[Ga. Code Ann. § 33-20C-1.]

§ 33-20C-1. Definitions: Accurate Provider Directories

As used in this chapter, the term:

(1) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

(2) "Facility" means an institution providing physical, mental, or behavioral health care services or a health care setting, including, but not limited to, hospitals; licensed inpatient centers; ambulatory surgical centers; skilled nursing facilities; residential treatment centers; diagnostic, treatment, or rehabilitation centers; imaging centers; and rehabilitation and other therapeutic health settings.

(3) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a standalone dental plan.

(4) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified physical, mental, or behavioral health care services consistent with his or her scope of practice under state law.

(5) "Health care provider" or "provider" means a health care professional, pharmacy, or facility.

(6) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance abuse disorders.

(7) "Insurer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and sickness insurance company, a health maintenance organization, a health care plan, or any other entity providing a health insurance plan, a health benefit plan, or health care services.

(8) "Network" means the group or groups of participating health care providers providing services under a network plan.

(9) "Network plan" means a health benefit plan of an insurer that either requires a covered person to use health care providers managed by, owned by, under contract with, or employed by the insurer or that creates incentives, including financial incentives, for a covered person to use such health care providers.

(10) "Standalone dental plan" means a plan of an insurer that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

(11) "Tiers" or "tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost sharing, or provider access requirements, or any combination thereof, apply for the same services.