

Complaint Data Reports Glossary

The glossary includes terms defined by the National Association of Insurance Commissioners (NAIC), Office of the Patient Advocate, and other state entities. Most terms for complaint reasons and results use the NAIC definitions. For the purpose of this report, references within the NAIC definitions to “Department of Insurance,” “insurer,” and “insured” may also apply to other California reporting entities, health plans, and health plan enrollees, respectively.

Term	Explanation
Abusive Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior (other than “twisting” or “churning”) by the insurer or its representative.
Access to Care	Complaint that needed care is inaccessible due to refusal of primary care doctor to authorize specialist care or due to inadequate provider network.
Accident Only	Health insurance pertaining to only accident coverage.
Additional Payment	The party complained against paid more money (i.e. claims payment) than was initially paid to the policyholder or claimant.
Advanced Premium Tax Credit	Financial assistance that eligible consumers may receive when enrolling in a Covered California health plan to assist them in paying their monthly premium costs. This tax credit is sometimes called premium assistance.
Advised Complainant	A complaint result indicating that the reporting entity informed the complainant of the state position, company status, agent status, or possible course of action.
Authorization Dispute	Complaint alleging that the insurer has improperly denied claim or assessed a penalty on the basis of required preauthorization not having been obtained.
Autism/PDD	Coverage provided for treatment of autism/persuasive developmental disorder in covered children under the age of 19.
BIC (Benefits Identification Card)	People who are eligible for Medi-Cal receive a Benefits Identification Card (BIC), which is used by Medi-Cal providers to check eligibility. Medi-Cal recipients enrolled in a Medi-Cal managed care health plan have both a BIC and a health plan member card.
Bronze	A Covered California health plan product type. Bronze tier indicates a level of coverage provided by a health plan with 60 percent of the total allowed costs of benefits paid by the health plan.
CalHEERS	The California Healthcare Enrollment, Eligibility and Retention System is a web-based system that streamlines the eligibility and enrollment process for all products and programs available through Covered California.
Cal MediConnect	A Department of Health Care Services, Medi-Cal Managed Care three-year demonstration program for dual Medi-Cal/Medicare eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system. See also Medi-Cal Coordinated Care Initiative.
Cancellation	Complaint alleging the insurer's improper cancellation of a policy and/or coverage before the expiration date.
Cancer/Dread Disease	An insurance product type that only pays benefits for the diagnosis and treatment of cancer and/or other specifically named serious disease or diseases.
Catastrophic	Health plans that meet all the requirements of a qualified health plan but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met.
Chiropractic	Coverage for care provided by a Chiropractor. Normally, not seen as regular health maintenance but as a term recovery plan.
Claim Delay	Complaint alleging that the insurer has unreasonably delayed the investigation and/or processing of a claim.
Claim Denial	Complaint alleging improper claim denial by insurer.
Claim Reopened	Regulated entity or individual has reopened claim for further investigation or settlement negotiation. A final resolution of the claim has not been determined.
Claim Settled	Claim brought to conclusion, in whole or in part, and no other disposition is appropriate.

Closed Complaint	A complaint that has been investigated by the state insurance department and given a resolution code. A complaint that has completed a complaint review process by a reporting entity or its official affiliate.
Closed Network/Provider Discrimination	Complaint regarding insurer's refusal to admit provider to network, due to lack of need.
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)	A U.S. statute which requires that employers sponsoring group health plans offer continuation of coverage under the group plan to employees and their dependents who have lost coverage because of the occurrence of a "qualifying event." Qualifying events include reduction in work hours, many types of termination of employment, death, and divorce.
Complaint	A written or oral complaint, grievance, appeal, independent medical review, hearing, or similar process to resolve a consumer problem or dispute.
Complaint Ratio	The number of complaints closed during the calendar year divided by the number of covered lives the insurer had in place by the end of a specific month. For this report the complaint ratio was calculated from complaints closed in 2014 divided by the number of covered lives from Spring 2014 enrollment, and the resulting ratio was divided by 10,000.
Complaint Reason	A complaint data element indicating the primary reasons for the consumer complaint. For this report a single complaint case can have up to three reasons. Examples of complaint reasons include cancellation, medical necessity denial, and claim denial.
Complaint Withdrawn	Complainant requested that the complaint be withdrawn.
Compromise Settlement/Resolution	Complaint resolved voluntarily by an insurer or regulated entity, via additional payment, restored benefit or policy status, and/or other means. No finding by the insurance department that the regulated entity or individual was in violation or otherwise at fault.
Consumer's Money Returned	A return of money or benefits was made to the insured/complainant.
Continuation of Benefits	Complaint regarding COBRA (Comprehensive Omnibus Budget Reconciliation Act) enrollment and/or coverage after the insured no longer qualifies for group coverage.
Continuity of Care	Complaint regarding the transition plan of continuing care.
Coordination of Benefits	Complaint alleging one or both insurers' failure to properly coordinate benefits.
Co-Pay, Deductible, and Co-Insurance Issues	Complaint alleging that the incorrect co-pay, deductible or co-insurance amounts has been applied to a claim.
Cost Containment	Complaint alleging insurer's misapplication of cost-containment measures such as pre-certification, utilization review, concurrent review, managed care, second opinion, etc.
Coverage Question	Complaint alleging insurer's inadequate response to insured's request for information on policy status or coverages, or for interpretation of policy provisions.
Covered California/Exchange/Market place	Coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Title 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. Covered California is California's state-run exchange.
Covered Lives	Policyholders, subscribers, enrollees, or other individuals participating in a health benefit plan.
CRM (Customer Relationship Management)	A call center technology system to manage and record interactions with people who contact the call center.
Customer Service Representative (CSR)	A person who answers telephone calls in a service center (or communicates with customers through other modes of contact, such as email).
Delay Resolved	A delay in provider service or information was resolved.
Delayed Authorization Decision	Complaint alleging insurer's delayed response to healthcare authorization request.
Delivery of Policy	Complaint alleging insurer's delayed delivery of, or failure to deliver, an insurance policy to the insured.
Denial of Covered California Coverage	Complaint that coverage through Covered California was improperly denied.
Denial of Specialty Mental Health Services by Mental Health Plan	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of mental health services, including access to care, quality of care, medical necessity denials, and others. DHCS indicated that their data currently cannot be separated into more specific standardized report reasons.
Dental Combined with Major Medical	A Product Type reported by CDI. See Dental Only and Major Medical definitions.

Dental Scope of Benefits	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of dental services, including access to care, quality of care, medical necessity denials, and others. DHCS indicated that their data currently cannot be separated into more specific standardized report reasons.
Dental Only	A line of business providing dental only coverage; coverage can be on a stand-alone basis or as a rider to a medical policy. If the coverage is as a rider, deductibles or out-of-pocket limits must be set separately from the medical coverage. Does not include self-insured business as well as FEHBP or Medicare and Medicaid programs.
Dental Stand Alone	Coverage provided by a limited scope dental benefits plan through an exchange or in conjunction with a qualified health plan.
Dis/Enrollment	Complaint regarding issues related to enrollment in coverage.
Disability Income	Coverage that provides benefits in case of the insured's inability to perform all or part of his/her occupational duties because of an accident or illness.
Eligibility Determination	Complaint is about a problem with eligibility for health care coverage, typically through a public program.
Emergency Services	Complaint regarding coverage, with respect to an emergency medical condition, arising out of a medical screening examination that is within the capability of an emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize a patient.
EPO (Exclusive Provider Organization)	An EPO is a kind of health plan that requires its members to use an exclusive network of contracted providers, but typically allows members to see network providers without a referral.
ERISA	The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most pension and health benefits voluntarily established by private industry employers to provide protection for individuals in these plans.
Exchange	Coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Title 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. Covered California is California's state-run Exchange.
Experimental	See definition for Experimental/Investigational Denial.
Experimental/ Investigational Denial	Complaint regarding denial of coverage for a treatment or service that the health plan has determined is experimental.
External review	Complaint alleging insurer's failure to comply with statutory process requirements for external review.
FI (Fiscal Intermediary)	A contracted company that serves as the government's agent for claims processing and managing related systems for administering a public health care program.
59 Hold	Refers to a status code in the Medi-Cal Eligibility Data System (MEDS) indicating that a health plan enrollment is on hold due to a change in the Medi-Cal recipient's status other than Medi-Cal eligibility (e.g., the recipient moved to a different county).
Fraud/Forgery	Complaint alleging some form of claim-related deception or unfair practice by a third party resulting in unfair financial or compensable gain.
Gold	A Covered California health plan product type. The gold tier indicates a level of coverage provided by a health plan with 80 percent of the total allowed costs of benefits paid by the health plan.
Grandfathered	Coverage provided by a group health plan, or a group or individual health insurance issuer, in which the individual was enrolled on March 23, 2010, for as long as it maintains that status under the rules of section 147.140 of Title 45 (Code of Federal Regulations).
Group Health Plan	Health insurance coverage policy purchased by an employer or other employee organization and offered to eligible employees as a benefit. Insurance that is issued to Insurance that is issued against sickness or injury where the group is the policyholder and the individual insured is the certificate holder.
Health Benefit Exchange Board	The Exchange is an independent public entity within state government with a five-member board appointed by the Governor and the Legislature. Two members are appointed by the Governor; one by Senate Rules Committee; and one by Speaker of the Assembly. The Secretary of the Health and Human Services Agency or another designee serves as an ex-officio voting member of the Board. Appointed members serve four year terms.

Health Only	Insurance covering sickness only. This can include an HMO (Health Maintenance Organization), who provides basic health care services to enrollees on a prepaid basis except for enrollees' responsibility for co-payments, deductibles, and a PPO (Preferred Providers Organization).
Health Plan/Health Insurer	A health plan or insurer is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members or policy holders for a fixed, prepaid premium. Health plans are licensed to operate in California by the Department of Managed Health Care. Health insurers are licensed by the California Department of Insurance. For this report, health plan may be used to refer to both health plans and health insurers.
Health Plan in Compliance	Complaint result category originally used by the NAIC to indicate that a company's tendencies comply with the state insurance regulations.
Health Plan Position Overturned	Complaint resolved by a regulated entity to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Insurance Department found the regulated entity to be in violation or otherwise at fault.
Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
Health Privacy	Complaint regarding the protections (or lack thereof) to ensure privacy of health information.
HIPAA	Health Insurance Portability and Accountability Act. Includes provisions that guarantees that employers are not able to impose preexisting condition limitations in the insurance they offer to new employees who had insurance coverage for at least 12 months with their previous employer.
HMO (Health Maintenance Organization)	A kind of managed care health plan that requires its members to use a network of contracted providers to get health care services.
Home Health Care	Health care provided in the home of the patient, usually by a private nurse or a state-licensed home health care agency. Services are usually limited to part-time or intermittent nursing care and physical or occupational rehabilitation.
Hospital Indemnity	Coverage that provides a predetermined flat benefit for each day of hospitalization regardless of expenses incurred.
Hospitalization	Complaint regarding coverage for expenses arising out of services provided during confinement in a hospital as a patient for diagnostic study and/or treatment.
Independent Medical Review (IMR)	An Independent Medical Review is an external review process for addressing certain qualifying complaints about treatment or service denials or delays. Doctors who aren't part of the complainant's health plan or insurance company conduct the review and make a determination. Under law an IMR must be resolved within 30 days.
Individual Health Plan or Individual/Commercial	Insurance that is issued to an individual insuring one (and one's dependents if on the same policy) against sickness or injury.
Inquiry	A request for assistance made by a consumer to a consumer assistance service center that does not initiate a complaint with the associated reporting entity. For this report, the general category of inquiry is used to refer to jurisdictional inquiries and non-jurisdictional inquiries/complaints.
Insufficient Information for Further Investigation	Complainant failed to provide sufficient information/documentation to warrant further investigation.
Interactive Voice Response (IVR)	A technology system used by telephone service centers that interacts with callers by allowing them to input information using their phone keypad and/or their voice. IVR systems often are used to gather information needed to route the call to the right customer service representative or to provide appropriate pre-recorded information.
Involuntary Termination by Plan	Complaint alleging improper termination of provider contract by insurer.
Jurisdictional	Within the authority of a consumer assistance service center to address or resolve.
Jurisdictional Complaint	Complaint that falls under the authority of the service center to address or resolve.
Language Access	With regards to internal claims and appeals and external review processes and federal health reform requirements to provide relevant notices in a culturally and linguistically appropriate manner, a consumer complaint alleging (1) failure to provide language access or (2) inadequate/improper notice regarding language accessibility.
Language Assistance	Assistance to provide relevant information and services in a culturally and linguistically appropriate manner.
Large Group	Coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and sometimes their dependents) through a group health plan maintained by a large employer, unless otherwise provided under state law.

Limited Benefits	A health insurance policy with limited benefit payments where all benefits have been paid to the beneficiary.
Long Term Care PACE	PACE stands for Program of All-Inclusive Care for the Elderly. PACE is a model of care provided through a DHCS program to coordinate health care, long term care, and other social services to help older adults who would otherwise reside in nursing facilities to remain in their own homes. A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis).
Long Term Care SCAN	SCAN stands for Senior Care Action Network. A Medicare Advantage Special Needs Plan provided through a DHCS program to coordinate health care and long term care services for beneficiaries in three counties who are eligible for Medicare and Medi-Cal.
Major Medical	Coverage which, after the limits of coverage have been exhausted under a basic plan, medical expenses relating to room and board, physician fees, miscellaneous expenses such as bandages, operating room expenses, drugs, x-ray, and fluoroscopy, are then met under a major medical plan.
Maternity and Newborn Care	Complaint regarding coverage for expenses arising out of hospital length of stay in connection with childbirth for a mother or her newborn, as described in §146.130 and §148.170 of Title 45.
Medical Exemption Request	A DHCS process for a Medi-Cal beneficiary to request continued medical care from a regular Medi-Cal Fee-for-Service provider who is not a part of a Medi-Cal managed care plan network.
Medi-Cal	California's Medicaid program to provide health coverage to low-income individuals. The Medi-Cal program is administered and overseen by DHCS.
Medi-Cal County Organized Health System (COHS) Model	A Medi-Cal managed care model approved by the federal government under an 1115 Waiver. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors. The health plan is run by the county. In a COHS county, everyone is in the same managed care plan.
Medi-Cal Coordinated Care Initiative (CCI)	A Medi-Cal managed care model approved by the federal government under an 1115 Waiver. CCI is a demonstration project in certain counties that promotes coordinated care models where seniors and disabled Medi-Cal beneficiaries receive all benefits in an organized delivery system. It includes medical services, long term support services and behavioral health services.
Medi-Cal Fee-for-Service	A health care delivery system of the Medi-Cal program. Under this model, providers render services to Medi-Cal beneficiaries and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.
Medi-Cal Geographic Managed Care (GMC) Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In GMC counties, DHCS contracts with several commercial plans to provide more choices for beneficiaries. GMC serves Medi-Cal beneficiaries in two counties: Sacramento and San Diego.
Medi-Cal Managed Care	A health care delivery system of the Medi-Cal program. Under managed care models, the Medi-Cal program contracts with managed care plans to provide services to beneficiaries through established networks of organized systems of care.
Medi-Cal Managed Care Imperial Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this rural Medi-Cal managed care model, there are two commercial plans that contract with DHCS. The Imperial model serves Medi-Cal beneficiaries in Imperial County.
Medi-Cal Managed Care Other Model	A Product Type category reported by DHCS used to display Medi-Cal Managed Care Models: Rural Model, Imperial Model, San Benito Model, Long Term: PACE, and Long Term: SCAN
Medi-Cal Managed Care San Benito Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this rural Medi-Cal managed care model, there is one commercial plan that contracts with DHCS. Beneficiaries can choose the managed care plan or regular (Fee-for-Service) Medi-Cal. The San Benito Model serves Medi-Cal beneficiaries in San Benito County.
Medi-Cal Managed Care Two Plan Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this Medi-Cal managed care model, DHCS contracts with a local initiative plan (county organized) and a commercial plan. The Two-Plan Model serves Medi-Cal beneficiaries in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare.
Medi-Cal/Medicare	A source of coverage category indicating the consumer has dual coverage through the Medi-Cal and Medicare programs.
Medical Necessity Denial	Complaint alleging that the insurer has improperly denied covered services as not medically necessary.
Medicare	A source of coverage indicating the consumer has Medicare, a federal government health insurance program for people age 65 years and older and for some people with disabilities.

Medicare Advantage	A source of coverage indicating the consumer has a type of Medicare health plan offered by a private company that contracts with Medicare to provide the consumer with his/her Part A and Part B benefits.
Medicare Prescription Drug/Part D	A source of coverage indicating a stand-alone drug plan that adds prescription drug coverage to Original Medicare and some other Medicare plans.
Medicare Supplement	Coverage that provides accident and health expenses not covered under Medicare. There are various types of standard policy form choices available for Medicare supplemental insurance coverage.
Mental Health	Coverage for professional mental health services. Including psychologist, crisis centers, rehabilitative therapy, etc. An emotional or organic mental impairment (usually excluding senility, retardation or other developmental disabilities, and substance addiction); a psychoneurotic or personality disorder; any psychiatric disease identified in a medical manual. (American Psychiatric Association's Diagnostic and Statistical Manual).
Mental Health Parity	With respect to mental health and substance abuse disorder services essential health benefits, including behavioral health treatment services, a complaint regarding improper application of lifetime and annual dollar limits and out of pocket maximums. Mental health parity laws require that health plans and insurers cover benefits for mental health and substance abuse disorders similarly to other health conditions.
Misrepresentation	Complaint alleging that the insurer or representative made misleading or untrue statements about policy terms, benefits, or about insurance during the marketing/sales process.
Mode of Contact	A report data element indicating the communication platform used by a consumer to contact a consumer assistance service center. Examples of modes of contact include telephone, mail, email, chat, and fax.
Multi State	Coverage provided by a health plan that is offered under a contract between the U.S. Office of Personnel Management and the Multi State Plan Program issuer pursuant to section 1334 of the Affordable Care Act and that meets the requirements of Title 45.
No Action Requested/Required	Department of Insurance received only a copy of a complaint that the complainant sent directly to the company, or there was no direct request for assistance.
No Jurisdiction	Complaint does not fall under the regulatory authority of the state's Insurance Department, and was not referred to any outside agency, Department or court system. Includes Action Suspended for litigation and/or formal arbitration.
Non-Jurisdictional	Not within the authority of a consumer assistance service center to address or resolve.
Non-Jurisdictional Inquiry/Complaint	A request for assistance to a consumer assistance service center from a consumer who requires education and a referral to another entity to address a question or resolve a complaint about a non-jurisdictional topic.
Nonrenewal	Complaint alleging insurer's failure to (or decision not to) offer policy renewal, and/or insurer's.
Notice Requirements	Consumer complaint alleging non-issuance or improper issuance of notice of grandfathered status and notice of choice of primary care provider.
Other	Indicating a category not fitting into any specific standardized report category.
Other Violation of Insurance Law/Regulation	Complaint about a violation of a provision of law or regulation not specified in another category.
Out of Network Benefits	Complaint regarding dissatisfaction with the administration or determination of benefits on a claim for services that have been requested, received or determined to be out-of-network.
Overtured/Health Plan Position Overtured	Complaint resolved by a regulated entity or individual to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Insurance Department found the regulated entity or individual to be in violation or otherwise at fault.
Participating Provider Availability/Timely Access to Care	Complaint alleging that no in-network provider available, and that a claim processed at the out-of-network benefit level should be reprocessed as an in-network claim.
Personnel Year	The actual or estimated portion of a position expended for the performance of work. A personnel year is equal to 12 months full-time employment of one person, or 12 persons employed for one month, two persons employed for six months, or any similar combination equal to one personnel year.
Pharmacy Benefits	Complaint regarding coverage for expenses for charges made by a pharmacy, for medically necessary prescription drugs or related supplies ordered by a physician.

Plan Subcontractor/Provider Billing/Reimbursement Issue	A complaint reason reported by DHCS for billing and reimbursement issues involving a managed care plan's subcontractor or provider.
Platinum	A Covered California health plan product type. The platinum tier indicates a level of coverage provided by a health plan with 90 percent of the total allowed costs of benefits paid by the health plan.
Policyholder Service	A general complaint classification that includes multiple complaint reason categories associated with a failure by the insurer to provide adequate and/or timely services to the policyholder. Examples of Policyholder Service complaints include abusive service, inaccessible care, failure to send premium-related notices, and delays in responding to a policyholder request for information.
POS (Point of Service)	A POS plan is a kind of managed care health plan. It combines characteristics of the health maintenance organization (HMO) and the preferred provider organization (PPO).
PPO (Preferred Provider Organization)	A PPO is a kind of managed care health plan. A PPO has a network of contracted providers but offers its members options to go outside of the network for care. In addition, members can see providers without prior approval from the plan.
Premium & Rating	Complaint regarding a disagreement, inquiry, or question about insurer's premium/rating structure, or manual rules (ratings). Includes complaints alleging that the insurer improperly classified the applicant as a higher risk than it should have, resulting in an improperly high premium.
Premium Notice/Billing	Complaints alleging insurer's failure to send notice regarding premium due date, premium increase/decrease, policy lapse, etc.
Preventive Care	Routine health care that includes screenings, check-ups, and patient counseling to prevent illness, disease, and other health problems. Most health plans must cover certain preventive services at no cost to the plan enrollee. Complaint regarding coverage for expenses arising out of preventive care/wellness services and/or chronic disease management, to include complaints about an insurer's assessment of cost-sharing (improper application of co-payments, deductibles, and co-insurance) for such services.
Product Type	A complaint data element used to identify details about specific areas of coverage, such as the health plan's model, structure, benefits, and/or other distinguishing characteristics. In this report, most product types align with NAIC's Type of Coverage/Accident & Health Second Level codes. Examples of product types include HMO, PPO, Silver, Platinum, Health Only, Dental, and Small Group.
Protocols	Performance standards, policies and procedures, and other system requirements that determine a service center's response to a consumer request for assistance.
Provider Attitude and Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior by a provider or their representative.
Provider Directory	A list of doctors and other providers who participate in a health plan's network. A complaint about a provider directory alleges improper reflection of provider participation status in the insurer's directory (also see Provider Listing Dispute).
Provider Listing Dispute	Complaint alleging improper reflection of provider participation status in insurer's directory.
Question of Fact/Contract/ Provision/Law Fall Outside Regulator	Complaint involves a question of fact, or a question of law involving a contract provision or interpretation thereof, and therefore falls outside the regulatory authority of the Insurance Department.
Quick Resolution (QR)	A complaint type reported by DMHC. QR complaints meet DMHC's Urgent Nurse (see Urgent Nurse definition) screening triggers but a DMHC staff review determines that the issues can be resolved without standard complaint or urgent nurse processes. The QR process includes issues such as requests to file a grievance/appeal, expedited review of a grievance/appeal, access to providers, out of network referrals, second opinion consultation, quality of care complaints, or refill of medication(s).
Quick Sort Calculator	A computer application tool used by Covered California's Service Center staff to decide if a caller is likely eligible for Medi-Cal and should be transferred to the county for further assistance.
Referral to Another State's Dept. of Insurance	Complaint falls under the regulatory jurisdiction of another state's insurance department.
Referred to Other Division for Possible Disciplinary Action	Complaint referred elsewhere within regulating agency (Legal, Agent Services, Investigations, etc.) based on apparent or suspected violations of state law, etc.
Referred to Outside Agency/Department	Complaint was referred to a different state agency/department.
Refund	A refund was made to the claimant.

Regulator	A government entity with the authority to oversee and enforce health insurance laws and regulations, including those related to licensing, product regulation, financial regulation, and market conduct. California has two state health insurance regulators, the Department of Insurance and the Department of Managed Health Care.
Reporting Entity	For this report, a state health care department or entity that is statutorily required to provide consumer complaint data and other consumer assistance information to the Office of the Patient Advocate (per Health and Safety Code section 136000). Reporting entities are the Department of Managed Health Care, Department of Health Care Services, Department of Insurance, and the Exchange (Covered California).
Request for Assistance	A call, email, or other contact made to a state reporting entity from a consumer who is looking for help resolving a problem or complaint or who has a question regarding his/her health care coverage. For this report this category includes all consumer contacts for jurisdictional and non-jurisdictional complaints and inquiries.
Resolution Time	The time from the date a complaint was filed by a consumer with a reporting entity to the date that a complaint was closed by that reporting entity. Reporting entities may have different protocols for when they register the opening and closing of a complaint case.
Self-Funded/ERISA	Self-funded refers to the coverage purchaser making financial preparations to meet pure risks by appropriating sufficient funds in advance to meet estimated losses, including enough to cover possible losses more than those estimated did. ERISA refers to the federal law establishing (a) the rights of pension plan participants, (b) standards for the investment of pension plan benefits, and (c) requirements for the disclosure of plan provisions and funding.
Service Center	Health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers. For this report, service centers refer to those operated or contracted by the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California.
Short Term Limited Duration Policy	A policy that is less than one year in duration and that is not guaranteed renewable.
Silver	A Covered California health plan product type. The Silver tier indicates a level of coverage provided by a health plan with 70 percent of the total allowed costs of benefits paid by the health plan.
Small Group	Coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.
Source of Coverage	A complaint data element used to identify a category of a health plan's contracting/purchasing mechanism, which is associated with an insurance market segment and related laws. Examples of coverage sources include Individual/Commercial, Group, Medi-Cal Managed Care, and COBRA.
Standard Complaint	A complaint type category for complaints that undergo the reporting entity's typical complaint review process. Examples of issues that may be addressed as a Standard Complaint include billing problems, cancellation of coverage, and a provider's attitude. Complaints that are urgent or require the intervention of a health care provider may also be addressed as Standard Complaints.
State Fair Hearing	A formal complaint process to adjudicate appeals from California residents who have applied for, have received, or are currently receiving benefits or service from an assistance program administered by the State of California. The California Department of Social Services is authorized to conduct State Fair Hearings for appeals regarding Covered California applications and eligibility determinations, as well as for all Medi-Cal appeals. A State Fair Hearing is sometimes called a State Hearing, Fair Hearing, or Medi-Cal Fair Hearing.
State Specific (Other)	Complaint is about a state specific code: regulatory agency will use a further state-specific code to track data needed for a purpose not shared by other states or the NAIC.
Student Health	Coverage provided by a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents.
Summary of Benefits	Complaint regarding the improper issuance or non-issuance of a Summary of Benefits and Coverage/Uniform Glossary.
Unknown	A complaint data category indicating data was not identified. Data listed as Unknown were for fields submitted as Unknown or blank (without data), either because the data was not collected by a reporting entity (CDI, Covered California, DHCS, or DMHC) or because there were complainants who did not provide information to a reporting entity.

Unsatisfactory Refund of Premium	Complaint alleging insurer or their representative failed to properly refund an unearned premium.
Unsatisfactory Settlement/Offer	Complaint that insurer's payment or settlement offer is less than or below the amount expected by the insured or claimant.
Upheld/Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
Upheld/Covered California Position Substantiated	A complaint result reported by Covered California. See definition for Upheld/Health Plan Position Substantiated.
Urgent Clinical	An expedited complaint resolution protocol for addressing a complaint potentially involving an urgent medical issue or emergency that puts the complainant's health at risk.
Urgent Nurse Complaint	A complaint type reported by DMHC. DMHC's Urgent Nurse process identifies and addresses complaints involving a potential health risk to the complainant and that may need immediate attention and expedited resolution by DMHC clinical staff, who are experienced in both health care and managed care systems.
Usual, Customary, and Reasonable Charges	The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. Complaint reason alleging that the insurer's "usual, customary and reasonable" reimbursement amounts are inadequate.
Vision	Health insurance coverage for eye examinations and eyeglasses or contact lens prescriptions.
Waiting Periods	Complaint alleging an insurer's improper application of waiting periods. A "waiting period" is defined as the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of a plan.
Warm Transfer	A process for transferring a call where the customer service representative who initially answered the call dials the referral phone number for the caller, helps to navigate phone system options, and speaks to the other customer service representative prior to completing the call transfer.
Willing Provider	Complaint alleging insurer's failure to comply with a state's any willing provider law.
Withdrawn/Complaint Withdrawn	Complainant requested that the complaint be withdrawn.