Glossary of Terms from the Office of the Patient Advocate's Annual Complaint Data Report for Measurement Year 2017

The glossary includes terms defined by the National Association of Insurance Commissioners (NAIC), Office of the Patient Advocate, and other state entities. Many 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
1095-A	An IRS tax form from Covered California to the consumer to report information on enrollment in a qualified health plan in the individual market through the Exchange marketplace, including – by month in the tax year – the premium of the qualified health plan, the premium of the second-lowest silver plan available, and the amount of advance payment of premium tax credit received by the consumer.
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.
Administrative Law Judge	A judge who resolves claims or disputes involving administrative law.
Appeal	A kind of complaint in which a consumer asks for a review of a decision made by a health plan or coverage program.
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.
Beneficiary	The person who benefits from an insurance policy or coverage program.
Benefits Identification Card (BIC)	People who are determined 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.
Billing/Reimbursement Issue	Complaint reported by DHCS regarding a problem with billing or reimbursement.
Breast and Cervical Cancer Treatment Program	A DHCS special program that provides treatment coverage for individuals diagnosed with breast or cervical cancer.
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.
CalPERS (California Public Employees' Retirement System)	A source of coverage data element indicating the organization that provides health and other benefits to California public employees, retirees, and their families.
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.

Term	Explanation
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. These plans also are called minimum coverage plans. Covered California minimum coverage plans are only available to people under age 30.
Chiropractic	Coverage for care provided by a chiropractor. Normally, not seen as regular health maintenance but as a term recovery plan.
Claim	Request to a health plan or coverage program asking for payment based on the terms of the insurance policy.
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. CDI uses this result to indicate that the claim was settled in the consumer's favor.
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.
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)	A U.S. statute that requires employers sponsoring group health plans to 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. As a complaint reason, indicates a complaint regarding a health plan with COBRA as the source of coverage, or a problem obtaining continuation coverage through COBRA.
Co-Insurance	A share of the cost of a health care service. Co-insurance is a percent of the bill for a service.
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 enrollees during the same year. Some complaint ratios are based on the number of health plan complaints divided by the number of health plan enrollees. Some complaint ratios are based on the number of coverage complaints in a county divided by the number of county enrollees. The report displays complaint ratios as complaints per 10,000 members.
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 Result	Primary outcome of the review of the consumer's complaint.
Complaint Type	A data category for complaints reported to OPA that identifies the complaint review process used by the reporting entity, such as Standard Complaint, State Fair Hearing, Independent Medical Review, Quick Resolution, and Urgent Nurse.
Complaint Withdrawn	Complainant requested that the complaint be withdrawn.

Term	Explanation
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 that the regulated entity or individual was in violation or otherwise at fault.
Consumer Received Requested Service	A complaint result indicating that the consumer received the requested service after the complaint was filed.
Continuation of Benefits	Complaint regarding COBRA (Comprehensive Omnibus Budget Reconciliation Act) enrollment and/or coverage after the insured no longer qualifies for group coverage.
Co-Pay	A fixed charge (flat fee) for a health care service. You usually pay the co-pay when you get the service. You pay the same fee each time.
Co-Pay, Deductible, and Co-Insurance Issues	Complaint alleging that the incorrect co-pay, deductible, or co-insurance amount has been applied to a claim.
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, all Medi-Cal members are in the same managed care plan.
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 Position Overturned	A Covered California complaint result identifying a complaint was resolved by Covered California to ensure compliance with applicable state law/requirement.
Covered California/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.
Covered Lives	Policyholders, subscribers, enrollees, or other individuals participating in a health benefit plan.
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).
Deductible	The amount you must pay each year for health care before your health plan starts to pay.
Delays/No Response	Complaint alleging untimely response to, or failure to respond to, policyholder request for information.
Denial of Coverage	Complaint that coverage was improperly denied.
Denied Services	Complaint alleging that the complainant was improperly refused health-related services.
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 Federal Employees Health Benefits Program or Medicare and Medicaid programs.
Denti-Cal	DHCS program that provides dental services to Medi-Cal members.
Dis/Enrollment	Complaint regarding issues related to enrollment in coverage.
Discount Plan	A product type licensed by DMHC. Discount plan companies charge a membership fee for members to be able to access discounted prices for health care services from contracted providers. Discount plans are not insurance.

Term	Explanation
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.
Enrollment	The process of a health plan initiating coverage for a new member or renewing a policy. Enrollment generally occurs after a coverage program or employer determines eligibility. Enrollment can also refer to the number of members who are a part of a health plan or coverage program.
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.
Ethnicity	A demographic data category for the Complaint Data Report consisting of elements Hispanic or Latino, Not Hispanic or Latino, Unknown, and Refused.
Exchange	A product type indicating 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.
Fiscal Intermediary (FI)	A contracted company that serves as the government's agent for claims processing and managing related systems for administering a public health care program.
Full-Service License	A full-service license is issued by DMHC to a health plan that meets requirements under the Knox-Keene Act and provides a full range of basic health care services, including preventive and routine care, physician and hospital services, and emergency and urgent care.
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.
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	A product type indicating 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). Grandfathered plans were made exempt from some provisions of the ACA.
Grievance	A complaint that you make to your health plan. In a grievance, you ask your health plan to solve a problem or change a decision they made about your care.

Term	Explanation
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 against sickness or injury where the group is the policyholder and the individual insured is the certificate holder.
Health Care Delivery	The provision of health care services to members enrolled in a health plan or coverage program. Health care delivery complaints include those related to provider access, quality of care, and payment for services.
Health Only	Insurance covering sickness only. This can include an HMO (Health Maintenance Organization), which provides basic health care services to enrollees on a prepaid basis except for enrollees' responsibility for co-payments and 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.
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.
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	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.
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.
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.

Term	Explanation
Limited Benefits Plan	A health insurance policy with limited benefit payments where all benefits have been paid to the beneficiary. These policies usually limit the services the plan will cover and have a low maximum amount the plan will pay out. Limited-benefits plans include critical illness plans, indemnity plans, and “hospital cash” policies.
Long Term Care	A product type indicating a range of services and support for personal care needs. Most long-term care isn't medical care, but rather help with basic personal tasks of everyday life, sometimes called activities of daily living.
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.
Managed Care	Health plans that contract with health care providers and medical facilities to provide care for members at reduced costs. HMOs, PPOs, EPOs, and POS plans are all managed care plans.
Medicaid	Medicaid is a Federal-State jointly-funded program that provides health care coverage to eligible children and adults with low incomes, including seniors and people with disabilities. Medicaid also provides long term care and related services to beneficiaries who qualify. California’s Medicaid program is called Medi-Cal and is administered by the California Department of Health Care Services.
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 Coordinated Care	A product type indicating a Medi-Cal managed care model approved by the federal government under an 1115 Waiver. The Coordinated Care Initiative’s Cal MediConnect demonstration project in certain counties provided beneficiaries with both Medicare and Medi-Cal (dual eligible) the option to receive all benefits in a single organized delivery system for medical, long-term care, and behavioral health services. The other major part of the initiative required all beneficiaries to join a Medi-Cal managed care plan to receive their Medi-Cal benefits, even if they opted out of Cal MediConnect or were not in a demonstration county.
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 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.
Medical Necessity Denial	Complaint alleging that the insurer has improperly denied covered services as not medically necessary.
Medi-Cal/Medicare	A source of coverage category indicating the consumer has dual coverage through the Medi-Cal and Medicare programs.
Medically Necessary	Care that you need in order to prevent, find, or treat a health problem. In general, health plans only cover medically necessary care. This care must meet accepted standards of medicine. There should be evidence that you need the treatment and that it can help problems like yours.

Term	Explanation
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 Supplement	A product type indicating coverage that provides for accident and health expenses not covered under Medicare. There are various types of standard policy form choices available for Medicare supplemental insurance coverage. Medicare supplemental insurance is sometimes referred to as Medigap.
Mental Health	A product type indicating coverage for professional mental health services such as psychologist, crisis centers, and rehabilitative therapy. A mental health diagnosis involving 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).
Mini-Med Plan	A health plan that features very limited benefits, usually limiting the services the plan will cover and with a low annual maximum amount the plan will pay out.
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.
Modified Adjusted Gross Income (MAGI)	A specified methodology defining households and counting income used for determining eligibility for the most common forms of Medi-Cal and for financial assistance through Covered California.
No Action Requested/Required	Complaint result indicating that the complaint review organization received only a copy of a complaint that the complainant sent directly to the company, or there was no direct request for assistance. For DHCS, this result indicates that the State Fair Hearing case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.
No Jurisdiction	Complaint does not fall under the regulatory authority or oversight of the reporting entity, 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.
Other	Indicating a category not fitting into any specific standardized report category.
Other Health Coverage (OHC)	An inquiry topic reported by DHCS that refers to private health insurance that Medi-Cal members are required to report to ensure that Medi-Cal is the payer of last resort.
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 filed for services that have been requested, received or determined to be, out-of-network.

Term	Explanation
Overturned/Health Plan Position Overturned	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. Reporting entity 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 was available, and that a claim processed at the out-of-network benefit level should be reprocessed as an in-network claim.
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. As a product type, indicates a plan that provides coverage for pharmacy benefits.
Plan/Staff Attitude and Service	A complaint reason alleging unacceptable attitude or treatment from a health plan's staff.
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.
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 usually see providers without prior approval from the plan.
Premium	The amount a person pays each month to keep their health plan. For many people, their employer or the government may pay all or part of the premium.
Premium Notice/Billing	A complaint reason alleging an 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.
Primary Language	The language a person was exposed to from birth or a very early age, or the main language a person uses to communicate. For the Complaint Data Report, primary language data elements include Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Refused, Russian, Spanish, Tagalog, Unknown, and Vietnamese.
Product Type	A complaint data category used to identify details about specific areas of coverage, such as the health program's delivery system or 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.

Term	Explanation
Provider	A health professional or heath practitioner who provides preventative, curative, promotional, or rehabilitative health care services. For this report, provider may refer to an individual or a hospital, clinic, medical group, or other group of professionals that provide medical services.
Provider Attitude and Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior by a provider or their representative.
Quality of Care	Complaint alleging that the health care provided was not appropriate for their health needs or the provider did not possess sufficient competency.
Question of Fact/Contract/Provision/Legal Issue	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 or oversight of the reporting entity.
Quick Resolution (QR)	A complaint type reported by DMHC. DMHC staff use the QR process for certain issues that can be resolved without standard complaint or urgent nurse processes, 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).
Race	A demographic data category for the Complaint Data Report consisting of data elements White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Other, Unknown, and Refused.
Recovery	A return of money or benefits to the insured/complainant.
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.
Refused/Unknown	A data element indicating that the complainant either was not asked for or refused to provide this information.
Regulator	Government entity that has the authority to oversee and enforce relevant laws and regulations that apply to a health plan. The oversight of commercial insurance includes laws and regulations related to licensing, product regulation, financial regulation, and market conduct. For the Complaint Data Report, plan regulator options include California Department of Insurance (CDI), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), Office of Personnel Management (OPM), Department of Labor (DOL), Out of State Department of Insurance, Other, and Unknown.
Rehabilitative/Habilitative Care	Health care services that help a person keep, get back, or improve skills and functioning for daily living that did not develop at a typical age, or that have been lost or impaired because a person was sick, hurt, or disabled. As a complaint reason, a complaint regarding coverage for rehabilitative and/or habilitative services and/or devices.
Renewal	The process of continuing with a health insurance plan from one coverage year to the next.
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).

Term	Explanation
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.
Scope of Benefits	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of 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.
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.
Share of Cost	An inquiry type reported by DHCS indicating the amount in health care costs certain Medi-Cal beneficiaries must pay each month before Medi-Cal pays for their care. The Share of Cost is determined by a beneficiary’s income.
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, and COBRA.
Specialty License	A license is issued by DMHC to a health plan that meets requirements under the Knox-Keene Act and provides health care services in a single specialized area, such as dental, vision, or mental health.
Stand Alone Dental	Coverage provided by a limited scope dental benefits plan through an exchange or in conjunction with a qualified health plan. This type of dental plan is not a part of the medical plan.
Standard Complaint	A report data element indicating a complaint type used 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.

Term	Explanation
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 Fair Hearing: Informal Resolution	A complaint type used by Covered California that identifies an appeal filed with the California Department of Social Services for a State Fair Hearing that was resolved by Covered California before the State Fair Hearing took place.
State Specific (Other)	A complaint data element indicating an element that is state-specific and cannot be conveyed with other available options. Reporting entities use further internal coding to track data as needed.
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.
Subsidy	In this report, indicates a tax credit from the federal government to help eligible low-income people pay for a health plan purchased through Covered California.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal to provide certain health care services to a fee-for-service beneficiary prior to payment.
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.
Uninsured	A product type and source of coverage data element reported by DMHC indicating that the complainant was not enrolled in a health plan or public coverage program at the time of filing the complaint. Other reporting entities may categorize product type and source of coverage by the coverage the uninsured complainant lost and/or was seeking.
Unknown	A complaint data element 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 (DMHC, DHCS, CDI, or Covered California) or because the complainants did not provide information to a reporting entity.
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/Covered California Position Substantiated	A Covered California complaint result indicating that Covered California's original position appears to be in compliance with applicable statutes/regulations.
Upheld/Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
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.

Term	Explanation
Urgent Nurse Complaint (or Urgent Nurse Case)	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.
Vision	Health insurance coverage for eye examinations and eyeglasses or contact lens prescriptions.
Withdrawn/Complaint Withdrawn	Complainant requested that the complaint be withdrawn.