

VALUEOPTIONS OF CALIFORNIA, INC. (“*ValueOptions*”)  
340 Golden Shore  
Long Beach, California 90802

**STANFORD UNIVERSITY’S VADEN STUDENT HEALTH SERVICE**

**CARDINAL CARE PLAN**

Clinical Referral Line: **1-800-667-7374**

Member Services: **1-800-667-7374**

**COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM**

Dear Cardinal Care Member:

*ValueOptions* of California, Inc. (“*ValueOptions*” or “Health Plan”) has agreed with Stanford University to arrange for the covered mental health and substance abuse services described in this Combined Evidence of Coverage and Disclosure Form (or “EOC”) to be provided to you, pursuant to a Subscriber Group Agreement between *ValueOptions* and Stanford University’s Vaden Student Health Service. This Plan includes coverage for the Medically Necessary treatment of Severe Mental Illness (“SMI”) for adults and children, and for Serious Emotional Disturbances (“SED”) of children. **Pursuant to California law, you have the right to view this EOC prior to enrollment in the *ValueOptions* Health Plan. This Combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage and is only a summary of the terms of the *ValueOptions* Health Plan. The Vaden Student Health Service Subscriber Group Agreement must be consulted to determine the exact terms and conditions of your coverage.** A copy of the Subscriber Group Agreement will be furnished to you upon request. If you require additional information about benefits, please call the Member Services telephone number listed above.

For clarity, this booklet refers to the Student as the “Subscriber,” or “Member”.

The goal of the *ValueOptions* Health Plan is to provide all Members with the most effective, efficient and convenient mental health treatment.

Please read the following information completely and carefully to make certain you understand the rules and procedures of the *ValueOptions* Health Plan so that you can get the most from your benefits. If you have special health care needs, you should carefully read the sections that apply to you. In particular, please remember that you must always use the Vaden Student Health Service Counseling and Psychology Services (“CAPS”) or *ValueOptions* Clinical Referral Line to obtain access to care, except in certain emergencies. This booklet will help you familiarize yourself with the services and requirements of the Health Plan.

After you have read this booklet, keep it in a convenient place so that you may refer to it whenever you have a question about your coverage. If you have additional questions, do not hesitate to contact a *ValueOptions* Member Services Representative at the number listed above.

We look forward to serving you.

Sincerely,

*ValueOptions* of California, Inc.

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## INTRODUCTION

In order to provide for the mental health needs of Stanford Students, Stanford University Vaden Student Health Service has contracted with *ValueOptions* of California, Inc. to provide you with 24 hour accessible, high quality mental health and substance abuse care and services.

*ValueOptions* is a California-based company specializing in the management and administration of mental health and substance abuse care. The Health Plan will provide you with a single source for all the necessary components of a comprehensive mental health and substance abuse program including:

- o Claims Payment
- o Member Services and Communication Materials
- o 24-Hour Referral Line to Access Care
- o Contracting Panel of Participating Providers

*ValueOptions'* panel of Participating Providers consists of a wide spectrum of private practitioners, facilities, and programs to meet your specific mental health and substance abuse treatment needs, and are conveniently located throughout the Service Area.

Vaden Student Health Service's Counseling and Psychological Services (CAPS) is the primary Mental Health provider for Stanford Students, and a member of *ValueOptions'* Participating Provider panel for Students enrolled in the Health Plan. CAPS provides personal, couples and group psychological counseling for all Stanford students. It offers evaluations and brief counseling without charge. A CAPS on-call clinician may be contacted for urgent situations at any time, or for a referral for services available through the Health Plan.

We look forward to providing you with the most effective, efficient and convenient mental health and substance abuse care. To help us do so, please take a few more minutes to read the information in this booklet. There are directions and procedures that you should understand and follow in order to reap the benefits of the Health Plan.

REMEMBER ... Only care that is:

- o Obtained by referral through the CAPS or the *ValueOptions* Clinical Referral Line; and
- o Provided by *ValueOptions* Participating Providers; and
- o Approved by *ValueOptions*; and
- o Included in the Health Plan's list of Covered Services

will be covered by the Health Plan. Special provisions that apply in the event of an emergency are described on page 9 of this booklet.

If you have questions, always feel free to contact a *ValueOptions* Member Services Representative at the telephone number listed in the front of this booklet.

## FEATURES OF THE HEALTH PLAN

- o NO DEDUCTIBLES: There are no deductibles for you to keep track of or pay.
- o COPAYMENTS: There are nominal Copayments that you will be required to pay in connection with some services. Copayments are paid to the Participating Provider when you receive services. The Benefits and Coverage Insert of this booklet will provide you with further details about Copayments.
- o MINIMUM PAPERWORK: The *ValueOptions* Participating Provider's office staff will handle the paperwork associated with your care. The office staff may collect some personal information from you and you may need to sign a completed claim form for them to release information and receive payment.
- o CLINICAL REFERRAL LINE: Because *ValueOptions*' panel of Participating Providers is constantly growing and changing, directories of providers are not published and distributed to Members. Instead, *ValueOptions* has set up a 24-hour, 7-day a week toll-free telephone referral line called the Clinical Referral Line. Unless you are currently under the care of a Participating Provider, or if you require emergency care, you must call the Clinical Referral Line in order to obtain care, even if you have been treated by a Participating Provider in the past.
- o ROUTINE CARE: When on campus, or whenever possible, you should call CAPS for evaluation and brief counseling without charge. Alternatively, you may call the Clinical Referral Line to obtain a referral for routine care. A *ValueOptions* Member Services Representative will give you the names and telephone numbers of a number of Participating Providers with offices convenient to your home or campus location. You can contact any of these providers for an appointment.
- o EMERGENCY CARE: If you believe that your medical condition requires emergency care, you should get care immediately by going to the nearest hospital emergency room or calling 911. There is no need to contact the *ValueOptions* Clinical Referral Line prior to receiving such care. However, should you need additional care or services following stabilization of the Emergency Medical or Behavioral Condition, including admission to the hospital or other facility, you, your doctor, the hospital staff or a family member must contact the *ValueOptions* Clinical Referral Line at **1-800-667-7374** within 48 hours or as soon as reasonably possible (see page 9).
- o PARTICIPATING PROVIDERS: *ValueOptions*' Participating Providers have agreed to provide Covered Services to Members in accordance with the terms of the Health Plan. Except in limited circumstances, all Covered Services must be obtained by Participating Providers in order to be covered by the Health Plan. Each Participating Provider has been trained so that he or she will be familiar with the Health Plan's benefits and requirements. Each Participating Provider's contract with *ValueOptions* specifically prohibits the provider from billing you for any charges for Covered Services that are not paid by *ValueOptions*, except for appropriate Copayments.

- o **MEMBERSHIP CARD:** Each Member will receive a Cardinal Care Plan Membership Card. This Card must be shown to the *ValueOptions* Participating Provider each time you receive services. The Card will contain information concerning copayments, as well as the toll-free telephone number to reach *ValueOptions*.

## SECOND OPINION

*ValueOptions* maintains a Second Opinion Policy relating to Covered Services. This Policy entitles you to coverage for a Second Opinion if you question or have concerns regarding a diagnosis, a treatment plan, and/or a Covered Service to be rendered by a Participating Provider to you. *ValueOptions* will approve all such requests whenever the Member continues to be eligible for benefit coverage. Members can request a Second Opinion by calling the *ValueOptions* Member Service number set forth herein and asking to speak with a Clinical Care Manager. The Clinical Care Manager will discuss the situation with you and provide names of appropriately qualified Participating Providers from whom you may obtain the Second Opinion. If the Member has a serious or imminent threat to their health, the Clinical Care Manager will expedite the review of the second opinion request. If the request is approved, a second opinion will be arranged as quickly as possible based on the urgency of the Member's condition but no later than within 72 hours of the request, whenever possible.

The Clinical Care Manager shall assist the Member in selecting a Participating Provider who is located within a reasonable distance of the Member, who is qualified to review the diagnosis, treatment plan, or Covered Service and offer a professional Second Opinion. A referral to a non-participating provider may be authorized only in the event that a Participating Provider with the appropriate qualifications to provide the Second Opinion is not reasonably available. The Clinical Care Manager shall also assist the Member in scheduling an appointment with the Provider in a time and manner appropriate for the nature of the Member's condition. The Member shall be responsible for any applicable co-payments.

If the Second Opinion does not confirm the diagnosis, treatment plan, or the appropriateness of a Covered Service, a *ValueOptions* Clinical Care Manager, the *ValueOptions* Medical Director or licensed clinician under the supervision of the Medical Director ("Peer Advisor") will be available to assist the Member in decisions regarding treatment, at the request of the Member or Participating Provider.

To obtain a copy or more information about *ValueOptions* Second Opinion Policy and timelines for reviewing second opinion requests, contact the Member Service Department at the toll-free number and address listed at the front of this EOC.

**PRINCIPAL BENEFITS AND COVERAGES**  
**COVERED SERVICES**

Members are entitled to receive the Covered Services described in this Section and in the Benefits and Coverage Insert to this booklet. Services and benefits will be Covered Services only if, in the judgment of your attending Participating Provider and *ValueOptions*' Medical Director, services and benefits are Medically Necessary for the prevention, diagnosis or treatment of your Mental Disorder or Substance Abuse Condition. In addition, coverage is subject to all of the requirements and Exclusions and Limitations described in this booklet. If you have not received a copy of the Insert or have any questions, please call the *ValueOptions* Member Services department at the toll-free telephone number listed at the front of this booklet.

**A. OUTPATIENT SERVICES:**

Outpatient mental health and substance abuse care for Crisis Intervention, short-term evaluation and therapy, longer term specialized therapy, and rehabilitation, as described in the Benefits and Coverage Insert.

Outpatient mental health services for the Medically Necessary treatment of Severe Mental Illnesses ("SMI") for adults and children and Serious Emotional Disturbances ("SED") of children.

Limitations and maximum benefits are described in the Section of this booklet entitled "Exclusions and Limitations" and in the Benefits and Coverage Insert.

**REMEMBER:**

- o Covered Services must be obtained by receiving a referral through CAPS or the *ValueOptions* Clinical Referral Line and must be provided by a Participating Provider.

**B. INPATIENT/ALTERNATE CARE SERVICES:**

Inpatient mental health and substance abuse care, and Alternate Care, for Crisis Intervention, specialized therapy and rehabilitation, as described in the Benefits and Coverage Insert, including:

- o Room and board, including routine psychiatric nursing care; and
- o Professional services by an attending physician who is either a *ValueOptions* Participating Provider or is authorized in advance by *ValueOptions* to provide those services; and
- o Other Medically Necessary care, not excluded or limited as described in this booklet, as are prescribed by the attending or consulting physician.

- o Inpatient mental health services and Alternate Care for the Medically Necessary treatment of Severe Mental Illnesses (“SMI”) and Serious Emotional Disturbances (“SED”) of children.

**REMEMBER:**

- o Inpatient and Alternate Care must be obtained by receiving a referral through CAPS or the *ValueOptions* Clinical Referral Line and provided by a Participating Provider in a hospital or other facility that is approved in advance by *ValueOptions*.

**C. OUT OF PLAN SERVICES:**

Out Of Plan Services are those services provided by non-Participating Providers, and are Covered Services only as follows:

- o For Medically Necessary Emergency Services (see page 9); or
- o Upon prior authorization by *ValueOptions*.

**D. OUT OF AREA SERVICES:**

Covered Services which are rendered outside the Service Area by a Provider accessed through the *ValueOptions* Clinical Referral Line will be covered under the Wellington Life Insurance Company policy. This is a separate policy between Stanford University and Wellington Life Insurance Company, which is administered by *ValueOptions* of California, Inc. Please refer to the Wellington Life Insurance Company Certificate of Coverage for a description of out of area benefits.

## EXCLUSIONS AND LIMITATIONS

The following services, treatments and supplies listed below are not Covered Services. These exclusions include:

Treatment of congenital and/or organic disorders, including, but not limited to, Organic Brain Disease and Alzheimer's disease; except for the acute behavioral manifestations of such disorders;

Treatment of mental retardation, other than the initial diagnosis thereof;

Private hospital rooms and/or private duty nursing, unless determined to be medically necessary and authorized by *ValueOptions*;

Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or education therapy for learning disabilities or other education services;

Treatment of obesity or weight reduction or for the cessation of smoking, including supplies;

All prescription or non-prescription drugs, except for drugs prescribed by a Participating Provider in the course of a Member's treatment as an inpatient;

Services, treatment, or supplies provided in a non-emergency by a provider that is not a Participating Provider;

Services, treatment or supplies provided without prior authorization as described in this booklet, except in the event a Member requires Emergency Services (see page 9);

Damage or other harm to a Participating Provider caused by a Member (the Member shall be solely responsible for all such damage or harm);

Services, treatment or supplies provided as a result of any Worker's Compensation or similar law, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof (exclusive of Medi-Cal) or caused by the conduct or omission of a third-party for which the Member has a claim for damages or relief, unless the Member provides *ValueOptions* with a lien against such claim for damages or relief in a form and manner satisfactory to *ValueOptions* (see page 16);

Services, treatment, or supplies for military services and other disability;

Psychological examinations, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for purposes of judicial or administrative proceedings (including but not limited to parole or probation proceedings);

Other psychological testing, except when conducted in the course of the diagnosis of a Mental Health or Substance Abuse Condition;

Marriage counseling, except for the treatment of a Mental Health or Substance Abuse Condition;

Sex therapy or treatment for sexual deviance, except for the treatment of a Mental Health Condition;

Treatment of pain, except by means of psychotherapy or counseling, when Medically Necessary for treatment of a Mental Health Condition;

Diagnosis and treatment for personal growth and/or development or in conjunction with professional certification;

Aversion therapy; and

Services, treatment, or supplies rendered to a Member which are not Medically Necessary, including but not limited to services, treatment, or supplies primarily for rest, custodial, domiciliary or convalescent care.

## EMERGENCY SERVICES

Emergency Services and Care are those Covered Services provided to treat an Emergency Medical or Behavioral Condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the persons or others in serious jeopardy; or (2) serious impairment to such person's bodily functions; or (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

For unexpected illnesses, unless it is an emergency, you must call CAPS or the *ValueOptions* Clinical Referral Line. A representative is available 24-hours a day, 7-days a week to coordinate your care with the appropriate provider.

If you believe that your medical condition is an emergency, you should get care immediately by going to the nearest hospital emergency room or calling 911. There is no need to contact CAPS or the *ValueOptions* Clinical Referral Line prior to receiving such emergency care. However, should you need additional care or services following Stabilization of the Emergency Medical or Behavioral Condition or be admitted to the hospital or other facility following Emergency Services and Care, you, your doctor, the hospital staff or a family member must contact the *ValueOptions* Clinical Referral Line at **1-800-667-7374** within 48 hours. If a Member's medical incapacity reasonably prevents notification to the Clinical Referral Line within forty-eight hours, the Member must notify the *ValueOptions* Clinical Referral Line within a reasonable period of time thereafter in order for the post Stabilization Services to be considered as Covered Services.

All Emergency Services and Care provided prior to notifying the Clinical Referral Line will be reviewed by *ValueOptions'* Medical Director. If the Medical Director determines that the situation at issue was an emergency meeting the above definition, subject to the other provisions regarding Cancellation and Termination of Coverage set forth in this EOC, the Plan will cover the cost of Covered Services and ambulance transport of the Member. If the Medical Director determines that those services were rendered in a situation that was not an emergency and do not meet the guidelines described in this section, the Member shall be liable to pay the entire cost of those services.

Emergency Services and Care rendered by non-participating providers within or outside the Service Area are Covered Services when, in the judgment of the Medical Director, those Emergency Services were Medically Necessary and meet the guidelines described in this section. Members requiring additional Medically Necessary services after Stabilization of the emergency condition will be transferred to the Service Area under the care of the appropriate Participating Provider whenever it is medically appropriate. *ValueOptions* will pay for reasonable transportation charges associated with the transfer back to the Service Area.

A transfer back to the Health Plan's Service Area may not be required, in circumstances where the Member is temporarily (e.g. school breaks, off-campus study programs, etc.) residing

outside of the Health Plan's Service Area and needs post Stabilization services following Emergency Services and Care. Covered Services which are rendered outside the Service Area by a Provider accessed through the *ValueOptions* Clinical Referral Line will be covered under the Wellington Life Insurance Company policy. Please refer to the Wellington Life Insurance Company Certificate of Coverage for a description of out of area benefits.

## **TREATMENT REVIEW PROCESS**

The clinical philosophy at *ValueOptions* is to provide a care management system that offers easy and immediate access to the most appropriate, quality mental health and/or substance abuse services for Members, and a utilization management system that supports providers in delivering clinically necessary and effective care with minimal administrative barriers. *ValueOptions'* Utilization Management Program includes policies and procedures for the review and management of all levels of care. Treatment requests are reviewed utilizing professionally recognized standards of practice and clinical protocols.

The clinical criteria used by *ValueOptions* to make admission, level of care, and continuing treatment decisions reflects *ValueOptions* philosophy and clinical values. Sources for various criteria include, but are not limited to, the American Psychiatric Association Manual for Peer Review, the Diagnostic and Statistical Manual IV, American Accreditation HealthCare Commission/URAC Standards, American Society of Addiction Medicine standards, Health Management Strategies International, and discussions with outside senior consultants in the field.

Members may access a description of *ValueOptions'* Utilization Management processes, procedures, and clinical review criteria, through the *ValueOptions* Internet site at [www.valueoptions.com](http://www.valueoptions.com). Or, the information may be requested by calling or writing the Member Services Department at the telephone number and address listed in the front of this EOC.

## **REFUSAL TO ACCEPT TREATMENT**

Certain Members may refuse to accept or follow procedures or treatment recommended or prescribed by a Participating Provider. Participating Providers and *ValueOptions*' Medical Director may regard such refusal to accept recommendations as noncompliance with proper health care and as incompatible with the continuance of the provider-patient relationship. If the Participating Provider and *ValueOptions*' Medical Director cannot determine a medically and professionally appropriate alternative procedure that is acceptable to the Member, *ValueOptions* shall promptly give the Member written notice of that fact. If the Member thereafter refuses to accept the recommended or prescribed procedures or treatment, then neither *ValueOptions* or any of its employee or agents, nor the Participating Provider or any other Participating Provider, shall have any further responsibility to provide care for the condition under treatment.

## **SERVICE AREA**

*ValueOptions'* Service Area is the geographical area for which *ValueOptions* is licensed to operate the Health Plan. The Service Area is specifically described in the Service Area Insert to the booklet. Services outside the Service Area provided by the Provider accessed through the *ValueOptions* Clinical Referral Line will be covered under the Stanford University Wellington Life Insurance Company mental health and substance abuse Policy.

## **LIABILITY OF MEMBERS FOR PAYMENT**

- o Other Charges; Copayments: Members are responsible for making Copayments to Participating Providers at the time services are rendered. The Copayments applicable under your Benefits Plan are listed in the Benefits and Coverage Insert. Copayments are subject to change from time to time upon 30 days written notice to Vaden Student Health Service, and Vaden Student Health Service will notify you of changes in Copayments. Failure to pay Copayments can result in the termination of a Members' coverage under the Health Plan.
  
- o Choice of Providers: Except in emergencies (see page 9), all Covered Services must be provided by Participating Providers upon prior authorization obtained by calling the *ValueOptions* Clinical Referral Line. If a Member obtains mental health or substance abuse services from a non-Participating Provider without *ValueOptions*' express authorization in advance, the Member will be liable to pay the full amount of the provider's charges for those services.
  
- o *ValueOptions*' Obligation to Pay: As is required by California law, every Participating Provider has agreed that Members will not be liable to pay the provider if *ValueOptions* fails to pay for amounts that *ValueOptions* owes the provider for rendering Covered Services.

## **REIMBURSEMENT PROVISIONS**

- o Care by Non-Participating Providers: Therapists and facilities that are not Participating Providers may require full and immediate payment for services. If you receive Emergency Services in accordance with the requirements described on page 9, or if you receive other Covered Services from a non-Participating Provider with *ValueOptions*' specific approval in advance, you should submit a claim to *ValueOptions* for reimbursement. Alternatively, the non-Participating Provider may bill *ValueOptions* directly. Claims can be submitted on any standard health insurance claim form or bill or by a letter. The following information must be included:
  - o Member's name, address and unique student ID number.
  - o Name and address of the non-Participating Provider, and the Provider's federal tax identification number.
  - o Date, procedure code and amount billed for each separate service.
  - o Mental health diagnosis code.

The claim should be sent to *ValueOptions*' Claims Processing Unit within 90 days of the first date of service described on the claim. Any claims submitted after one year from the date of services will not be paid.

If *ValueOptions* denies payment of a claim, the Member will receive a written notice of the decision and the reason for denial. The Member may request reconsideration of a denied claim in accordance with *ValueOptions*' Grievance Procedures (see page 17).

## **COORDINATION OF BENEFITS**

The benefits provided pursuant by the Health Plan are subject to coordination and may be reduced if there is another group health plan providing similar benefits to a Member so that the benefits and services received from all group coverages shall not exceed 100% of the Covered Services provided by the Health Plan. If a Member is covered by both *ValueOptions* and another carrier or plan, *ValueOptions* shall determine which coverage shall be considered as “primary” and which shall be considered “secondary” for purposes of payment, using the rules set forth in *ValueOptions*’ agreement with Vaden Student Health Service.

## **THIRD PARTY LIABILITY**

The benefits and coverages provided by the Health Plan are not intended to duplicate any coverage or other right to reimbursement or payment available to a Member from any other source. *ValueOptions* may provide or arrange for the provision of Covered Services for which a Member has other coverage or such a right to reimbursement or payment, but *ValueOptions* reserves the right to reimbursement, and to perfect a lien to enforce that right, for the value of those Covered Services provided to the Member. *ValueOptions*’ right to reimbursement applies to all monetary recoveries that a Member receives or is entitled to receive from any source, including another person or the Member’s or another person’s insurance or workers’ compensation carrier.

Members are required to furnish all necessary information related to third party claims to *ValueOptions* promptly upon request. In addition, Members are required to sign and deliver to *ValueOptions* all documents reasonably requested to enable *ValueOptions* to obtain the reimbursement or payment to which *ValueOptions* is entitled.

*ValueOptions*’ rights to reimbursement applies to the full amount of any monetary recovery that a Member receives, even if that recovery, whether obtained by judgment, award, settlement or other means, (i) is less than the total amount of the Member’s alleged damages, (ii) does not specify a monetary amount for medical or mental health expenses or (iii) specifies that all or part of the recovery is for damages other than medical or mental health expenses.

## GRIEVANCE PROCEDURES

**Telephone Inquiries:** If a Member has a question or complaint regarding eligibility, coverage, a denial of benefits or any other matter to the Health Plan, he or she may telephone *ValueOptions'* Member Services Department. *ValueOptions'* address and telephone number are listed on the inside cover of this EOC. The Member Services staff will work with the Member to resolve the matter.

**Grievances:** *ValueOptions* has a grievance and appeal procedure. If the telephone inquiry does not resolve the question or complaint to the Member's satisfaction, he or she may submit a grievance to *ValueOptions* in writing, in person or by telephone. *ValueOptions* will mail a grievance form for this purpose, and a copy of *ValueOptions'* Grievance Procedure, to the Member upon request. If the Member wishes, *ValueOptions'* Member Services staff will assist in completing the grievance form. Completed grievance forms must be mailed or delivered to *ValueOptions* at **P.O. Box 6065, Cypress, CA 90630**. *ValueOptions* will acknowledge receipt of a written grievance within five days.

*ValueOptions* will respond in writing to a grievance within thirty (30) days. However, in some cases, *ValueOptions* may not be able to answer the grievance within the thirty days because additional time is needed to resolve or research the issues presented. In those cases, the Member will be notified of the reason for the delay within the initial thirty (30) day period. If the grievance response does not resolve the question or complaint to the Member's satisfaction, the Member may submit the matter for a Level I grievance review by a *ValueOptions* staff member who did not handle the initial determination.

If the level I grievance response does not resolve the question or complaint to the Member's satisfaction, he or she may submit the matter for review by a Level II grievance or appeal Committee. The Committee is composed of individuals not involved in the initial determination or level I grievance/appeal cases. The Member has the right to appear before this Committee, or, if the Member cannot appear in person, the Member has the opportunity to communicate with the panel telephonically.

**Expedited Grievances and Appeals:** If a requested service has been denied, you have the right to an expedited review for cases involving an imminent and serious threat to the health of the Member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by you or by your provider. Call the Member Services Department at the number in the front of this EOC and tell the representative that a requested service has been denied and you are asking for an expedited appeal. You may expect a decision in no more than 72 hours. A written confirmation of the decision will be issued to you.

Subsequent to the submission of a claim to the grievance procedure, if the Member is not satisfied by *ValueOptions'* response to a grievance, he or she may request arbitration of the matter. A request for arbitration must be made in writing to *ValueOptions* within thirty (30) days after *ValueOptions'* response to the grievance. The procedure for initiating arbitration is described in more detail below.

The **California Department of Managed Health Care** is responsible for regulating health care service plans. The Department's Health Plan Division has a toll-free telephone number (**1-800-400-0815**) to receive complaints regarding health plans. The hearing and/or speech impaired may use the California Relay Service's toll-free telephone numbers, **1-800-735-2929 (TTY)** or **1-888-877-5378 (TTY)**, to contact the Department. The Department's Internet website (<http://www.corp.ca.gov>) has complaint forms and instructions online. If you have a grievance against the health plan, you should first telephone a Member Services Representative at **1-800-667-7374** and use the plan's grievance process before contacting the Health Plan Division. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the Health Plan Division's toll-free telephone number for assistance. The plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you and your failure to use these processes does not preclude your use of any other remedy provided by law.

### ARBITRATION

Any claim arising under the Group Subscriber Agreement must be submitted to binding arbitration following an attempt at resolution through the *ValueOptions'* Grievance Procedure, if the claim is for monetary damages that exceed the jurisdictional limits of the Small Claims Court. Either the Member, Cowell Student Health Service or *ValueOptions* may commence arbitration by serving a demand for arbitration on the other. Arbitration will be conducted under the commercial rules of the American Arbitration Association ("AAA") then in effect, using a mutually selected attorney arbitrator. If the parties are unable to select a neutral arbitrator within thirty (30) days after service of a written demand requesting the designation, then a court of competent jurisdiction, on petition of a party to the arbitration, shall appoint the arbitrator as follows:

When a petition is made to the court to appoint a neutral arbitrator, the court shall nominate five (5) persons from lists of persons supplied by the American Arbitration Association. The parties seeking arbitration and against whom arbitration is sought may within five (5) days of receipt of notice of such nominees from the court jointly select the arbitrator whether or not such arbitrator is among the nominees. If such parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

The cost of the arbitration shall be divided equally between the parties. In cases of extreme hardship, *ValueOptions* shall assume all or a portion of a Member's share of the fees and expenses of the neutral arbitrator. Upon request, *ValueOptions* shall provide a Member with an application for relief from such fees and expenses. Approval or denial of the application shall be determined by a neutral arbitrator who is not assigned to hear the underlying dispute, who has been selected pursuant to the paragraph immediately above, and whose fees and expenses are paid for by *ValueOptions*. The arbitrator's award may be enforced in any court having jurisdiction thereof by the filing of a petition to enforce the award. Costs of filing such a petition may be recovered by the party filing the petition.

## **ELIGIBILITY AND PREPAYMENT FEES**

If you meet Vaden Student Health Service's criteria for participation in the *ValueOptions* Health Plan, Vaden Student Health Service will include you in its quarterly eligibility lists to *ValueOptions*. You may ask Vaden Student Health Service to provide a description of these eligibility criteria to you. Vaden Student Health Service is responsible for payment of the quarterly premiums required for your coverage. Vaden Student Health Service will notify you when you are required to pay the premium for your coverage.

For a person who enrolls for the Fall quarter on or before the first day of class, coverage begins on the Plan's effective date. For a person who enrolls subsequent to the effective date, coverage begins on the first day of the academic quarter for which the student is enrolled.

If your *ValueOptions* membership was terminated for a reason specified in the "Termination of Coverage" section of this booklet, you will not be eligible to re-enroll.

If a Member is confined in a hospital or other facility on the date that coverage by the Health Plan would begin, coverage will not begin until the end of that confinement, unless the Member agrees to come under the care of the Health Plan. *ValueOptions* may elect to transfer the Member to a hospital or other facility that is a Participating Provider when it is medically appropriate to do so.

## **AMENDMENT AND RENEWAL PROVISIONS**

The Group Service Agreement may be amended and/or renewed at any time by mutual agreement by *ValueOptions* and Vaden Student Health Service.

## CANCELLATION AND TERMINATION OF COVERAGE

Vaden Student Health Service is required to give you written notice of any termination of the Group Service Agreement. Except as described below, all of your coverage terminates upon any termination, cancellation or expiration of the Agreement.

Subject to and in accordance with the Health Plan's Grievance Procedures, *ValueOptions* may terminate the coverage of any Member immediately upon written notice if such Member:

- o makes repeated and unreasonable demands for services which are not Medically Necessary Covered Services;
- o threatens the life or well-being of a Participating Provider or its personnel, or of another Member;
- o otherwise acts in such a disruptive manner as to prevent the orderly operations of the Health Plan;
- o fails to pay any Copayment or other amount due to *ValueOptions* or Participating Provider within thirty-one (31) days after notice of the amounts due;
- o knowingly furnishes fraudulent or deceptive enrollment information to Vaden Student Health Service or *ValueOptions* (enrollment information includes, but is not limited to, a Member's date of birth).
- o permits the use of his or her or any other Member's identification card by another person, or uses another person's card, the card will be retained by *ValueOptions*, and the coverage of the Subscriber may be terminated effective immediately upon written notice.

California law provides that any Member who alleges that enrollment in the Health Plan has been canceled or not renewed because of the Member's health status or requirements for health care services may request a review of the cancellation or nonrenewal of enrollment by the California Director of the Department of Managed Health Care.

If a Member is totally disabled on the date of any termination of the Group Agreement and at that time is under the treatment of a Participating Provider, *ValueOptions* shall extend the benefits and services provided, subject to all of the exclusions and restrictions described in this booklet, to the extent that such services relate directly to the condition causing the total disability, and for no other condition, illness or injury. Such extended benefits will be provided until the first of the following occurs:

- o the end of a maximum period of 12 consecutive months; or
- o the provision by the Health Plan of the maximum amount of benefits available; or
- o the end of the total disability; or
- o the commencement of coverage, without limitation as to the disabling condition, under any other health plan or agreement.

## CONTINUATION OF CARE

*ValueOptions* shall, at the request of a Member, arrange for the continuation of Covered Services rendered to a Member who is undergoing a course of treatment from a Terminated Provider for an Acute Condition or a Serious Chronic Condition at the time such provider's status becomes that of a Terminated Provider. *ValueOptions* shall provide such continuation of care for up to 90 days or a longer period, if necessary, for a safe transfer to another provider as determined by *ValueOptions* in consultation with the Terminated Provider, consistent with good professional practice. You may request continuity of care by contacting a *ValueOptions* Members Services Representative at the number listed on the first page of this EOC.

## **PUBLIC POLICY**

*ValueOptions* appoints up to three persons who represent enrolled groups to its Public Policy Committee to participate in establishing public policy for the Health Plan. If you are interested in being appointed to the committee, write to the **Public Policy Committee, ValueOptions, P.O. Box 6065, Cypress, CA 90630.**

## DEFINITIONS

- Acute Condition:** A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.
- Alternate Care:** A structured program, including diagnostic, therapeutic and medical treatment, whereby the patient does not require full-time hospitalization but does require more intensive care than can be provided by traditional outpatient treatment.
- ValueOptions:** *ValueOptions* of California, Inc., a California corporation specializing in the management and administration of mental health and substance abuse care.
- Benefit Plan:** The particular benefits package selected pursuant to the Group Subscriber Agreement between Vaden Student Health Service and *ValueOptions*. The coverage and copayments which apply to you are described in the Benefits and Coverage Insert. If you have questions about your benefits, call *ValueOptions*' Member Services Department.
- Clinical Referral Line:** *ValueOptions*' 24-hour, toll-free telephone line through which Members obtain access to treatment by Participating Providers.
- Coordination of Benefits:** The act of coordinating with other group health care insurance, hospital or health service plan, labor-management trustee plan, employee organization plan, or group coverage sponsored by or provided through a school or education institution, providing in whole or in part, mental health services or benefits, or that the total of all expenses paid for covered services under such group coverages will not exceed 100% of the expenses incurred for those covered services and benefits during any benefit period.
- Copayments:** Those amounts to be paid by Members to Participating Providers for the provision of Covered Services.
- Covered Services:** Mental health and substance abuse services as described in the Benefits and Coverage Insert.
- Crisis Intervention:** Treatment directed toward alleviation of an acute mental health or substance abuse condition by short-term intensive therapy to reduce impairment or disability.

**Emergency Medical  
Or Behavioral  
Condition:**

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the persons or others in serious jeopardy; or (2) serious impairment to such person's bodily functions; or (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

**Emergency Services  
and Care:**

Means those Covered Services provided for screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

**Group:**

The legal entity (Vaden Student Health Service) which enters into a Subscriber Group Agreement with *ValueOptions* to provide coverage to members of the Group.

**Health Plan:**

The specialized health care service plan operated by *ValueOptions* pursuant to which *ValueOptions* provides and arranges for the provision of mental health and substance abuse services.

**Medically  
Necessary:**

Those services or supplies for the treatment of an active Mental Disorder or Chemical Dependency which are determined by the *ValueOptions* Medical Director or designee to be:

1. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM-IV) that threatens life, causes pain or suffering, or results in illness or infirmity.
2. Expected to improve an individual's condition or level of functioning.
3. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.

4. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
5. Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.
6. Not primarily intended for the convenience of the recipient, caretaker, or provider.
7. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
8. Not a substitute for non-treatment services addressing environmental factors.

**Member:** An individual whose status as a Student, is the basis for that individual's eligibility to enroll in the Health Plan and who has enrolled.

**Mental Health or Substance Abuse Condition or Mental Disorder:**

A nervous or mental condition that (1) is a clinically significant behavioral or psychological syndrome or pattern; (2) is associated with a painful symptom, such as distress; (3) substantially or materially impairs a patient's ability to function in one or more major life activities; and (4) is a condition listed as an Axis I Disorder (except for V codes) of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV - Revised) by the American Psychiatric Association. Mental Disorders include Severe Mental Illnesses ("SMI") of a person of any age and Serious Emotional Disturbances ("SED") of a child.

**Mental Retardation:** Subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both.

**Participating Provider:**

A health care provider that has entered into an agreement accepted by *ValueOptions*, or is otherwise expressly approved by *ValueOptions*, to provide Covered Services to Members. Participating Providers include without limitation psychologists, psychiatrists, clinical social workers and counselors, hospitals and other facilities.

**Plan Year:** The time frame of effective coverage, September 1 through August 31.

**Serious Chronic Condition:**

A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature, and that does either of the following: (i) persists without full cure or worsens over an extended period of time; or (ii) requires ongoing treatment to maintain remission or prevent deterioration.

**Serious Emotional Disturbances of Child:**

A Serious Emotional Disturbance (“SED”) of a child is defined as a child who:

1. Has one or more Mental Disorders as defined by the Diagnostic and Statistical Manual (DSM-IV), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child’s age according to expected developmental norms; and
2. Is under the age of eighteen (18) years old.
3. Furthermore, the child must meet one or more of the following criteria:
  - a. As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
    - (i) the child is at risk of removal from home or has already been removed from the home,
    - (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment, or
  - b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder, or
  - c. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

**Service Area:**

The geographical area for which *ValueOptions* is licensed pursuant to the Knox-Keene Health Care Service Plan Act to operate the Health Plan. For a detailed description of Service Area, see Attachment 2.

**Severe Mental  
Illness:**

Severe Mental Illness (“SMI”) includes the diagnosis and Medically Necessary treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or Autism
- Schizoaffective Disorder
- Schizophrenia

**Stabilization:**

Means that in the opinion of the treating provider, the Member's Emergency Medical or Behavioral Condition is such that, within reasonable medical probability, no material deterioration of the Member's condition is likely to result from, or occur during, a transfer of the patient.

**Subscriber:**

Means an individual who is enrolled as a student at Stanford University for the current academic year and who has enrolled in the Plan.

**Terminated  
Provider:**

A provider whose contract to provide services to Members is terminated or not renewed by *ValueOptions* or one of *ValueOptions*' contracting provider groups. A Terminated Provider is not a provider who voluntarily leaves *ValueOptions* or one of its contracting provider groups.

**BENEFITS AND COVERAGE**

Subject to all of the terms, conditions, limitations and exclusions of this Agreement, and to the Limitations and Exclusions described below, upon payment of any Copayments described below, *ValueOptions* will provide the following Covered Services to Members (Covered Services do not include Out of Network Services or services for Dependents):

Section A

The following benefits (A1 – A3) will be provided for all Members whose diagnoses are categorized as Severe Mental Illness. \*

\* Severe Mental Illness (SMI) is defined by the diagnosis of one of the following conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder (PPD) or autism, anorexia nervosa and bulimia nervosa. For children under the age of 18, Severe Mental Illness (SMI) is defined by any of the above diagnosis as well as the diagnosis of serious emotional disturbances of children. (SED)

**A1. Outpatient Services.**

Outpatient mental health assessment, diagnosis and psychotherapy, including Crisis Intervention, as Medically Necessary for the treatment of Severe Mental Illness. \*

<b><u>Limit</u></b>	<b><u>Number</u></b>	<b><u>Copayment</u></b>
Outpatient Psychotherapy Services	N/A	\$10 (Precertification required by <i>ValueOptions</i> )
Individual <u>Plan Year</u> Dollar Maximum		N/A
Individual Lifetime Dollar Maximum		N/A

Individual Copayment Dollar Maximum (the maximum amount \$500 of Copayments that any one Member will be required to pay for all covered outpatient services during any one calendar year):

**A2. Inpatient Services.**

Inpatient mental health assessment, diagnosis and psychotherapy and inpatient prescription drugs prescribed by a *ValueOptions* participating provider at a *ValueOptions* participating facility, as Medically Necessary for the treatment of Severe Mental Illness. \*

<u>Limit</u>	<u>Number</u>	<u>Copayment</u>
Inpatient Psychotherapy Services	N/A	N/A (Precertification required by <i>ValueOptions</i> )

Individual Plan Year Dollar Maximum (the maximum benefit and coverage for these inpatient services that *ValueOptions* will provide to any one Member during any one Plan year): N/A

Individual Lifetime Dollar Maximum (the maximum benefit and coverage for these inpatient services that *ValueOptions* will provide to any one Member during that individual's lifetime): N/A

Individual Lifetime Limit Maximum (the maximum number of courses of treatment, regardless of cost, that *ValueOptions* will provide to any one Member during that individual's lifetime): N/A

Individual Copayment Dollar Maximum (the maximum amount of Copayments that any one Member will be required to pay for these inpatient services during any one Plan year): N/A

**A3. Coverage for all such inpatient services described in #A1 – A2 above and Alternative Levels of Care shall include:**

- Treatment by the attending physician who shall be a Participating Provider; and
- Treatment by other consulting physicians, as Medically Necessary and approved by *ValueOptions*; and
- Room and board, including routine psychiatric nursing care, at an appropriate hospital or other facility that is a Participating Provider; and
- Such additional Medically Necessary services that are approved by *ValueOptions*.

Section B

Subject to all of the terms, conditions, limitations and exclusions of this Agreement, and to the Limitations and Exclusions described below, upon payment of any Copayments described below, *ValueOptions* will provide the following Covered Services to Members (Covered Services do not include Out of Network Services or services for Dependents):

The following benefits (B1 – B4) will be provided for all Members other than those whose diagnoses are categorized as Severe Mental Illness \* (as defined in Section A).

**B1. Outpatient Services.**

Outpatient mental health assessment, diagnosis and psychotherapy, including Crisis Intervention, as Medically Necessary for the treatment of Mental Disorders including and substance abuse.

<u>Limit</u>	<u>Number</u>	<u>Copayment</u>
Outpatient Psychotherapy Services	N/A	50% up to \$50.00 per day (Precertification required by <i>ValueOptions</i> )

Individual Plan Year Dollar Maximum (the maximum benefit and coverage for these outpatient services that *ValueOptions* will provide to any one Member during any one Plan year): \$1,500

Individual Lifetime Dollar Maximum (the maximum benefit and coverage for these outpatient services that *ValueOptions* will provide to any one Member during that individual's lifetime): N/A

Individual Copayment Dollar Maximum (the maximum amount of Copayments that any one Member will be required to pay for these outpatient services during any one calendar year): N/A

**B2. Inpatient Services.**

Inpatient mental health assessment, diagnosis and psychotherapy, as Medically Necessary for the treatment of Mental Disorders, including substance abuse.

<u>Limit</u>	<u>Number</u>	<u>Copayment</u>
Inpatient Psychotherapy Services	N/A	N/A (Precertification required by <i>ValueOptions</i> )

Individual Plan Year Dollar Maximum (the maximum benefit and coverage for these inpatient services that *ValueOptions* will provide to any one Member during any one Plan year): \$10,000

Individual Lifetime Dollar Maximum (the maximum benefit and coverage for these inpatient services that *ValueOptions* will provide to any one Member during that individual's lifetime): N/A

Individual Lifetime Limit Maximum (the maximum number of courses of treatment, regardless of cost, that *ValueOptions* will provide to any one Member during that individual's lifetime): N/A

Individual Copayment Dollar Maximum (the maximum amount of Copayments that any one Member will be required to pay for these inpatient services during any one Plan year): N/A

**B3. Alcohol and Drug Abuse Treatment.**

Inpatient Alcohol and Drug Abuse Treatment, as Medically Necessary.

<u>Limit</u>	<u>Number</u>	<u>Copayment</u>
Inpatient Alcohol and Drug Abuse Treatment	N/A	N/A (Precertification by <i>ValueOptions</i> required)
Individual <u>Plan Year</u> Combined Dollar Maximum (the maximum benefit and coverage for these services that <i>ValueOptions</i> will provide to any one Member during any one Plan year):		\$10,000
Individual Lifetime Dollar Maximum (the maximum benefit and coverage for these services that <i>ValueOptions</i> will provide to any one Member during that individual's lifetime):		N/A
Individual Lifetime Limit Maximum (the maximum number of courses of treatment, regardless of cost, that <i>ValueOptions</i> will provide to any one Member during that individual's lifetime):		N/A

**B4. Coverage for all such inpatient services described in #B1 – B3 above and Alternative Levels of Care shall include:**

- Treatment by the attending physician who shall be a Participating Provider; and
- Treatment by other consulting physicians, as Medically Necessary and approved by *ValueOptions*; and
- Room and board, including routine psychiatric nursing care, at an appropriate hospital or other facility that is a Participating Provider; and
- Such additional Medically Necessary services that are approved by *ValueOptions*.
- The limits on all Section B inpatient services and alternative care are mutually inclusive of each other.

**SERVICE AREA**

The *ValueOptions* Service Area includes the following California counties:

Alameda	Sacramento
Butte	San Benito
Calaveras	San Bernardino
Contra Costa	San Diego
Del Norte	San Francisco
El Dorado	San Joaquin
Fresno	San Luis Obispo
Humbolt	San Mateo
Glenn	Santa Barbara
Imperial	Santa Clara
Kern	Santa Cruz
Kings	Shasta
Los Angeles	Siskiyou
Madera	Solano
Marin	Sonoma
Merced	Stanislaus
Monterrey	Sutter
Napa	Tehama
Nevada	Tulare
Orange	Ventura
Placer	Yolo
Riverside	Yuba