our operations. This includes internal development of new products, programs and technology applications, and may include acquisitions.

AARP

In January 1998, we entered into a 10-year contract to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare. Under the terms of the contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from our portion of the AARP insurance offerings were approximately $4.9 billion in 2005, $4.5 billion in 2004 and $4.1 billion in 2003.

The underwriting gains or losses related to the AARP business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member services expenses, marketing expenses and premium taxes. Underwriting gains and losses are recorded as an increase or decrease to the RSF and accrue to the overall benefit of the AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. To the extent underwriting losses exceed the balance in the RSF, we would have to fund the deficit. Any deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. As further described in Note 11 to the consolidated financial statements, the RSF balance is reported in Other Policy Liabilities in the accompanying Consolidated Balance Sheets. We believe the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract.

Medicare Part D Pharmacy Benefits Contract

The Company has contracted with the Centers for Medicare & Medicaid Services to serve as a Prescription Drug Plan sponsor offering Medicare Part D prescription drug insurance coverage to eligible Medicare beneficiaries, beginning January 1, 2006. This product is either offered as a stand-alone product or as an element of the Medicare Advantage products.

As a result of this contract and the December 2005 acquisition of PacifiCare, premium revenues from Medicare-related programs, which have historically been approximately 10% of total premium revenues, are expected to increase to approximately 25% in 2006.

Regulatory Capital and Dividend Restrictions

We conduct a significant portion of our operations through companies that are subject to standards established by the National Association of Insurance Commissioners (NAIC). These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each state, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary, without prior approval by state regulatory authorities, is limited based on the entity's level of statutory net income and statutory capital and surplus. The agencies that assess our creditworthiness also consider capital adequacy levels when establishing our debt ratings. Consistent with our intent to maintain our senior debt ratings in the "A" range, we maintain an aggregate statutory capital level for our regulated subsidiaries that is significantly higher than the minimum level regulators require. As of December 31, 2005, our regulated subsidiaries had aggregate statutory capital of approximately $6.4 billion, which is significantly more than the aggregate minimum regulatory requirements.

Critical Accounting Policies and Estimates

Critical accounting policies are those policies that require management to make the most challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting policies involve judgments and uncertainties that are sufficiently sensitive to result in materially different results under different assumptions and conditions. We believe our most critical accounting policies are those described below. For a detailed discussion of these and other accounting policies, see Note 2 to the consolidated financial statements.

Medical Costs

Each reporting period, we estimate our obligations for medical care services that have been rendered on behalf of insured consumers but for which claims have either not yet been received or processed, and for liabilities for physician, hospital and other medical cost disputes. We develop estimates for medical care services incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, seasonal variances in medical care consumption, provider contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, benefit plan changes, and business mix changes related to products, customers and geography. Depending on the health care provider and type of service, the typical billing lag for services can range from two to 90 days from the date of service. Substantially all claims related to medical care services are known and settled within nine to 12 months from the date of service. We estimate liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the

period in which the change is identified. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Historically, the net impact of estimate developments has represented less than 1% of annual medical costs, less than 5% of annual earnings from operations and less than 4% of medical costs payable.

In order to evaluate the impact of changes in medical cost estimates for any particular discrete period, one should consider both the amount of development recorded in the current period pertaining to prior periods and the amount of development recorded in subsequent periods pertaining to the current period. The accompanying table provides a summary of the net impact of favorable development on medical costs and earnings from operations (in millions).

	Favorable Development	Net Impact on Medical Costs(a)	Medical Costs		Earnings from Operations	
			As Reported	As Adjusted(b)	As Reported	As Adjusted(b)
2002	$ 70	($ 80)	$18,192	$18,112	$2,186	$2,266
2003	$150	($ 60)	$20,714	$20,654	$2,935	$2,995
2004	$210	($190)	$27,000	$26,810	$4,101	$4,291
2005	$400	(c)	$32,725	(c)	$5,373	(c)

(a) The amount of favorable development recorded in the current year pertaining to the prior year less the amount of favorable development recorded in the subsequent year pertaining to the current year.

(b) Represents reported amounts adjusted to reflect the net impact of medical cost development.

(c) Not yet determinable as the amount of prior period development recorded in 2006 will change as our December 31, 2005 medical costs payable estimate develops throughout 2006.

Our estimate of medical costs payable represents management's best estimate of the company's liability for unpaid medical costs as of December 31, 2005, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover the company's liability for unpaid claims as of December 31, 2005; however, actual claim payments may differ from established estimates. The increase in favorable medical cost development in 2005 was driven primarily by lower than anticipated medical costs as well as growth in the size of the medical cost base and related medical payables due to organic growth and businesses acquired since the beginning of 2004. Assuming a hypothetical 1% difference between our December 31, 2005 estimates of medical costs payable and actual costs payable, excluding the AARP business, 2005 earnings from operations would increase or decrease by $63 million and diluted net earnings per common share would increase or decrease by $0.03 per share.

Contingent Liabilities

Because of the nature of our businesses, we are routinely involved in various disputes, legal proceedings and governmental audits and investigations. We record liabilities for our estimates of the probable costs resulting from these matters. Our estimates are developed in consultation with outside legal counsel and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverages, if any, for such matters. We do not believe any matters currently threatened or pending will have a material adverse effect on our consolidated financial position or results of operations. It is possible, however, that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions.

Goodwill, Intangible Assets and Other Long-Lived Assets

As of December 31, 2005, we had long-lived assets, including goodwill, other intangible assets, property, equipment and capitalized software, of $19.9 billion. We review our goodwill for impairment annually at the

reporting unit level, and we review our remaining long-lived assets for impairment when events and changes in circumstances indicate we might not recover their carrying value. To determine the fair value of our long-lived assets and assess their recoverability, we must make assumptions about a wide variety of internal and external factors including estimated future utility and estimated future cash flows, which in turn are based on estimates of future revenues, expenses and operating margins. If these estimates or their related assumptions change in the future, we may be required to record impairment charges for these assets that could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs.

Revenues

Revenues are principally derived from health care insurance premiums. We recognize premium revenues in the period eligible individuals are entitled to receive health care services. Customers are typically billed monthly at a contracted rate per eligible person multiplied by the total number of people eligible to receive services, as recorded in our records. Employer groups generally provide us with changes to their eligible population one month in arrears. Each billing includes an adjustment for prior month changes in eligibility status that were not reflected in our previous billing. We estimate and adjust the current period's revenues and accounts receivable accordingly. Our estimates are based on historical trends, premiums billed, the level of contract renewal activity and other relevant information. We revise estimates of revenue adjustments each period, and record changes in the period they become known.

Investments

As of December 31, 2005, we had approximately $9.6 billion of investments, primarily held in marketable debt securities. Our investments are principally classified as available for sale and are recorded at fair value. We exclude unrealized gains and losses on investments available for sale from earnings and report them together, net of income tax effects, as a separate component in shareholders' equity. We continually monitor the difference between the cost and fair value of our investments. As of December 31, 2005, our investments had gross unrealized gains of $105 million and gross unrealized losses of $53 million. If any of our investments experience a decline in fair value that is determined to be other than temporary, based on analysis of relevant factors, we record a realized loss in our Consolidated Statements of Operations. Management judgment is involved in evaluating whether a decline in an investment's fair value is other than temporary. New information and the passage of time can change these judgments. We revise impairment judgments when new information becomes known and record any resulting impairment charges at that time. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

Inflation

The current national health care cost inflation rate significantly exceeds the general inflation rate. We use various strategies to lessen the effects of health care cost inflation. These include setting commercial premiums based on anticipated health care costs and coordinating care with physicians and other health care providers. Through contracts with physicians and other health care providers, we emphasize preventive health care, appropriate use of health care services consistent with clinical performance standards, education and closing gaps in care.

We believe our strategies to mitigate the impact of health care cost inflation on our operating results have been and will continue to be successful. However, other factors including competitive pressures, new health care and pharmaceutical product introductions, demands from physicians and other health care providers and consumers, major epidemics, and applicable regulations may affect our ability to control the impact of health care cost inflation. Because of the narrow operating margins of our risk-based products, changes in medical cost trends that were not anticipated in establishing premium rates can create significant changes in our financial results.

Legal Matters

Because of the nature of our businesses, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. We record liabilities for our estimates of probable costs resulting from these matters. These matters include, but are not limited to, claims relating to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices.

Beginning in 1999, a series of class action lawsuits were filed against both UnitedHealthcare and PacifiCare, and virtually all major entities in the health benefits business. In December 2000, a multidistrict litigation panel consolidated several litigation cases involving UnitedHealth Group and our affiliates, including PacifiCare, in the Southern District Court of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and the Racketeer Influenced Corrupt Organization Act (RICO) in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. During the course of the litigation, there have been co-defendant settlements. Through a series of motions and appeals, all direct claims against us have been compelled to arbitration. A trial date has been set for September 2006. The trial court has ordered that the trial be split into separate liability and damage proceedings. In August 2005, the capitation-related claims were dismissed from litigation. On January 31, 2006, the trial court dismissed all remaining claims against PacifiCare. A March 14, 2006 hearing date has been scheduled for our summary judgment motion.

On March 15, 2000, the American Medical Association filed a lawsuit against the company in the Supreme Court of the State of New York, County of New York. On April 13, 2000, we removed this case to the United States District Court for the Southern District of New York. The suit alleges causes of action based on ERISA, as well as breach of contract and the implied covenant of good faith and fair dealing, deceptive acts and practices, and trade libel in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. The suit seeks declaratory, injunctive and compensatory relief as well as costs, fees and interest payments. An amended complaint was filed on August 25, 2000, which alleged two classes of plaintiffs, an ERISA class and a non-ERISA class. After the Court dismissed certain ERISA claims and the claims brought by the American Medical Association, a third amended complaint was filed. On October 25, 2002, the court granted in part and denied in part our motion to dismiss the third amended complaint. On May 21, 2003, we filed a counterclaim complaint in this matter alleging antitrust violations against the American Medical Association and asserting claims based on improper billing practices against an individual provider plaintiff. On May 26, 2004, we filed a motion for partial summary judgment seeking the dismissal of certain claims and parties based, in part, due to lack of standing. On July 16, 2004, plaintiffs filed a motion for leave to file an amended complaint, seeking to assert RICO violations.

Although the results of pending litigation are always uncertain, we do not believe the results of any such actions currently threatened or pending, including those described above, will, individually or in aggregate, have a material adverse effect on our consolidated financial position or results of operations.

Quantitative and Qualitative Disclosures About Market Risks

Market risk represents the risk of changes in the fair value of a financial instrument caused by changes in interest rates or equity prices. The company's primary market risk is exposure to changes in interest rates that could impact the fair value of our investments and long-term debt.

Approximately $14.7 billion of our cash equivalents and investments at December 31, 2005 were debt securities. Assuming a hypothetical and immediate 1% increase or decrease in interest rates applicable to our fixed-income investment portfolio at December 31, 2005, the fair value of our fixed-income investments would decrease or increase by approximately $345 million. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

To mitigate the financial impact of changes in interest rates, we have entered into interest rate swap agreements to more closely match the interest rates of our long-term debt with those of our cash equivalents and short-term investments. Including the impact of our interest rate swap agreements, approximately $6.2 billion of our commercial paper and debt had variable rates of interest and approximately $0.9 billion had fixed rates as of December 31, 2005. A hypothetical 1% increase or decrease in interest rates would not be material to the fair value of our commercial paper and debt.

At December 31, 2005, we had $261 million of equity investments, a portion of which were held by our UnitedHealth Capital business in various public and non-public companies concentrated in the areas of health care delivery and related information technologies. Market conditions that affect the value of health care or technology stocks will likewise impact the value of our equity portfolio.

Concentrations of Credit Risk

Investments in financial instruments such as marketable securities and accounts receivable may subject UnitedHealth Group to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our board of directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. Government and Agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups that constitute our customer base. As discussed more fully in Note 3 to the consolidated financial statements, we have a $1.8 billion reinsurance receivable resulting from the sale of our life and annuity business. We regularly evaluate the financial condition of the reinsurer and only record the reinsurance receivable to the extent that the amounts are deemed probable of recovery. As of December 31, 2005, there were no other significant concentrations of credit risk.

Cautionary Statements

The statements contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the Securities and Exchange Commission, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words or phrases "believes," "anticipates," "expects," "plans," "seeks," "intends," "will likely result," "estimates," "projects" or similar expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed in the forward-looking statements.

The following discussion contains certain cautionary statements regarding our business that investors and others should consider. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Form 10-K and in any other public filings or statements we make may

turn out to be wrong. They can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed in our prior communications.

We must effectively manage our health care costs.

Under our risk-based product arrangements, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based products (excluding AARP) have typically comprised approximately 75% to 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our risk-based products depends in large part on our ability to predict, price for, and effectively manage health care costs. Total health care costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue is typically fixed in price for a 12-month period and is generally priced one to four months before the contract commences. We base the premiums we charge on our estimate of future health care costs over the fixed premium period; however, inflation, regulations and other factors may cause actual costs to exceed what was estimated and reflected in premiums. These factors may include increased use of services, increased cost of individual services, catastrophes, epidemics, the introduction of new or costly treatments and technology, new mandated benefits or other regulatory changes, insured population characteristics and seasonal changes in the level of health care use. As a measure of the impact of medical cost on our financial results, relatively small differences between predicted and actual medical costs as a percentage of premium revenues can result in significant changes in our financial results. For example, if medical costs increased by 1% without a proportional change in related revenues for UnitedHealthcare's commercial insured products, our annual net earnings for 2005 would have been reduced by approximately $130 million. In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. If these estimates prove too high or too low, the effect of the change in estimate will be included in future results. That change can be either positive or negative to our results.

We face competition in many of our markets and customers have flexibility in moving between competitors.

Our businesses compete throughout the United States and face competition in all of the geographic markets in which they operate. For our Uniprise and Health Care Services segments, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc., and WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and enterprises that serve more limited geographic areas. Our Specialized Care Services and Ingenix segments also compete with a number of businesses. The addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. In particular markets, competitors may have capabilities or resources that give them a competitive advantage. Greater market share, established reputation, superior supplier or provider arrangements, existing business relationships, and other factors all can provide a competitive advantage to our businesses or to their competitors. In addition, significant merger and acquisition activity has occurred in the industries in which we operate, both as to our competitors and suppliers in these industries. Consolidation may make it more difficult for us to retain or increase customers, to improve the terms on which we do business with our suppliers, or to maintain or advance profitability.

Our relationship with AARP is important.

Under our 10-year contract with AARP, which commenced in 1998, we provide Medicare supplement and hospital indemnity health insurance and other products to AARP members. As of December 31, 2005, our portion of AARP's insurance program represented approximately $4.9 billion in annual net premium revenue from approximately 3.8 million AARP members. The AARP contract may be terminated early by us or AARP under certain circumstances, including a material breach by either party, insolvency of either party, a material

adverse change in the financial condition of either party, and by mutual agreement. The success of our AARP arrangement depends, in part, on our ability to service AARP and its members, develop additional products and services, price the products and services competitively, and respond effectively to federal and state regulatory changes.

Some of the favorable and unfavorable effects of changes in Medicare remain uncertain.

The changes in Medicare as a result of the Medicare Modernization Act of 2003 (MMA) are complex and wide-ranging and continue to affect our businesses. We have taken advantage of new opportunities to partner with the federal government created by the MMA, including Medicare Part D prescription drug coverage, Medicare Advantage Regional PPOs, and Special Needs Plans for chronically ill Medicare beneficiaries. We have invested considerable resources in creating new Medicare product offerings for these initiatives and in analyzing how to best address uncertainties and risks associated with these new programs and other changes arising from the MMA. In particular, the Part D program presents challenges because of the size and scope of the new program. Our ability to successfully participate in the Part D program depends in part on coordination of information and information systems between us, CMS and state governments. We have been working with CMS to correct systems issues that they have experienced with respect to certain low income people eligible to participate in Part D. The inability to receive correct information due to systems issues by the federal government, the applicable state government or us could adversely affect our business. Additionally, our participation in the Part D program is based upon certain assumptions regarding enrollment, utilization, pharmaceutical costs and other factors. In the event any of these assumptions are materially incorrect, either as a result of unforeseen changes to the Part D program or otherwise, our results could be materially affected. Any positive or negative results of the Part D program are likely to have a significant impact on us as a result of the size of our enrollment in our Part D program.

We are subject to funding risks with respect to revenue received from participation in Medicare and Medicaid programs.

We participate as a payer in Medicare Advantage, Part D, and Medicaid programs and receive revenues from the Medicare and Medicaid programs to provide benefits under these programs. Revenues for these programs are dependent upon annual funding from the federal government or applicable state governments. Funding for these programs is dependent upon many factors outside of our control including general economic conditions at the federal or applicable state level and general political issues and priorities. An unexpected reduction in government funding for these programs may adversely affect our revenues and financial results.

Our business is subject to routine government scrutiny, and we must respond quickly and appropriately to frequent changes in government regulations.

Our business is regulated at the federal, state, local and international levels. The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Existing or future laws and rules could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, and increase our liability in federal and state courts for coverage determinations, contract interpretation and other actions. We must obtain and maintain regulatory approvals to market many of our products, to increase prices for certain regulated products and to complete certain acquisitions and dispositions. Delays in obtaining approvals or our failure to obtain or maintain these approvals could reduce our revenue or increase our costs.

We participate in federal, state and local government health care coverage programs. These programs generally are subject to frequent change, including changes that may reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or health care costs under such programs. Such changes have adversely affected our financial results and willingness to participate in such programs in the past, and may do so in the future.

State legislatures and Congress continue to focus on health care issues. Legislative and regulatory proposals at state and federal levels may affect certain aspects of our business, including contracting with physicians, hospitals and other health care professionals; physician reimbursement methods and payment rates; coverage determinations; claim payments and processing; drug utilization and patient safety efforts; use and maintenance of individually identifiable health information; medical malpractice litigation; and government-sponsored programs. We cannot predict if any of these initiatives will ultimately become binding law or regulation, or, if enacted, what their terms will be, but their enactment could increase our costs, expose us to expanded liability, require us to revise the ways in which we conduct business or put us at risk for loss of business.

We typically are involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Department of Justice and U.S. Attorneys. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs. In addition, public perception or publicity surrounding routine governmental investigations may adversely affect our stock price, damage our reputation in various markets or make it more difficult for us to sell products and services.

Relationships with physicians, hospitals and other health care providers are important to our business.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for competitive prices. Our results of operations and prospects are substantially dependent on our continued ability to maintain these competitive prices. A number of organizations are advocating for legislation that would exempt certain of these physicians and health care professionals from federal and state antitrust laws. In any particular market, these physicians and health care professionals could refuse to contract, demand higher payments, or take other actions that could result in higher health care costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician/hospital organizations or multispecialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part.

In addition, we have capitation arrangements with some physicians, hospitals and other health care providers. Under the typical arrangement, the provider receives a fixed percentage of premium to cover all the medical costs provided to the capitated member. Under some capitated arrangements, the provider may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the provider. To the extent that a capitated provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that are the responsibility of the capitated provider and for which we have already paid the provider under the capitation arrangement.

The nature of our business exposes us to litigation risks.

Periodically, we become a party to the types of legal actions that can affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims, shareholder suits, and intellectual property-related litigation. In addition, because of the nature of our business, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. These matters include, among others, claims related to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices. In 1999, a number of class action lawsuits were filed against UnitedHealthcare and PacifiCare and virtually all major entities in the health benefits business, although all claims against PacifiCare have been dismissed. The suits are

purported class actions on behalf of physicians for alleged breaches of federal statutes, including ERISA and RICO . In March 2000, the American Medical Association filed a lawsuit against us in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. Although the expenses we have incurred to date in defending the 1999 class action lawsuits and the American Medical Association lawsuit have not been material to our business, we will continue to incur expenses in the defense of these lawsuits and other matters, even if they are without merit.

The Company is largely self-insured with regard to litigation risks; however, we maintain excess liability insurance with outside insurance carriers to minimize risks associated with catastrophic claims. Although we believe that we are adequately insured for claims in excess of our self-insurance, certain types of damages, such as punitive damages, are not covered by insurance. We record liabilities for our estimates of the probable costs resulting from self-insured matters. Although we believe the liabilities established for these risks are adequate, it is possible that the level of actual losses may exceed the liabilities recorded.

Our businesses providing pharmacy benefit management (PBM) services face regulatory and other risks associated with the pharmacy benefits management industry that may differ from the risks of providing managed care and health insurance products.

In connection with the PacifiCare merger, we acquired a pharmacy benefits management business, Prescription Solutions. We also provide pharmacy benefits management services through UnitedHealth Pharmaceutical Solutions. Prescription Solutions and UnitedHealth Pharmaceutical Solutions are subject to federal and state anti-remuneration and other laws that govern their relationships with pharmaceutical manufacturers, customers and consumers. Federal and state legislatures are considering new regulations for the industry that could adversely affect current industry practices, including the receipt of rebates from pharmaceutical companies. In addition, if a court were to determine that our PBM business acts as a fiduciary under the Employee Retirement Income Security Act, or ERISA, we could be subject to claims for alleged breaches of fiduciary obligations in implementation of formularies, preferred drug listings and therapeutic intervention programs, contracting network practices, speciality drug distribution and other transactions. Our PBM also conducts business as a mail order pharmacy, which subjects it to extensive federal, state and local laws and regulations, as well as risks inherent in the packaging and distribution of pharmaceuticals and other health care products. The failure to adhere to these laws and regulations could expose our PBM subsidiary to civil and criminal penalties. We also face potential claims in connection with purported errors by our mail order pharmacy.

Our businesses depend on effective information systems and the integrity of the data in our information systems.

Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to accurately report our financial results depends on the integrity of the data in our information systems. As a result of our acquisition activities, we have acquired additional systems. We have been taking steps to reduce the number of systems we operate and have upgraded and expanded our information systems capabilities. If the information we rely upon to run our businesses were found to be inaccurate or unreliable or if we fail to maintain our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have disputes with customers, physicians and other health care providers have regulatory problems, have increases in operating expenses or suffer other adverse consequences.

The value of our intangible assets may become impaired.

Due largely to our recent acquisitions, goodwill and other intangible assets represent a substantial portion of our assets. Goodwill and other intangible assets were approximately $18.2 billion as of December 31, 2005, representing approximately 44% of our total assets. If we make additional acquisitions it is likely that we will record additional intangible assets on our books. We periodically evaluate our goodwill and other intangible

assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to earnings may be necessary. Any future evaluations requiring an asset impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

Our knowledge and information-related businesses depend on our ability to maintain proprietary rights to our databases and related products.

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services.

We must comply with restrictions on patient privacy and information security, including taking steps to ensure that our business associates who obtain access to sensitive patient information maintain its confidentiality.

The use of individually identifiable data by our businesses is regulated at the international, federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and disclosure of individually identifiable health data. Most are derived from the privacy and security provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996, (HIPAA). HIPAA also imposes guidelines on our business associates (as this term is defined in the HIPAA regulations). Even though we provide for appropriate protections through our contracts with our business associates, we still have limited control over their actions and practices. Compliance with these proposals, requirements, and new regulations may result in cost increases due to necessary systems changes, the development of new administrative processes, and the effects of potential noncompliance by our business associates. They also may impose further restrictions on our use of patient identifiable data that is housed in one or more of our administrative databases.

The anticipated benefits of acquiring PacifiCare may not be realized.

We acquired PacifiCare with the expectation that the merger will result in various benefits including, among others, benefits relating to a stronger and more diverse network of doctors and other health care providers, expanded and enhanced affordable health care services, enhanced revenues, a strengthened market position for UnitedHealth Group in the Western United States, cross-selling opportunities, technology, cost savings and operating efficiencies. Achieving the anticipated benefits of the merger is subject to a number of uncertainties, including whether UnitedHealth Group integrates PacifiCare in an efficient and effective manner and general competitive factors in the marketplace. Failure to achieve these anticipated benefits could result in increased costs, decreases in the amount of expected revenues and diversion of management's time and energy, which could materially impact our business, financial condition and operating results.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The information called for by this Item is incorporated herein by reference to Item 7 of this report under the heading "Quantitative and Qualitative Disclosures about Market Risk."

UnitedHealth Group

Consolidated Statements of Operations

(in millions, except per share data)	For the Year Ended December 31, 2005	2004	2003
Revenues			
Premiums	**$41,058**	$33,495	$25,448
Services	**3,808**	3,335	3,118
Investment and Other Income	**499**	388	257
Total Revenues	**45,365**	37,218	28,823
Medical and Operating Costs			
Medical Costs	**32,725**	27,000	20,714
Operating Costs	**6,814**	5,743	4,875
Depreciation and Amortization	**453**	374	299
Total Medical and Operating Costs	**39,992**	33,117	25,888
Earnings From Operations	**5,373**	4,101	2,935
Interest Expense	**(241)**	(128)	(95)
Earnings Before Income Taxes	**5,132**	3,973	2,840
Provision for Income Taxes	**(1,832)**	(1,386)	(1,015)
Net Earnings	**$ 3,300**	$ 2,587	$ 1,825
Basic Net Earnings per Common Share	**$ 2.61**	$ 2.07	$ 1.55
Diluted Net Earnings per Common Share	**$ 2.48**	$ 1.97	$ 1.48
Basic Weighted-Average Number of Common Shares Outstanding	**1,265**	1,252	1,178
Dilutive Effect of Common Stock Equivalents	**65**	58	56
Diluted Weighted-Average Number of Common Shares Outstanding	**1,330**	1,310	1,234

See Notes to Consolidated Financial Statements.

UnitedHealth Group

Consolidated Balance Sheets

(in millions, except per share data)	As of December 31, 2005	As of December 31, 2004
Assets		
Current Assets		
Cash and Cash Equivalents	**$ 5,421**	$ 3,991
Short-Term Investments	**590**	514
Accounts Receivable, net of allowances of $105 and $101	**1,290**	906
Assets Under Management	**1,825**	1,930
Deferred Income Taxes	**645**	353
Other Current Assets	**869**	547
Total Current Assets	**10,640**	8,241
Long-Term Investments	**8,971**	7,748
Property, Equipment, and Capitalized Software, net of accumulated depreciation and amortization of $966 and $660	**1,647**	1,139
Goodwill	**16,206**	9,470
Other Intangible Assets, net of accumulated amortization of $192 and $103	**2,020**	1,205
Other Assets	**1,890**	76
Total Assets	**$41,374**	$27,879
Liabilities and Shareholders' Equity		
Current Liabilities		
Medical Costs Payable	**$ 7,301**	$ 5,540
Accounts Payable and Accrued Liabilities	**3,301**	2,107
Other Policy Liabilities	**1,824**	1,933
Commercial Paper and Current Maturities of Long-Term Debt	**3,261**	673
Unearned Premiums	**957**	1,076
Total Current Liabilities	**16,644**	11,329
Long-Term Debt, less current maturities	**3,850**	3,350
Future Policy Benefits for Life and Annuity Contracts	**1,761**	1,669
Deferred Income Taxes and Other Liabilities	**1,386**	814
Commitments and Contingencies (Note 12)		
Shareholders' Equity		
Common Stock, $0.01 par value - 3,000 shares authorized; 1,358 and 1,286 shares outstanding	**14**	13
Additional Paid-In Capital	**6,921**	3,088
Retained Earnings	**10,765**	7,484
Accumulated Other Comprehensive Income:		
Net Unrealized Gains on Investments, net of tax effects	**33**	132
Total Shareholders' Equity	**17,733**	10,717
Total Liabilities and Shareholders' Equity	**$41,374**	$27,879

See Notes to Consolidated Financial Statements.

UnitedHealth Group

Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Retained Earnings	Net Unrealized Gains on Investments	Total Shareholders' Equity	Comprehensive Income
Balance at December 31, 2002	1,198	$12	$ 164	$ 4,104	$148	$ 4,428	
Issuances of Common Stock, and related tax benefits	34	—	490	—	—	490	
Common Stock Repurchases	(66)	—	(602)	(1,005)	—	(1,607)	
Comprehensive Income							
Net Earnings	—	—	—	1,825	—	1,825	$1,825
Other Comprehensive Income Adjustments:							
Change in Net Unrealized Gains on Investments, net of tax effects	—	—	—	—	1	1	1
Comprehensive Income							$1,826
Common Stock Dividend	—	—	—	(9)	—	(9)	
Balance at December 31, 2003	1,166	12	52	4,915	149	5,128	
Issuances of Common Stock, and related tax benefits	223	2	6,481	—	—	6,483	
Common Stock Repurchases	(103)	(1)	(3,445)	—	—	(3,446)	
Comprehensive Income							
Net Earnings	—	—	—	2,587	—	2,587	$2,587
Other Comprehensive Income Adjustments:							
Change in Net Unrealized Gains on Investments, net of tax effects	—	—	—	—	(17)	(17)	(17)
Comprehensive Income							$2,570
Common Stock Dividend	—	—	—	(18)	—	(18)	
Balance at December 31, 2004	**1,286**	**13**	**3,088**	**7,484**	**132**	**10,717**	
Issuances of Common Stock, and related tax benefits	**126**	**1**	**6,390**	**—**	**—**	**6,391**	
Common Stock Repurchases	**(54)**	**—**	**(2,557)**	**—**	**—**	**(2,557)**	
Comprehensive Income							
Net Earnings	**—**	**—**	**—**	**3,300**	**—**	**3,300**	**$3,300**
Other Comprehensive Income Adjustments:							
Change in Net Unrealized Gains on Investments, net of tax effects	**—**	**—**	**—**	**—**	**(99)**	**(99)**	**(99)**
Comprehensive Income							**$3,201**
Common Stock Dividend	**—**	**—**	**—**	**(19)**	**—**	**(19)**	
Balance at December 31, 2005	**1,358**	**$14**	**$6,921**	**$10,765**	**$ 33**	**$17,733**	

See Notes to Consolidated Financial Statements.

UnitedHealth Group

Consolidated Statements of Cash Flows

(in millions)	For the Year Ended December 31, 2005	2004	2003
Operating Activities			
Net Earnings	**$ 3,300**	$ 2,587	$ 1,825
Noncash Items			
Depreciation and Amortization	**453**	374	299
Deferred Income Taxes and Other	**167**	125	91
Net Change in Other Operating Items, net of effects from acquisitions, and changes in AARP balances:			
Accounts Receivable and Other Current Assets	**(83)**	(30)	(46)
Medical Costs Payable	**193**	322	276
Accounts Payable and Other Accrued Liabilities	**580**	623	547
Unearned Premiums	**(284)**	134	11
Cash Flows From Operating Activities	**4,326**	4,135	3,003
Investing Activities			
Cash Paid for Acquisitions, net of cash assumed and other effects	**(2,562)**	(2,225)	(590)
Cash Transferred on Sale of Business	**(363)**	—	—
Purchases of Property, Equipment and Capitalized Software	**(509)**	(350)	(352)
Purchases of Investments	**(5,876)**	(3,190)	(2,583)
Maturities and Sales of Investments	**5,821**	4,121	2,780
Cash Flows Used For Investing Activities	**(3,489)**	(1,644)	(745)
Financing Activities			
Proceeds from (Payments of) Commercial Paper, net	**2,556**	194	(382)
Proceeds from Issuance of Long-Term Debt	**500**	2,000	950
Payments for Retirement of Long-Term Debt	**(400)**	(150)	(350)
Common Stock Repurchases	**(2,557)**	(3,446)	(1,607)
Proceeds from Common Stock Issuances	**423**	583	268
Dividends Paid	**(19)**	(18)	(9)
Other	**90**	75	4
Cash Flows From (Used For) Financing Activities	**593**	(762)	(1,126)
Increase in Cash and Cash Equivalents	**1,430**	1,729	1,132
Cash and Cash Equivalents, Beginning of Period	**3,991**	2,262	1,130
Cash and Cash Equivalents, End of Period	**$ 5,421**	$ 3,991	$ 2,262
Supplemental Schedule of Noncash Investing and Financing Activities			
Common Stock Issued for Acquisitions	**$ 5,696**	$ 5,557	$ —

See Notes to Consolidated Financial Statements.

Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (also referred to as "UnitedHealth Group," "the company," "we," "us," and "our") is a diversified health and well-being company dedicated to making health care work better. Through strategically aligned, market-defined businesses, we design products, provide services and apply technologies that improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable.

2. Summary of Significant Accounting Policies

Basis of Presentation

We have prepared the consolidated financial statements according to accounting principles generally accepted in the United States of America and have included the accounts of UnitedHealth Group and its subsidiaries. We have eliminated all significant intercompany balances and transactions.

Use of Estimates

These consolidated financial statements include certain amounts that are based on our best estimates and judgments. These estimates require us to apply complex assumptions and judgments, often because we must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to medical costs, medical costs payable, contingent liabilities, intangible asset valuations, asset impairments and revenues. We adjust these estimates each period, as more current information becomes available. The impact of any changes in estimates is included in the determination of earnings in the period in which the estimate is adjusted.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is fixed, typically for a one-year period, and we assume the economic risk of funding our customers' health care services and related administrative costs. We recognize premium revenues in the period in which eligible individuals are entitled to receive health care services. We record health care premium payments we receive from our customers in advance of the service period as unearned premiums.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the medical costs of their employees and their dependents. Under service fee contracts, we recognize revenue in the period the related services are performed based upon the fee charged to the customer. The customers retain the risk of financing medical benefits for their employees and their employees' dependents, and we administer the payment of customer funds to physicians and other health care providers from customer-funded bank accounts. Because we do not have the obligation for funding the medical expenses, nor do we have responsibility for delivering the medical care, we do not recognize gross revenue and medical costs for these contracts in our consolidated financial statements.

For both premium risk-based and fee-based customer arrangements, we provide coordination and facilitation of medical services; transaction processing; customer, consumer and care provider services; and access to contracted networks of physicians, hospitals and other health care professionals.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services that have been rendered on behalf of insured consumers but for which we have either not yet received or processed claims,

and for liabilities for physician, hospital and other medical cost disputes. We develop estimates for medical costs incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, care provider contract rate changes, medical care consumption and other medical cost trends. We estimate liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that generally have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments. Investments with maturities of less than one year are classified as short-term. We may sell investments classified as long-term before their maturities to fund working capital or for other purposes. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. We classify these investments as held to maturity and report them at amortized cost. All other investments are classified as available for sale and reported at fair value based on quoted market prices.

We exclude unrealized gains and losses on investments available for sale from earnings and report it, net of income tax effects, as a separate component of shareholders' equity. We continually monitor the difference between the cost and estimated fair value of our investments. If any of our investments experiences a decline in value that is determined to be other than temporary, based on analysis of relevant factors, we record a realized loss in Investment and Other Income in our Consolidated Statements of Operations. To calculate realized gains and losses on the sale of investments, we use the specific cost or amortized cost of each investment sold.

Assets Under Management

We administer certain aspects of AARP's insurance program (see Note 11). Pursuant to our agreement, AARP assets are managed separately from our general investment portfolio and are used to pay costs associated with the AARP program. These assets are invested at our discretion, within investment guidelines approved by AARP. We do not guarantee any rates of return on these investments and, upon transfer of the AARP contract to another entity, we would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with the AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. As such, they are not included in our earnings.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software is stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development.

We calculate depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are: from three to seven years for furniture, fixtures and equipment; from 35 to 40 years for buildings; the shorter of the useful life or remaining

lease term for leasehold improvements; and from three to nine years for capitalized software. The weighted-average useful life of property, equipment and capitalized software at December 31, 2005 was approximately five years. The net book value of property and equipment was $876 million and $543 million as of December 31, 2005 and 2004, respectively. The net book value of capitalized software was $771 million and $596 million as of December 31, 2005 and 2004, respectively.

Goodwill and Other Intangible Assets

Goodwill represents the amount by which the purchase price of businesses we have acquired exceed the estimated fair value of the net tangible assets and separately identifiable intangible assets of these businesses. Goodwill and intangible assets with indefinite useful lives are not amortized, but are tested at least annually for impairment. Intangible assets with discrete useful lives are amortized on a straight-line basis over their estimated useful lives.

Long-Lived Assets

We review long-lived assets, including property, equipment, capitalized software and intangible assets, for events or changes in circumstances that would indicate we might not recover their carrying value. We consider many factors, including estimated future utility and cash flows associated with the assets, to make this decision. An impairment charge is recorded for the amount by which an asset's carrying value exceeds its estimated fair value. We record assets held for sale at the lower of their carrying amount or fair value, less any costs for the final settlement.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP program (see Note 11), customer balances related to experience-rated insurance products and the current portion of future policy benefits for life insurance and annuity contracts. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Income Taxes

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

Future Policy Benefits for Life and Annuity Contracts and Reinsurance Receivables

Future policy benefits for life insurance and annuity contracts represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products. As a result of the October 2005 sale of the life and annuity business within our subsidiary Golden Rule Financial Corporation (Golden Rule) under an indemnity reinsurance arrangement described in Note 3, we have maintained a liability associated with the reinsured contracts, as we remain primarily liable to the policyholders, and have recorded a corresponding reinsurance receivable due from the purchaser on the Consolidated Balance Sheet as of December 31, 2005. We regularly evaluate the financial condition of the reinsurer and only record the reinsurance receivable to the extent that the amounts are deemed probable of recovery.

Policy Acquisition Costs

For our health insurance contracts, costs related to the acquisition and renewal of customer contracts are charged to expense as incurred. Our health insurance contracts typically have a one-year term and may be cancelled upon 30 days notice by either the company or the customer.

Stock-Based Compensation

We account for activity under our stock-based employee compensation plans under the recognition and measurement principles of Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees." Accordingly, we do not recognize compensation expense in connection with employee stock option grants because we grant stock options at exercise prices not less than the fair value of our common stock on the date of grant.

The following table shows the effect on net earnings and earnings per share had we applied the fair value expense recognition provisions of Statement of Financial Accounting Standards (FAS) No. 123, "Accounting for Stock-Based Compensation," (FAS 123) to stock-based employee compensation.

	For the Year Ended December 31,		
(in millions, except per share data)	**2005**	**2004**	**2003**
Net Earnings			
As Reported	**$3,300**	$2,587	$1,825
Compensation Expense, net of tax effect	**(160)**	(132)	(122)
Pro Forma	**$3,140**	$2,455	$1,703
Basic Net Earnings Per Common Share			
As Reported	**$ 2.61**	$ 2.07	$ 1.55
Pro Forma	**$ 2.48**	$ 1.96	$ 1.45
Diluted Net Earnings Per Common Share			
As Reported	**$ 2.48**	$ 1.97	$ 1.48
Pro Forma	**$ 2.36**	$ 1.87	$ 1.38
Weighted-Average Fair Value Per Share of Options Granted	**$ 13**	$ 10	$ 6

Information on our stock-based compensation plans and data used to calculate compensation expense in the table above are described in more detail in Note 9.

As discussed more fully within Note 9, FAS No. 123 (revised 2004), "Share Based Payment," (FAS 123R) was effective during the first quarter of 2006, and requires us to measure compensation expense for all share-based payments (including employee stock options) at fair value and recognize the expense over the related service period. We adopted this standard on a retrospective restatement basis as of January 1, 2006 and the adoption did not result in any change to the pro forma compensation expense amounts historically disclosed under FAS 123.

Net Earnings Per Common Share

We compute basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. We determine diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares that might be issued upon the exercise of common stock options or the conversion of convertible subordinated debentures.

Derivative Financial Instruments

As part of our risk management strategy, we enter into interest rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and

recognized over the life of the agreements as an adjustment to interest expense in the Consolidated Statements of Operations. Our existing interest rate swap agreements convert a majority of our interest rate exposure from a fixed to a variable rate and are accounted for as fair value hedges. Additional information on our existing interest rate swap agreements is included in Note 7.

Recently Issued Accounting Standards

In November 2005, the FASB issued Staff Position No. 115-1, "The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments" (FSP 115-1). FSP 115-1 provides accounting guidance for evaluating and recording other-than-temporary impairment losses on certain debt and equity investments. FSP 115-1 nullifies certain provisions of Emerging Issues Task Force Issue No. 03-1 while retaining its disclosure requirements, which had already been adopted. The Company has adopted FSP 115-1 and its adoption did not have any impact on our consolidated financial position or results of operations.

In June 2005, the FASB issued an exposure draft of a proposed standard entitled "Business Combinations — a replacement of FASB Statement No. 141." The proposed standard, if adopted, would provide new guidance for evaluating and recording business combinations and would be effective on a prospective basis for business combinations whose acquisition dates are on or after January 1, 2007. Upon issuance of a final standard, the Company will evaluate the impact of this new standard and its effect on the process for recording business combinations.

3. Acquisitions and Divestitures

On December 20, 2005, the company acquired PacifiCare Health Systems, Inc. (PacifiCare). PacifiCare provides health care and benefit services to individuals and employers, principally in markets in the Western United States. This merger significantly strengthened our resources by enhancing our capabilities on the Pacific Coast and in other Western states and broadening the scope of our product offerings for a host of specialized services. The operations of PacifiCare reside primarily within our Health Care Services and Specialized Care Services segments. Under the terms of the agreement, PacifiCare shareholders received 1.1 shares of UnitedHealth Group common stock and $21.50 in cash for each share of PacifiCare common stock they owned. Total consideration issued for the transaction was approximately $8.8 billion, composed of approximately 99.2 million shares of UnitedHealth Group common stock (valued at approximately $5.3 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of July 6, 2005), approximately $2.1 billion in cash, $960 million cash paid to retire PacifiCare's existing debt and UnitedHealth Group vested common stock options with an estimated fair value of approximately $420 million issued in exchange for PacifiCare's outstanding vested common stock options. The purchase price and costs associated with the acquisition exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately $7.1 billion. Pending completion of an independent valuation analysis, we have preliminarily allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of $1.0 billion and associated deferred tax liabilities of $392 million, and goodwill of approximately $6.5 billion. The finite-lived intangible assets consist primarily of member lists, health care physician and hospital networks and trademarks, with an estimated weighted-average useful life of 13 years. The acquired goodwill is not deductible for income tax purposes. Our preliminary estimate of acquired net tangible assets and liabilities are categorized as follows: cash and cash equivalents of $810 million; investments of $2.4 billion; accounts receivable and other current assets of $750 million; property, equipment and capitalized software and other assets of $380 million; medical costs payable of $1.4 billion and other liabilities of $1.2 billion.

On February 24, 2006, our Health Care Services business segment acquired John Deere Health Care, Inc. (John Deere Health). John Deere Health serves employers primarily in central and eastern Iowa, western Illinois, eastern Tennessee and southwestern Virginia. This acquisition will strengthen our market position in these areas. We paid approximately $500 million in cash in exchange for all of the outstanding equity of John Deere Health. Due to the timing of the acquisition, management is still in the process of estimating the acquired net tangible assets, intangible assets and goodwill resulting from this acquisition.

On September 19, 2005, our Health Care Services business segment acquired Neighborhood Health Partnership (NHP). NHP serves local employers primarily in South Florida. This acquisition strengthened our market position in this region and provided expanded distribution opportunities for our other UnitedHealth Group businesses. We paid approximately $185 million in cash in exchange for all of the outstanding equity of NHP. The results of operations and financial condition of NHP have been included in our consolidated financial statements since the acquisition date. The pro forma effects of the NHP acquisition on our consolidated financial statements were not material.

On December 10, 2004, our Uniprise business segment acquired Definity Health Corporation (Definity). Definity is a national market leader in consumer-driven health benefit programs. This acquisition strengthened our position in the emerging consumer-driven health benefits marketplace. We paid $305 million in cash in exchange for all of the outstanding stock of Definity. The purchase price and costs associated with the acquisition exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately $263 million. Based on management's consideration of fair value, which included an independent valuation analysis, we have allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of $34 million and associated deferred tax liabilities of $13 million, and goodwill of approximately $242 million. The finite-lived intangible assets consist primarily of customer contracts and trademarks, with an estimated weighted-average useful life of 13 years. The acquired goodwill is not deductible for income tax purposes. The results of operations and financial condition of Definity have been included in our consolidated financial statements since the acquisition date. The pro forma effects of the Definity acquisition on our consolidated financial statements were not material. Acquired net tangible assets of $42 million consisted mainly of cash, cash equivalents, accounts receivable, property and equipment and other assets partially offset by current liabilities.

On July 29, 2004, our Health Care Services business segment acquired Oxford Health Plans, Inc. (Oxford). Oxford provides health care and benefit services for individuals and employers, principally in New York City, northern New Jersey and southern Connecticut. This merger strengthened our market position in this region and provided substantial distribution opportunities in this region for our other UnitedHealth Group businesses. Under the terms of the purchase agreement, Oxford shareholders received 1.2714 shares of UnitedHealth Group common stock and $16.17 in cash for each share of Oxford common stock they owned. Total consideration issued was approximately $5.0 billion, composed of approximately 104.4 million shares of UnitedHealth Group common stock (valued at approximately $3.4 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of April 26, 2004), approximately $1.3 billion in cash and UnitedHealth Group vested common stock options with an estimated fair value of $240 million issued in exchange for Oxford's outstanding vested common stock options. The purchase price and costs associated with the acquisition exceeded the estimated fair value of the net tangible assets acquired by approximately $4.2 billion. Based on management's consideration of fair value, which included an independent valuation analysis, we have allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of approximately $600 million and associated deferred tax liabilities of approximately $225 million, and goodwill of approximately $3.8 billion. The finite-lived intangible assets consist primarily of member lists, health care physician and hospital networks and trademarks, with an estimated weighted-average useful life of 16 years. The acquired goodwill is not deductible for income tax purposes. Acquired net tangible assets and liabilities are categorized as follows: cash, cash equivalents and investments of $1.7 billion; accounts receivable and other current assets of $162 million; property, equipment and capitalized software and other assets of $37 million; medical costs payable of $713 million and other current liabilities of $334 million.

On February 10, 2004, our Health Care Services business segment acquired Mid Atlantic Medical Services, Inc. (MAMSI). MAMSI offers a broad range of health care coverage and related administrative services for individuals and employers in the mid-Atlantic region of the United States. This merger strengthened UnitedHealthcare's market position in the mid-Atlantic region and provided substantial distribution opportunities for our other UnitedHealth Group businesses in this region. Under the terms of the purchase agreement, MAMSI

shareholders received 1.64 shares of UnitedHealth Group common stock and $18 in cash for each share of MAMSI common stock they owned. Total consideration issued was approximately $2.7 billion, comprised of 72.8 million shares of UnitedHealth Group common stock (valued at $1.9 billion based on the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of October 27, 2003) and approximately $800 million in cash. The purchase price and costs associated with the acquisition exceeded the estimated fair value of the net tangible assets acquired by approximately $2.1 billion. Based on management's consideration of fair value, which included an independent valuation analysis, we have allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of approximately $280 million and associated deferred tax liabilities of approximately $100 million, and goodwill of approximately $1.9 billion. The finite-lived intangible assets consist primarily of member lists, health care physician and hospital networks and trademarks, with an estimated weighted-average useful life of 17 years. The acquired goodwill is not deductible for income tax purposes. Acquired net tangible assets and liabilities are categorized as follows: cash, cash equivalents and investments of $736 million; accounts receivable and other current assets of $228 million; property, equipment and capitalized software and other assets of $57 million; medical costs payable of $283 million and other current liabilities of $140 million.

The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in our consolidated financial statements since the respective acquisition dates. The unaudited pro forma financial information presented below assumes that the acquisitions occurred as of the beginning of the respective periods. The pro forma adjustments include the pro forma effect of UnitedHealth Group shares issued in the acquisitions, the amortization of finite-lived intangible assets arising from the purchase price allocations, interest expense related to financing the cash portion of the purchase price and the associated income tax effects of the pro forma adjustments. The following unaudited pro forma results have been prepared for comparative purposes only and do not purport to be indicative of the results of operations that would have occurred had the acquisitions been consummated at the beginning of the periods presented.

(in millions, except per share data)	For the Year Ended December 31, 2005	For the Year Ended December 31, 2004
	Pro forma - unaudited	
Revenues	$59,426	$53,051
Net Earnings	$ 3,568	$ 3,012
Earnings Per Share:		
Basic	$ 2.62	$ 2.12
Diluted	$ 2.48	$ 2.02

In October 2005, we sold the life insurance and annuity business within Golden Rule to OneAmerica Financial Partners, Inc. (OneAmerica) through an indemnity reinsurance arrangement. Under the arrangement, OneAmerica assumes the risks associated with the future policy benefits for the life and annuity contracts. We remain liable for claims if OneAmerica fails to meet its obligations to policy holders. Because we remain primarily liable to the policy holders, the liabilities and obligations associated with the reinsured contracts remain on our Consolidated Balance Sheet with a corresponding reinsurance receivable from OneAmerica, which is classified in other noncurrent assets and totaled approximately $1.8 billion as of December 31, 2005. We transferred approximately $1.3 billion of investments and $363 million in cash to OneAmerica in conjunuction with the arrangement. We realized a small gain on the sale which has been deferred and is being amortized over the estimated remaining life of the reinsured contracts.

For the years ended December 31, 2005, 2004 and 2003, aggregate consideration paid or issued for smaller acquisitions accounted for under the purchase method was $196 million, $158 million and $127 million, respectively. These acquisitions were not material to our consolidated financial statements.

4. Cash, Cash Equivalents and Investments

As of December 31, the amortized cost, gross unrealized gains and losses, and fair value of cash, cash equivalents and investments were as follows (in millions):

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
2005				
Cash and Cash Equivalents	**$ 5,421**	**$ —**	**$ —**	**$ 5,421**
Debt Securities — Available for Sale	**9,011**	**60**	**(52)**	**9,019**
Equity Securities — Available for Sale	**217**	**45**	**(1)**	**261**
Debt Securities — Held to Maturity	**281**	**—**	**—**	**281**
Total Cash and Investments	**$14,930**	**$ 105**	**$ (53)**	**$14,982**
2004				
Cash and Cash Equivalents	$ 3,991	$ —	$ —	$ 3,991
Debt Securities — Available for Sale	7,723	205	(9)	7,919
Equity Securities — Available for Sale	199	10	(2)	207
Debt Securities — Held to Maturity	136	—	—	136
Total Cash and Investments	$12,049	$ 215	$ (11)	$12,253

As of December 31, 2005 and 2004, respectively, debt securities consisted of $2,256 million and $1,551 million in U.S. Government and Agency obligations, $4,554 million and $2,932 million in state and municipal obligations, and $2,490 million and $3,572 million in corporate obligations. At December 31, 2005, we held $767 million in debt securities with maturities of less than one year, $3,469 million in debt securities with maturities of one to five years, $2,808 million in debt securities with maturities of five to 10 years and $2,256 million in debt securities with maturities of more than 10 years.

As of December 31, 2005 we had only $5 million of investments, mainly corporate obligations, in a continuous unrealized loss position for 12 months or greater. Gross unrealized losses of $53 million were primarily a result of changes in interest rates and relate to debt securities with an aggregate fair value of $3.8 billion at December 31, 2005. We evaluate the credit rating of the state and municipal obligations and the corporate obligations and do not believe that there has been any significant deterioration since purchase. The contractual cash flows of any U.S. Government and Agency obligations are either guaranteed by the U.S. Government or an agency of the U.S. Government. The equity securities were evaluated for duration of unrealized loss and other market factors. After taking into account these and other factors, we determined the unrealized losses on our investments were temporary and, as such, no impairment was required.

We recorded realized gains and losses on sales of investments, excluding the UnitedHealth Capital disposition described below, as follows:

	For the year ended December 31,		
(in millions)	**2005**	**2004**	**2003**
Gross Realized Gains	**$ 54**	$ 37	$ 45
Gross Realized Losses	**(50)**	(18)	(23)
Net Realized Gains (Losses)	**$ 4**	$ 19	$ 22

During the first quarter of 2004, we realized a capital gain of $25 million on the sale of certain UnitedHealth Capital investments. With the gain proceeds from this sale, we made a cash contribution of $25 million to the United Health Foundation in the first quarter of 2004. The realized gain of $25 million and the related contribution expense of $25 million are included in Investment and Other Income in the accompanying Consolidated Statements of Operations.

5. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by segment, during the years ended December 31, 2005 and 2004, were as follows:

(in millions)	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Consolidated
Balance at December 31, 2003	$ 1,770	$698	$409	$632	$ 3,509
Acquisitions and Subsequent Payments	5,724	205	—	32	5,961
Balance at December 31, 2004	**7,494**	**903**	**409**	**664**	**9,470**
Acquisitions and Subsequent Payments	**6,340**	**14**	**323**	**59**	**6,736**
Balance at December 31, 2005	**$13,834**	**$917**	**$732**	**$723**	**$16,206**

The weighted-average useful life, gross carrying value, accumulated amortization and net carrying value of other intangible assets as of December 31, 2005 and 2004 were as follows:

		December 31, 2005			December 31, 2004		
(in millions)	Weighted-Average Useful Life	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer Contracts and Membership Lists	15 years	**$1,830**	**$(106)**	**$1,724**	$1,153	$ (46)	$1,107
Patents, Trademarks and Technology	10 years	**221**	**(62)**	**159**	86	(39)	47
Other	16 years	**161**	**(24)**	**137**	69	(18)	51
Total	15 years	**$2,212**	**$(192)**	**$2,020**	$1,308	$(103)	$1,205

Amortization expense relating to intangible assets was $94 million in 2005, $62 million in 2004 and $18 million in 2003. Estimated future amortization expense relating to intangible assets for the years ending December 31 are as follows: $175 million in 2006, $168 million in 2007, $164 million in 2008, $156 million in 2009, and $148 million in 2010.

6. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2005	2004	2003
Medical Costs Payable, Beginning of Period	**$ 5,540**	$ 4,152	$ 3,741
Acquisitions	**1,469**	1,040	165
Reported Medical Costs			
Current Year	**33,125**	27,210	20,864
Prior Years	**(400)**	(210)	(150)
Total Reported Medical Costs	**32,725**	27,000	20,714
Claim Payments			
Payments for Current Year	**(27,985)**	(23,173)	(17,411)
Payments for Prior Years	**(4,448)**	(3,479)	(3,057)
Total Claim Payments	**(32,433)**	(26,652)	(20,468)
Medical Costs Payable, End of Period	**$ 7,301**	$ 5,540	$ 4,152

The increase in favorable medical cost development in 2005 was driven primarily by lower than anticipated medical costs as well as growth in the size of the medical cost base and related medical payables due to organic growth and businesses acquired since the beginning of 2004.

7. Commercial Paper and Debt

Commercial paper and debt consisted of the following as of December 31:

(in millions)	2005		2004	
	Carrying Value	Fair Value[1]	Carrying Value	Fair Value[1]
Commercial Paper	**$ 2,829**	**$ 2,829**	$ 273	$ 273
3.0% Convertible Subordinated Debentures	**432**	**432**	—	—
7.5% Senior Unsecured Notes due November 2005	**—**	**—**	400	417
5.2% Senior Unsecured Notes due January 2007	**400**	**402**	400	413
3.4% Senior Unsecured Notes due August 2007	**550**	**537**	550	546
3.3% Senior Unsecured Notes due January 2008	**500**	**485**	500	493
3.8% Senior Unsecured Notes due February 2009	**250**	**242**	250	247
4.1% Senior Unsecured Notes due August 2009	**450**	**438**	450	452
4.9% Senior Unsecured Notes due April 2013	**450**	**448**	450	453
4.8% Senior Unsecured Notes due February 2014	**250**	**245**	250	248
5.0% Senior Unsecured Notes due August 2014	**500**	**498**	500	503
4.9% Senior Unsecured Notes due March 2015	**500**	**490**	—	—
Total Commercial Paper and Debt	**7,111**	**7,046**	4,023	4,045
Less Current Maturities	**(3,261)**	**(3,261)**	(673)	(690)
Long-Term Debt, less current maturities	**$ 3,850**	**$ 3,785**	$3,350	$3,355

[1] Estimated based on third-party quoted market prices for the same or similar issues

In November and December 2005, we issued $2.6 billion of commercial paper, primarily to finance the cash portion of the purchase price of the PacifiCare acquisition described above, to retire a portion of the PacifiCare debt upon closing of the acquisition as well as to refinance maturing long term debt. As of December 31, 2005, our outstanding commercial paper had interest rates ranging from 4.2% to 4.4%.

In March 2005, we issued $500 million of 4.9% fixed-rate notes due March 2015. We used the proceeds from this borrowing for general corporate purposes including repayment of commercial paper, capital expenditures, working capital and share repurchases.

In July 2004, we issued $1.2 billion of commercial paper to fund the cash portion of the Oxford purchase price. In August 2004, we refinanced the commercial paper by issuing $550 million of 3.4% fixed-rate notes due August 2007, $450 million of 4.1% fixed-rate notes due August 2009 and $500 million of 5.0% fixed-rate notes due August 2014.

In February 2004, we issued $250 million of 3.8% fixed-rate notes due February 2009 and $250 million of 4.8% fixed-rate notes due February 2014. We used the proceeds from the February 2004 borrowings to finance a majority of the cash portion of the MAMSI purchase price.

To more closely align the floating interest rate received on our cash and cash equivalent balances, we have entered into interest rate swap agreements to convert the majority of our interest rate exposure from a fixed rate to a variable rate. These interest rate swap agreements qualify as fair value hedges. The interest rate swap agreements have aggregate notional amounts of $3.4 billion with variable rates that are benchmarked to the London Interbank Offered Rate (LIBOR). At December 31, 2005, the rates used to accrue interest expense on these agreements ranged from 4.3% to 5.0%. The differential between the fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as an adjustment to interest expense in the Consolidated Statements of Operations.

In December 2005, we amended and restated our $1.0 billion five-year revolving credit facility supporting our commercial paper program. We increased the capacity to $1.3 billion and extended the maturity date to

December 2010. In October 2005, we executed a $3.0 billion 364-day revolving credit facility to support a $3.0 billion increase in our commercial paper program. As of December 31, 2005, we had no amounts outstanding under either of these credit facilities.

PacifiCare had approximately $100 million par value of 3% convertible subordinated debentures (convertible notes) which were convertible into approximately 5.2 million shares of UnitedHealth Group's common stock and $102 million of cash as of December 31, 2005. In December 2005, we initiated a consent solicitation to all of the holders of outstanding convertible notes pursuant to which we offered to compensate all holders who elected to convert their notes in accordance with existing terms and consent to an amendment to a covenant in the indenture governing the convertible notes. The compensation consisted of the present value of interest through October 18, 2007, the earliest mandatory redemption date, plus a pro rata share of $1 million. On January 31, 2006, approximately 91% of the convertible notes were tendered pursuant to the offer, for which we issued approximately 4.8 million shares of UnitedHealth Group common stock and cash of $99 million.

Our debt arrangements and credit facilities contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio below 45% and to exceed specified minimum interest coverage levels. We are in compliance with the requirements of all debt covenants.

Maturities of commercial paper and debt for the years ending December 31 are as follows: $3,261 million in 2006, $950 million in 2007, $500 million in 2008, $700 million in 2009, and $1,700 million thereafter.

We made cash payments for interest of $219 million, $100 million and $94 million in 2005, 2004 and 2003, respectively.

8. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

We conduct a significant portion of our operations through companies that are subject to standards established by the National Association of Insurance Commissioners (NAIC). These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each state, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary, without prior approval by state regulatory authorities, is limited based on the entity's level of statutory net income and statutory capital and surplus. At December 31, 2005, approximately $270 million of our $15.0 billion of cash and investments was held by non-regulated subsidiaries and available for general corporate use, including acquisitions and share repurchases.

The agencies that assess our creditworthiness also consider capital adequacy levels when establishing our debt ratings. Consistent with our intent to maintain our senior debt ratings in the "A" range, we maintain an aggregate statutory capital and surplus level for our regulated subsidiaries that is significantly higher than the minimum level regulators require. As of December 31, 2005, our regulated subsidiaries had aggregate statutory capital and surplus of approximately $6.4 billion, which is significantly more than the aggregate minimum regulatory requirements.

Stock Repurchase Program

Under our board of directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. During 2005, we repurchased 53.6 million shares at an average price of approximately $48 per share and an aggregate cost of approximately $2.6 billion. As of December 31, 2005, we had board of directors' authorization to purchase up to an additional 55.5 million shares of our common stock.

Common Stock Split

In May 2005, our board of directors declared a two-for-one stock split. The stock split was effective on May 27, 2005 for shareholders of record on May 20, 2005. All share and per share amounts have been restated to reflect the stock split.

Preferred Stock

At December 31, 2005, we had 10 million shares of $0.001 par value preferred stock authorized for issuance, and no preferred shares issued and outstanding.

9. Stock-Based Compensation Plans

As of December 31, 2005, we had approximately 96.9 million shares available for future grants of stock-based awards under our stock-based compensation plan including, but not limited to, incentive or non-qualified stock options, stock appreciation rights and restricted stock.

Stock options are granted at an exercise price not less than the fair value of our common stock on the date of grant. They generally vest ratably over four years and may be exercised up to 10 years from the date of grant. Activity under our stock-based compensation plan is summarized in the tables below (shares in millions):

	2005		2004		2003	
	Shares	Weighted-Average Exercise Price	Shares	Weighted-Average Exercise Price	Shares	Weighted-Average Exercise Price
Outstanding at Beginning of Year	**176.3**	**$ 18**	174.6	$ 14	172.8	$ 11
Granted	**26.2**	**$ 51**	34.1	$ 36	36.9	$ 22
Assumed in Acquisitions	**10.9**	**$ 16**	15.2	$ 17	—	$ —
Exercised	**(23.6)**	**$ 15**	(43.5)	$ 12	(30.7)	$ 8
Forfeited	**(3.0)**	**$ 28**	(4.1)	$ 18	(4.4)	$ 15
Outstanding at End of Year	**186.8**	**$ 23**	176.3	$ 19	174.6	$ 14
Exercisable at End of Year	**110.7**	**$ 14**	89.6	$ 11	85.4	$ 8

As of December 31, 2005	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted-Average Remaining Option Term (years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$ 0-$10	49.7	3.7	$ 6	49.5	$ 6
$11-$20	50.9	6.1	$ 17	35.1	$ 16
$21-$40	58.9	7.8	$ 30	24.8	$ 27
$41-$65	27.3	9.5	$ 50	1.3	$ 46
$ 0-$65	186.8	6.5	$ 23	110.7	$ 14

We also maintain a 401(k) plan and an employee stock purchase plan. Activity related to these plans was not significant in relation to our consolidated financial results in 2005, 2004 and 2003.

To determine compensation expense related to our stock-based compensation plans under the fair value method, the fair value of each option grant is estimated on the date of grant using an option-pricing model. For purposes of estimating the fair value of our employee stock option grants, we utilized a binomial model. The principal assumptions we used in applying the option pricing models were as follows:

	2005	2004	2003
Risk-Free Interest Rate	**4.3%**	3.3%	2.6%
Expected Volatility	**23.5%**	28.5%	30.9%
Expected Dividend Yield	**0.1%**	0.1%	0.1%
Expected Life in Years	**4.1**	4.2	4.1

Information regarding the effect on net earnings and net earnings per common share had we applied the fair value expense recognition provisions of FAS 123 is included in Note 2.

In December 2004, the Financial Accounting Standards Board (FASB) issued FAS 123R, which amended FAS 123 and 95. FAS 123R requires all companies to measure compensation expense for all share-based payments (including employee stock options) at fair value and recognize the expense over the related service period. Additionally, excess tax benefits, as defined in FAS 123R, are recognized as an addition to paid-in-capital and are reclassified from operating cash flows to financing cash flows in the Consolidated Statements of Cash Flows. We adopted this standard as of January 1, 2006, and the adoption did not result in any change to the pro forma compensation amounts historically disclosed under FAS 123.

10. Income Taxes

The components of the provision for income taxes are as follows:

Year Ended December 31, (in millions)	2005	2004	2003
Current Provision			
Federal	**$1,638**	$1,223	$ 932
State and Local	**106**	78	46
Total Current Provision	**1,744**	1,301	978
Deferred Provision	**88**	85	37
Total Provision for Income Taxes	**$1,832**	$1,386	$1,015

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes is as follows:

Year Ended December 31, (in millions)	2005	2004	2003
Tax Provision at the U.S. Federal Statutory Rate	**$1,796**	$1,391	$ 994
State Income Taxes, net of federal benefit	**77**	54	29
Tax-Exempt Investment Income	**(40)**	(33)	(30)
Other, net	**(1)**	(26)	22
Provision for Income Taxes	**$1,832**	$1,386	$1,015

The components of deferred income tax assets and liabilities are as follows:

As of December 31, (in millions)	2005	2004
Deferred Income Tax Assets		
Accrued Expenses and Allowances	**$ 317**	$ 227
Unearned Premiums	**44**	57
Medical Costs Payable and Other Policy Liabilities	**208**	85
Long Term Liabilities	**87**	78
Net Operating Loss Carryforwards	**110**	123
Other	**87**	31
Subtotal	**853**	601
Less: Valuation Allowances	**(28)**	(28)
Total Deferred Income Tax Assets	**825**	573
Deferred Income Tax Liabilities		
Capitalized Software Development	**(270)**	(223)
Net Unrealized Gains on Investments	**(19)**	(72)
Intangible Assets	**(776)**	(406)
Property and Equipment	**(5)**	(63)
Other	**—**	(16)
Total Deferred Income Tax Liabilities	**(1,070)**	(780)
Net Deferred Income Tax Assets (Liabilities)	**$ (245)**	$(207)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal and state net operating loss carryforwards. Federal net operating loss carryforwards expire beginning in 2018 through 2024, and state net operating loss carryforwards expire beginning in 2006 through 2025.

We made cash payments for income taxes of $1,377 million in 2005, $898 million in 2004 and $783 million in 2003. We recorded a tax benefit upon the exercise of non-qualified stock options of $320 million in 2005, $358 million in 2004, and $222 million in 2003.

Consolidated income tax returns for fiscal years 2003 and 2004 are currently being examined by the Internal Revenue Service. We do not believe any adjustments that may result from the examination will have a significant impact on our consolidated financial statement position or results of operations.

11. AARP

In January 1998, we entered into a 10-year contract to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare. Under the terms of the contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from our portion of the AARP insurance offerings were approximately $4.9 billion in 2005, $4.5 billion in 2004 and $4.1 billion in 2003.

The underwriting gains or losses related to the AARP business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service expenses, marketing expenses and premium taxes. Underwriting gains and losses are recorded as an increase or decrease to the RSF and accrue to the overall benefit of the AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. To the extent underwriting losses exceed the balance in the RSF, we would have to fund the deficit. Any

deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. The RSF balance is reported in Other Policy Liabilities in the accompanying Consolidated Balance Sheets. We believe the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract.

The following AARP program-related assets and liabilities are included in our Consolidated Balance Sheets:

	Balance as of December	
(in millions)	**2005**	**2004**
Accounts Receivable	**$ 414**	$ 389
Assets Under Management	**$1,792**	$1,883
Medical Costs Payable	**$1,001**	$ 899
Other Policy Liabilities	**$ 939**	$1,162
Other Current Liabilities	**$ 266**	$ 211

The effects of changes in balance sheet amounts associated with the AARP program accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, we do not include the effect of such changes in our Consolidated Statements of Cash Flows.

Pursuant to our agreement, AARP assets under management are managed separately from our general investment portfolio and are used to pay costs associated with the AARP program. These assets are invested at our discretion, within investment guidelines approved by AARP. We do not guarantee any rates of investment return on these investments and, upon transfer of the AARP contract to another entity, we would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. As such, they are not included in our earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the AARP RSF and were $90 million, $103 million and $101 million in 2005, 2004 and 2003, respectively. Assets under management are reported at their fair market value, and unrealized gains and losses are included directly in the RSF associated with the AARP program. As of December 31, 2005 and 2004, the amortized cost, gross unrealized gains and losses, and fair value of cash, cash equivalents and investments associated with the AARP insurance program, included in Assets Under Management, were as follows (in millions):

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
2005				
Cash and Cash Equivalents	**$ 409**	**$ —**	**$ —**	**409**
Debt Securities — Available for Sale	**1,390**	**6**	**(13)**	**1,383**
Total Cash and Investments	**$1,799**	**$ 6**	**$ (13)**	**$1,792**
2004				
Cash and Cash Equivalents	$ 184	$ —	$ —	$ 184
Debt Securities — Available for Sale	1,664	37	(2)	1,699
Total Cash and Investments	$1,848	$ 37	$ (2)	$1,883

As of December 31, 2005 and 2004, respectively, debt securities consisted of $779 million and $809 million in U.S. Government and Agency obligations, $19 million and $20 million in state and municipal obligations and $585 million and $870 million in corporate obligations. At December 31, 2005, the AARP assets under management included debt securities of $149 million with maturities of less than one year, $459 million with maturities of one to five years, $435 million with maturities of five to 10 years and $340 million with maturities of more than 10 years. As of December 31, 2005, we had no investments under the AARP agreement in a continuous unrealized loss position for 12 months or greater.

12. Commitments and Contingencies

Leases

We lease facilities, computer hardware and other equipment under long-term operating leases that are noncancelable and expire on various dates through 2026. Rent expense under all operating leases was $152 million in 2005, $137 million in 2004 and $133 million in 2003.

At December 31, 2005, future minimum annual lease payments, net of sublease income, under all noncancelable operating leases were as follows: $167 million in 2006, $159 million in 2007, $128 million in 2008, $107 million in 2009, $76 million in 2010, and $172 million thereafter.

Service Agreements

We have noncancelable contracts for certain support services, which expire on various dates through 2010. Expenses incurred in connection with these agreements were $239 million in 2005, $265 million in 2004 and $256 million in 2003. At December 31, 2005, future minimum obligations under our noncancelable contracts were as follows: $151 million in 2006, $33 million in 2007, $12 million in 2008, $3 million in 2009 and $3 million in 2010.

Legal Matters

Because of the nature of our businesses, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. We record liabilities for our estimates of probable costs resulting from these matters. These matters include, but are not limited to, claims relating to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices.

Beginning in 1999, a series of class action lawsuits were filed against both UnitedHealthcare and PacifiCare, and virtually all major entities in the health benefits business. In December 2000, a multidistrict litigation panel consolidated several litigation cases involving UnitedHealth Group and our affiliates in the Southern District Court of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and RICO in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. During the course of the litigation, there have been co-defendant settlements. Through a series of motions and appeals, all direct claims against us have been compelled to arbitration. A trial date has been set for April 2006. The trial court has ordered that the trial be split into separate liability and damage proceedings. In August 2005, the capitation related claims were dismissed from litigation. On January 31, 2006, the trial court dismissed all remaining claims against PacifiCare. A March 14, 2006 hearing date has been scheduled for our summary judgment motion.

On March 15, 2000, the American Medical Association filed a lawsuit against the company in the Supreme Court of the State of New York, County of New York. On April 13, 2000, we removed this case to the United States District Court for the Southern District of New York. The suit alleges causes of action based on ERISA, as well as breach of contract and the implied covenant of good faith and fair dealing, deceptive acts and practices, and trade libel in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. The suit seeks declaratory, injunctive and compensatory relief as well as costs, fees and interest payments. An amended complaint was filed on August 25, 2000, which alleged two classes of plaintiffs, an ERISA class and a non-ERISA class. After the Court dismissed certain ERISA claims and the claims brought by

the American Medical Association, a third amended complaint was filed. On October 25, 2002, the court granted in part and denied in part our motion to dismiss the third amended complaint. On May 21, 2003, we filed a counterclaim complaint in this matter alleging antitrust violations against the American Medical Association and asserting claims based on improper billing practices against an individual provider plaintiff. On May 26, 2004, we filed a motion for partial summary judgment seeking the dismissal of certain claims and parties based, in part, due to lack of standing. On July 16, 2004, plaintiffs filed a motion for leave to file an amended complaint, seeking to assert RICO violations.

Although the results of pending litigation are always uncertain, we do not believe the results of any such actions currently threatened or pending, including those described above, will, individually or in aggregate, have a material adverse effect on our consolidated financial position or results of operations.

Government Regulation

Our business is regulated at federal, state, local and international levels. The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. State legislatures and Congress continue to focus on health care issues as the subject of proposed legislation. Existing or future laws and rules could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, and increase our liability in federal and state courts for coverage determinations, contract interpretation and other actions. Further, we must obtain and maintain regulatory approvals to market many of our products.

We typically are involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the Centers for Medicare & Medicaid Services (CMS), state insurance and health and welfare departments and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Department of Justice, and U.S. Attorneys. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs. We record liabilities for our estimate of probable costs resulting from these matters. In addition, public perception or publicity surrounding routine governmental investigations may adversely affect our stock price, damage our reputation in various markets or make it more difficult for us to sell products and services. Although the results of pending matters are always uncertain, we do not believe the results of any of the current investigations, audits or reviews, currently threatened or pending, individually or in aggregate, will have a material adverse effect on our consolidated financial position or results of operations.

13. Segment Financial Information

Factors used in determining our reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the company's chief operating decision-maker to evaluate our results of operations.

Our accounting policies for business segment operations are the same as those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between business segments principally consist of customer service and transaction processing services that Uniprise provides to Health Care Services, certain product offerings sold to Uniprise and Health Care Services customers by Specialized Care Services, and sales of medical benefits cost, quality and utilization data and predictive modeling to Health Care Services and Uniprise by Ingenix. These transactions are recorded at management's best estimate of fair value, as if the services were purchased from or sold to third parties. All intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each segment using estimates of pro-rata usage. Cash and investments are assigned such that each segment has minimum specified levels of regulatory capital or working capital for non-regulated businesses.

Substantially all of our operations are conducted in the United States. In accordance with accounting principles generally accepted in the United States of America, segments with similar economic characteristics may be combined. The financial results of UnitedHealthcare, Ovations and AmeriChoice have been combined in the Health Care Services segment column in the following tables because these businesses have similar economic characteristics and have similar products and services, types of customers, distribution methods and operational processes, and operate in a similar regulatory environment, typically within the same legal entity.

The following table presents segment financial information as of and for the years ended December 31, 2005, 2004 and 2003 (in millions):

	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Intersegment Eliminations	Consolidated
2005						
Revenues - External Customers	**$39,583**	**$3,060**	**$1,686**	**$ 537**	**$ —**	**$44,866**
Revenues - Intersegment	**—**	**752**	**1,095**	**257**	**(2,104)**	**—**
Investment and Other Income	**436**	**38**	**25**	**—**	**—**	**499**
Total Revenues	**$40,019**	**$3,850**	**$2,806**	**$ 794**	**$(2,104)**	**$45,365**
Earnings From Operations	**$ 3,815**	**$ 799**	**$ 582**	**$ 177**	**$ —**	**$ 5,373**
Total Assets[1]	**$35,734**	**$2,599**	**$2,179**	**$1,057**	**$ (841)**	**$40,728**
Net Assets[1]	**$22,483**	**$1,414**	**$1,449**	**$ 849**	**$ (841)**	**$25,354**
Purchases of Property, Equipment and Capitalized Software	**$ 238**	**$ 134**	**$ 88**	**$ 49**	**$ —**	**$ 509**
Depreciation and Amortization	**$ 227**	**$ 110**	**$ 54**	**$ 62**	**$ —**	**$ 453**
2004						
Revenues - External Customers	$32,333	$2,688	$1,363	$ 446	$ —	$36,830
Revenues - Intersegment	—	647	914	224	(1,785)	—
Investment and Other Income	340	30	18	—	—	388
Total Revenues	$32,673	$3,365	$2,295	$ 670	$(1,785)	$37,218
Earnings From Operations	$ 2,810	$ 677	$ 485	$ 129	$ —	$ 4,101
Total Assets[1]	$23,799	$2,366	$1,269	$ 971	$ (879)	$27,526
Net Assets[1]	$13,138	$1,385	$ 765	$ 795	$ (879)	$15,204
Purchases of Property, Equipment and Capitalized Software	$ 147	$ 112	$ 56	$ 35	$ —	$ 350
Depreciation and Amortization	$ 173	$ 95	$ 44	$ 62	$ —	$ 374
2003						
Revenues - External Customers	$24,592	$2,496	$1,077	$ 401	$ —	$28,566
Revenues - Intersegment	—	583	787	173	(1,543)	—
Investment and Other Income	215	28	14	—	—	257
Total Revenues	$24,807	$3,107	$1,878	$ 574	$(1,543)	$28,823
Earnings From Operations	$ 1,865	$ 610	$ 385	$ 75	$ —	$ 2,935
Total Assets[1]	$13,597	$2,024	$1,191	$ 919	$ (366)	$17,365
Net Assets[1]	$ 5,008	$1,116	$ 710	$ 766	$ (347)	$ 7,253
Purchases of Property, Equipment and Capitalized Software	$ 122	$ 130	$ 48	$ 52	$ —	$ 352
Depreciation and Amortization	$ 116	$ 86	$ 40	$ 57	$ —	$ 299

[1] Total Assets and Net Assets exclude, where applicable, debt and accrued interest of $7,161 million, $4,054 million and $1,993 million, income tax-related assets of $646 million, $353 million and $269 million, and income tax-related liabilities of $1,106 million, $786 million and $401 million as of December 31, 2005, 2004 and 2003, respectively.

14. Quarterly Financial Data (Unaudited)

(in millions, except per share data)	For the Quarter Ended March 31	June 30	September 30	December 31
2005				
Revenues	**$10,887**	**$11,111**	**$11,322**	**$12,045**
Medical and Operating Costs	**$ 9,631**	**$ 9,801**	**$ 9,944**	**$10,616**
Earnings From Operations	**$ 1,256**	**$ 1,310**	**$ 1,378**	**$ 1,429**
Net Earnings	**$ 779**	**$ 809**	**$ 842**	**$ 870**
Basic Net Earnings per Common Share	**$ 0.61**	**$ 0.64**	**$ 0.67**	**$ 0.69**
Diluted Net Earnings per Common Share	**$ 0.58**	**$ 0.61**	**$ 0.64**	**$ 0.65**
2004				
Revenues	$ 8,144	$ 8,704	$ 9,859	$10,511
Medical and Operating Costs	$ 7,268	$ 7,759	$ 8,767	$ 9,323
Earnings From Operations	$ 876	$ 945	$ 1,092	$ 1,188
Net Earnings	$ 554	$ 596	$ 698	$ 739
Basic Net Earnings per Common Share	$ 0.46	$ 0.49	$ 0.55	$ 0.57
Diluted Net Earnings per Common Share	$ 0.44	$ 0.47	$ 0.52	$ 0.54

[1] UnitedHealth Group acquired PacifiCare in December 2005 for total consideration of approximately $8.8 billion, Oxford in July 2004 for total consideration of approximately $5.0 billion and MAMSI in February 2004 for total consideration of approximately $2.7 billion. These acquisitions affect the comparability of 2005 and 2004 financial information to prior fiscal years. The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in UnitedHealth Group's consolidated financial statements since the respective acquisition dates. See Note 3 to the consolidated financial statements for a detailed discussion of these acquisitions.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2005 and 2004, and the related consolidated statements of operations, changes in shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2005. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2005 and 2004, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2005, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of the Company's internal control over financial reporting as of December 31, 2005, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 24, 2006, expressed an unqualified opinion on management's assessment of the effectiveness of the Company's internal control over financial reporting and an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP
Minneapolis, Minnesota
February 24, 2006

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

As of December 31, 2005, an evaluation was carried out under the supervision and with the participation of the company's management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934). Based upon that evaluation, the Chief Executive Officer and the Chief Financial Officer concluded that the design and operation of these disclosure controls and procedures were effective.

Internal Control Over Financial Reporting

Report of Management

The management of UnitedHealth Group is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. The company's internal control over financial reporting includes those policies and procedures that:

- Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company;
- Provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and
- Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the company's internal control over financial reporting as of December 31, 2005. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control—Integrated Framework*. Based on our assessment and those criteria, we believe that, as of December 31, 2005, the company maintained effective internal control over financial reporting.

Management excluded from its assessment of the effectiveness of the Company's internal control over financial reporting the internal controls of PacifiCare Health Systems, Inc. (PacifiCare) which was acquired by the Company on December 20, 2005, and is included in the Company's consolidated financial statements for the period from that date through yearend. Such exclusion was in accordance with Securities and Exchange Commission guidance that an assessment of a recently acquired business may be omitted in management's report on internal controls over financial reporting in the year of acquisition. Total assets and total liabilities of

PacifiCare represented approximately 29% and 13%, respectively, of the Company's consolidated assets and liabilities as of December 31, 2005, and less than 1% of consolidated revenues and operating income for the year then ended.

Changes to certain processes, information technology systems, and other components of Internal Control resulting from the acquisition of PacifiCare may occur and will be evaluated by management as such integration activities are implemented. Other than the impact of the acquisition, there were no changes in Internal Control that have materially affected, or are reasonably likely to materially affect, the Company's Internal Control during the year ended December 31, 2005.

The company's independent registered public accounting firm has audited management's assessment of the effectiveness of the company's internal control over financial reporting as of December 31, 2005, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses unqualified opinions on management's assessment and on the effectiveness of the company's internal controls over financial reporting as of December 31, 2005.

February 24, 2006

/s/ WILLIAM W. MCGUIRE, MD

William W. McGuire, MD
Chairman and Chief Executive Officer

/s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
President and Chief Operating Officer

/s/ PATRICK J. ERLANDSON

Patrick J. Erlandson
Chief Financial Officer

New York Stock Exchange Certification

Pursuant to Section 303A.12(a) of the NYSE listed company manual, the company submitted an unqualified certification of its Chief Executive Officer to the NYSE in 2005. We have also filed as exhibits to this Annual Report on Form 10-K, the Chief Executive Officer and Chief Financial Officer Certifications required under the Sarbanes-Oxley Act.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited management's assessment, included in the accompanying Report of Management, that UnitedHealth Group Incorporated and Subsidiaries (the "Company") maintained effective internal control over financial reporting as of December 31, 2005, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. As described in the Report of Management, management excluded from their assessment the internal control over financial reporting at PacifiCare Health Systems, Inc. (PacifiCare), which was acquired on December 20, 2005 and whose financial statements reflect total assets and revenues constituting approximately 29 and 1 percent, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2005. Accordingly, our audit did not include the internal control over financial reporting at PacifiCare. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express an opinion on management's assessment and an opinion on the effectiveness of the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, evaluating management's assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, management's assessment that the Company maintained effective internal control over financial reporting as of December 31, 2005, is fairly stated, in all material respects, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2005, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2005 of the Company and our report dated February 24, 2006 expressed an unqualified opinion on those financial statements.

/s/ DELOITTE & TOUCHE LLP
Minneapolis, Minnesota
February 24, 2006

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

Code of Ethics

We have adopted a Code of Business Conduct and Ethics which applies to all of our employees and directors. The Code of Ethics is published on our Web site at www.unitedhealthgroup.com. Any amendments to the Code of Ethics and waivers of the Code of Ethics for our Chief Executive Officer, Chief Financial Officer or Controller will be published on our Web site. We will provide a copy of our Code of Business Conduct and Ethics, free of charge, upon request. To request a copy, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary.

The information included under the headings "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

Board of Directors and Committees of the Board

William C. Ballard, Jr.
Of Counsel
Greenebaum Doll & McDonald PLLC

Richard T. Burke
Director of Meritage Homes Corporation and First Cash Financial Services, Inc.

Stephen J. Hemsley
President and Chief Operating Officer
UnitedHealth Group

James A. Johnson
Vice Chairman of Perseus, LLC

Thomas H. Kean
Former President of Drew University
Former Governor of New Jersey

Douglas W. Leatherdale
Former Chairman and
Chief Executive Officer of
The St. Paul Companies, Inc.

William W. McGuire, MD
Chairman and
Chief Executive Officer
UnitedHealth Group

Mary O. Mundinger, DrPH, RN
Dean, School of Nursing and Centennial Professor in Health Policy, and Associate Dean, Faculty of Medicine
Columbia University

Robert L. Ryan
Former Senior Vice President and
Chief Financial Officer Medtronic, Inc.

Donna E. Shalala, PhD
President of University of Miami

William G. Spears
Senior Principal
Spears Grisanti & Brown LLC

Gail R. Wilensky, PhD
Senior Fellow, Project HOPE

Committees of the Board

Audit Committee
William C. Ballard, Jr.
Thomas H. Kean
Douglas W. Leatherdale

Compensation and Human Resources Committee
James A. Johnson
Mary O. Mundinger
William G. Spears

Compliance and Government Affairs Committee
Donna E. Shalala
Gail R. Wilensky

Nominating Committee
William C. Ballard, Jr.
Thomas H. Kean
Douglas W. Leatherdale
William G. Spears

Executive Committee
William C. Ballard, Jr.
Douglas W. Leatherdale
William W. McGuire
William G. Spears

ITEM 11. EXECUTIVE COMPENSATION

The information included under the heading "Executive Compensation" in our definitive proxy statement for our Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our Annual Meeting of Shareholders to be held May , 2006, is incorporated herein by reference.

Equity Compensation Plan Information

Plan Category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
Equity compensation plans approved by shareholders[1]	174,030,671	$23.60	102,707,501[3]
Equity compensation plans not approved by shareholders[2]	—	—	—
Total	174,030,671	$23.60	102,707,501

(1) Consists of the UnitedHealth Group Incorporated 2002 Stock Incentive Plan, as amended, and the 1993 Qualified Employee Stock Purchase Plan, as amended.

(2) Excludes 12,752,378 shares underlying stock options assumed by us in connection with our acquisition of the companies under whose plans the options originally were granted. These options have a weighted-average exercise price of $16.20 and an average remaining term of approximately 5.74 years. The options are administered pursuant to the terms of the plan under which the option originally was granted. No future options or other awards will be granted under these acquired plans.

(3) Includes 5,834,475 shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2005, and 96,873,026 shares available under the 2002 Stock Incentive Plan as of December 31, 2005. Shares available under the 2002 Stock Incentive Plan may become the subject of future awards in the form of stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards and other stock-based awards, except that only 26,233,466 of these shares are available for future grants of awards other than stock options or stock appreciation rights.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

Information regarding certain relationships and related transactions that appears under the heading "Certain Relationships and Transactions" in our definitive proxy statement for the Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

Information regarding accountant fees and services that appears under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for the Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES AND REPORTS ON FORM 8-K

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

Consolidated Statements of Operations for the years ended December 31, 2005, 2004, and 2003.

Consolidated Balance Sheets as of December 31, 2005 and 2004.

Consolidated Statements of Changes in Shareholders' Equity for the years ended December 31, 2005, 2004 and 2003.

Consolidated Statements of Cash Flows for the years ended December 31, 2005, 2004 and 2003.

Notes to Consolidated Financial Statements.

Reports of Independent Registered Public Accounting Firm.

(a) 2. *Financial Statement Schedules*

None

(a) 3. *Exhibits***

3(a) Articles of Amendment to Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Current Report on From 8-K dated May 24, 2005)

3(b) Articles of Amendment to Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2001)

3(c) Articles of Merger amending the Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)

3(d) Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1995)

3(e) Second Amended and Restated Bylaws of the Company (incorporated by reference to Exhibit 3(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)

4(a) Senior Indenture, dated as of November 15, 1998, between the Company and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, filed on January 11, 1999)

4(b) Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the Company and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)

*10(a) UnitedHealth Group Incorporated 2002 Stock Incentive Plan, Amended and Restated Effective May 15, 2002 (incorporated by reference to Exhibit 10(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)

*10(b) Form of Agreement for Stock Option Award to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated January 31, 2006)

*10(c) Form of Agreement for Stock Option Award to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated September 24, 2004).

*10(d) Form of Agreement for Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated September 24, 2004)

*10(e) Form of Agreement for Initial Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated September 24, 2004)

*10(f) Form of Restricted Stock Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated January 31, 2006)

*10(g) Form of Restricted Stock Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated September 24, 2004)

*10(h) Form of Restricted Stock Unit Award Agreement under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K dated September 24, 2004)

*10(i) Form of Stock Appreciation Rights Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 of the Company's Current Report on Form 8-K dated January 31, 2006)

*10(j) Form of Stock Appreciation Rights Award Agreement to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 of the Company's Current Report on Form 8-K dated January 31, 2006)

*10(k) UnitedHealth Group Incorporated Executive Incentive Plan (incorporated by reference to Exhibit 10(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)

*10(l) UnitedHealth Group Executive Savings Plans (2004 Statement) (incorporated by reference to Exhibit 10(e) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)

*10(m) UnitedHealth Group Directors' Compensation Deferral Plan (2002 Statement) (incorporated by reference to Exhibit 10(d) of the Company's Annual Report on Form 10-K for the year ended December 31, 2002)

*10(n) First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (2002 Statement) (incorporated by reference to Exhibit 10(g) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)

*10(o) Employment Agreement, dated as of October 13, 1999, between the Company and William W. McGuire, M.D. (incorporated by reference to Exhibit 10(f) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)

*10(p) Letter to William W. McGuire, M.D., dated as of February 13, 2001, regarding Employment Agreement (incorporated by reference to Exhibit 10(h) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)

*10(q) Amendment to Employment Agreement, dated as of August 5, 2005, between the Company and William W. McGuire, M.D. (incorporated by reference to Exhibit 10(c) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)

*10(r) Employment Agreement dated as of October 13, 1999, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10(g) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)

*10(s) Letter to Stephen J. Hemsley, dated as of February 13, 2001, regarding Employment Agreement (incorporated by reference to Exhibit 10(j) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)

*10(t) Amendment to Employment Agreement, dated August 5, 2005, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10(d) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)

*10(u) Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)

*10(v) Employment Agreement, dated as of November 1, 2004, between United HealthCare Services, Inc. and Richard H. Anderson (incorporated by reference to Exhibit 10(p) of the Company's Annual Report on Form 10-K for the year ended December 31, 2004)

*10(w) Employment Agreement, dated as of October 1, 1998, as amended, between United HealthCare Services, Inc. and Tracy L. Bahl (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)

*10(x) Employment Agreement, dated as of October 1, 1998, between United HealthCare Services, Inc. and Patrick J. Erlandson (incorporated by reference to Exhibit 10(m) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)

*10(y) Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and David J. Lubben, as amended (incorporated by reference to Exhibit 10(p) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)

*10(z) Employment Agreement, dated as of October 1, 1998, between United HealthCare Services, Inc. and William A. Munsell, as amended (incorporated by reference to Exhibit 10(t) of the Company's Annual Report on Form 10-K for the year ended December 31, 2004)

*10(aa) Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and Lois E. Quam, as amended, and Memorandum of Understanding, effective as of October 11, 1999, between Lois E. Quam and United HealthCare Services, Inc. (incorporated by reference to Exhibit 10(l) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)

*10(bb) Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and Robert J. Sheehy, as amended (incorporated by reference to Exhibit 10(l) to the Company's Annual Report on Form 10-K for the year ended December 31, 2001)

*10(cc) Employment Agreement, dated as of October 1, 1998, as amended, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10(o) to the Company's Annual Report on Form 10-K for the year ended December 31, 2003)

†10(dd) AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company dated as of February 26, 1997 (incorporated by reference to Exhibit 10(p) to the Company's Annual Report on Form 10-K/A for the year ended December 31, 1996)

†10(ee) First Amendment to the AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company effective January 1, 1998 (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter period ended June 30, 1998)

†10(ff) Second Amendment to the AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company effective January 1, 1998 (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1998)

†10(gg) Amendments to the AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company (incorporated by reference to Exhibit 10(s) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)

†10(hh) Amendments to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, entered into between April and October 2003 (incorporated by reference to Exhibit 10(v) to the Company's Annual Report on Form 10-K for the year ended December 31, 2003)

†10(ii) 10th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2004 (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2004)

†10(jj) 11th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2005 (incorporated by reference to Exhibit 10(dd) to the Company's Annual Report on Form 10-K for the year ended December 31, 2004)

10(kk) 12th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2005 (incorporated by reference to Exhibit 10(a) of the Company's Quarterly Report on From 10-Q for the quarter ended June 30, 2005)

10(ll) 13th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of December 21, 2005

11 Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 to the Notes to Consolidated Financial Statements included under Item 8)

12 Ratio of Earnings to Fixed Charges

21 Subsidiaries of the Company

23 Consent of Independent Registered Public Accounting Firm

24 Powers of Attorney

31 Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

32 Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

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† Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, confidential portions of these Exhibits have been deleted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

**Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 24, 2006

UNITEDHEALTH GROUP INCORPORATED

By /s/ WILLIAM W. MCGUIRE, M.D.

William W. McGuire, M.D.
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ WILLIAM W. MCGUIRE, M.D. **William W. McGuire, M.D.**	Director, Chief Executive Officer (principal executive officer)	February 24, 2006
/s/ PATRICK J. ERLANDSON **Patrick J. Erlandson**	Chief Financial Officer (principal financial and accounting officer)	February 24, 2006
* **William C. Ballard, Jr.**	Director	February 24, 2006
* **Richard T. Burke**	Director	February 24, 2006
* **Stephen J. Hemsley**	Director	February 24, 2006
* **James A. Johnson**	Director	February 24, 2006
* **Thomas H. Kean**	Director	February 24, 2006
* **Douglas W. Leatherdale**	Director	February 24, 2006
* **Mary O. Mundinger**	Director	February 24, 2006
* **Robert L. Ryan**	Director	February 24, 2006
* **Donna E. Shalala**	Director	February 24, 2006
* **William G. Spears**	Director	February 24, 2006
* **Gail R. Wilensky**	Director	February 24, 2006

*By /s/ DAVID J. LUBBEN

David J. Lubben
As Attorney-in-Fact

EXHIBIT INDEX

Item	Description
*Exhibits***	
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3(d)	Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1995)
3(e)	Second Amended and Restated Bylaws of the Company (incorporated by reference to Exhibit 3(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
4(a)	Senior Indenture, dated as of November 15, 1998, between the Company and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, filed on January 11, 1999)
4(b)	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the Company and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
*10(a)	UnitedHealth Group Incorporated 2002 Stock Incentive Plan, Amended and Restated Effective May 15, 2002 (incorporated by reference to Exhibit 10(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10(b)	Form of Agreement for Stock Option Award to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated January 31, 2006)
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*10(k)	UnitedHealth Group Incorporated Executive Incentive Plan (incorporated by reference to Exhibit 10(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
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*10(m)	UnitedHealth Group Directors' Compensation Deferral Plan (2002 Statement) (incorporated by reference to Exhibit 10(d) of the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10(n)	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (2002 Statement) (incorporated by reference to Exhibit 10(g) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
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*10(q)	Amendment to Employment Agreement, dated as of August 5, 2005, between the Company and William W. McGuire, M.D. (incorporated by reference to Exhibit 10(c) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)
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*10(t)	Amendment to Employment Agreement, dated August 5, 2005, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10(d) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)
*10(u)	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10(v)	Employment Agreement, dated as of November 1, 2004, between United HealthCare Services, Inc. and Richard H. Anderson (incorporated by reference to Exhibit 10(p) of the Company's Annual Report on Form 10-K for the year ended December 31, 2004)
*10(w)	Employment Agreement, dated as of October 1, 1998, as amended, between United HealthCare Services, Inc. and Tracy L. Bahl (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)

Item	Description
*10(x)	Employment Agreement, dated as of October 1, 1998, between United HealthCare Services, Inc. and Patrick J. Erlandson (incorporated by reference to Exhibit 10(m) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
*10(y)	Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and David J. Lubben, as amended (incorporated by reference to Exhibit 10(p) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
*10(z)	Employment Agreement, dated as of October 1, 1998, between United HealthCare Services, Inc. and William A. Munsell, as amended (incorporated by reference to Exhibit 10(t) of the Company's Annual Report on Form 10-K for the year ended December 31, 2004)
*10(aa)	Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and Lois E. Quam, as amended, and Memorandum of Understanding, effective as of October 11, 1999, between Lois E. Quam and United HealthCare Services, Inc. (incorporated by reference to Exhibit 10(l) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
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†10(ff)	Second Amendment to the AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company effective January 1, 1998 (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1998)
†10(gg)	Amendments to the AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company (incorporated by reference to Exhibit 10(s) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
†10(hh)	Amendments to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, entered into between April and October 2003 (incorporated by reference to Exhibit 10(v) to the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
†10(ii)	10th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2004 (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2004)
†10(jj)	11th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2005 (incorporated by reference to Exhibit 10(dd) to the Company's Annual Report on Form 10-K for the year ended December 31, 2004)
10(kk)	12th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2005 (incorporated by reference to Exhibit 10(a) of the Company's Quarterly Report on From 10-Q for the quarter ended June 30, 2005)

Item	Description
10(ll)	13th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of December 21, 2005
11	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 to the Notes to Consolidated Financial Statements included under Item 8)
12	Ratio of Earnings to Fixed Charges
21	Subsidiaries of the Company
23	Consent of Independent Registered Public Accounting Firm
24	Powers of Attorney
31	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

† Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, confidential portions of these Exhibits have been deleted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.