CHECKLIST | Compliance Checklist for Self-insured Health Plans

Presented by Parrott Benefit Group

Employer-sponsored health plans generally fall into one of two categories: fully insured or self-insured. With a fully insured plan, the financial risk is largely transferred from the employer to the insurance carrier, meaning the employer's healthcare cost exposure is capped at its premium payments. A self-insured plan, on the other hand, keeps most of the financial risk with the employer. Rather than paying set premiums to an insurer, the employer covers medical claims as they arise throughout the plan year. Level-funded health plans, while structured differently, are typically treated as self-insured for compliance purposes.

When choosing a funding approach, employers should weigh several factors, including compliance obligations. Self-insured plans offer greater design flexibility since they are not bound by state insurance mandates, mini-COBRA laws or the Affordable Care Act's (ACA) essential health benefits (EHB) requirement. However, they are subject to nondiscrimination rules that do not apply to fully insured arrangements, and they must meet the full range of compliance requirements under the HIPAA Privacy and Security Rules.

This checklist summarizes federal compliance obligations for self-insured health plans.

Health Plan Design

Requirement	Applicability	Answer	
		Yes (or N/A)	No
Do you offer health plan coverage to your full-time employees that is affordable and provides minimum value? The ACA requires applicable large employers (ALEs) to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or potentially face a penalty from the IRS. This employer mandate is also known as the "pay-or-play" rules. An ALE is an employer that had, on average, at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year. Small employers who are not ALEs are not subject to the ACA's pay-or-play rules. A full-time employee is an employee who, on average, has at least 30 hours of service per week or 130 hours per calendar month. An ALE's health coverage is considered affordable if the employee's required contribution does not exceed 9.5% (as adjusted each year) of the employee's household income for	Health plans sponsored by ALEs	☐	☐

Health Plan Design

Requirement	Applicability	Answer	
		Yes (or N/A)	No
the taxable year. For plan years beginning in 2026, the adjusted affordability percentage is 9.96% (up from 9.02% for plan years beginning in 2025). A health plan provides minimum value if it covers at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan.			
If your health plan imposes a waiting period, is it 90 days or less? The ACA prohibits health plans from imposing any waiting period exceeding 90 days. Other eligibility conditions that are not based solely on the lapse of time are generally allowed. Also, employers may require employees to successfully complete a reasonable and bona fide employment-based orientation period as a condition for health plan eligibility. However, any permitted orientation period may not exceed one month.	All health plans	☐	☐
Does your health plan comply with the ACA's prohibition on annual or lifetime dollar limits on EHB? Under the ACA, health plans cannot impose lifetime and annual limits on the dollar value of EHB. EHB reflects the scope of benefits covered by a typical employer and covers at least 10 general categories of items and services, such as outpatient care, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder benefits, prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness services, and pediatric services, including oral and vision care.	All health plans	☐	☐
Does your health plan's out-of-pocket maximum (OOPM) for EHB comply with the ACA's limit (as adjusted for inflation each year)? The ACA requires non-grandfathered health plans to comply with an overall annual limit on total enrollee cost sharing for EHB, commonly referred to as an OOPM. For plan years beginning in 2026, the OOPM is $10,600 for self-only coverage and $21,200 for family coverage. These limits increase to $12,000 and $24,000, respectively, for plan years beginning in 2027. Note that if your health plan is a high deductible health plan (HDHP) compatible with health savings account (HSA) contributions, lower cost-sharing limits apply.	All non-grandfathered health plans	☐	☐

Requirement	Applicability	Answer	
		Yes (or N/A)	No
Does your health plan cover the latest recommended preventive care services without imposing cost-sharing? Under the ACA, non-grandfathered health plans must cover certain preventive health services without imposing cost-sharing requirements (i.e., deductibles, copayments or coinsurance) when in-network healthcare providers provide the services. The ACA's preventive care guidelines are periodically updated based on medical research and recommendations. In general, coverage must be provided for a newly recommended preventive health service or item for plan years beginning on or after the one-year anniversary of when the recommendation was issued.	All non-grandfathered health plans	☐	☐
Does your health plan cover dependent children up to age 26 (without varying the terms of coverage based on age)? The ACA requires health plans that provide dependent coverage for children to make the coverage available for adult children until they reach age 26. In addition, the terms of the plan providing dependent coverage for children, including the premiums charged, cannot vary by age (except for children age 26 or older).	All health plans	☐	☐
Does your health plan comply with the ACA's prohibition on preexisting condition exclusions? The ACA prohibits health plans from imposing preexisting condition exclusions. A preexisting condition exclusion is a limitation or exclusion of benefits related to a condition that was present before the date of enrollment for the coverage, regardless of whether any medical advice, diagnosis, care or treatment was recommended or received before that date.	All health plans	☐	☐
Does your health plan comply with the ACA's prohibition on discrimination against plan participants who participate in clinical trials? Under the ACA, non-grandfathered health plans cannot terminate coverage because an individual participates in an approved clinical trial or deny coverage for routine medical care that would otherwise be provided solely because an individual is enrolled in a clinical trial.	All non-grandfathered health plans	☐	☐
Does your health plan comply with the ACA's prohibition on rescissions of health coverage? The ACA prohibits health plans from rescinding coverage for covered individuals, unless there is fraud or an individual makes an intentional misrepresentation of a material fact. A cancellation of coverage is not	All health plans	☐	☐

Requirement	Applicability	Answer	
		Yes (or N/A)	No
considered a rescission if it has only a prospective (future) effect or is effective retroactively due to a failure to timely pay required premiums or contributions toward the cost of coverage. When a rescission is permitted, health plans must provide at least 30 calendar days' advance notice to each affected participant before coverage may be rescinded.			
Does your health plan comply with the ACA's patient protections for designating a primary care provider and covering benefits for emergency services? Health plans that require the designation of a participating primary care provider must permit covered individuals to designate any available participating primary care provider (including a pediatrician for children) and may not require preauthorization or referral for obstetrical or gynecological care. Health plans must provide emergency services benefits without requiring prior authorization, regardless of whether the provider is in-network. Also, health plans may not impose requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network emergency services. Cost-sharing requirements, such as copayments or coinsurance rates, imposed on out-of-network emergency services cannot exceed those imposed on in-network emergency services.	All health plans	☐	☐
Does your health plan's coverage for mental health and substance use disorder (MH/SUD) benefits comply with federal parity requirements? The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity between a group health plan's medical and surgical (M/S) benefits and its MH/SUD benefits. In general, MHPAEA requires health plans to: • Offer the same access to care and impose the same patient costs for MH/SUD benefits as those that apply to M/S benefits; • Treat MH/SUD coverage and M/S coverage equally in terms of out-of-pocket costs, benefit limits and practices, such as prior authorization and utilization review; and • Contain a single combined deductible for MH/SUD coverage and M/S coverage. Employers should watch for warning signs of MHPAEA noncompliance in their plan design.	All health plans (except self-insured health plans sponsored by employers with 50 or fewer employees and grandfathered plans are exempt)	☐	☐

Requirement	Applicability	Answer	
		Yes (or N/A)	No
Does your health plan provide special enrollment rights after certain life events? The Health Insurance Portability and Accountability Act (HIPAA) requires health plans to provide special enrollment opportunities outside of their regular enrollment periods in the following situations: • An employee (or dependent) loses eligibility for other health coverage; • An employee's (or dependent's) coverage under Medicaid or a state Children's Health Insurance Program (CHIP) ends due to a loss of eligibility; • An employee acquires a new spouse or dependent by marriage, birth, adoption or placement for adoption; and • An employee (or dependent) becomes eligible for a premium assistance subsidy under Medicaid or a state CHIP.	All health plans	☐	☐
Does your health plan extend coverage to children in accordance with qualified medical child support orders (QMCSOs)? The Employee Retirement Income Security Act (ERISA) requires health plans to extend coverage to the children of a parent-employee when ordered to do so by state authorities. Generally, a state court or agency may require an ERISA-covered health plan to provide coverage to children by issuing a QMCSO.	All health plans	☐	☐
Does your health plan cover minimum hospital stays for mothers and newborns? The Newborns' and Mothers' Health Protection Act prohibits health plans from restricting mothers' and newborns' benefits for hospital stays to less than 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section.	All health plans	☐	☐
Does your health plan provide benefits for reconstructive surgery following mastectomies? The Women's Health and Cancer Rights Act (WHCRA) requires health plans that provide medical and surgical benefits for mastectomies to also provide benefits for reconstructive surgery. This coverage must include: • All stages of reconstruction of the breast on which a mastectomy has been performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and	All health plans	☐	☐

Requirement	Applicability	Answer	
		Yes (or N/A)	No
• Prostheses and treatment for physical complications of mastectomy, including lymphedema.			
Does your health plan comply with HIPAA's prohibition on discrimination based on health status? HIPAA prohibits health plans from discriminating against individuals with regard to eligibility, premiums or coverage based upon a health status-related factor. As an exception, wellness programs that are related to a health plan may require individuals to satisfy a standard related to a health factor to receive a reward, if certain nondiscrimination standards are met.	All health plans	☐	☐
Do you continue health coverage for employees during military leave? Under the Uniformed Services Employment and Reemployment Rights Act, if an employee leaves their job to perform military service, they have the right to continue existing employer-based health plan coverage. If the employee is absent from work for less than 31 days, they may continue coverage by paying their regular premium. An employee who is absent for 31 or more days may elect to continue coverage for up to 24 months by paying a premium that is no more than 102% of the full premium under the plan.	All health plans	☐	☐
Do you continue health coverage for employees during FMLA leave? While an employee is on FMLA leave, their health plan coverage must be maintained on the same terms as if the employee continued to work. Employees may be required to pay their portion of the health plan premium during leave. If an employee chooses not to retain health plan coverage during FMLA leave, they are entitled to have their health coverage reinstated upon return from leave, on the same terms as before taking the leave.	All health plans sponsored by employers covered by the FMLA (i.e., private-sector employers with 50 or more employees)	☐	☐
Do you offer COBRA continuation coverage to eligible employees and dependents who would otherwise lose coverage due to a qualifying event? Eligible employees and their dependents may be eligible to continue group health coverage for 18 or 36 months following a qualifying event, which may include the covered employee's death, a termination (or reduction in hours) of a covered employee's	All health plans sponsored by employers covered by COBRA (i.e., private-sector employers	☐	☐

Requirement	Applicability	Answer	
		Yes (or N/A)	No
employment, the divorce of a covered employee and spouse or a child's loss of dependent status under the plan.	with 20 or more employees)		

The following compliance requirements do NOT apply to self-insured health plans:

- **State continuation coverage (mini-COBRA):** Fully insured health plans must comply with applicable state continuation coverage requirements.
- **EHB package:** Non-grandfathered fully insured health plans in the small group market must offer a comprehensive package of items and services, known as the EHB package.
- **State insurance mandates:** Fully insured health plans must comply with applicable state insurance mandates, which require these plans to provide coverage for certain benefits, providers and individuals.
- **Premium rating restrictions:** Non-grandfathered fully insured health plans in the small group market are subject to the ACA's premium rating restrictions. Premium rates may only vary based on age, geography, family size and tobacco use.

Annual Reporting

Requirement	Applicability	Complete	
		Yes (or N/A)	No
Include the cost of health coverage on employees' Forms W-2. Large employers must report the aggregate cost of employer-sponsored health plan coverage on their employees' Forms W-2, which must be filed and furnished by Jan. 31 each year.	Employers that filed at least 250 Forms W-2 for the prior calendar year	☐	☐
Submit Medicare Part D disclosure to the Centers for Medicare and Medicaid Services (CMS). Employers must submit an online form to CMS indicating whether their health plan's prescription drug coverage is creditable or noncreditable. The deadline for submitting this annual disclosure is 60 days after the beginning of the plan year. For calendar-year plans, this deadline is March 1 (or Feb. 29 in a leap year)	Employers with health plans that provide prescription drug coverage to individuals who are eligible for Medicare Part D	☐	☐

Requirement	Applicability	Complete	
		Yes (or N/A)	No
Report coverage to the IRS and offer to provide related statements to individuals upon request (ACA reporting). ALEs are required to report information to the IRS about their compliance with the pay-or-play rules and the health coverage they have (or have not) offered. ALEs use IRS Forms 1094-C and 1095-C for this reporting requirement. Non-ALEs with self-insured health plans must file information returns with the IRS every year, reporting information for individuals who were provided with minimum essential coverage during the applicable calendar year. Self-insured employers that are not ALEs use IRS Forms 1094-B and 1095-B for this reporting requirement. In general, the reporting deadline is March 31 each year, although employers may request an automatic 30-day extension by filing Form 8809 by the filing due date. In addition, employers must post a clear, conspicuous and reasonably accessible website notice by March 2 (or March 1 in a leap year), stating that employees may receive a copy of their individual coverage statement upon request. This notice must remain posted through Oct. 15. Instead of posting the notice and providing statements upon request, employers may automatically furnish individual coverage statements by the deadline for posting the website notice.	ALEs and non-ALEs with self-insured health plans	☐	☐
Submit detailed information on prescription drug and healthcare spending to CMS (RxDC reporting). Employers must annually submit detailed information on their health plan's prescription drug and healthcare spending to CMS by June 1 each year. This reporting is referred to as the prescription drug data collection (or RxDC report). Most employers rely on third parties, such as health insurance issuers, third-party administrators (TPAs) or pharmacy benefit managers (PBMs), to prepare and submit the RxDC report for their health plans. Employers can enter into written agreements with their issuers, TPAs or PBMs, as applicable, to assign this reporting responsibility to the service provider. However, unlike fully insured health plans, the legal obligation for RxDC reporting stays with a self-insured health plan even when a written agreement assigns this responsibility to a third party.	All health plans	☐	☐

Requirement	Applicability	Complete	
		Yes (or N/A)	No
Report and pay PCORI fees. Employers with self-insured health plans must pay annual Patient-Centered Outcomes Research Institute (PCORI) fees to fund comparative effectiveness research. Currently, these fees apply through the plan year ending before Oct. 1, 2029. PCORI fees are due each year by July 31 of the year following the last day of the plan year and are reported and paid on IRS Form 720.	Self-insured health plans	☐	☐
File Form 5500 with the Department of Labor (DOL). Employers must file Form 5500 for their ERISA-covered employee benefit plans with the DOL by the last day of the seventh month following the end of the plan year. For calendar-year plans, this deadline is July 31. An automatic extension of 2.5 months may be requested by filing IRS Form 5558 by the due date. Small welfare benefit plans (fewer than 100 participants at the beginning of the plan year) that are fully insured, unfunded or a combination of insured/unfunded are generally exempt from the Form 5500 filing requirement. Note that self-insured health plans that use a trust or separately maintained fund to pay benefits do not qualify for this exemption.	All ERISA-covered health plans, except those qualifying for the small plan exemption	☐	☐
Submit a gag clause attestation. Employers must submit attestations of compliance with the prohibition on gag clauses to CMS by Dec. 31 each year. A federal transparency law prohibits health plans from entering into contracts with healthcare providers, TPAs or other service providers that include gag clauses (i.e., clauses that restrict the plan from providing, accessing or sharing certain information about provider prices and quality and de-identified claims). Employers with self-insured health plans can enter into written agreements with their service providers to provide the attestation, but the legal responsibility remains with the health plan.	All health plans	☐	☐

Plan Documentation

Documentation	Applicability	Complete (or N/A)
Review your company's compliance with the following plan documentation requirements:		
Plan Documents: ERISA requires employers to maintain an official plan document for their health plans and to provide copies of certain plan documents within 30 days of a participant's written request. These documents include the latest summary plan description (SPD), summaries of material modifications (SMMs), Form 5500, trust agreements and other instruments under which the plan is established or operated.	All ERISA-covered health plans	☐
SPD: To comply with ERISA, a health plan's SPD must be provided to new plan participants within 90 days of the start of their coverage. An updated SPD must be provided to covered employees at least every five years if material modifications have been made during that period. If no material modifications have been made, an updated SPD must be provided at least every 10 years.		☐
SMM: Under ERISA, an SMM must be provided when there is a material modification to the plan's terms or any change to the information required to be in the SPD. As a general rule, the SMM must be provided within 210 days after the close of the plan year in which the change was adopted. A shorter deadline may apply in some circumstances, depending on the nature of the modification or change. If the change is a material reduction in health plan benefits or services, the deadline for providing the SMM is 60 days after the change is adopted. Also, employers must provide 60 days' advance notice of any material modification to plan terms or coverage that takes effect mid-plan year and affects the content of the plan's summary of benefits and coverage (SBC). The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM.		☐
Comparative Analysis of MH/SUD Benefits: MHPAEA requires health plans to conduct comparative analyses of the design and application of nonquantitative treatment limitations (NQTLs) used for MH/SUD benefits compared to M/S benefits. Health plans must make their comparative analysis available upon request to federal agencies, such as the DOL, as well as applicable state authorities. Employers with self-insured health plans should contact their TPAs or other service providers for assistance with their comparative analyses.	All health plans (except self-insured health plans sponsored by employers with 50 or fewer employees and grandfathered plans are exempt)	☐

ERISA Fiduciary Duties

Fiduciary Duties	Applicability	Complete (or N/A)
Review your company's compliance with ERISA's fiduciary duty standards on an ongoing basis. Enforcement of ERISA's strict standards of fiduciary conduct has traditionally focused on retirement plans. However, recent litigation has drawn more attention to employers' fiduciary responsibilities in managing a broader range of employee benefit plans, including health plans. ERISA requires fiduciaries to discharge their duties with respect to employee benefit plans: • Solely in the interest of plan participants and their beneficiaries; • For the exclusive purpose of providing plan benefits (and for defraying reasonable expenses of plan administration); • With the care, skill, prudence and diligence that a prudent person in similar circumstances would use; • By diversifying the plan's investments to minimize the risk of large losses; and • In accordance with the plan's documents (unless inconsistent with ERISA).	All ERISA-covered health plans	☐

Nondiscrimination Testing

Section 105(h) Nondiscrimination Testing	Applicability	Complete
Perform nondiscrimination testing each year. Self-insured health plans are subject to nondiscrimination rules under Internal Revenue Code Section 105(h). Under these rules, self-insured health plans cannot discriminate in favor of highly compensated employees (HCEs) with respect to eligibility or benefits. If a plan discriminates in favor of HCEs, HCEs will be taxed on excess reimbursements that would have otherwise been excluded from their income. Depending on the health plan's design, employers may wish to consider testing their self-insured health plans before the year begins to proactively address any issues and after the plan year concludes to confirm compliance. Although the ACA included nondiscrimination requirements for non-grandfathered, fully insured health plans, these rules have been delayed indefinitely and are not being enforced.	Self-insured health plans	☐

HIPAA Privacy and Security Rules

HIPAA Requirements	Applicability	Complete (or N/A)
Comply with the HIPAA Privacy and Security Rules' requirements for protected health information (PHI). Employers' compliance obligations under the HIPAA Rules vary considerably depending on whether a health plan is self-insured or fully insured and the employer's involvement in plan administration. Employers sponsoring fully insured plans with limited access to PHI have minimal obligations under the HIPAA Rules, while those administering self-insured plans have significantly more responsibilities, including the following: • Implement policies and procedures that address the Privacy Rule's requirements, considering the health plan's size and types of activities involving PHI; • Designate a privacy officer and a security official; • Train workforce members on HIPAA policies and procedures; • Adopt a sanctions policy for employees who fail to comply with applicable HIPAA requirements; • Implement appropriate administrative, technical and physical safeguards to protect the privacy of PHI; • Amend the health plan documents to impose restrictions on the employer's use and disclosure of PHI; • Provide a Privacy Notice; • Do not use PHI from the health plan in any employment-related action or decision or in connection with any other benefit plan; • Comply with individual rights' requirements; • Enter into business associate agreements, as necessary; • Perform a risk analysis regarding any electronic PHI (ePHI) that the group health plan creates or receives; • Adopt appropriate administrative, technical and physical safeguards for ePHI (these requirements are scalable); • Adopt a breach notification policy; and • Maintain HIPAA documentation for at least six years.	All health plans (except self-insured plans with fewer than 50 participants that are self-administered are exempt)	☐

Notices and Disclosures

Notice and Disclosure Requirements	Applicability	Complete (or N/A)
SBC: Health plans are required to provide an SBC to applicants and enrollees each year during open enrollment or renewal. Federal agencies have provided a template for the SBC, which health plans are required to use.	All health plans	☐
Medicare Part D Disclosures: Employer-sponsored health plans offering prescription drug coverage to individuals who are eligible for Medicare Part D must disclose whether the plan's prescription drug coverage is creditable or noncreditable. This disclosure must be provided at certain times, including before the Medicare Part D Annual Coordinated Election Period (Oct. 15 through Dec. 7 of each year). Model forms are available from CMS.	Employers with health plans that provide prescription drug coverage to individuals who are eligible for Medicare Part D	☐
CHIP Notice: Some states offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored health coverage through a Medicaid plan or a Children's Health Insurance Plan (CHIP). If an employer's health plan covers residents in a state that provides such a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in the state. A model notice is available from the DOL.	Employers with health plans that cover residents of a state that provides a premium assistance subsidy	☐
HIPAA Privacy Notice: The HIPAA Privacy Rule requires health plans to provide a Notice of Privacy Practices (or Privacy Notice) to covered individuals at certain times, including to new enrollees at the time of enrollment. Also, at least once every three years, health plans must either redistribute the Privacy Notice or notify participants that the Privacy Notice is available and explain how to obtain a copy. A model Privacy Notice is available from HHS. Self-insured health plans are required to maintain and provide their own Privacy Notices. However, there is an exemption for self-insured health plans with fewer than 50 participants that are administered by their sponsoring employer. Also, special rules apply to fully insured plans that make the health insurance issuer, rather than the health plan itself, primarily responsible for the Privacy Notice.	Self-insured health plans (except those with fewer than 50 participants that are self-administered are exempt)	☐
Exchange Notice: The ACA requires employers to provide all new hires with a written notice about the health insurance Exchanges.	Employers that are subject to	☐

Notice and Disclosure Requirements	Applicability	Complete (or N/A)
The DOL has provided model exchange notices for employers to use.	the federal Fair Labor Standards Act	
HIPAA Special Enrollment: At or before enrollment, a health plan must provide each eligible employee with a notice of their special enrollment rights under HIPAA. This notice is often included in the plan's SPD or benefits booklet.	All health plans	☐
Notice of Patient Protections: If a health plan requires participants to designate a participating primary care provider, the plan must provide a notice of patient protections whenever the SPD or similar description of benefits is provided to a participant. This notice is often included in the plan's SPD or benefits booklet. The DOL has a model notice for employers to use.	All health plans	☐
WHCRA Notice: Health plans must provide a notice about the WHCRA's coverage requirements at the time of enrollment and annually after enrollment. The annual WHCRA notice can be provided at any time during the year, but it is often included with the plan's open enrollment materials. Model language is available in the DOL's model notice guide.	All health plans	☐
Summary Annual Report (SAR): Health plans that are subject to the Form 5500 filing requirement must provide a SAR within nine months after the end of the plan year. If the deadline for filing the Form 5500 was extended, the SAR must be provided within two months after the end of the extension period. Plans that are exempt from the Form 5500 filing requirement are not required to provide the SAR. Unfunded welfare plans, regardless of size, are also generally exempt from the SAR requirement.	Health plans that are required to file a Form 5500 (except unfunded health plans are exempt)	☐
Grandfathered Plan Notice: Employers with health plans that have grandfathered status under the ACA must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as open enrollment materials). The DOL has a model notice for employers to use.	Grandfathered health plans	☐

Transparency Disclosures

Requirement	Applicability	Complete	
		Yes	No
Post detailed pricing information in MRFs. Health plans and issuers must disclose detailed pricing information on a public website in machine-readable files (MRFs). Self-insured employers typically rely on third parties, such as TPAs, to provide the MRFs. Employers with self-insured health plans should confirm that their written agreements address this obligation and monitor the third party's compliance with this disclosure requirement. It is ultimately the responsibility of the self-insured health plan to ensure that the third party provides the required information.	All health plans	☐	☐
Make an internet-based price comparison tool available to participants, beneficiaries and enrollees. Health plans and issuers must make an internet-based self-service tool available to participants, beneficiaries and enrollees to disclose personalized price and cost-sharing liability for all covered healthcare items and services, including prescription drugs. Employers with self-insured health plans typically rely on TPAs and PBMs to develop and maintain this tool. Self-insured employers should confirm their written agreements address this responsibility and monitor their service providers to ensure they provide the required cost-sharing disclosures, as they ultimately remain liable for compliance with this disclosure requirement.	All health plans	☐	☐
Post a balance billing notice. Health plans and issuers must provide protections against balance billing and out-of-network cost sharing for emergency services, air ambulance services furnished by nonparticipating providers and nonemergency services furnished by nonparticipating providers at participating facilities. Health plans and issuers must publicly post a notice of these protections and include the notice with any EOB for an item or service to which the protections apply. Employers with self-insured health plans should confirm that their TPA has posted this notice and is providing it with applicable EOBs.	All health plans	☐	☐