



*California's Protection & Advocacy System
Toll-Free (800) 776-5746*

Medi-Cal Managed Care Health Plans

What are they?

What do I need to know about them?

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1. What is managed care?

Managed care is a system for providing and paying for health care services. Managed care means that you receive your health care from a managed care plan. A managed care plan is an organized network of health care providers that emphasizes primary and preventive care. Hospitals, physicians and other health care providers are members of the network. The managed care plan can be public or private.

Many well-known companies offer managed care plans such as Kaiser Permanente or Anthem Blue Cross. Other managed care plans are offered by individual county health care systems or by a combination of counties. There are a wide variety of plans. 85% of Californians with health care coverage (other than Medi-Cal) receive their care through managed care plans.

2. How is managed care different from traditional medical care?

At one time, most private health insurance companies and many government programs such as Medi-Cal and Medicare paid health care providers on a “fee-for-service” (FFS) basis. That means that after a health care provider provided a service, the provider would send a bill to someone for that particular service. For example, if your doctor charges \$40 for an office visit, and you went to the doctor, the doctor would send a bill for \$40 after the visit. The bill could be sent to you, to a private

insurance company, or to a government health care program such as Medi-Cal or Medicare, depending on who is responsible for payment. The only limit is that a provider who is willing to bill a program such as Medi-Cal or Medicare for your care has to be enrolled in the program as a provider.

Managed care is different. People who receive medical care through managed care plans must sign up for a plan. When people do this, they are “members” or “enrollees” of the plan. Under the typical managed care arrangement, the managed care plan pays providers, such as primary care physicians a flat fee in advance to provide health care for each member of the plan who needs the care. This is called a capitation payment or capitated rate. However, there are many variations on this model. For example, a managed care plan might pay some providers in the network on a capitated basis, but other providers in the network on a fee-for-service basis according to rates negotiated in advance.

All of this means that managed care plans must have adequate provider networks to provide all of their members with services when the services are needed. This means having enough hospitals, primary care physicians, specialists and other health care providers in the geographical area where the managed care plan provides services, and where the members of the plan live. It also means that the providers have to be located in different places within that geographical area so that the members won't have to travel too far to get services. As a rule, providers should not be more than 30 minutes away. Finally, it means that providers must be able to deliver services to each member without discrimination. This includes having facilities that are physically accessible to people with disabilities such as mobility impairments, providing culturally competent services, and ensuring language access, including access to people who are limited-English-proficient or who need sign language interpreters or materials in alternative formats.

3. Are there any advantages to managed care?

Yes. Managed care plans can provide you with the following:

- Help coordinating your care
- Help finding primary care doctors and specialists

- Help finding a pharmacy
- Ongoing referrals to specialists
- Telephone advice nurses
- Customer service centers
- Support groups
- Health education programs to help you:
 - Quit smoking
 - Prevent and deal with drug and alcohol problems
 - Manage chronic pain
 - Eat well and exercise safely
- Help getting to and from medical appointments (non-medical transportation)

4. Are there any drawbacks to managed care?

Yes. The main one is that managed care plans usually require you to get your health care from the managed care network of providers. Not all doctors, hospitals, or other providers are members of the network. If you are joining a managed care plan for the first time, or switching plans, you may have to change doctors or other providers.

Another drawback to managed care is that there may not be enough providers in the network to provide with you with all of the services you need in a location that is close to you or convenient to you. Managed care plans are supposed to have adequate provider networks, but there are sometimes gaps. Also, some managed care plans may have networks in a relatively small geographic area, such as only one county, so it can sometimes be a challenge to get services from providers in a nearby county. However, if the network is not adequate to meet your needs, the managed care plan has an obligation to expand the network so that it is adequate, or to provide you with out-of-network services if necessary to meet your needs.

5. Under managed care do I have a right to make my own health care decisions?

Yes. Under managed care you have the same right to make informed choices about your health care that you do under the fee-for-service system. Managed care plans may require you to get your health care

services from a certain network of providers, but those providers cannot take away your right to make your own decisions about your health care. No one can deny you the right to make your own decisions about your health care unless a court has decided that you do not have the capacity to make choices for yourself.

6. Is managed care the same as case management?

No. Managed care has to do with how health care services are delivered and paid for. Under managed care you join a managed care plan so that you can receive your health care services from the managed care plan's network of providers. In contrast, case management has to do with help in accessing or utilizing services. Most people in managed care plans do not receive case management.

7. What kinds of managed care plans are available under Medi-Cal?

All counties now have Medi-Cal managed care plans (MCPs). Sometimes, these Medi-Cal managed care plans are also called Medi-Cal health care plans (HCPs). An MCP is the same as an HCP. In addition, these types of Medi-Cal managed care plans are covered under the broader umbrella of Managed Care Organization (MCO). Some of these managed care plans also fit within the definition of Health Maintenance Organization (HMO). You may see all of these terms in various places. Medi-Cal managed care plan or MCO will be used in this memo to describe the types of plans listed below.

There are two basic types of Medi-Cal MCPs: COHS (County-Organized Health Systems) model plans and non-COHS model plans. General information about Medi-Cal managed care can be found on the California Department of Health Care Services website here: <http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>.

Under the COHS model, there is only one managed care plan available in the county where the beneficiary lives, and almost all Medi-Cal beneficiaries in those counties must enroll. For the most part, there is no fee-for-service Medi-Cal system in COHS model counties. The following is a list of the COHS plans and the counties which they serve. Almost all Medi-Cal beneficiaries living on one of those counties must enroll in the

COHS plan, and receive many, but not all, of their Medi-Cal services from the plan.

COHS Plans and Counties	
CalOptima Orange	Partnership HealthPlan of California Solano Napa Yolo Sonoma Mendocino Marin Del Norte Humboldt Lake Lassen Modoc Shasta Siskiyou Trinity
CenCal Health Santa Barbara San Luis Obispo	
Central California Alliance for Health Santa Cruz Monterey Merced	
Gold Coast Health Plan Ventura	
Health Plan of San Mateo San Mateo	

Under the non-COHS models, there are at least two plans available in each county (except that San Benito County has only one plan). The Non-COHS plans fall into the following three categories:

1. Two-plan model
2. GMC (Geographic Managed Care) model
3. Regional model

Counties with two-plan model managed care offer a choice of only two plans. One plan is a commercial plan (CP), such as Anthem Blue Cross, Health Net, or Molina Healthcare. The other plan is a local initiative (LI), which is established by the county board of supervisors. Local initiatives are publicly operated partnerships that include county health systems, other safety net providers, and private providers (except for Tulare County where the LI is operated by a commercial plan, Anthem Blue Cross).

The GMC model is used only in Sacramento and San Diego Counties. It operates much like the two-plan model. There are two main differences.

First, there is no local initiative (LI) under the GMC model—all of the plans are commercial plans. Second, there is a choice among more than two commercial plans (CP)—four in Sacramento County and five in San Diego County.

The following is a list of the 16 counties with two-plan or GMC model managed care. The list includes the local initiative (LI) plans and commercial plans (CP) available in each county. In addition, local initiative plans often subcontract with commercial plans, such as Kaiser Permanente, Health Net, Anthem Blue Cross, or Molina Healthcare, to provide services to some members.

Two-Plan/GMC Managed Care Counties and Plans	
Alameda	Alameda Alliance for Health (LI)
	Anthem Blue Cross (CP)
Contra Costa	Contra Costa Health Plan (LI)
	Anthem Blue Cross (CP)
Fresno/Kings/Madera	CalViva Health (LI)
	Anthem Blue Cross (CP)
Kern	Kern Family Health Care (LI)
	Health Net (CP)
Los Angeles	LA Care (LI)
	Health Net (CP)
Riverside/San Bernardino	Inland Empire Health Plan (LI)
	Molina Healthcare (CP)
Sacramento (GMC)	Anthem Blue Cross (CP)
	Health Net (CP)
	Kaiser Permanente (CP)
	Molina Healthcare (CP)
San Diego (GMC)	Care 1st (CP)
	Community Health Group (CP)
	Health Net (CP)
	Kaiser Permanente (CP)
	Molina Healthcare (CP)
San Francisco	San Francisco Health Plan (LI)
	Anthem Blue Cross (CP)
San Joaquin/Stanislaus	Health Plan of San Joaquin (LI)
	Health Net (CP)

Santa Clara	Santa Clara Family Health Plan (LI)
	Anthem Blue Cross (CP)
Tulare	Anthem Blue Cross (LI)
	Health Net (CP)

The regional model is used in counties that are primarily rural. Medi-Cal beneficiaries in regional model counties can choose between two commercial plans (except in San Benito County where there is a choice between one plan and fee-for-service Medi-Cal). Regional model counties do not have local initiative plans. Regional model plans follow GMC model rules.

Regional Managed Care Counties and Plans	
Alpine Amador Butte Calaveras Colusa El Dorado Glenn Inyo Mariposa Mono Nevada Placer Plumas Sierra Sutter Tehama Tuolumne Yuba.	Anthem Blue Cross (CP)
	California Health and Wellness (CP)
	Imperial
California Health and Wellness (CP)	
San Benito	Anthem Blue Cross (CP)
	Medi-Cal fee-for-service (Regular Medi-Cal)

Also, there is a contract between the state and Kaiser Permanente to provide managed care to certain former Healthy Families beneficiaries who have been transitioned into the Medi-Cal program.

8. Do I have to enroll in Medi-Cal managed care?

It depends on the county where you live. There are different rules for COHS model and non-COHS model counties.

If you live in a COHS model county, you have to enroll in Medi-Cal managed care with few exceptions.

If you live in a two-plan, GMC, or regional model county, you generally have to enroll in a Medi-Cal managed care plan but there are a number of exceptions. You do not have to enroll in a Medi-Cal managed care plan if:

1. You have Medicare as well as Medi-Cal (“dual-eligible”)
Note: Beginning in 2014, most dual-eligible beneficiaries in 8 counties will have to enroll in Medi-Cal managed care—these counties are San Mateo, San Diego, Orange, Riverside/San Bernardino, Los Angeles, Alameda and Santa Clara
2. You receive foster care or adoption assistance benefits
3. You are enrolled in a private health care plan (other health coverage, or “OHC”)
4. You are in a long-term care facility (LTC) such as a nursing home or intermediate care facility
5. You have a share of cost for Medi-Cal
6. You receive services from the California Children’s Services (CCS) program (except in San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa Counties)
7. You are enrolled in a Program of All-Inclusive Care for the Elderly (PACE)
8. You are a senior or a person with a disability and live in a regional model county

A complete list of the categories of beneficiaries who are exempt from enrollment in Medi-Cal managed care can be found on the managed care aid code chart, located here:

<http://www.dhcs.ca.gov/services/Documents/MMCD/AidCodeChart.pdf>.

The aid code chart also lists the categories of Medi-Cal beneficiaries who can voluntarily enroll in Medi-Cal managed care.

Note: Even if you are not required to enroll in Medi-Cal managed care, you may have to in order to get certain services that are available only through Medi-Cal managed care plans. In many counties, this includes Community-Based Adult Services (CBAS). In 8 counties it will soon include other Long-Term Services and Supports (LTSS), such as In-Home Supportive Services (IHSS). These 8 counties are San Mateo, San Diego, Orange, Riverside/San Bernardino, Los Angeles, Alameda and Santa Clara.

9. Do the Medi-Cal managed care plans provide all Medi-Cal services?

No. Not all Medi-Cal services are provided through Medi-Cal managed care plans. Services that are not provided through Medi-Cal managed care are said to be “carved out” of managed care. Most carved-out services are provided under the traditional fee-for-service system. However, some carved out services are provided through other types of Medi-Cal managed care plans. For example, Medi-Cal specialty mental health services are provided by county “mental health plans” or “MHPs,” even though specialty mental health benefits are carved out of the four types of Medi-Cal managed care plans (MCPs) listed above. Some of the carved-out services are listed below.

Mental Health

Medi-Cal specialty mental health services are provided through county mental health plans (MHPs). Medi-Cal beneficiaries who are entitled to specialty mental health services must receive those services through the county MHP. This means that Medi-Cal beneficiaries who are enrolled in one of the four types of Medi-Cal managed care plans listed above (MCPs) will receive Medi-Cal services through two separate managed care plans—one plan will be an MCP and the other plan will be the county MHP. The MCP and the MHP must have a memorandum of understanding (MOU) for coordination of care. In addition, psychiatric medications will be provided through the Medi-Cal managed care plan even if the medications are prescribed by the MHP.

This does not mean that all Medi-Cal mental health services are provided through county MHPs. First, mental health conditions that would be responsive to physical-health-care-based treatment are not provided by the county MHP. This allows primary care physicians, for example, to prescribe psychiatric medications, such as antidepressants and anti-anxiety medications, if the physician chooses to do so. Second, beginning in January 2014, mental health treatment for mild and moderate mental health conditions is available through the MCPs. MCPs will provide the following non-specialty mental health services when needed:

1. Individual and group mental health evaluation and treatment (psychotherapy)
2. Psychological testing when clinically indicated to evaluate a mental health condition
3. Outpatient services for the purposes of monitoring medication treatment
4. Outpatient laboratory, medications, supplies and supplements
5. Psychiatric consultation

Note: If the Medi-Cal beneficiary is not enrolled in an MCP, psychiatric medications and the non-specialty mental health services listed above are provided through the Medi-Cal fee-for-service system.

In-Home Supportive Services (IHSS)

In-Home Supportive Services (IHSS) are not provided through Medi-Cal managed care. However, they soon will be in the 8 counties that will be enrolling beneficiaries who receive both Medicare and Medi-Cal. IHSS will be offered through Medi-Cal managed care in those counties for all Medi-Cal beneficiaries, whether or not they also receive Medicare.

Home and Community-Based Waiver Services (HCBS)

Home and Community-Based Waiver Services (HCBS) are not provided through Medi-Cal managed care. However, Medi-Cal beneficiaries who receive services under an HCBS waiver are not necessarily exempt from enrollment in Medi-Cal managed care.

Dental

Dental services are not provided through the four types of Medi-Cal managed care plans listed above. Dental services are generally provided through the Medi-Cal fee-for-service system (commonly known as “Denti-Cal”). However, there are separate dental managed care (DMC) plans in Sacramento and Los Angeles Counties. Enrollment in dental managed care is mandatory for some Medi-Cal beneficiaries in Sacramento County. There is no mandatory enrollment in Los Angeles County. In addition, some Medi-Cal beneficiaries who also receive Medicare and are enrolled in Medicare managed care plans (Medicare Advantage) may be able to obtain some dental services through their Medicare managed care plan.

California Children’s Services (CCS)

Services provided under the California Children’s Services (CCS) program are not provided through Medi-Cal managed care (except in San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa Counties).

Local Education Agency (LEA)

Services provided by school districts for the purpose of enabling students to obtain free appropriate public educations, and which are paid for by Medi-Cal, are not provided through the Medi-Cal managed care system. However, school districts can contract with various Medi-Cal managed care organizations for provision of services. This is particularly common in the case of county mental health plans.

Special Programs

Some special Medi-Cal programs are not provided through Medi-Cal managed care. These include tuberculosis treatment, pregnancy-only services, minor-consent services, and emergency-care or limited-scope Medi-Cal for undocumented residents.

10. If I’m in managed care, can I keep the same doctors I have now?

It depends. Ordinarily, your doctor must be part of the managed care network. However, the managed care network must provide you with “continuity of care.” What this means is that if you now have a doctor who is *not* part of the managed care network, you can keep that doctor; but only if the doctor is both willing to keep seeing you and willing to accept either the managed care network’s payment rate or the Medi-Cal fee-for-service rate, whichever is higher. The doctor becomes a part of the managed care network just for purposes of caring for you. The doctor will have access to network providers for purposes of referrals, etc.

For more information about this important continuity of care right, go to the Medi-Cal managed care website:

<http://www.dhcs.ca.gov/individuals/Pages/MMCDContOfCareFAQ.aspx>.

11. If I don't already have doctors I like, will the health plan provide ones who know about my disability?

The Medi-Cal managed care plan can help you find a doctor's office that will meet your special needs. Your doctor and the health plan will be responsible for helping to coordinate your care. This includes helping you find the specialists you need. In addition, the managed care plan has telephone advice nurses to answer your health questions and customer service call centers to answer questions about your benefits. If you don't like your doctor or other provider, you can change your doctor or other provider if you want.

12. What if I don't like managed care – can I get out?

Maybe. You may be able to get an “exemption” to stay in fee-for-service Medi-Cal for all of your care for up to 12 months initially if you have a complex or progressive medical condition that requires ongoing medical supervision or medical treatment which cannot be interrupted. This exemption will have to be renewed at least every 12 months. You are not eligible for an exemption if your doctor is in a Medi-Cal managed care plan.

If you want an exemption from enrolling in managed care you and your doctor have to fill out the Medical Exemption Request (MER) form. Call

Health Care Options (HCO) at 1-800-430-4263 to get a copy of the MER form or download and print the form here:

http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/Exception_to_Plan_Enrollment_Forms.aspx

It is important for your doctor to include information describing the ongoing medical supervision and/or complex medical treatment you receive, and why this prevents you from transferring into managed care right now. Call HCO if you have any questions. You or your doctor can also get help with your medical exemption request by calling the Medi-Cal managed care ombudsman at 1-888-452-8609, or sending an email to the following address:

merhelp@dhcs.ca.gov. If your request is denied, you can file a request for Medi-Cal fair hearing and stay in fee-for-service Medi-Cal pending the hearing. Be sure to ask to stay in fee-for-service Medi-Cal in your request for hearing.

13. How do I choose a health plan?

The rules are different depending on whether you live in a COHS county, on the one hand, or a non-COHS county, on the other hand. In non-COHS counties, the rules are different depending on whether certain categories of Medi-Cal beneficiaries are currently required to enroll in managed care or are being transitioned into managed care from fee-for-service Medi-Cal for the first time.

In COHS counties, you will be enrolled in the COHS plan when you apply for Medi-Cal. If you move into a COHS county from another county, you will be enrolled in the COHS plan when you notify the county Medi-Cal office of your change of address.

In two-plan, GMC and regional model counties, you enroll in a plan by sending a choice enrollment form to the enrollment broker, Health Care Options (HCO). If you move into a two-plan, GMC or regional model county from another county, you will need to submit a new choice enrollment form to HCO. You need to do this in addition to notifying the county Medi-Cal office of your change of address.

If you are being transitioned from fee-for-service Medi-Cal into mandatory Medi-Cal managed care, you will receive a notice from HCO at least 90 days before you have to enroll notifying you that you will need

to choose a managed care plan and notifying you that you will be receiving more information. You will receive an enrollment packet at least 60 days before you are required to enroll. You will then need to choose a plan and send the enrollment choice form to HCO. You will receive a reminder notice at least 30 days before you are required to enroll. If you do not enroll, you will be enrolled automatically by default in one of the plans.

You can get general information about enrollment on the HCO website here:

<http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/default.aspx>. You can get a choice enrollment form on the HCO website here:

http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/ChoiceEnrollment_Form.aspx. There are PowerPoints on the HCO website

describing the enrollment process for each county here:

http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Presentation_Sites/default.aspx.

14. Can I change to a different Medi-Cal managed care plan? If so, how?

You can change to a different Medi-Cal managed care plan at any time (except in COHS plan counties). You change plans by submitting a choice enrollment form to HCO. The change is effective the first of the month after HCO receives the form. You can get general information about changing plans on the HCO website here:

<http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/default.aspx>. You can get a choice enrollment form on the HCO website here:

http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/ChoiceEnrollment_Form.aspx.

15. I am dissatisfied with a decision of the managed care plan. What can I do?

You have a number of options. First, it's always best to talk directly with your provider or call your plan's customer service number. If that does not resolve the issue, you can do one or more of the following.

You can file a grievance orally or in writing with your managed care plan. If you are dissatisfied with the grievance resolution, you can file an appeal with your managed care plan. After you have exhausted these internal remedies, and if the issue is whether the service is covered or medically necessary, you can file a request for independent medical review (IMR) with the California Department of Managed Health Care (DMHC). Information about DMHC can be found here: http://dmhc.ca.gov/dmhc_consumer/pc/pc_default.aspx.

In addition, or instead, if the issue is whether the service is covered by Medi-Cal or medically necessary, you can file a request for a Medi-Cal fair hearing with the California Department of Social Services (CDSS). The CDSS hearing website is here: <http://www.dss.cahwnet.gov/shd/default.htm>. Information about requesting a fair hearing is here: <http://www.dss.cahwnet.gov/shd/PG1104.htm>. The procedure is the same as for other Medi-Cal fair hearings. Note: you cannot file a request for fair hearing while an IMR is pending—you must wait until the IMR is complete. In addition, you cannot request an IMR while a request for a Medi-Cal fair hearing is pending. Finally, you cannot request an IMR after a Medi-Cal fair hearing decision has been made. This means that if you want both an IMR and a fair hearing you must first request an IMR and then request a Medi-Cal fair hearing after the IMR decision has been made.

You can also report a problem or file a complaint with the California Department of Health Services, State Ombudsman. Call 1-888-452-8609, Monday through Friday, from 8:00 a.m. to 5:00 p.m. The ombudsman's website is here: <http://www.dhcs.ca.gov/services/med-cal/Pages/MMCDOOfficeoftheOmbudsman.aspx>.

You can also report a problem or file a complaint with the California Department of Managed Health Care, Office of the Patient Advocate (OPA). Call 1-888-466-2219, 24 hours a day, seven days a week. The OPA's website is here: <http://www.opa.ca.gov/Pages/Home.aspx>.

16. Can I get aid paid pending my appeal?

Yes, but only if you request a Medi-Cal fair hearing before your services are reduced, suspended or terminated. (Note: you can also get your services reinstated pending the hearing if you were not given proper written notice of the reduction, suspension or termination.)

You may want to file a grievance and request a fair hearing at the same time. You can then request postponement of the fair hearing pending resolution of the grievance and any subsequent appeal. That way, you can get aid paid pending the hearing.

If you want an IMR and a Medi-Cal fair hearing with aid paid pending the hearing, the IMR will have to be completed before your services are reduced, suspended or terminated. The IMR has to be completed before you request the hearing because you can only request a Medi-Cal fair hearing *after* the IMR is complete, and, in order to get aid paid pending, you have to request the hearing *before* the reduction, suspension or termination of services takes place.

17. I don't have to enroll in managed care but I want to. Is it possible for me to enroll voluntarily?

Yes, most Medi-Cal beneficiaries can voluntarily enroll in Medi-Cal managed care. A complete list of the categories of beneficiaries who can voluntarily enroll in Medi-Cal managed care can be found on the managed care aid code chart, located here:
<http://www.dhcs.ca.gov/services/Documents/MMCD/AidCodeChart.pdf>.

18. How can I find out more about the managed care plans in my area and pick the best one for me?

You can find information about all of the Medi-Cal managed care plans available in each county here:
<http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx>.

You can find general information about two-plan, GMC and regional model Medi-Cal managed care plans on the Health Care Options (California Department of Health Care Services) website here:
<http://www.healthcareoptions.dhcs.ca.gov/HCO CSP/Home/>.

You can compare plans here:

http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/Enrollment/Plan_Comparison_Charts.aspx. Consumer guides to help you compare can be found here:

<http://www.dhcs.ca.gov/individuals/Pages/MMCDConsumerGuide.aspx>.

General enrollment information for two-plan, GMC and regional model Medi-Cal managed care plans can be found here:

http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/Enrollment/default.aspx.

Specific enrollment information, including enrollment notices and specific informing materials for each plan (such as evidence of coverage), can be found here:

<http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDBeneInfCounty.aspx>.

Specific enrollment forms for two-plan, GMC and regional model Medi-Cal managed care plans can be found here:

http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/Enrollment/Choice_Enrollment_Form.aspx. Instructions for completing the form are here: http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/Enrollment/content/en/Medical_Enrollment.pdf.

You can also find out about two-plan, GMC and regional model plans by contacting Health Care Options directly. You can call Health Care Options directly at: 1-800-430-4263. More Health Care Options contact information can be found here:

http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/HCO_Program/Contact_Us.aspx. You can fill out a Health Care Options online contact form here:

http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/HCO_Program/Contact_Form.aspx. There are also Health Care Options contact numbers for languages other than English. The following is the list of telephone numbers.

**Health Care Options
(California Department of Health Care Services)
Contact Numbers**

Language	Phone Number
Arabic	1-800-576-6881
Armenian	1-800-840-5032
Cambodian	1-800-430-5005
Cantonese	1-800-430-6006
English	1-800-430-4263
Farsi	1-800-840-5034
Hmong	1-800-430-2022
Korean	1-800-576-6883
Laotian	1-800-430-4091
Mandarin	1-800-576-6885
Russian	1-800-430-7007
Spanish	1-800-430-3003
Tagalog	1-800-576-6890
Vietnamese	1-800-430-8008
TDD	1-800-430-7077

Disability Rights California is funded by a variety of sources, for a complete list of funders, go to <http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html>.