CA

53895 Information to New Members

(a)

The plan shall send information to new members, as described below, by the seventh day of the first month of enrollment in the plan by the new member and annually thereafter.

(b)

Each plan shall provide to each member in writing, in addition to those items of information contained in the Welfare and Institutions Code, section 14406, the following information, as approved by the department: (1) The plan name and the address and telephone number within the plan's service area where member services are available. (2) The effective date of enrollment. (3) A description of all available services and an explanation of any service limitations, exclusions from coverage or charges for services, when applicable. (4) An explanation of how to use the fee-for-service system when Medi-Cal covered services are excluded or limited under the plan and how to obtain additional information. (5) Information on the availability of transitional Medi-Cal eligibility and how the member may apply for this program. (6) The name, telephone number, and service site address of the primary care provider selected by the member or instructions to select a primary care provider within thirty days and that failure to timely select a primary care physician will result in the member being assigned a primary care provider by the plan, in accordance with section 53890. The plan shall notify the primary care

provider of selection by or assignment of the eligible beneficiary within ten days of selection or assignment. (7) Procedures for changing the member's primary care provider and an explanation that the member can make this change at any time. (8) Information concerning any non-medical transportation services available to the member from the plan and through the local EPSDT and CHDP programs, and how to obtain such services. (9) The appropriate use of health care services in a managed care system and the contributions the member can make toward the maintenance of the member's own health, including the value of scheduling an initial health assessment appointment. (10) An explanation of the member's right to request a fair hearing under Welfare and Institutions Code section 10950, et seq. without going through the plan's grievance procedures when a health care service requested by the member or a provider has not been provided. (11) Information on the availability of and procedures for obtaining services at Federally Qualified Health Centers and Indian Health Services facilities. (12) Information on the member's right to seek family planning services from any provider eligible to provide family planning services under the Medi-Cal program, including providers outside the plan's provider network, and a description of those services. (13) Information on the member's eligibility for nurse midwife and nurse practitioner services and how to obtain these services. (14) Information concerning the provision and availability of services covered under the CCS program from providers outside the plan's provider network and how to access these services. (15) An explanation of the expedited disenrollment process for members meeting the criteria in section 53889(j). (16) Information on how to obtain minor consent services through the plan, and an explanation of those services. (17) A description of the Medi-Cal Managed Care Ombudsman Program and the Department of Managed Health Care's Office of Patient Advocate, including the toll-free telephone

numbers for each.

(1)

The plan name and the address and telephone number within the plan's service area where member services are available.

(2)

The effective date of enrollment.

(3)

A description of all available services and an explanation of any service limitations, exclusions from coverage or charges for services, when applicable.

(4)

An explanation of how to use the fee-for-service system when Medi-Cal covered services are excluded or limited under the plan and how to obtain additional information.

(5)

Information on the availability of transitional Medi-Cal eligibility and how the member may apply for this program.

(6)

The name, telephone number, and service site address of the primary care provider selected by the member or instructions to select a primary care provider within thirty days and that failure to timely select a primary care physician will result in the member being assigned a primary care provider by the plan, in accordance with section 53890. The plan shall notify the primary care provider of selection by or assignment of the eligible beneficiary within ten days of selection or assignment.

(7)

Procedures for changing the member's primary care provider and an explanation that the member can make this change at any time.

(8)

Information concerning any non-medical transportation services available to the member from the plan and through the local EPSDT and CHDP programs, and how to obtain such services.

(9)

The appropriate use of health care services in a managed care system and the contributions the member can make toward the maintenance of the member's own health, including the value of scheduling an initial health assessment appointment.

(10)

An explanation of the member's right to request a fair hearing under Welfare and Institutions Code section 10950, et seq. without going through the plan's grievance procedures when a health care service requested by the member or a provider has not been provided.

(11)

Information on the availability of and procedures for obtaining services at Federally Qualified Health Centers and Indian Health Services facilities.

(12)

Information on the member's right to seek family planning services from any provider eligible to provide family planning services under the Medi-Cal program, including providers outside the plan's provider network, and a description of those services.

(13)

Information on the member's eligibility for nurse midwife and nurse practitioner services and how to obtain these services.

(14)

Information concerning the provision and availability of services covered under the CCS program from providers outside the plan's provider network and how to access these

services.

(15)

An explanation of the expedited disenrollment process for members meeting the criteria in section 53889(j).

(16)

Information on how to obtain minor consent services through the plan, and an explanation of those services.

(17)

A description of the Medi-Cal Managed Care Ombudsman Program and the Department of Managed Health Care's Office of Patient Advocate, including the toll-free telephone numbers for each.