

UNIVERSAL
AMERICAN

A Healthy Collaboration®



**J.P. Morgan
31st Annual
Healthcare Conference**

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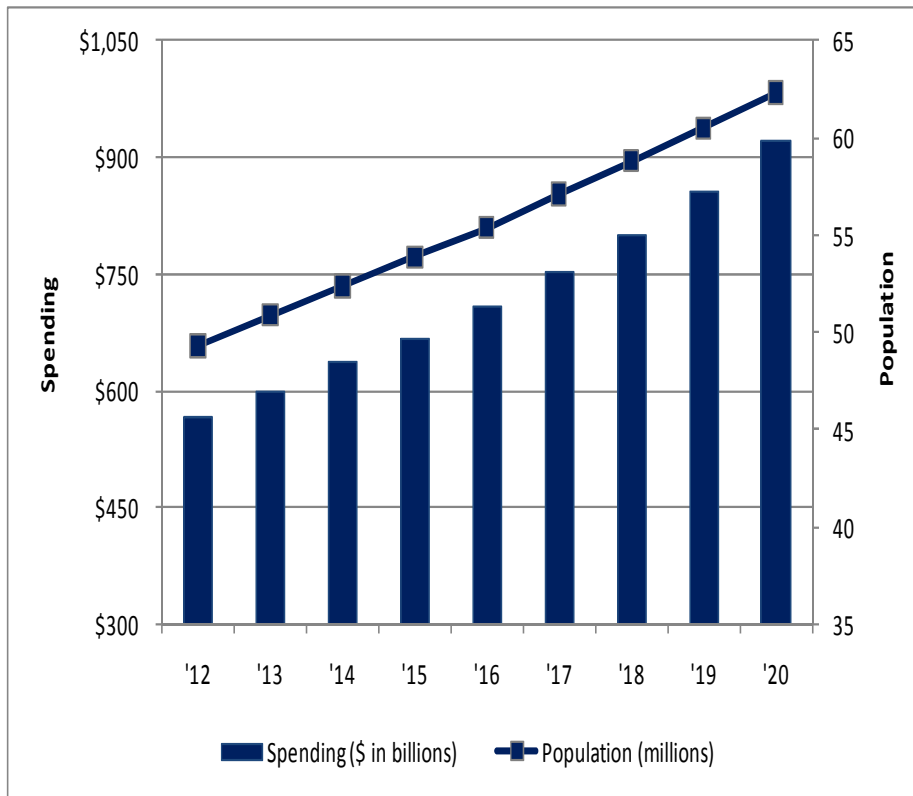
Forward-Looking Statements/Non GAAP Financial Measures

This presentation may contain forward-looking statements within the meaning of the Federal securities laws. These statements, which reflect management's current expectations, projections and beliefs, are subject to risks and uncertainties that may cause actual results to differ materially. For a discussion of these risks and uncertainties we recommend that you review the Company's risk factors and other disclosures set forth in our SEC filings. We undertake no obligation to update or revise any forward-looking statements to reflect events, developments or circumstances after the date hereof.

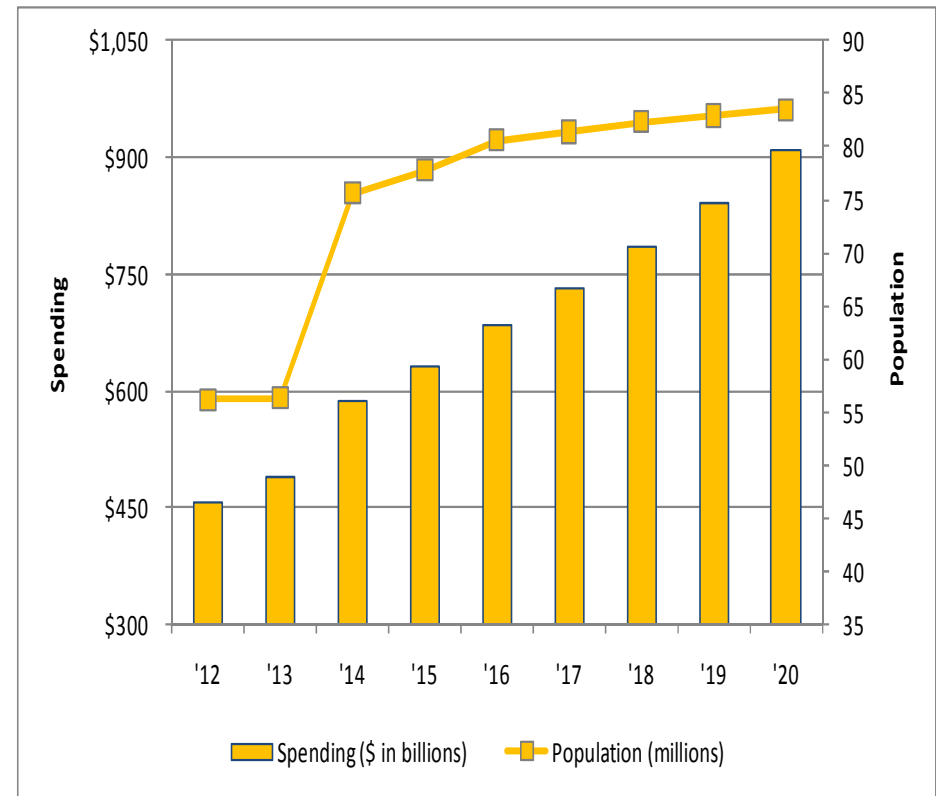
During this presentation, we will also be referring to certain non-GAAP financial measures. Please refer to the reconciliation tables listed in our quarterly earnings press releases for a discussion of these non-GAAP financial measures, which can be found in the Investor Relations section of our website at www.universalamerican.com.

It's Only Just Beginning...

Medicare Market



Medicaid Market



Fastest growing demographic segment. Baby boomers started to reach 65 in 2010.

Approximately 9 million dual eligible members with combined Medicaid and Medicare spend of \$322 billion.

2013 Healthcare Landscape



- Implementation of Affordable Care Act Accelerates
 - Benefits exchanges and Plan participation
 - Individual mandate and Medicaid expansion
- But the real and immediate driver of change is that all ultimate payers are actively looking to reduce their costs: Federal, State, Municipalities, Companies, Individuals
 - Medicare
 - More ‘savings’ expected from Medicare – raising eligibility, benefits, inflation adjuster tied to CPI, etc.
 - Accountable Care Organizations
 - Major demonstrations around Duals, bundled payments, Stars
 - Medicaid
 - All states are now focused on reducing cost of providing Medicaid services
 - Many states (even some “blue” states) have requested block grants and waivers to manage their own systems with less control by the Federal government
 - Focus on formerly unmanaged dual eligible and ABD populations
 - Companies that know how to **control costs, improve quality** of healthcare and **deliver value** will thrive in this environment



Universal American – Healthy Collaboration Model

- **Work in collaboration with healthcare providers to help them assume and manage risk, in order to achieve measurably better quality and lower cost**
- **Engage the people we serve to help them make smart and economic choices about their healthcare**
- **Employ enabling technology**
- **Align incentives**

Universal American - 2013

Medicare Advantage

- Successful 2013 AEP: growth in core markets
 - 135.8K members; \$1.6 billion of annualized revenue
 - Lower attrition, especially in core markets
- Core markets: Southwest HMOs, Northeast (NY /PA), Southeast (SC, VA, GA)
- Building physician engagement in HMO and PPO markets
- G&A Reduction
- Continued improvement in Stars

Accountable Care Organizations

- Medicare Shared Savings Program
- Approximately 30 ACOs expected with approx. 2,000 physicians, including core SE Texas docs. Approximately 300k lives expected as of 1/1/13
- Partnership with primary care physicians
- Extend ACOs to Medicare Advantage, Medicaid , Exchange

Medicaid

- Partner with provider-based organizations to participate in ABD, LTC, Duals expansion
- Direct to State: Fee for service
- Direct to Health Plans: Fee for service / Risk
- Select RFPs

Universal American - 2013

Operations

- Build best-in-class medical management, complex case management and IT
- Quality as a necessity
- Measurement of results: cost and quality

Traditional

- Manage run-off

Capital Structure

- 3Q Balance Sheet Stats (Proforma for \$1 dividend):
 - \$11.09 BVPS; \$8.35/share (ex goodwill); \$7.29/share (ex all intangibles)
 - 15.2% debt to cap
- \$645 million in unregulated cash and statutory capital of which approximately \$340 million is “excess” of 350% RBC
- Approximately \$55-\$60 million of ordinary dividends available in 2013
- Appropriate use of excess capital
 - Invest in business
 - Return to shareholders

Medicare Advantage Membership

(000s)	Ending 2012	Estimated January 2013	Change
Southwest HMO	56.7	61.5	8%
Northeast Network	36.0	38.6	7%
Southeast Network	5.8	6.0	4%
Core Markets	98.4	106.1	8%
All Other Network	16.5	14.7	-11%
Rural PFFS	16.1	14.9	-7%
Total Medicare Advantage	131.0 *	135.8	4%

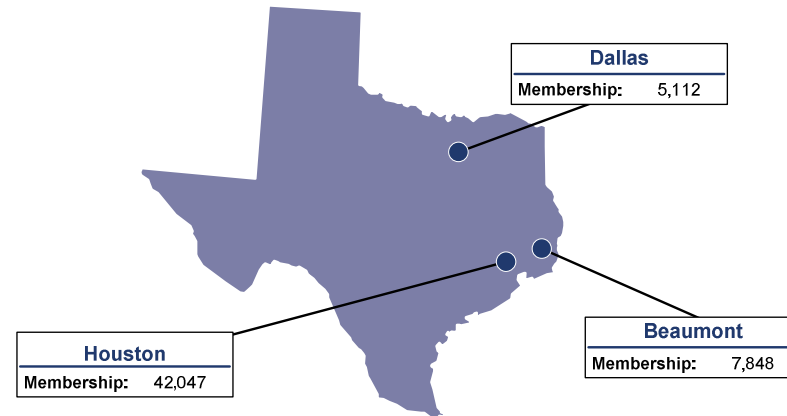
* Excludes 3.3 Service Area Reductions (SARs)

Medicare Advantage Reimbursement

Transition Period	Target Benchmark / FFS Cost Ratio				Total
	95.0%	100.0%	107.5%	115.0%	
2013	1%	1%	3%	7%	12%
2015	3%	3%	3%	15%	23%
2017	46%	1%	2%	16%	65%
Total	50%	5%	8%	37%	100%

Southwest HMO	100%	0%	0%	0%	100%
Northeast Network	0%	1%	4%	95%	100%
Southeast Network	0%	8%	18%	74%	100%
All Other Network	23%	21%	26%	30%	100%
Rural	20%	19%	26%	34%	100%

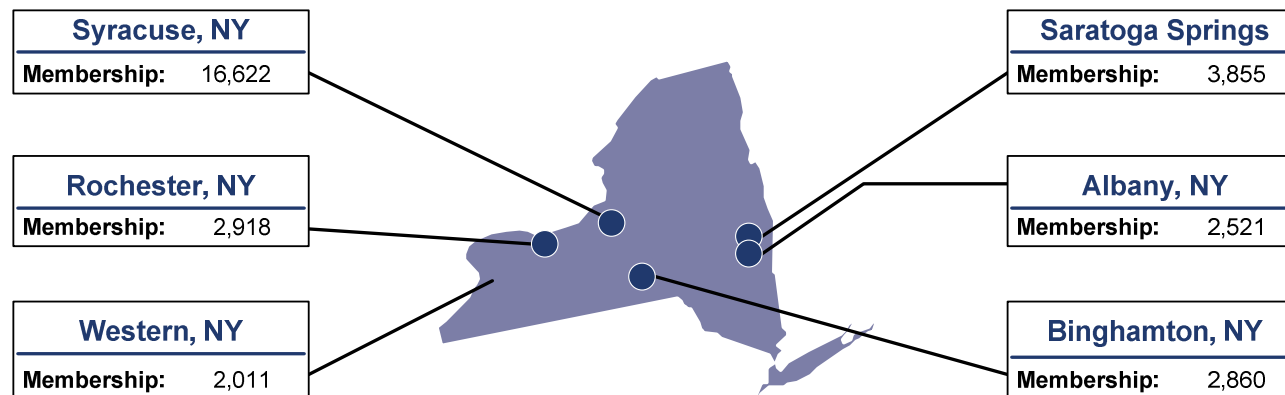
Key Markets – Southwest



- Solid #1 and #2 positions in growing Houston and Beaumont markets
- Emerging success in Dallas/Fort Worth and Oklahoma City markets
- Committed, aligned physician groups in all markets
- Zero Premium Products with high value Supplemental Benefits
 - Rates will decline from 110% of FFS to 95% of FFS Benchmark, but
 - Solid market presence and ample time to adjust to the new rate environment
- Increased penetration of Medicaid and ABD populations
 - 21% of members (including both Dual and LIS)
- Improved STARS will buffer 2014 headwinds

Key Markets – Northeast

- Most rates in NYS will settle out at 115% of FFS Benchmark
 - Can offer an attractive benefit package
- Strong market position
- Loyal and productive agency field force
- Evolve from indemnity to managed care: Healthy Collaboration strategy and newly adopted medical management program



Accountable Care Organizations

- The Affordable Care Act established the Medicare Shared Savings Program as a tool to improve quality and lower costs through increased care coordination in Medicare Fee-for-Service program
 - 36 million traditional Fee-for-Service Medicare opportunity
- ACOs are legal entities that contract with CMS for 3 year periods to serve FFS Medicare population
 - Fee-for-Service members are assigned to ACOs based on plurality of services provided by primary physician
 - ACOs and CMS share savings as compared to trended benchmarks based on actual costs
- **UAM has created approximately 30 partnerships with more than 2,000 providers and approx. 300,000 prospective members throughout the United States based on Healthy Collaboration™ model**
 - Capitalize on 12+ years of risk sharing arrangements in which providers and beneficiaries benefits from efficient and quality care

Illustrative ACO Financial Model¹

Number of Patients	10,000	Expected Average
Blended Monthly Benchmark	\$850	
Estimated Savings Achieved	6.0%	Maximum savings allowed: 20%
Gross Savings	\$ 6,120,000	
Less: CMS Portion	(3,060,000)	Savings are split 50/50 with CMS
ACO Savings	3,060,000	
ACO Expenses	(1,200,000)	Care Management Estimate
ACO Operating Income	1,860,000	
Provider Share (~50%)	(930,000)	ACO Savings split with Providers
UAM Share (~50%)	930,000	
UAM Non-Shared Expenses	(240,000)	
UAM Operating Income	690,000	Overhead

Notes:

1. Financial projections are illustrative only and not indicative of projected or actual performance.

Medicaid Capabilities

Knowledge of Medicare, Medicaid and Managed Long Term Care

- Currently providing services to Dual Eligibles in ABD populations in several states
- Experienced with LTC (Florida Diversion, Traditional Insurance products)

Population Health Management

- Chronic care management and medical management services including behavioral health, general population management, disease management, and medication therapy management

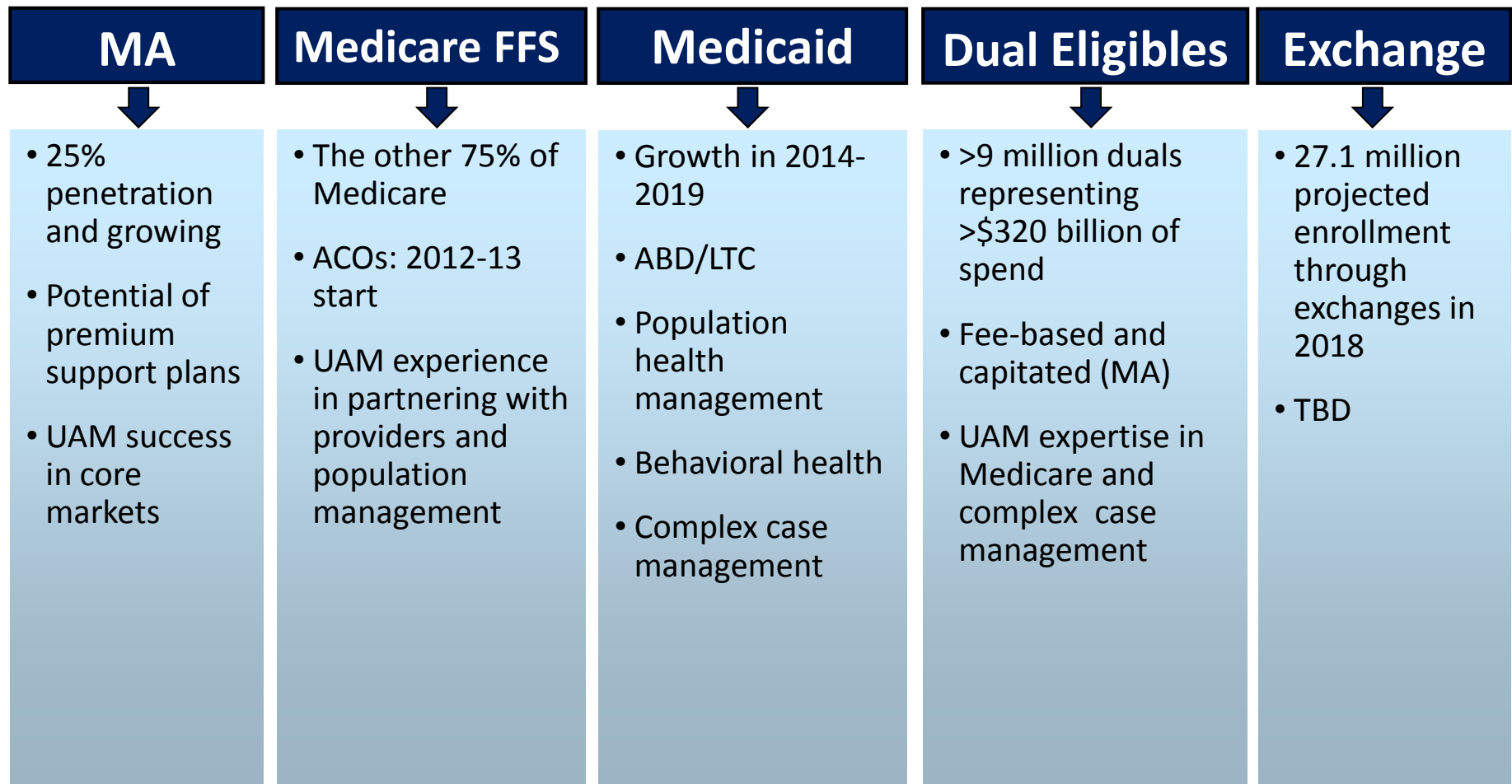
Financial and Clinical Data Systems and Analytics

- Analytics engine (Percolator™) for predictive modeling and expenditure optimization: population management, risk stratification, financial modeling and projected savings based on sound clinical interventions-care transitions and best practices. Proven clinical and financial improvements documented by third party reviewers

CMS and State Application Preparation and Network Development

- Develops applications and provider networks including home and community based providers, physicians, hospitals and outpatient services

Universal American is positioned to participate in high growth areas of healthcare



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