number of lives covered for the entire policy year and divided the sum by 365.

Example 2. Insurance Company F reports 12,000,000 as its member months on its NAIC Supplemental Health Care Exhibit filed for calendar year 2012. Under the member months method, Insurance Company F calculates the average number of lives covered for 2012 by dividing 12,000,000 (member months) by 12 (number of months in the reporting period), and then multiplying the result (1,000,000) by ¼, which equals 250,000. Accordingly, the average number of lives covered for policies with policy years ending on or after October 1, 2012, and before January 1, 2013, is 250,000.

(4) Applicable dollar amount. For policy years ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is $1. For policy years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is $2. For any policy year ending in any Federal fiscal year beginning on or after October 1, 2014, the applicable dollar amount is the sum of—

(i) The applicable dollar amount for the policy year ending in the previous Federal fiscal year; plus

(ii) The amount equal to the product of—

(A) The applicable dollar amount for the policy year ending in the previous Federal fiscal year; and

(B) The percentage increase in the projected per capita amount of the National Health Expenditures most recently released by the Department of Health and Human Services before the beginning of the Federal fiscal year.

(d) Effective/Applicability date. This section applies for policies with policy years ending on or after October 1, 2012, and before October 1, 2019.

§ 46.4376–1 Fee on sponsors of self-insured health plans.

(a) In general—(1) General rule. A plan sponsor of an applicable self-insured health plan is liable for a fee imposed by section 4376 for plans with plan years ending on or after October 1, 2012, and before October 1, 2019. Paragraph (b) of this section provides the definitions that apply for purposes of section 4376 and this section. Paragraph (d) of this section provides the applicability date. For rules relating to filing the required return and paying the fee, see §§ 40.6011(a)–1 and 40.6071(a)–1.

(2) [Reserved]

(b) Definitions. The following definitions apply for purposes of section 4376 and this section. See § 46.4377–1 for additional definitions.

(1) Applicable self-insured health plan—

(i) In general. Except as provided in paragraph (b)(1)(ii) of this section and § 46.4377–1, applicable self-insured health plan means a plan that provides for accident and health coverage (within the meaning of § 46.4377–1(a)) if any portion of the coverage is provided other than through an insurance policy and the plan is established or maintained—

(A) By one or more employers for the benefit of their employees or former employees;

(B) By one or more employee organizations for the benefit of their members or former members;

(C) Jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees;

(D) By a voluntary employees’ beneficiary association, as described in section 501(c)(9);

(E) By an organization described in section 501(c)(6); or

(F) By a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA)), a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA), or a rural cooperative association (as defined in section 3(40)(B)(v) of ERISA).

(ii) Exceptions. The term applicable self-insured health plan does not include any of the following:

(A) A plan that provides benefits substantially all of which are excepted benefits, as defined in section 9832(c). For example, a health flexible spending arrangement (health FSA) (as described in section 106(c)(2)) that satisfies the requirements to be treated as an excepted benefit under section 9832(c) and § 54.9831–1(c)(3)(v) of this chapter is not an applicable self-insured health plan. A health FSA that is not treated as an excepted benefit under section 9832(c) and § 54.9831–1(c)(3)(v) is an applicable self-insured health plan.
Internal Revenue Service, Treasury § 46.4376–1

(B) An employee assistance program, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.

(C) A plan that, as demonstrated by the facts and circumstances surrounding the adoption and operation of the plan, was designed specifically to cover primarily employees who are working and residing outside the United States (as defined in §46.4377–1(a)(3)).

(iii) Multiple self-insured arrangements established or maintained by the same plan sponsor. For purposes of section 4376, two or more arrangements established or maintained by the same plan sponsor that provide for accident and health coverage (within the meaning of §46.4377–1(a)) other than through an insurance policy and that have the same plan year may be treated as a single applicable self-insured health plan for purposes of calculating the fee imposed by section 4376. For example, if a plan sponsor establishes or maintains a self-insured arrangement providing major medical benefits, and a separate self-insured arrangement providing prescription drug benefits, the two arrangements may be treated as one applicable self-insured health plan so that the same life covered under each arrangement would count as only one covered life under the plan for purposes of calculating the fee. Similarly, if a plan sponsor provides a Health Reimbursement Arrangement (HRA) and another applicable self-insured health plan that provides major medical coverage, the HRA and the major medical plan may be treated as one applicable self-insured health plan if the HRA and the self-insured plan have the same plan year.

(iv) Examples. The following examples illustrate the principle of this paragraph (b)(1):

Example 1. (i) Plan Sponsor D sponsors and maintains three separate plans to provide certain benefits to its employees—Plan 501, Plan 502, and Plan 503.

(ii) Plan 501 is a calendar year plan that provides accident and health benefits, other than through insurance (that is, on a self-insured basis), to employees of Plan Sponsor D. Plan 502 is a calendar year HRA that can be used to pay for qualified accident and medical expenses for employees of Plan Sponsor D and their eligible dependents. Plan 503 provides accident and health benefits, other than through insurance (that is, on a self-insured basis).

(iii) Because Plan 501 and Plan 502 provide accident and health coverage (within the meaning of §46.4377–1(a)) and are maintained by Plan Sponsor D for the benefit of its employees, Plans 501 and 502 are applicable self-insured health plans that are subject to the fee imposed by section 4376. Because dental and vision benefits are excepted benefits, as defined in section 9832(c), Plan 503 is not an applicable self-insured health plan subject to the section 4376 fee. Under the special rule set forth in §46.4376–2(b)(1)(ii)(A), Plan Sponsor D may treat Plans 501 and 502 (both self-insured plans with a calendar year plan year) as a single plan for purposes of calculating the fee imposed by section 4376.

Example 2. Same facts as Example 1, except Plan 503 is not a Plan that provides dental and vision benefits, but rather a plan that provides accident and health coverage solely to employees who are working and residing outside the United States and does not provide any benefits to employees who are not working and residing outside the United States. Plan 503 is designed specifically to provide coverage to employees working and residing outside the United States because it limits coverage to these employees. Therefore, in accordance with the exception described in §46.4376–1(b)(1)(ii)(C), Plan 503 is not an applicable self-insured health plan.

(2) Plan sponsor—(1) In general. The term plan sponsor means—

(A) The employer, in the case of an applicable self-insured health plan established or maintained by a single employer;

(B) The employee organization, in the case of an applicable self-insured health plan established or maintained by an employee organization;

(C) The joint board of trustees, in the case of a multiemployer plan (as defined in section 414(f));

(D) The committee, in the case of a multiple employer welfare arrangement (as defined in section 3(40) of ERISA);

(E) The cooperative or association that establishes or maintains an applicable self-insured health plan established or maintained by a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA) or rural cooperative association (as defined in section 3(40)(B)(v) of ERISA);
(F) The trustee, in the case of an applicable self-insured health plan established or maintained by a voluntary employees’ beneficiary association (meaning that the voluntary employees’ beneficiary association is not merely serving as a funding vehicle for a plan that is established or maintained by an employer or other person); or

(G) In the case of an applicable self-insured health plan the plan sponsor of which is not described in paragraphs (b)(2)(i)(A) through (F) of this section, the person identified by the terms of the document under which the plan is operated as the plan sponsor, or the person designated by the terms of the document under which the plan is operated as the plan sponsor for section 4376 purposes, provided that designation is made in writing, and that person has consented to the designation in writing, by no later than the date by which the return paying the fee under section 4376 for that plan year is required to be filed, after which date that designation for that plan year may not be changed or revoked, and provided further that a person may be designated as the plan sponsor only if the person is one of the persons establishing or maintaining the plan (for example, one of the employers that establishes or maintains the plan with one or more other employers or employee organizations).

(H) In the case of an applicable self-insured health plan the sponsor of which is not described in paragraphs (b)(2)(i)(A) through (F) of this section, and for which no identification or designation of a plan sponsor has been made pursuant to paragraph (b)(2)(i)(G) of this section, each employer that establishes or maintains the plan (with respect to members of that employee organization), and each board of trustees, cooperative, or association that establishes or maintains the plan, meaning that each plan sponsor must file a separate Form 720, “Quarterly Federal Excise Tax Return,” reflecting its separate liability under section 4376.

(ii) Examples. The following examples illustrate the principles of paragraph (b)(2) of this section:

Example 1. (i) Corporation XYZ is a holding company with no employees that owns all the issued and outstanding shares of Employer X, Employer Y, and Employer Z. Employer X, Employer Y, and Employer Z are employers that have established the XYZ Group Health Plan to provide accident and health coverage, provided other than through an insurance policy, for the benefit of their employees. The XYZ Group Health Plan has a calendar year plan year. In addition, there is no plan sponsor identified or designated in the plan document.

(ii) Because the XYZ Group Health Plan provides accident and health coverage other than through an insurance policy, and is established by one or more employers for the benefit of their employees, the XYZ Group Health Plan is an applicable self-insured health plan under section 4376(c)(2)(A) and paragraph (b)(1)(i)(A) of this section. Because a plan sponsor is not identified or designated in the governing plan document, the plan sponsor, for purposes of section 4376, is determined under paragraph (b)(2)(i)(H) of this section as each employer that establishes or maintains the plan (Employer X, Employer Y, and Employer Z), each with respect to its employees covered under the plan. Accordingly, Employer X, Employer Y, and Employer Z each must file a Form 720 reflecting their separate liabilities under section 4376, calculated based on lives covered that are employees of that employer (or spouses, dependents, or other beneficiaries of employees of that employer) and the applicable dollar amount in effect for the plan year.

Example 2. The same facts as Example 1, except that the governing plan document designates Employer X as the plan sponsor of the XYZ Group Health Plan for purposes of the fee under section 4376 and Employer X consents to this designation no later than the due date for paying the fee under section 4376. Accordingly, the plan sponsor for purposes of section 4376 is determined under paragraph (b)(2)(i)(G) of this section as Employer X. Employer X must file a Form 720 reflecting liabilities under section 4376, calculated based upon lives covered that are employees of Employer X, Employer Y, or Employer Z, or spouses, dependents, or other beneficiaries of employees of those employers and the applicable dollar amount in effect for the plan year.

(c) Calculation of fee—(1) In general. The amount of the fee for a plan year is equal to the product of the average number of lives covered under the plan for the plan year (determined in accordance with paragraph (c)(2) of this
multiply that amount by 9,000.

under paragraph (c)(3) of this section and
determine the applicable dollar amount

For the plan year

3,285,000 divided by 365, or 9,000. To calculate

average number of lives covered under the plan

Employer A must
calculate the sum of lives covered for each day of the

paragraph (c)(1) and (c)(2)(iii)(A) of this section:

Example. Employer A is the plan sponsor of

the Employer A Self-Insured Health Plan,

which has a calendar year plan year. Em-
ployer A calculates the sum of lives covered

under the plan for each day of the plan year

ending December 31, 2013 as 3,285,000. The av-
erage number of lives covered under the plan

for the plan year ending December 31, 2013, is

3,285,000 divided by 365, or 9,000. To calculate

the section 4376 fee for the plan under para-

graph (c)(1) of this section for the plan year

ending December 31, 2013, Employer A must
determine the applicable dollar amount

under paragraph (c)(3) of this section and

multiply that amount by 9,000.

(iv) Snapshot method—(A) In general.

A plan sponsor may determine the aver-
age number of lives covered under an

applicable self-insured health plan for a plan year

by adding the totals of lives covered on a date during the first,

second, or third month of each quarter

of the plan year (or more dates in each

quarter if an equal number of dates is

used in each quarter), and dividing that
total by the number of dates on which a count was made. For purposes of this

paragraph (c)(2)(iv), each date used for the

second, third and fourth quarter

must be within three days of the date

in that quarter that corresponds to the
date used for the first quarter, and all

dates used must fall within the same

plan year. If a plan sponsor uses mul-
tiple dates for the first quarter, the

plan sponsor must use dates in the sec-

ond, third, and fourth quarters that correspond to each of the dates used for

the first quarter or are within three
days of such corresponding dates, and

all dates used must fall within the

same plan year. The 30th and 31st day

of a month are treated as the last day

of the month for purposes of deter-
imining the corresponding date for any

month that has fewer than 31 days (for example, if either March 30 or March 31

is used for a calendar year plan, June

30 is the corresponding date for the sec-

ond quarter). For purposes of this para-

graph (c)(2)(iv), the number of lives

covered on a designated date may be
determined using either the snapshot

factor method described in paragraph

(c)(2)(iv)(B) of this section or the snap-

shot count method described in para-

graph (c)(2)(iv)(C) of this section.

(B) Snapshot factor method. Under the

snapshot factor method, the number of

lives covered on a date is equal to the sum of—

(i) The number of participants with

self-only coverage on that date; plus

(ii) The number of participants with

coverage other than self-only coverage

on the date multiplied by 2.35.

(C) Snapshot count method. Under the

snapshot count method, the number of

lives covered on a date equals the ac-

tual number of lives covered on the

designated date.

(D) Examples. The following examples

illustrate the principles of paragraphs

(c)(1) and (c)(2)(iv) of this section:

Example 1. (i) Employer B is the plan spon-

sor of the Employer B Self-Insured Health

Plan, which has a calendar year plan year.

Employer B uses the snapshot method to de-

termine the average number of lives covered

under the plan and uses the snapshot count

method to determine the number of lives covered on a day in the first month of each calendar quarter of the plan year.
(ii) On January 4, 2013, the Employer B Self-Insured Health Plan covers 2,000 lives, on April 5, 2013, 2,100 lives, on July 5, 2013, 2,050 lives, and on October 4, 2013, 2,050 lives. Under the snapshot method, Employer B must determine the average number of lives covered under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2013, as 8,200 (2,000 + 2,100 + 2,050 + 2,050) divided by 4, or 2,050. To calculate the section 4376 fee under paragraph (c)(1) of this section, Employer B must determine the average number of lives covered other than self-only coverage to 809 employees. On April 11, 2013, Employer B Self-Insured Health Plan covers 2,000 lives, on July 5, 2013, 2,100 lives, on July 5, 2013, 2,050 lives, and on October 4, 2013, 2,050 lives.

Example 2. (i) Same facts as Example 1, except that for the 2014 plan year Employer B determines the number of lives covered that are not covered by self-only coverage using the snapshot factor method (that is, based on the number of participants with coverage other than self-only coverage multiplied by 2.35 (the factor set forth in (c)(2)(iv) of this section)).

(ii) On January 10, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 600 employees and other than self-only coverage to 800 employees. On April 11, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 608 employees and other than self-only coverage to 800 employees. On July 11, 2014 and October 10, 2014, Employer B Self-Insured Health Plan provides self-only coverage to 610 employees and other than self-only coverage to 809 employees.

(iii) Under the snapshot factor method, Employer B must determine the average number of lives covered under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2014 as 9,988 [(600 x 2.35)] + [(608 x (800 x 2.35))] + [(610 x (809 x 2.35))] + [(610 x (809 x 2.35))] divided by 4, or 2,497. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending December 31, 2014, Employer B must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 2.497.

4 Form 5500 method—(A) Calculation method. A plan sponsor may determine the average number of lives covered under a plan for a plan year based on the number of participants reported on the Form 5500, “Annual Return/Report of Employee Benefit Plan,” or the Form 5500–SF, “Short Form Annual Return/Report of Small Employee Benefit Plan,” that is filed for the applicable self-insured health plan for that plan year, provided that the Form 5500 or Form 5500–SF is filed no later than the due date for the fee imposed by section 4376 for that plan year. For purposes of this paragraph (c)(2)(v), the average number of lives covered under the plan for the plan year for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 or Form 5500–SF for the applicable self-insured health plan, divided by 2. For purposes of this paragraph (c)(2)(v), the average number of lives covered under the plan for the plan year for a plan offering self-only coverage and coverage other than self-only coverage equals the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 or Form 5500–SF filing for the applicable self-insured health plan.

(B) Examples. The following examples illustrate the principles of paragraphs (c)(1) and (c)(2)(v)(A) of this section:

Example 1. Employer C is the plan sponsor of the Employer C Self-Insured Health Plan, which has a calendar year plan year ending on December 31, 2013. Employer C is required to file a Form 5500 for the 2013 plan year by July 31, 2014. However, on July 30, 2014, Employer C obtains an automatic 2½ month extension for filing the 2013 Form 5500. Employer C files the 2013 Form 5500 on September 30, 2014 (that is, before the October 15 extended due date). Employer C is not eligible to use the Form 5500 method to determine the average number of lives covered under Plan C for the plan year ending December 31, 2013, because the 2013 Form 5500 was not filed by the original due date. (That is, by July 31, 2014) for the return that reports liability for the fee imposed by section 4376 for the 2013 plan year.

Example 2. Same facts as Example 1, except that the Employer C Self-Insured Health Plan has a fiscal year plan year ending on July 31, 2013, and offers only self-only coverage. Employer C files a Form 5500 for the Employer C Self-Insured Health Plan for the plan year ending July 31, 2013 (the 2012 Form 5500), on the extended due date for filing the 2012 Form 5500 (May 15, 2014). Employer C is eligible to use the Form 5500 method to determine the average number of lives covered under Plan C for the plan year ending on July 31, 2013, because the 2012 Form 5500 had been filed by the due date for the return that reports liability for the fee imposed by section 4376 for that plan year (July 31, 2014).

Example 3. Same facts as Example 2, provided further that the Employer C Self-Insured Health Plan 2012 Form 5500 reports 4,000 plan participants on the first day of the plan year and 4,200 plan participants on the plan year and 4,200 plan participants on the...
last day of the 2012 plan year. For purposes of calculating the fee under section 4376 using the Form 5500 method, Employer C must treat the number of lives covered for the plan year ending July 31, 2013, as equal to the sum of 4,000 and 4,200, divided by 2, or 4,100. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending July 31, 2013, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 4,100.

Example 4. Same facts as Example 3, except that the Employer C Self-Insured Health plan offers self-only coverage and family coverage. For purposes of calculating the fee under section 4376 using the Form 5500 method, Employer C must treat the number of lives covered for the plan year ending July 31, 2013, as equal to the sum of 4,000 and 4,200, or 8,200. To calculate the section 4376 fee under paragraph (c)(1) of this section for the plan year ending July 31, 2013, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 4,100.

(vi) Special rule for health FSAs and HRAs. For purposes of this section, if a plan sponsor does not establish or maintain an applicable self-insured health plan other than a health flexible spending arrangement (health FSA) (as described in section 106(c)(2)) or a health reimbursement arrangement (as described in Notice 2002–45 (2002–2 CB 93)) (HRA), the plan sponsor may treat each participant’s health FSA or HRA as covering a single life (and therefore the plan sponsor is not required to include as lives covered any spouse, dependent, or other beneficiary of the individual participant in the health FSA or HRA, as applicable). If a health FSA or HRA that is an applicable self-insured health plan has the same plan sponsor and plan year as another applicable self-insured health plan other than a health FSA or HRA, the two arrangements may be treated as a single plan under paragraph (b)(1)(iii) of this section. However, the special counting rule in this paragraph applies only for purposes of the health FSA or HRA and, therefore, applies only for purposes of the participants in the health FSA or HRA that do not participate in the other applicable self-insured health plan. The participants in the health FSA or HRA that participate in the other applicable self-insured health plan will be counted in accordance with the method applied for counting lives covered under that other plan as described in paragraph (b)(1)(i) of this section. See §601.601(d)(2) of this chapter.

(vii) Special rule for lives covered solely by the fully-insured options under an applicable self-insured health plan. (A) In general. If an applicable self-insured health plan provides accident and health coverage through fully-insured options and self-insured options, the plan sponsor is permitted to disregard the lives that are covered solely under the fully-insured options in determining the lives covered taken into account for the actual count method (described in paragraph (c)(2)(iii) of this section), the snapshot method (described in paragraph (c)(2)(iv) of this section), and the Form 5500 method (described in paragraph (c)(2)(v) of this section).

(B) Example. The following example illustrates the principles of paragraph (c)(2)(vii) of this section:

Example. (i) Employer C is the plan sponsor of the Employer C Health Plan (Plan P). The Plan offers self-only or family health and accident coverage under fully-insured or self-insured options. On June 28, 2015, Employer C files a Form 5500 for Plan P for the plan year ending December 31, 2014 indicating: (1) a total of 4,000 plan participants on the first day of the 2014 plan year; and (2) a total of 4,200 plan participants on the last day of the plan year. Employer C determines that there were 3,000 plan participants (and their families, as applicable) covered under the fully-insured option offered under the plan on the first day of the 2014 plan year, and 2,900 plan participants (and their families, as applicable) covered under the fully-insured option on the last day of the 2014 plan year. Employer C uses the Form 5500 method to calculate the number of lives covered for the 2014 plan year.

(ii) Pursuant to paragraph (c)(2)(vii) of this section, Employer C determines the number of lives covered for the 2014 plan year as: the sum of 1,000 (4,000 total participants on the first day of the plan year—3,000 participants covered by the specified health insurance policy on the first day of the plan year) and 1,300 (4,200 total participants—2,900 participants covered by the specified health insurance policy on the first day of the plan year), or 2,300. To calculate the section 4376 fee under paragraph (c)(1) of this section for the 2014 plan year, Employer C must determine the applicable dollar amount under paragraph (c)(3) of this section and multiply that amount by 2,300.
§ 46.4377–1

(vii) Special rule for the first year the fee is in effect. Notwithstanding paragraph (c)(2)(i) of this section, for a plan year beginning before July 11, 2012, and ending on or after October 1, 2012, a plan sponsor may determine the average number of lives covered under the plan for the plan year using any reasonable method.

(3) Applicable dollar amount. For a plan year ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is $1. For a plan year ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is $2. For any plan year ending in any Federal fiscal year beginning on or after October 1, 2014, the applicable dollar amount is equal to the sum of—

(i) The applicable dollar amount for the plan year ending in the previous Federal fiscal year; and

(ii) The percentage increase in the projected per capita amount of the National Health Expenditures most recently released by the Department of Health and Human Services before the beginning of the Federal fiscal year.

(4) Examples. The following examples illustrate the principle of paragraph (c)(3) of this section.

Example 1. (Calendar year plan). (i) Plan Sponsor C maintains Plan X which has a calendar year plan year; the plan continues in operation for the entire calendar years 2012 through 2019. Plan X is an applicable self-insured health plan, within the meaning of §46.4376–1(b)(1), and Plan Sponsor C is liable for the fee imposed by section 4376, determined in accordance with these regulations, beginning with the 2012 plan year—the plan year beginning January 1, 2012, and ending December 31, 2012—and ending with the 2018 plan year—the plan year beginning January 1, 2018, and ending December 31, 2018. In accordance with §46.4371(a)–1(c) of this chapter:

(ii) The first Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2012 plan year (January 1, 2012, through December 31, 2012) and must be filed no later than July 31, 2013, and the fee reported on this form must be calculated using the applicable dollar amount in effect for plan years ending on or after October 1, 2012, and before October 1, 2013; and

(iii) The last Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2018 plan year (January 1, 2018, through December 31, 2018) and must be filed no later than July 31, 2019, and the fee reported on this form must be calculated using the applicable dollar amount in effect for plan years ending on or after October 1, 2018, and before October 1, 2019.

Example 2. (Fiscal year plan). (i) Plan Sponsor B maintains Plan W, which has a fiscal year plan year ending on July 31; the plan continues in operation for the entire fiscal year plan years from August 1, 2012, through July 31, 2019. Plan W is an applicable self-insured health plan, within the meaning of §46.4376–1(b)(1), and Plan Sponsor B is liable for the fee imposed by section 4376, determined in accordance with these regulations, beginning with the 2012 plan year—the plan year beginning on August 1, 2012, and ending on July 31, 2013—and ending with the 2018 plan year—plan year beginning on August 1, 2018, and ending July 31, 2019. In accordance with §46.4371(a)–1(c) of this chapter:

(ii) The first Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2012 plan year (August 1, 2012, through July 31, 2013) and must be filed no later than July 31, 2014, and the fee reported on this form must be calculated by multiplying the average number lives by $1 (the applicable dollar amount in effect for plans with plan years beginning on or after October 1, 2012, and before October 1, 2013); and

(iii) The last Form 720 that must be filed to report and pay the fee imposed by section 4376 for Plan X covers the 2018 plan year (August 1, 2018, through July 31, 2019) and must be filed no later than July 31, 2019, and the fee must be calculated using the applicable dollar amount in effect for plan years ending on or after October 1, 2018, and before October 1, 2019.

(d) Effective/Applicability date. This section applies for plan years that end on or after October 1, 2012, and before October 1, 2019.

§ 46.4377–1 Definitions and special rules.

(a) Definitions. The following definitions apply for purposes of sections 4375 and 4376 and §§ 46.4375–1 and 46.4376–1.

(1) Accident and health coverage. The term accident and health coverage means any coverage that, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section