LB987
2026

LEGISLATURE OF NEBRASKA

ONE HUNDRED NINTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 987

Introduced by Lonowski, 33.

Read first time January 12, 2026

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to insurance; to adopt the Vision Benefit Plan Act; to provide an operative date; to provide severability; and to declare an emergency.

Be it enacted by the people of the State of Nebraska,

LB987
2026

Section 1. Sections 1 to 14 of this act shall be known and may be cited as the Vision Benefit Plan Act.

Sec. 2. For purposes of the Vision Benefit Plan Act:

(1) Chargeback means a dollar amount, fee, surcharge, rebate, or item of value that reduces, modifies, or offsets all or part of the enrollee's responsibility, provider reimbursement, allowed amount, or fee schedule for a covered service or covered material;

(2) Covered materials means materials for which reimbursement from an insurer, vision benefit manager, or subcontractor is provided to an eye care provider by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, copayments, or coinsurance, regardless of how the materials are listed or described in an enrollee's benefit plan's definition of benefits;

(3) Covered services means the professional work performed by an eye care provider for which reimbursements for an insurer, vision benefit manager, or subcontractor are provided to an eye care provider by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual plan limitations of deductibles, copayments, or coinsurance, regardless of how the services are listed or described in an enrollee's benefit plan's definition of benefits;

(4) Director means the Director of Insurance;

(5) Enrollee means any individual participating in a health benefit plan, vision benefit plan, or vision benefit discount plan that is purchased by an individual or provided to an individual by an entity that purchases or supplies coverage for a health benefit plan, vision benefit plan, or vision benefit discount plan;

(6) Extrapolation means a mathematical formula, process, or technique used by a vision benefit manager, or the vision benefit manager's agent, in the audit of an optometrist to estimate audit results

LB987
2026

or findings for a larger batch of claims not reviewed by the vision benefit manager;

(7) Eye care provider means a licensed doctor of optometry practicing under the authority of the Optometry Practice Act or a licensed medical or osteopathic doctor practicing under the authority of the Medicine and Surgery Practice Act;

(8) Fee schedule means the document or system that lists the predetermined payment rates or allowed amounts for covered services or covered materials and determines how much eye care providers are reimbursed by the insurer or vision benefit manager and how much patients are charged by the insurer, vision benefit manager, or eye care provider;

(9) Insurer means an individual, corporation, partnership, company, organization, group, health maintenance organization, captive risk-retention group, self-insurance group, optometric service and indemnity corporation, or other entity, whether organized for profit or not for profit, whether foreign or domestic, that conducts business in this state and that offers a vision benefit plan or provides coverage for vision-related services or vision-related materials to enrollees. For avoidance of doubt, an entity is considered an insurer for purposes of the Vision Benefit Plan Act irrespective of (a) its corporate form or category of licensure, if applicable, including whether it is otherwise subject to insurance regulations or any other regulations, (b) whether it, either directly or indirectly, reimburses, indemnifies, pays, or discounts the costs of vision services or vision materials, or (c) whether it delegates, assigns, or contracts performance of any function regulated by the act to an affiliate, subsidiary, contractor, intermediary, or network leasing entity;

(10) Materials means ophthalmic devices, including, but not limited to, lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coatings, contact lenses, low vision devices, vision

LB987
2026

therapy devices, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa, or any material allowed to be utilized by the Board of Optometry and the Optometry Practice Act;

(11) Nominal means, when there is no corresponding reimbursement in the current year's published Physician Fee Schedule released annually by the federal Centers for Medicare and Medicaid Services or in the current year's published state medicaid fee schedule, an amount less than the reasonable compensation to the eye care provider rendering the covered service or covered materials, taking into account the provider's direct and indirect costs, including the actual acquisition costs and actual pro rata overhead costs and reasonable profit;

(12) Participating eye care provider means an eye care provider that has entered into a contractual agreement or other business relationship with an insurer, vision benefit manager, third-party administrator, or subcontractor to provide covered services or covered materials;

(13) Subcontractor means an individual, company, organization, group, or other entity, including, but not limited to, agents, servants, brokers, wholesalers, distributors, partially owned or wholly owned subsidiaries, and controlled organizations, that is contracted by the vision benefit manager to supply services or materials to another vision benefit manager, eye care provider, or enrollee to execute or fulfill the health benefit plan, vision benefit plan, or vision benefit discount plan of a vision benefit manager;

(14) Vision benefit discount plan means a policy, contract, or agreement offered by an insurer or vision benefit manager to an enrollee that solely provides for a discount for vision care services or materials;

(15) Vision benefit manager means an individual, company, organization, group, or other entity, including, but not limited to, an insurer, a third-party administrator, and a subcontractor, that creates,

LB987
2026

promotes, sells, provides, advertises, or administers an integrated or stand-alone vision benefit plan, vision benefit discount plan, or other insurance policy or contract which provides vision benefits or discounts to an enrollee pertaining to the provision of covered services or covered materials; and

(16) Vision benefit plan means a policy, contract, agreement, or any prepaid vision plan offered by an insurer or vision benefit manager to an enrollee to pay for, reimburse, discount, or offset healthcare costs.

Sec. 3. (1) An insurer or vision benefit manager shall disclose the following information publicly on its website and with all documents and document packages, including, but not limited to, proposals, responses to requests for proposals, sales documents, enrollment documents, benefit plan documents, purchaser contracts, enrollee contracts, and provider agreements that are presented to purchasers, potential purchasers, enrollees, potential enrollees, participating eye care providers, potential participating providers, and state agencies with jurisdictional, regulatory, or enforcement authority over its business:

(a) Its legal name and entity type;

(b) Its legal address and the state in which the legal entity is formed or organized;

(c) The physical address, mailing address, electronic mail address, and phone number of its operational headquarters;

(d) The agencies, departments, committees, commissions, and other bodies that have jurisdictional, regulatory, or enforcement authority over its business;

(e) A statement that no jurisdictional, regulatory, or enforcement authority exists over its business, if none exists;

(f) The names, physical addresses, mailing addresses, electronic mail addresses, and phone numbers of all parent companies, related holding companies, wholly owned subsidiary companies, and partially owned subsidiary companies;

LB987
2026

(g) All federal and state litigation in which the insurer or vision benefit manager is, or has been, a party in the current year and during the preceding five years; and

(h) All formal complaints to the Department of Insurance against the insurer or vision benefit manager in the current year and during the preceding five years by purchasers, enrollees, or eye care providers.

(2) All information required to be disclosed by an insurer or vision benefit manager in subsection (1) of this section shall be conveyed in plain language, shall be typed with a minimum of ten-point font size, and shall be prominently displayed:

(a) On the insurer's or vision benefit manager's website in a publicly accessible section titled "Required Transparency Information for Patients, Doctors, and Purchasers"; and

(b) In a separately created document titled "Required Transparency Information for Patients, Doctors, and Purchasers" that shall be included with all documents and document packages, including, but not limited to, proposals, responses to requests for proposals, benefit plan documents, sales documents, enrollment documents, purchaser contracts, enrollee contracts, and provider agreements.

(3) An insurer or vision benefit manager shall provide notice to each participating eye care provider of any proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents via electronic mail.

(4) A participating eye care provider shall be provided with a minimum of ninety calendar days from the time of distribution to review changes and respond, if necessary, to any proposed amendments from an insurer or vision benefit manager to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents. Any such proposed amendments proffered by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law.

LB987
2026

(5) Any proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents by an insurer or vision benefit manager delivered to a participating eye care provider shall be:

(a) Enumerated in a cover letter;

(b) Marked with highlights or in tracked changes within the applicable agreements or documents to clearly display all changes over the previous version; and

(c) Structured to include implications of agreeance or non-agreeance by the participating eye care provider.

(6) An insurer or vision benefit manager shall maintain:

(a) A phone number to company representatives to receive questions and communications from participating eye care providers at all times during standard business hours;

(b) The ability for an eye care provider to leave voice messages at all times; and

(c) The ability for an eye care provider to have a live phone discussion with a company representative within twenty-four hours of an initial phone call or a voice message left with the insurer or vision benefit manager.

(7) An insurer or vision benefit manager shall maintain a physical mailing address and an electronic mail address to company representatives to receive questions, disputes, and communications from participating eye care providers about all matters, at all times, including, but not limited to, proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, and related policy documents, and shall publish instructions for mail submission and electronic mail submission of questions, disputes, and communications in a place visible to participating eye care providers, including on its website and in any provider agreements, provider handbooks, provider manuals, or related policy documents.

LB987
2026

(8) An insurer or vision benefit manager shall acknowledge receipt of an electronic mail message within one hour by use of a return electronic mail message with a communication tracking number and shall respond to the substantive questions or communications of the electronic mail message within seventy-two hours in writing by use of a return electronic mail message.

(9) An insurer or vision benefit manager shall, at all times, make available to the eye care provider the most up-to-date provider agreements, fee schedules, provider handbooks, provider manuals, and related policy documents via website access.

(10) Insurers or vision benefit managers shall not engage in marketing or advertising activities that are misleading or deceptive to the public. Such acts are considered deceptive trade practices and subject to penalty under the Uniform Deceptive Trade Practices Act.

(11) Upon request by a state agency with jurisdictional, regulatory, or enforcement authority over its business, an insurer or vision benefit manager shall submit all information related to a health benefit plan, vision benefit plan, or vision benefit discount plan, including, but not limited to, proposals, responses to requests for proposals, benefit plan documents, sales documents, enrollment documents, purchaser contracts, enrollee contracts, provider agreements, and marketing and advertising activities, for review.

Sec. 4. (1) No agreement or contract between an insurer or vision benefit manager and an eye care provider may seek to or require that an eye care provider provide services or materials at a fee limited or set by the insurer or vision benefit manager unless the services or materials are defined and reimbursed as covered services or covered materials under the agreement or contract.

(2) An insurer or vision benefit manager shall only use standardized codes, names, descriptions, and definitions published in the Healthcare Common Procedure Coding System, including Current Procedural Terminology

LB987
2026

codes published by the American Medical Association and Level II codes published by the federal Centers for Medicare and Medicaid Services, to identify and describe covered services and covered materials of the vision benefit plan to purchasers, enrollees, and eye care providers of the vision benefit plan.

(3) An insurer or vision benefit manager shall adhere to the standardized codes, names, descriptions, and definitions published in the Healthcare Common Procedure Coding System, including all Current Procedural Terminology codes published by the American Medical Association and all Level II codes published by the federal Centers for Medicare and Medicaid Services, to create and offer a fee schedule for covered services and covered materials in an agreement between the insurer or vision benefit manager and an eye care provider.

(4) An insurer or vision benefit manager shall not attempt to alter the meaning of any of the standardized codes, names, descriptions, or definitions published in the Healthcare Common Procedure Coding System, including all Current Procedural Terminology codes published by the American Medical Association and all Level II codes published by the federal Centers for Medicare and Medicaid Services. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law.

(5) All fee schedules in an agreement between an insurer or vision benefit manager and an eye care provider and all reimbursements paid by an insurer or vision benefit manager to an eye care provider for all covered services and covered materials shall not be nominal or de minimis. There shall be no limitation on the ability of an individual eye care provider or a group of eye care providers who practice under a single employer identification number or tax identification number to engage in direct negotiations with the insurer or vision benefit manager regarding reimbursement fee schedules and ultimately agreeing to a

LB987
2026

different fee schedule than the fee schedule provided by the insurer or vision benefit manager to other participating providers or groups.

(6) All fee schedule allowed amounts and all reimbursements paid by an insurer or vision benefit manager for each covered service and covered material shall be clearly and individually listed on a fee schedule made available to the eye care provider:

(a) At the time an agreement is offered to the eye care provider by an insurer or vision benefit manager;

(b) Within fifteen business days from the date an application is made to become a participating eye care provider with the insurer or vision benefit manager by the eye care provider; and

(c) At all times via electronic means to the participating eye care provider.

(7) A contract between an insurer or vision benefit manager and an eye care provider shall include a fee schedule that includes and individually identifies each covered service and covered material and its corresponding allowed amount, reimbursement amount paid to the eye care provider, and any form of a cost-sharing amount paid by the enrollee to the eye care provider.

(8) Insurers or vision benefit managers shall not advertise, claim, or represent to purchasers or enrollees that services and materials provided by a participating eye care provider are covered, included, or covered with an additional deductible, copay, or coinsurance if the insurer or vision benefit manager does not remit an actual payment to the participating eye care provider as full or partial reimbursement for the service or material.

(9) A service or material provided by a participating eye care provider cannot be designated as a covered service or covered material by the insurer or vision benefit manager in the design of a health benefit plan, vision benefit plan, or vision benefit discount plan if the reimbursement amount to the participating eye care provider is only

LB987
2026

comprised of an enrollee's payment to the participating eye care provider.

(10) Insurers or vision benefit managers shall not condition application to or network participation in a health benefit plan, vision benefit plan, or vision benefit discount plan by an eye care provider based on the eye care provider's usual and customary pricing or discounts on usual and customary pricing for services or materials that are not covered services or not covered materials. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law.

(11) Insurers or vision benefit managers shall not make conditional a fee schedule proposed or made to an eye care provider of a health benefit plan, vision benefit plan, or vision benefit discount plan for covered services or covered materials based on the eye care provider's usual and customary pricing or discounts on usual and customary pricing for services or materials that are not covered services or not covered materials. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law.

(12) A contract between an insurer or vision benefit manager and an eye care provider shall not contain a provision, fee schedule, or reimbursement amount in which the eye care provider, with consideration of any applicable deductibles, copays, coinsurances, discounts, rebates, or chargebacks, provides covered services or covered materials to an enrollee at a financial loss. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law.

(13) The period of time prescribed by a contract between any insurer or vision benefit manager and an eye care provider for the insurer or vision benefit manager to recover any reimbursement amount from an eye

LB987
2026

care provider shall be the same period of time allowed or required for any insurer or vision benefit manager to remit the applicable reimbursement following an eye care provider's submission of a clean claim for services rendered or materials furnished. This subsection shall not limit the ability of an insurer or vision benefit manager to conduct an audit of claims, in accordance with the insurer's or vision benefit manager's written policies and applicable law, in the event that the insurer or vision benefit manager has a reasonable belief that the eye care provider has engaged in fraud, waste, or abuse.

(14) Insurers or vision benefit managers shall not falsely represent the number of participating providers in a region or the benefits that comprise a health benefit plan, vision benefit plan, or vision benefit discount plan to clients, groups, employers, purchasers, companies, enrollees, or prospective enrollees. Such acts are considered deceptive trade practices and subject to penalty under the Uniform Deceptive Trade Practices Act.

(15) An insurer or vision benefit manager shall not promote or use in any marketing or advertising for a health benefit plan, vision benefit plan, or vision benefit discount plan that a covered service or covered material is free, no charge, complimentary, or any materially similar language to induce a client, group, employer, purchaser, company, enrollee, or prospective enrollee to purchase services, materials, supplies, or plans from the insurer, vision benefit manager, or an affiliate of the insurer or vision benefit manager.

(16) Insurers or vision benefit managers shall not offer enrollees of a health benefit plan, vision benefit plan, or vision benefit discount plan varying deductibles, copays, coinsurances, coverage amounts, rebates, gift cards, or other monetary or nonmonetary incentives to obtain covered services, covered materials, noncovered services, or noncovered materials:

(a) At any particular participating eye care provider;

LB987
2026

(b) At a retail establishment owned by, partially owned by, contracted with, or otherwise affiliated with the insurer or vision benefit manager; or

(c) At any Internet or virtual provider or retailer owned by, partially owned by, contracted with, or otherwise affiliated with the insurer or vision benefit manager.

(17) Insurers or vision benefit managers shall remit to the participating eye care provider the contracted reimbursement amount from the fee schedule for a covered service or covered material provided to an enrollee if the enrollee is verified to be eligible by the participating eye care provider through customary verification methods of the insurer or vision benefit manager to receive the covered service or covered material on the date of service.

(18) Insurers or vision benefit managers shall not retroactively reverse a reimbursement or withhold a future reimbursement to a participating eye care provider who relied in good faith on an individual's presented coverage credentials and the customary verification methods of the insurer or vision benefit manager if the vision benefit manager later determines that the enrollee was ineligible to receive covered services or covered materials on the date of service.

(19) Insurers or vision benefit managers shall not require a participating eye care provider, purchaser, or enrollee of a health benefit plan, vision benefit plan, or vision benefit discount plan to obtain prior authorization, preauthorization, precertification, or any similar mechanism that restricts the enrollee from receiving a covered service or covered material recommended by the eye care provider and requested by the enrollee.

(20) Participating eye care providers are allowed, but not required, to offer an enrollee the opportunity to pay the participating eye care provider directly for covered services and covered materials if such direct payment would be less costly to the enrollee than the total out-

LB987
2026

of-pocket cost required under the terms of a health benefit plan or vision benefit plan. A provider may not be subject to an audit, removed from participation in the network, or otherwise penalized or discriminated against in any manner for offering an enrollee the opportunity to pay the participating provider directly under the conditions described in this subsection.

(21)(a) Insurers or vision benefit managers shall not, in the course of adjudicating a claim for reimbursement by a participating eye care provider for a covered service or covered material, alter, delete, substitute, or otherwise change any code or modifier submitted by the eye care provider, including by downcoding, bundling, or reassigning to a different code, if such change would reduce payment or otherwise adversely affect the provider or enrollee.

(b) For purposes of this subsection:

(i) Bundling means to combine, substitute, or treat two or more distinct services, supplies, or materials reported on the same claim or date of service as included within a single code, package, or global service, and denying, reducing, or disallowing separate reimbursement for one or more of these codes; and

(ii) Downcoding means to alter, delete, substitute, or assign a code that results in a lower level of service, a lower-valued code, or a reduced reimbursement amount relative to the code submitted by the eye care provider.

(22) All provisions of this section shall apply to all affiliates, parent companies, third-party administrators, and subcontractors that are used by an insurer or vision benefit manager to supply covered services or covered materials to an eye care provider or enrollee, and such affiliates, parent companies, third-party administrators, and subcontractors shall be subject to all applicable penalties as provided in this section.

(23) An insurer or vision benefit manager shall not require or

LB987
2026

request an eye care provider to opt in or opt out of the provisions set forth in the Vision Benefit Plan Act.

Sec. 5. (1) No agreement between an insurer or vision benefit manager and an eye care provider shall require that an eye care provider must participate with, be credentialed by, or enter into an agreement with any specific vision benefit plan or vision benefit discount plan as a condition for participation in the health benefit plan provider network of the insurer or vision benefit manager to provide covered services or covered materials to the enrollees of the health benefit plan.

(2) No agreement between an insurer or vision benefit manager and an eye care provider shall require that an eye care provider must participate with, be credentialed by, or enter into an agreement with any specific health benefit plan as a condition for participation in the vision benefit plan or vision benefit discount plan provider network of the insurer or vision benefit manager to provide covered services or covered materials to the enrollees of the vision benefit plan or vision benefit discount plan.

(3) Any insurer or vision benefit manager issuing or renewing a health benefit plan, vision benefit plan, or vision benefit discount plan which provides benefits for covered services or covered materials rendered by a physician or osteopath duly licensed under the Medicine and Surgery Practice Act that are within the scope of practice of an optometrist duly licensed under the Optometry Practice Act shall provide the same reimbursement for covered services or covered materials to optometrists as allowed for those covered services or covered materials rendered by physicians or osteopaths.

(4) An insurer or vision benefit manager shall apply the same terms and conditions of participation for all eye care providers, irrespective of their educational credentials, subject to the permitted scope of practice for the provider under applicable state law.

(5) An insurer or vision benefit manager shall not require an eye

LB987
2026

care provider to possess, offer, procure, or sell materials or covered materials in the provider's office as a condition of participation in the provider network of the health benefit plan, vision benefit plan, or vision benefit discount plan. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law.

(6) If an eye care provider enters into any subcontract agreement with another provider to provide his or her licensed health care services to an enrollee or a covered dependent of an enrollee of a health benefit plan, vision benefit plan, or vision benefit discount plan where the subcontracted provider will seek reimbursement from the plan or enrollee for the subcontracted services, the subcontract agreement must meet all requirements of the Vision Benefit Plan Act.

(7) The provisions of this section shall apply to any agreements an insurer or vision benefit manager enters into with another entity to provide an enrollee with covered services or covered materials.

Sec. 6. (1) It is prohibited for an insurer or vision benefit manager that offers multiple health benefit plans, vision benefit plans, or vision benefit discount plans to require an eye care provider, as a condition of participation in the network for a health benefit plan, vision benefit plan, or vision benefit discount plan, to participate in the network of any of the insurer's or vision benefit manager's other health benefit plans, vision benefit plans, or vision benefit discount plans. A contract provision violating this subsection is void as a matter of law.

(2) It is prohibited for an insurer or vision benefit manager that offers multiple health benefit plans, vision benefit plans, or vision benefit discount plans to withhold participation in the network of one or more of the insurer's or vision benefit manager's other health benefit plans, vision benefit plans, or vision benefit discount plans if the eye care provider, having completed the credentialing requirements of the

LB987
2026

insurer or vision benefit manager for participation, is already participating in the network of one or more of the insurer's or vision benefit manager's health benefit plans, vision benefit plans, or vision benefit discount plans and seeks to participate in the network of the insurer's or vision benefit manager's other health benefit plans, vision benefit plans, or vision benefit discount plans.

(3) Subsections (1) and (2) of this section apply to all plan types that a health benefit plan, vision benefit plan, or vision benefit discount plan sells, administers, or offers, including, but not limited to, individually purchased plans, employer-sponsored plans, and government-sponsored plans.

Sec. 7. (1) An insurer or vision benefit manager shall include on its website:

(a) A method for an eye care provider to submit an application for inclusion and credentialing as a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan; and

(b) A description of the credentialing requirements, which must be reasonable, related to the delivery of covered eye care services, and applied in an objective, uniform, and nondiscriminatory manner.

(2) An insurer's or vision benefit manager's application for inclusion and credentialing as a participating eye care provider in the health benefit plan, vision benefit plan, or vision benefit discount plan must impose the same application and credentialing requirements on each eye care provider.

(3) No later than the tenth business day after the date the insurer or vision benefit manager receives an application from an eye care provider for inclusion and credentialing as a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan, the insurer or vision benefit manager shall make available electronically to the eye care provider a proposed participating provider agreement, including applicable fee schedules, provider handbooks, and

LB987
2026

provider manuals.

(4) No later than the thirtieth business day after the date the insurer or vision benefit manager receives an application from an eye care provider for inclusion and credentialing as a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan, the insurer or vision benefit manager shall complete the credentialing determination of the eye care provider, approve or disapprove the application of the eye care provider, and deliver electronically a proposed participating provider agreement described in subsection (3) of this section for acceptance and signature of the approved eye care provider.

(5) If the application for inclusion and credentialing as a participating provider is denied by the insurer or vision benefit manager, the insurer or vision benefit manager shall deliver to the applicant eye care provider a detailed explanation for the denial both electronically and in writing via certified mail.

(6) If the application for inclusion and credentialing as a participating provider is denied by the insurer or vision benefit manager, the eye care provider must be allowed a reasonable period of time in which to appeal the decision to the insurer or vision benefit manager and provide in the appeal evidence that supports the reconsideration of the denied application. The insurer or vision benefit manager shall consider, and render a decision on, the eye care provider's appeal submission within thirty days of the date of receipt of the submission by the insurer or vision benefit manager.

(7) If the appeal of the application denial for inclusion and credentialing as a participating provider is denied by the insurer or vision benefit manager, the insurer or vision benefit manager shall deliver to the applicant eye care provider a detailed explanation for the denial of the appeal both electronically and in writing via certified mail.

LB987
2026

(8) An insurer or vision benefit manager, concurrent with the electronic delivery of the proposed participating provider agreement to the approved eye care provider pursuant to subsection (4) of this section, must provide the name, email address, and phone number of a representative of the insurer or vision benefit manager to allow the approved eye care provider the opportunity to:

(a) Contact the representative before signing the agreement;

(b) Discuss the proposed agreement with the representative before signing the agreement; and

(c) Electronically send the representative modifications to the proposed agreement before signing the agreement.

(9) In the event that the approved eye care provider sends the representative of the insurer or vision benefit manager modifications to the proposed participating provider agreement pursuant to subdivision (8)(c) of this section, the insurer or vision benefit manager must respond to the submission of the approved eye care provider within five business days. Each subsequent response made by the insurer, vision benefit manager, or approved eye care provider to the other party must be responded to within five business days by the receiving party.

(10) Once the insurer or vision benefit manager has approved and delivered electronically a proposed participating provider agreement pursuant to subsection (4) of this section, the approved eye care provider has a total allotted timeframe of ninety business days to reach agreement with the insurer or vision benefit manager and sign a participating provider agreement. If the parties fail to reach agreement and no participating provider agreement is signed by the approved eye care provider within the allotted timeframe, the insurer or vision benefit manager may retract the participating provider agreement.

(11) No later than the twentieth business day after the date the approved eye care provider signs a participating provider agreement, the insurer or vision benefit manager shall include the credentialed and

approved eye care provider as a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan and list the eye care provider in all of the plan's directories that are available to enrollees and the public.

(12) The earliest that an eye care provider may submit another application to an insurer or vision benefit manager after a previous approval and subsequent unsuccessful attempt to negotiate a mutually acceptable participating provider agreement is one hundred eighty calendar days from the date of submission of the previous application.

(13) The earliest that an eye care provider may submit another application to an insurer or vision benefit manager after a previous disapproval of an application is one hundred eighty calendar days from the date of submission of the previous application.

(14) An insurer or vision benefit manager shall allow an eye care provider to become a participating provider in the network of a health benefit plan, vision benefit plan, or vision benefit discount plan if the eye care provider (a) meets the credentialing requirements of the insurer or vision benefit manager and (b) agrees in writing to the applicable provider agreement.

(15) An insurer or vision benefit manager shall not exclude an eye care provider from applying to, or becoming a participating provider in, the network of a health benefit plan, vision benefit plan, or vision benefit discount plan because of:

(a) The aggregate number of eye care providers in a state, county, city, zip code, or other geographically defined service area;

(b) The time, distance, or appointment availability for an enrollee to access a participating eye care provider; or

(c) The provider's professional designation, independent practice affiliation, or participation status in other health benefit plans, vision benefit plans, or vision benefit discount plans.

Sec. 8. (1) An insurer or vision benefit manager shall not change

LB987
2026

or alter a provider agreement, including terms, reimbursements, fee schedules, policies, procedures, or provider manuals incorporated by reference into the provider agreement, entered into with a participating eye care provider unless the insurer or vision benefit manager performs the following steps at least ninety days before the date the proposed change would take effect:

(a) A certified letter, or an electronic communication requiring an electronic signature proving receipt, clearly detailing the proposed changes must be sent to the eye care provider;

(b) A face-to-face or virtual meeting must be held to discuss proposed changes if requested by the eye care provider;

(c) The eye care provider must either agree to or protest in writing the proposed changes. If the changes are not agreed to by the eye care provider, then the current agreement shall continue and the insurer or vision benefit manager shall not remove the eye care provider from participation with a health benefit plan, vision benefit plan, or vision benefit discount plan for not accepting the proposed changes; and

(d) Any proposed amendment to an existing provider agreement must be presented to the participating eye care provider in a manner conducive to the eye care provider's review. The proposed changes shall be (i) enumerated in a cover letter and (ii) clearly marked in tracked changes within the body of the applicable agreement.

(2) Termination of any provider agreement shall be permissible only in the event of a material breach, wherein the eye care provider fails to remedy the alleged breach to the reasonable satisfaction of the insurer or vision benefit manager within thirty days of receipt of written notice specifying the alleged breach.

(3) It shall be prohibited for an insurer or vision benefit manager to require an eye care provider to establish a security interest in all or part of the provider's property and assets, including assets pertaining to the provider's practice, in a sum equivalent to the funds

LB987
2026

owed to the insurer or vision benefit manager at termination. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law.

(4) A provider agreement between an insurer or vision benefit manager and an eye care provider shall not contain a provision requiring the provider to accept a reimbursement payment in the form of a virtual credit card or any other payment method wherein a processing fee, administrative fee, percentage amount, or dollar amount is assessed for the provider to receive the reimbursement payment.

(5) A provider agreement between an insurer or vision benefit manager and an eye care provider shall not contain a provision obligating the eye care provider to share equally the expenses of arbitration. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law. Each party shall bear their own arbitration costs, contingent upon a fee-shifting provision that grants prevailing party status.

(6) An insurer or vision benefit manager shall not retaliate in any manner against an eye care provider for discussing, or attempting in good faith to negotiate, the terms and provisions of a provider agreement with the insurer or vision benefit manager.

(7) An insurer or vision benefit manager shall not retaliate in any manner against an eye care provider for filing a complaint against the insurer or vision benefit manager with any state agency with jurisdictional, regulatory, or enforcement authority over the business of the insurer or vision benefit manager.

(8) Should retaliation by an insurer or vision benefit manager occur against an eye care provider in violation of subsection (6) or (7) of this section, a state agency that has jurisdictional, regulatory, or enforcement authority over the business of the insurer or vision benefit

LB987
2026

manager may sanction the insurer or vision benefit manager, including fines and other remedies deemed appropriate, and provide an appropriate remedy for the aggrieved eye care provider.

Sec. 9. (1) No agreement between an insurer or vision benefit manager and an eye care provider shall restrict or limit, either directly or indirectly, the eye care provider's choice or use of sources and suppliers of covered or uncovered services or materials, including the choice or use of optical laboratories, provided by the eye care provider to an enrollee. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of this subsection shall be void and unenforceable as a matter of law.

(2) An insurer or vision benefit manager shall not directly or indirectly:

(a) Control or attempt to control the professional judgment, manner of practice, or practice of an eye care provider;

(b) Employ an eye care provider to provide a covered service or covered material;

(c) Reimburse an eye care provider a different amount for covered services or covered materials because of the eye care provider's choice of:

(i) Optical laboratory;

(ii) Source of supplier of:

(A) Contact lenses;

(B) Ophthalmic lenses;

(C) Ophthalmic glasses frames; or

(D) Covered or noncovered services or materials;

(iii) Equipment used for patient care;

(iv) Retail optical affiliation;

(v) Vision support organization;

(vi) Group purchasing organization;

(vii) Doctor alliance;

LB987
2026

(viii) Professional trade association membership;

(ix) Electronic health record software, electronic medical record software, or practice management software; or

(x) Third-party claim filing service, billing service, or electronic data interchange clearinghouse company;

(d) Restrict, limit, or influence an eye care provider's choice of sources or suppliers of services or materials, including optical laboratories used by the eye care provider to provide services or materials to the enrollee;

(e) Restrict, limit, or influence an eye care provider's choice of electronic health record software, electronic medical record software, or practice management software;

(f) Restrict, limit, or influence an eye care provider's choice of third-party claim filing service, billing service, or electronic data interchange clearinghouse company;

(g) Restrict or limit an eye care provider's access to an enrollee's complete plan coverage information, including in-network and out-of-network coverage details;

(h) Apply a chargeback to an enrollee or eye care provider if the chargeback is for a covered product or service for which the insurer or vision benefit manager does not incur the cost to produce, deliver, or provide such product or service to the enrollee or eye care provider;

(i) Require an eye care provider to disclose an enrollee's confidential or protected health information unless the disclosure is expressly authorized by the enrollee, or permitted without authorization under the Health Insurance Portability and Accountability Act of 1996;

(j) Require an eye care provider to disclose or report a medical history or diagnosis as a condition to file a claim, adjudicate a claim, or receive reimbursement for a routine or wellness eye exam; or

(k) Require an eye care provider to disclose or report an enrollee's glasses prescription, contact lens prescription, ophthalmic device

LB987
2026

measurements, facial photograph, or unique anatomical measurements as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim, unless the information is needed for the vision benefit manager to manufacture, or cause to be manufactured, a covered product that is submitted on the applicable claim.

(3) An insurer or vision benefit manager shall not solicit patients or referrals for supplies on behalf of itself or its affiliates by identifying participating eye care providers in an inaccurate or otherwise misleading manner in any list of participating providers or in any communications to purchasers or enrollees. All communications which distinguish between participating eye care providers, or which otherwise claim professional superiority or the performance of a professional service in a superior manner, based on the following characteristics shall be readily subject to verification by the Department of Insurance:

(a) A discount or incentive offered by the participating eye care provider on services and materials that are not covered by the insurer or vision benefit manager;

(b) The dollar amount, volume amount, or percent usage amount of any material, product, or good purchased by the participating eye care provider; or

(c) The brand, source, manufacturer, or supplier of a covered service or covered material utilized by the participating eye care provider.

(4) For the avoidance of doubt, this section does not prohibit advertising, provided that such advertising is (a) not false, misleading, or deceptive or (b) readily subject to verification.

Sec. 10. An insurer or vision benefit manager shall not use extrapolation to complete an audit of a participating eye care provider. Any additional payment due to a participating eye care provider or any refund due to the insurer or vision benefit manager shall not be based on an extrapolation, but shall be based on the actual overpayment or

LB987
2026

underpayment, as determined after an investigation by the insurer or vision benefit manager, and after the participating eye care provider has been afforded, and has exhausted, all opportunities to appeal the insurer's or vision benefit manager's findings, as set forth in the provider manual or policy document or applicable law.

Sec. 11. (1) The requirements of the Vision Benefit Plan Act are in addition to, and do not limit, any other requirement applicable to an insurer under state law. In the event of a conflict between the act and another provision of state law applicable to insurers, the provision that affords greater protection to eye care providers or plan enrollees shall control.

(2) Notwithstanding any other provision of state law, including any law that purports to be the sole body of law governing the insurer, an insurer shall comply with the Vision Benefit Plan Act, to the extent not preempted by federal law.

Sec. 12. The director may adopt and promulgate rules and regulations to carry out the Vision Benefit Plan Act.

Sec. 13. (1) Except as provided in subsection (2) of this section, the director shall enforce the Vision Benefit Plan Act, and any violation of the act or any rule and regulation adopted and promulgated pursuant to the act shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

(2) The Attorney General shall enforce any violations of the Vision Benefit Plan Act that are considered to be deceptive trade practices subject to penalty under the Uniform Deceptive Trade Practices Act.

(3) The director shall provide a mechanism for aggrieved individuals, whether actively or formerly enrolled with a particular vision benefit plan, to submit complaints to the director for review, investigation, and, as appropriate, discipline under applicable law.

(4) The penalties and remedies provided in this section for a violation of the Vision Benefit Plan Act shall be in addition to any

LB987
2026

other penalties and remedies available under state law and shall not waive, limit, or otherwise affect the applicability of any other law providing for civil or criminal penalties or remedies for unfair, deceptive, or unlawful business practices.

Sec. 14. The Vision Benefit Plan Act shall apply to insurer or vision benefit manager policies, contracts, agreements, and plans delivered, issued for delivery, continued, or renewed in this state on or after the operative date of this act.

Sec. 15. This act becomes operative on July 1, 2026.

Sec. 16. If any section in this act or any part of any section is declared invalid or unconstitutional, the declaration shall not affect the validity or constitutionality of the remaining portions.

Sec. 17. Since an emergency exists, this act takes effect when passed and approved according to law.