medicaid director determines that this provision can be implemented without a waiver, sections 3901.38 and 3901.381 of the Revised Code apply to claims submitted electronically or non-electronically that are made with respect to coverage of medicaid recipients by health insuring corporations licensed under Chapter 1751. of the Revised Code, instead of the prompt payment requirements of 42 C.F.R. 447.46;

(E) A third-party payer for coverage provided under the tricare program offered by the United States department of defense.

Sec. 3901.95. A direct primary care agreement that meets all of the following shall not be considered insurance and nothing in Title XXXIX of the Revised Code shall apply to such an agreement:

(A) It is in writing.

(B) It is between a patient, or that patient's legal representative, and a health care provider and is related to services to be provided in exchange for the payment of a fee to be paid on a periodic basis.

(C) It allows either party to terminate the agreement as specified in the agreement.

(D) It requires termination to be accomplished through written notification.

(E) It permits termination to take effect immediately upon the other party's receipt of the notification or not more than sixty days after the other party's receipt of the notification.

(F) It does not impose a termination penalty or require payment of a termination fee.

(G) It describes the health care services to be provided under the agreement and the basis on which a periodic fee is to be paid in exchange for those services.
(H) It specifies the periodic fee required and any additional fees that may be charged.

(I) It authorizes the periodic fee and any additional fees to be paid by a third party.

(J) It prohibits the health services provider from charging or receiving any fee other than the fees prescribed in the agreement for those services prescribed in the agreement.

(K) It conspicuously and prominently states that the agreement is not health insurance and does not meet any individual health insurance mandate that may be required under federal law.

Sec. 3902.31. (A) As used in this section:

(1) "Pay in full" means paying for a health service in its entirety without cost-sharing on the part of a third-party payer. "Pay in full" includes payment made under a deductible requirement.

(2) "Third-party payer" and "provider" have the same meanings as in section 3901.38 of the Revised Code.

(B)(1) Subject to division (C) of this section, a provision in a contract entered into between a third-party payer and a provider is void and against public policy if it does either of the following:

   (a) Establishes a minimum amount that the provider is required to charge an individual for a health service when that individual pays in full for the service;

   (b) Prohibits a provider from advertising the provider's rates for a service.

(2) Division (B)(1)(b) of this section shall not be construed as prohibiting a provision in a contract between a provider and a third-party payer that prohibits a provider from disclosing or