UnitedHealthcare, including Oxford plans, recognizes that our American health system requires fundamental change to provide affordable, quality care. Health reform is a start but more is needed to address health care costs that are rising continually and a system where care is too variable. Innovative, value-oriented and outcome-focused approaches can help make the system work better for everyone.

Our goal is helping people live healthier lives. Through the use of best practices, we’re working to build a better, more affordable health care system. We help make this happen by:

- Providing innovative and affordable choices in the health plans we offer
- Modernizing the delivery of health care by developing tools and programs to make health care easier to understand and navigate
- Focusing on quality of service and simplicity of administration
- Informing and engaging your employees regarding their health to help them make healthier choices

The Affordable Care Act (ACA) brings significant changes to how Americans access and pay for health care. And while change is good, it can be challenging. We want to help you understand health reform and let you know that you are not in this alone. We’re here to help you understand the changes, and how they impact you and your Oxford plan. We’ve taken steps to ensure that our Oxford plan designs conform to the ACA’s mandates. We are partnering with employers and working to provide affordable solutions.

Changes in federal law are just one way to move toward a more modern health care delivery system. We’re at the forefront of improving access to quality care, containing costs, using technology to increase transparency and changing the way the system pays for care. We understand that when physicians, insurance companies, employers, consumers and the government bring their best ideas to the table, we can help improve access to quality and affordable care.
Looking Back

Here are key health reform changes that went into effect on or before Dec. 31, 2013:

- Accountable Care Organization (ACO) requirements for Medicare (2012)
- Administrative Simplification — some initiatives began in 2013, others are expected to be implemented in 2014 and 2015
- Annual fee on medical devices (2013)
- Appeals provision* (Sep. 23, 2010 to Jan. 1, 2012)
- Deduction for expenses allocable to the Part D subsidy for “qualified prescription drug plans” eliminated (2013)
- Dependent coverage up to age 26 (2010)
- Exchanges began open enrollment (coverage began in many states on Jan. 1, 2014)
- Limitation on Health Flexible Spending Accounts (FSAs) to $2,500 (2013)
- Health FSAs allow carryover up to $500 of unused amounts into the next plan year (2013)
- Medical Loss Ratio (MLR) rebates (2012)
- Patient-Centered Outcomes Research Institute (PCORI) Fee (2012 - 2019)
- Patient Protections* (2010)
- No pre-existing condition exclusions (2014)
- Preventive services as well as an expanded list of women’s preventive services including breast-feeding support, contraceptive coverage and well-woman visits with no cost-sharing* (2012)
- Quality bonus began for Medicare Advantage plans (2012)
- Removal of lifetime and per-beneficiary annual restricted dollar limits for Essential Health Benefits (EHB) (2014)
- Summary of Benefits and Coverage (SBC), the Uniform Glossary and 60-day advance notice of material modifications (2013)
- W-2 reporting of the value of employer-sponsored health benefits (2013)

*Not required of grandfathered plans

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What’s New for 2014

Adjusted Community Rating

Adjusted community rating (ACR) rules will apply to non-grandfathered individual and small group insurance markets effective for plan years (policy years in the individual market) beginning on or after Jan. 1, 2014. Under the ACA provision, the use of actual or expected health status or claims experience to set rates for premiums is prohibited. Other rating factors such as age, geographic area and tobacco use may be used to vary premiums, within certain limits. The only groups not affected by the rating changes are self-funded groups and grandfathered plans along with large fully insured groups in most states. In some states, small groups or individuals with coverage in effect as of Oct. 1, 2013, may be able to renew their coverage (“keep their coverage”) if their renewal date falls between Jan. 1, 2014, and Oct. 1, 2014.

Clinical Trials

For new and renewing plans effective on or after Jan. 1, 2014, all non-grandfathered health plans are required to cover certain routine patient costs incurred in approved clinical trials. An approved clinical trial is one conducted in relation to the prevention, diagnosis or treatment of cancer or other life-threatening diseases or conditions and which has been approved or sponsored by one of a number of federal health-related agencies. Coverage is for routine patient costs and care that would be a covered benefit even if the member was not a participant in a clinical trial, but not for the device, medication or data collection costs associated with the trial.

Exchanges

Exchanges offer another option for individuals and small groups to shop for, select and enroll in high-quality, affordable health plans.

Public Exchanges

The ACA required Exchanges to be established in each state by Jan. 1, 2014. While many people will continue to access health insurance as they do today — through an employer, government program or health insurers, the online Exchanges provide another way for individuals and small businesses to research, compare and enroll in health insurance offered by health insurers. Exchanges exist in each state and are operated by either the state government, by the federal government or as a partnership between the two.

There are two types of Exchanges: one for small businesses, called Small Business Health Options Program (SHOP) and another for individuals, called the Individual Marketplace. Employees meeting certain requirements who cannot afford the coverage provided by their employer may purchase a plan in the Exchange. Unaffordable means the premium costs more than 9.5 percent of the employee’s yearly income.

From 2014 through 2016, only individuals and employers in the small group market are eligible to participate in an Exchange. In 2017, states may permit employers in the large group market to participate.

Private Exchanges

Private exchanges have been in place for several years. However, with increased interest in private exchanges for active employees and retirees, a number of private exchanges are being established by a variety of different entities such as consulting firms and cooperatives. Private exchanges are available to all business segments and fully insured or self-funded groups of all sizes. Because private exchanges are operated by private entities, subsidies are not available to those purchasing health care insurance through a private exchange.
**Flexible Spending Account (FSA)**
Effective as of 2013, there is a maximum of $2,500 that can be set aside in a health FSA. In subsequent plan years, the maximum is expected to increase based on inflation. This change is in addition to no longer allowing health FSAs to be used for over-the-counter medications, which became effective in 2011. Also, an exception to the longstanding “use-or-lose” rule associated with FSAs now allows health FSAs to carry over up to $500; however, employers may specify a lower amount or not permit the carryover at all. The accumulated unused amount carried over plan year to plan year cannot exceed $500. Additionally, the same carryover limit must apply to all plan participants. Plan documents must be amended to include the carryover provision. An FSA carryover provision and an FSA grace period cannot be offered at the same time.

**Health Plan Identifier**
The health plan identifier (HPID) is a numeric identifier assigned to payers to facilitate claims transactions. Fully insured customers would not need an HPID as we manage their claim transactions. Self-funded customers, however, need to obtain HPIDs through the Centers for Medicare and Medicaid Services. Health issuers and self-funded customers have until Nov. 5, 2014, to comply, and small plans have until Nov. 5, 2015.

**ICD-10**
Effective Oct. 1, 2014, the new ICD-10 code format will be adopted. The limited and dated ICD-9 codes often require additional documentation to accurately explain the diagnosis or procedure. ICD-10 reflects advances in medicine and current medical terminology. The new codes have an expanded format to encompass greater detail within the code and more specific information about the diagnosis. The changes are significant. Under the current ICD-9, there are 13,000 diagnosis codes; under ICD-10, there are 68,000 diagnosis codes. Under ICD-9, there are 3,000 procedure codes; under ICD-10, there are 87,000 procedure codes. ICD-9 has three to four digits; ICD-10 has seven.

With the adoption of ICD-10, members can expect more accurate payments for new procedures, fewer rejected claims, improved disease management, and harmonization of disease monitoring and reporting worldwide.

We are on track to be ICD-10 code-ready. We have engaged more than 10,000 providers across the country to share industry-informative materials as well as our transition plans.

**Individual Mandate**
Beginning Jan. 1, 2014, the ACA requires individuals who are not exempt to either maintain minimum essential coverage for themselves and any nonexempt family members or include an individual shared responsibility payment with their Federal income tax return. However, there is transitional relief offered in 2014. Employees purchasing coverage in the SHOP Exchange will not be subject to the individual shared responsibility payment if they have enrolled in the employer’s coverage by March 31, 2014. There is also transition relief ensuring that employees who are eligible to enroll in a non-calendar year employer-sponsored plan with a plan year beginning in 2013 and ending in 2014 (the 2013-2014 plan year), who did not elect coverage in 2013, will not be subject to the fines associated with the individual mandate during that plan's 2013-2014 plan year. The health insurance required must be minimum essential coverage or an individual would pay a potential penalty for noncompliance.

For this individual mandate, coverage may be obtained through government programs such as Medicare or Medicaid; employer or individual insurance market; or Exchange. If individuals do not elect coverage offered by their employer, do not have other coverage and do not meet one of the narrow exceptions, there will be a tax penalty based on an individual's income as outlined below. Please consult a tax advisor with questions.

- **2014** – $95 per uninsured person or 1 percent of household income over the filing threshold (whichever is greater)
- **2015** – $325 per uninsured person or 2 percent of household income over the filing threshold (whichever is greater)
- **2016** – and beyond, $695 per uninsured person or 2.5 percent of household income over the filing threshold (whichever is greater)
- **2017** – going forward, the penalties will be increased by the cost-of-living adjustment.

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Integrated Health Reimbursement Account (HRA)

An HRA is considered integrated with a group health plan if, under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out and waive future reimbursements from the HRA.

Mental Health Parity

The Final Rules will begin to apply on the first day of the plan year that starts on or after July 1, 2014. The rules do not mandate coverage of any mental health and substance use disorder benefits. If a plan chooses to provide coverage for mental health and substance use disorder benefits, it must do so in compliance with the rules.

Plans may define which conditions they will cover and which they will not; however, fully insured plans are also subject to state law mandates and both fully insured and self-funded plans may be subject to mandates under the ACA that include coverage of mental health and substance use disorder treatment benefits.

Provider Scope of License (Provider Non-Discrimination Provision)

Effective for plan years beginning on or after Jan. 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable state law.

- Does not require that group health plans or health insurance issuers contract with any health care provider willing to abide by their terms and conditions for participation.
- Does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.
- Similar language is included in section 1852(b)(2) of the Social Security Act and implementing HHS regulations (Medicare Advantage plans).

Removal of Pre-existing Condition Exclusions

For plan/policy years that began on or after Jan. 1, 2014, the health reform law removes any restrictions on pre-existing conditions for individuals of all ages. Therefore, coverage may not be denied for pre-existing conditions nor will individuals with pre-existing conditions be charged more. This is an update to the provision from 2010 that did not allow exclusions for children under the age of 19 with a pre-existing condition. This applies to grandfathered and non-grandfathered plans; however, grandfathered individual health plans are exempt from this requirement.

Taxes and Fees

The permanent Insurer Fee will be collected from health insurance issuers based on net written premiums. The annual fee is permanent and expected to total $8 billion in 2014 for all insurers, increasing each year to $14.3 billion in 2018, and increasing by the rate of premium growth thereafter. Based on industry analysis, the impact on premium is about 2.5 percent. The Insurer Fee will fund premium tax subsidies for low-income individuals and families who purchase health insurance through Exchanges. The fee impacts fully insured customers only.

The temporary Transitional Reinsurance Fee applies for years 2014 to 2016. The ACA imposes a fee on health insurance issuers and self-funded plans and then distributes the funds to issuers in the non-grandfathered individual market that disproportionately attract individuals at risk for high medical costs. The intent is to spread the financial risk across all health insurers to provide greater financial stability.

The fee will be assessed on a per capita basis. The health reform law specifies the total amounts of the Reinsurance Fee that must be collected for the Reinsurance Program: $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016, totaling $25 billion. States are permitted to increase these fees at their discretion. Based on industry estimates, the average projected cost is about $5 per member/per month in 2014, which then decreases each year for the subsequent two years.

The temporary Patient-Centered Outcomes Research Institute (PCORI) Fee funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services. The fee is effective 2012 to 2019 and increases from $1 to $2 per member per year for policy or plan years ending Oct. 1, 2013, through Sept. 30, 2014. The PCORI Fee is indexed to medical inflation thereafter.
Waiting Period Limits
Employers will need to offer new employees health benefit coverage no later than day 90 of their employment. The 90-day waiting period limit applies to all group health plans, fully insured and self-funded, grandfathered and non-grandfathered, for the plan year on or after Jan. 1, 2014. For employers that currently offer compliant waiting periods, no change is being made. Based on the platform on which you are enrolled, we may automatically make your waiting period compliant upon renewal. In other situations when your group is larger and/or complex, we will discuss waiting period options with you during your renewal.

Wellness Programs
The final wellness rules are effective for plan years beginning on or after Jan. 1, 2014, for grandfathered and non-grandfathered plans. The new rules essentially increase the maximum reward permissible under a health-contingent wellness program offered in connection with a group health plan from 20 percent to 30 percent of the cost of coverage and up to 50 percent for wellness programs that are designed to reduce or prevent tobacco use. The new rules also divide health-contingent wellness programs into two subcategories (activity-only programs and outcome-based programs); provide clarifications regarding the reasonable design of these programs and the reasonable alternatives that must be offered in order to avoid prohibited discrimination.

Keeping Your Grandfathered Plan
For employers who decided to “grandfather” their health benefit plan, some of the health reform changes may not apply. Grandfathering a plan means that you decided to keep the plan that you had in effect on March 23, 2010, and made no or only minimal changes as permitted by the grandfather rules. However, there are a number of changes that apply to all plans whether or not they are a grandfathered plan.

In 2014, grandfathered plans may not have to implement a number of health reform law provisions, including:
- Rating restrictions such as adjusted community rating (small group plans only)
- Providing essential health benefits (small group plans only)
- Capping deductibles and/or implementation of the ACA’s out-of-pocket limits
- Providing coverage for clinical trials

In general, plan changes that can cause loss of grandfathered status include eliminating certain benefits, increasing coinsurance, increasing fixed-dollar cost-sharing (copayments, deductibles and out-of-pocket limits) beyond allowed amounts, and the plan sponsor’s decrease in its contributions toward the cost of coverage by more than 5 percent below the contribution rate on March 23, 2010.

Employers that have chosen to maintain grandfathered status will need to satisfy the required notice and recordkeeping obligations for maintaining grandfathered status.
Questions employers may want to discuss with their tax advisor or legal counsel with the employer mandate in mind:

1. How do the plans we offer measure up to the minimum value requirements that became effective in 2014?

2. Do we offer affordable health care according to the definition in the employer mandate?

3. Should we continue to offer coverage but change what we offer to suit the ACA’s guidelines?

What’s Coming in 2015

Employer Mandate: Requirements and Penalties

Beginning in 2015, employers with 100 or more full-time employees and full-time equivalents may be subject to a penalty if they do not offer medical coverage to full-time employees that provides MEC, is affordable and meets minimum value requirements. If the employer does not offer coverage, or the coverage is deemed unaffordable and does not provide minimum value, full-time employees may obtain health insurance through an Exchange and qualify for a premium credit or subsidy. The penalty would apply if an employee applied to the Exchange and was deemed eligible for a subsidy either because the employer did not offer MEC or the coverage the employer offered did not meet minimum value or affordability requirements. While voluntary compliance with the mandate is encouraged for 2014, the penalty does not go into effect until 2015 for employers with 100 or more full-time employees and full-time equivalents, and 2016 for employers with 50-99 full-time employees and full-time equivalents. The employer mandate penalty is calculated as follows:

- **Employers not offering coverage**: For 2015, if an employer does not offer health benefits coverage or medical coverage that provides MEC to at least 70 percent of their full-time employees, and one or more full-time employee or dependent(s) qualifies for a premium tax credit or cost-sharing reduction through the Exchange, the annual penalty is $2,000 (adjusted annually after 2014) per full-time employee. When calculating the penalty, the first 80 full-time employees are subtracted from the payment calculation. This penalty is assessed per full-time employee for each month an employer does not offer coverage, or MEC, to its employees.

- **Employers offering unaffordable coverage**: If an employer offers MEC but the full-time employee’s contribution is deemed unaffordable and does not provide minimum value, full-time employees may obtain health insurance through an Exchange and qualify for a premium credit or cost-sharing reduction. The annual penalty of $3,000 (adjusted annually after 2014) per full-time employee would apply if an employee applied to the Exchange and was deemed eligible for a subsidy. This penalty is assessed per full-time employee who receives a premium tax credit or cost-sharing reduction for each month the employee qualifies for such assistance.

Small Group Plans that Kept their Coverage

Non-grandfathered small group employers that renewed their non-ACA-compliant plans in 2014 under the “Keep Your Coverage” program will need to move to an ACA-compliant plan at their 2015 renewal. In 2015, all non-grandfathered small group coverage will need to have plans that include ACR, EHB and other required market reform provisions applicable to small group plans.

For a comprehensive list of provisions beyond 2015, please visit the United for Reform Resource Center at uhc.com/reform.
Example: ABC Company is a large group, fully insured, ERISA employer. ABC’s 100 employees are covered by a non-grandfathered health plan with an April 1 renewal date. Eligible retirees of ABC Company are covered under a retiree plan. In anticipation of health reform provisions, the company developed the following approach to stay informed of health reform changes and, when necessary, communicate any changes to employees that may affect them:

<table>
<thead>
<tr>
<th>Month</th>
<th>Health Reform Mandate</th>
<th>ABC Company Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2013</td>
<td>Internal Revenue Service (IRS) guidance (2013-71) issued on Oct. 21, 2013 has created an exception to the longstanding “use-or-lose” rule associated with health flexible spending accounts (FSAs). The rule has been modified to now allow health FSAs to carryover up to $500 of unused amounts into the next plan year.</td>
<td>ABC Company must amend plan documents to include the carryover provision.</td>
</tr>
<tr>
<td>December 2013</td>
<td>The Retiree Drug subsidy paid to ABC Company is now considered taxable income.</td>
<td>ABC Company must include the Retiree Drug subsidy paid to it on its 2013 tax return.</td>
</tr>
<tr>
<td></td>
<td>As of Jan. 1, 2013, health care FSA contributions were limited to a maximum of $2,500. The limit is adjusted according to the consumer price index (CPI) starting in 2014.</td>
<td>ABC Company must update its plan documentation to reflect the changes to the FSA contribution limit.</td>
</tr>
<tr>
<td>January 2014</td>
<td>Employers who filed 250 or more W-2 Forms in the previous year are required to report to employees the cost of employer-sponsored health benefit coverage on their W-2 Forms. Companies need only share the cost of coverage for those to whom it issues a W-2 Form.</td>
<td>Because ABC Company filed 100 employee W-2 Forms, it is not required to report the cost of its health benefit coverage on employees’ 2013 W-2 Forms. <strong>Note:</strong> Employers with 250-plus employees may want to notify their employees about W-2 reporting. Once the W-2 Forms are distributed, employers may want to let employees know that the requirement is informational only and does not mean that the cost of employer-provided coverage will be subject to income tax.</td>
</tr>
<tr>
<td></td>
<td>IRS Notice 2013-54 provides guidance on the application of certain provisions of the Affordable Care Act (ACA) for health reimbursement accounts (HRAs), including HRAs integrated with a group health plan. The notice also confirms prior guidance clarifying that an employee cannot use funds from a stand-alone HRA to purchase individual health insurance on a tax-favored basis.</td>
<td>Notice applies to ABC Company for plan years beginning on and after Jan. 1, 2014.</td>
</tr>
<tr>
<td>March 2014</td>
<td>Group health plans and health insurance issuers offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable state law.</td>
<td>Applies to ABC Company (non-grandfathered group health plans and health insurance issuers) offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after Jan. 1, 2014. Requirements apply to private health insurance and not Medicare or Medicaid program plans.</td>
</tr>
<tr>
<td></td>
<td>As part of the employer mandate, ABC Company carefully evaluated its health plan and premiums and has decided to continue to offer coverage to its employees.</td>
<td>Because ABC Company’s health plan is affordably priced and offers slightly more than the essential health benefits outlined in the ACA, the company decided that it was more cost-effective to continue offering coverage instead of paying the penalties described in the employer mandate.</td>
</tr>
<tr>
<td>July 2014</td>
<td>ABC Company received written notice that its group was eligible to receive rebates as set forth by the guidelines of Medical Loss Ratio (MLR).</td>
<td>ABC Company’s insurer is required to issue a written notice to relevant group health plan subscribers about the rebate. ABC company is obligated to use the portion of the rebate attributable to the premium paid by ABC’s subscribers in a way that benefits the subscribers and is consistent with Department of Labor guidance. See <a href="http://www.dol.gov/ebsa/newsroom/tr11-04.html">http://www.dol.gov/ebsa/newsroom/tr11-04.html</a></td>
</tr>
<tr>
<td>November 2014</td>
<td>It’s open enrollment time, and ABC Company’s employees have made their health insurance plan choice for the upcoming year.</td>
<td>As required by law, ABC Company has chosen the option to issue an electronic copy (instead of a paper copy) of the summary of benefits and coverage (SBC) to all participants enrolling in the health plan following the mandated formatting guidelines.</td>
</tr>
</tbody>
</table>

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Some Things for Employers to Keep in Mind

As regulations, mandates and laws become effective over the next months and years, it’s important to know where to begin and what to focus on to be sure your business and employees are prepared. Depending on your group size, some of these changes may involve changing your processes as well as updating plan documents and materials to comply with the new regulations.

A number of taxes and fees related to the health reform law will affect employers. Several health reform fees will impact premiums and rates. Employers need to know who is responsible for submitting each fee and the effective dates.

Employers filing 250 or more W-2 Forms are required to report the cost of employees’ health benefit coverage on the employees’ W-2 Forms. The W-2 reporting requirement is informational only for the individual and does not mean that they will be taxed on these dollars.

Exchanges began open enrollment in most states on Oct. 1, 2013, and could affect how employers offer coverage to their employees in the future. Employers were required to provide all employees and new hires with information about the Exchanges. Model notices to share with employees are available on the United for Reform Resource Center (uhc.com/reform).

Small group plans with effective dates on or after Jan. 1, 2014, were automatically adjusted to be compliant with ACA requirements. Small groups were required to implement changes within the plans they offer, including:

- Expanding coverage to their employees to include Essential Health Benefits (EHB). Fully insured non-grandfathered small group employers are required to cover all EHB specified in the state EHB benchmark plan in their situs state. All annual and lifetime dollar limits will be removed from EHB.
- For non-grandfathered groups, ensuring that out-of-pocket limits do not exceed the limit as outlined by health savings accounts (HSAs). This change affects large groups as well.
- In some states, small groups or individuals may be allowed to keep their coverage if they renew by Oct. 1, 2014.

Small groups with fewer than 25 full-time employees can leverage tax credits. The Small Business Health Care Tax Credit is designed to encourage small businesses and small, tax-exempt organizations to offer health insurance coverage for their employees. A modeling tool was developed (available at uhc.com/reform) to assist employers and brokers in determining eligibility for the credit and estimating the potential credit amount. In 2014, the tax credit rate increased to 50 percent (35 percent for tax-exempt employers) and is available only to employers who enroll in a qualified health plan offered through a Small Business Health Options Program (SHOP) Exchange. Additionally, the credit for tax years beginning in 2014 or later will only be available to eligible employers for two consecutive taxable years. Always seek advice from an accountant and attorney to determine how the credit may affect your specific situation.

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We Can Help

It’s important to help your employees understand the health reform changes that affect them now. Take advantage of our online tools to communicate changes or create programs for your employees: *Healthy Mind Healthy Body*® e-newsletter, member portals, videos from the award-winning “Health Care Reform Demystified” video series and the *Ten-Minute Guide to Health Reform* available on the United for Reform Resource Center at uhc.com/reform.

Questions?

Talk with your broker or account representative, who can address your specific concerns. We’re here to help you:

- Stay updated on ongoing policy changes through our special websites dedicated to health reform news
- Find the most affordable health benefit plans
- Talk about health reform with your employees
- Refer to the United for Reform Resource Center for updates and more detailed information at uhc.com/reform.

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Modernizing Health Care

As one of the largest participants in the health care system, we know firsthand the significant challenges our nation faces in improving access to quality care and managing costs for all Americans. We are actively working across the nation with states and the federal government to support broader access to health care coverage while lowering health care costs for our customers and helping to improve delivery of care.

We’re committed to moving toward a modernized care delivery system, ensuring that changes in health care are made as effectively as possible for the health of the American people.

Please refer to the United for Reform Resource Center for updates and more detailed information at uhc.com/reform.