Other Important Information

Quality improvement programs

We have quality improvement programs that were developed to improve your health care experience. Components of the program include:

- Measuring member and provider satisfaction
- Providing data on key clinical measures to physicians and provider groups to promote evidence-based medical care
- Reporting on and improving our performance on clinical and service measures and measures of customer satisfaction
- Investigating, trending and analyzing quality of care and quality of service complaints
- Promoting public accountability through the accreditation process and reporting to governmental agencies
- Credentialing of our physician and health care professional network

We strive to make improvements in the following areas:

- Quality of care measures, such as rates of cancer screening procedures, and care to children, pregnant women and patients with chronic illnesses such as diabetes
- Member experience measures, such as satisfaction with customer service and the health plan
- Customer service measures, such as hold time or abandonment rate
- Operational measures, such as timeliness in resolving appeals

You may request more information about our quality improvement program by calling us at the toll-free phone number on your health plan ID card.

How to make your health care safer

We want to help you find the safest health care possible. Poor quality can lead to higher complication and surgical repeat rates, unnecessary hospitalizations, and a higher chance of wrong diagnosis. That's why we develop innovative tools such as the UnitedHealth Premium® designation program. We believe that by supporting and promoting doctors who meet national standards for quality and local benchmarks for cost efficiency, as well as engaging consumers in the health care decision-making process, we can help achieve better health outcomes while improving the experience and reducing costs.[9]

[9]The UnitedHealth Premium® program is a resource for informational purposes only. Designations are displayed in online provider directory tool of your member website, such as oxfordhealth.com or myuhc.com. You should always visit your member website for the most current information. **Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician.** Please visit your member website, such as oxfordhealth.com or myuhc.com, for detailed program information and methodologies.

You can find a doctor's Premium designation within the provider search feature of your member website. For more information about why choosing a quality doctor and hospital is important, visit **unitedhealthpremium.com**.

We also provide hospital safety information from an organization called The Leapfrog Group®. The Leapfrog Group is a nationally recognized organization of health care purchasers that focus on improvements in patient safety, quality, affordability and transparency of health care. The Leapfrog Group evaluates hospitals based on their self-reported adherence to patient safety and quality measures. For more information about The Leapfrog Group, visit leapfroggroup.org.

The Leapfrog Group assigns letter grades (A, B, C, D, and F) to hospitals based on their overall performance in keeping patients safe from preventable harm and medical errors. The grades are derived from expert analysis of publicly available data using national evidence-based measures of hospital safety. To find more information or download the free Hospital Safety Score mobile application (app), visit www.hospitalsafetygrade.org.

Advance directives

Many people choose to put their health care preferences in writing while they are still able to make such decisions. An advance directive, also known as a "living will," is a document that states the kinds of health care treatment you wish to receive in the event you cannot speak for yourself. A health care proxy is a document that allows you to name a health care agent— someone you trust to make health care decisions for you if you are unable to make or communicate decisions yourself. Both documents should be considered regardless of age or medical condition. Be sure to discuss your advance directives with your physicians, family, friends, health care agent and religious advisors so your wishes are understood. These documents are optional and have no effect on your health coverage.

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, benefits are provided for mastectomy and for the following covered health services, as you determine appropriate with your attending physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such covered health services (including copayments, coinsurance and any annual deductible) and the benefit coverage limitations are the same as are required for any other covered health service as described in your COC or SPD.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification (sometimes referred to as preauthorization). For information on precertification, please call us at the toll-free phone number on your health plan ID card.

Why the last weeks of pregnancy count

You may not have a choice about when to have your baby. If there are problems with your pregnancy or your baby's health, you may need to deliver your baby early. But if you have no medical problems and you're planning to schedule your baby's birth, you should wait until the thirty-ninth completed week of your pregnancy. Births scheduled before the thirty-ninth completed week of pregnancy for non-medical reasons can cause problems for both mothers and babies. For babies, this time is also vital in the development of their brain and lungs.

For more information about why the last few weeks of pregnancy are so important to you and your baby, along with additional resources and tools, visit our Health Library at https://healthlibrary.uhc.com/content/healthlibrary/uhc/hl/womens-health/healthy_pregnancy/resources.html. To find information on how often your hospital schedules early cesarean sections and inductions as reported in The Leapfrog Group annual hospital survey statistics, visit https://ratings.leapfroggroup.org/.

Evaluation of new medical technology

Our Medical Technology Assessment Committee evaluates the strength of clinical evidence supporting the use of new and existing health services. Conclusions of this Committee help to determine whether new medical technology and health services will be covered. The Medical Technology Assessment Committee includes medical directors with diverse specialties and subspecialties from throughout UnitedHealth Group and its affiliated companies, guest subject matter experts when required, and staff from various relevant areas within UnitedHealth Group. To assist us in making informed coverage decisions, the Committee meets at least 10 times a year to review published clinical evidence, information from government regulatory agencies, and nationally accepted clinical position statements regarding new and existing medical technologies and treatments.

Financial incentives

We want you to know that the staff, physicians and other health care professionals who make decisions on the health care services you receive do so based on the contract your employer has with us.

- The decisions are made based on the appropriateness of care and service, and existence of coverage.
- The staff of UnitedHealthcare, its delegates, and the physicians and other health care professionals making these decisions are not specifically rewarded for issuing noncoverage decisions.
- UnitedHealthcare and its delegates do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services.