



BULLETIN NO. 2025-10

TO: All Health Insurance Companies, HMOs, and Other Interested Parties

RE: Senate Bill 515 (2025 Session)

FROM: Glen Mulready, Insurance Commissioner

DATE: October 31, 2025

Disclaimer: The purpose of this bulletin is to inform all health insurers licensed in Oklahoma of specific legislative changes for 2025. The Department's intent is to help licensees be aware of changes that establish substantive mandates or require implementation changes. This bulletin is not intended to include every legislative change made in 2025. Please refer to the [Oklahoma Supreme Court Network \(OSCN\) webpage](#) to view all changes.

Senate Bill 515 relates to health care services, creating new law and providing definitions to be found at 36 O.S. §§ 6060.51 and 6060.52.

The bill defines “health benefit plan” as group hospital coverage, individual and group medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the Oklahoma Employees Insurance Plan, and coverage provided by a multiple employer welfare arrangement. The term “health benefit plan” shall not include:

1. a plan that provides coverage:
 - (1) only for a specified disease or diseases or under an individual limited benefit policy,
 - (2) only for accidental death or dismemberment,
 - (3) only for dental or vision care,
 - (4) for a hospital confinement indemnity policy,
 - (5) for disability income insurance or a combination of accident-only and disability income insurance, or
 - (6) as a supplement to liability insurance,
2. any health plan offered by a contracted entity, as defined in Section 4002.2 of Title 56 of the Oklahoma Statutes, that provides coverage to members of the state Medicaid program,
3. a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),
4. workers’ compensation insurance coverage,
5. medical payment insurance issued as part of a motor vehicle insurance policy,

6. a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan, or
7. short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less.

The bill defines “health care provider” as having the same definition found at 36 O.S. § 1219.6.

The bill defines “health care service” as any service provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relates to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition. The term shall also include mental health and substance use disorder services, as defined at 36 O.S. § 6060.10, and durable medical equipment as defined by 59 O.S. § 375.2. However, the term shall not include the administration or prescription of pharmaceutical products or services.

The bill establishes that an enrollee may choose to pay out of pocket for a health care service from a health care provider if an enrollee obtains a medically necessary service covered by their health benefit plan and negotiates a price lower than the average amount established by their benefit plan, which is provided to the enrollee upon request. The enrollee may electronically send documentation to the carrier that provides the following:

1. The health care service the enrollee or patient received and the name of the health care provider and contact information;
2. If an order by the health care provider is required by the policy, the order from the health care provider given to the enrollee or patient and the final bill or statement for the health care service; and
3. The negotiated cost of the health care service that the enrollee received and that:
 - a. the enrollee paid out of pocket for the health care services received, and
 - b. the health care entity is not making a claim against the carrier for payment for the health care service provided to the enrollee or patient.

The health care provider must accept the payment from the enrollee as payment in full and must not bill the enrollee or the benefit plan for any balance between the amount collected from the enrollee and the billed charge for the service by the provider.

A carrier that receives the necessary documentation shall count the full amount paid out of pocket toward the deductible and annual maximum out-of-pocket expense if the service is covered under the health benefit plan of the enrollee and the enrollee negotiated for a lower cost for the health care service than the average allowed amount established by their health benefit plan for that covered health care service.

The amount of out-of-pocket cost shall be attributed to the in-network deductible and annual maximum out-of-pocket expense if the provider was in-network, and it will be attributed to the out-of-network deductible and annual maximum out-of-pocket expense if the provider was out-of-network.

The amount counted towards an applicable out-of-pocket deductible and annual maximum out-of-pocket expense shall not exceed the total amount an enrollee is required to pay out of pocket during a contractually agreed upon time for health care services that are included under their benefit plan and will not carry over when a new plan contract or agreement plan begins.

SB 515 becomes effective November 1, 2025.

Questions concerning this bulletin should be directed to the Oklahoma Insurance Department's Legal Division at 405-521-2746 or to Assistant General Counsel, Tyler Trammell, by email at Tyler.Trammell@oid.ok.gov.