MEDICAL ASSISTANCE FOR CHILDREN, PREGNANT WOMEN, & PARENT/CARETAKER RELATIVES INSERT

Complete this Insert to see if you qualify for any of the following health coverage choices:

- Medical Assistance available through the New Hampshire Medicaid program;
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well; or
- A new tax credit that can immediately help pay your premiums for health coverage.

NOTE: You only need to complete this Insert if you are applying for health coverage for a child, you are pregnant, or you are a parent or caretaker relative of a child and want health coverage.

You may use this Insert to apply for yourself or anyone in your family.

- You may apply for Medical Assistance even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage;
- You may apply if your family includes immigrants. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen; and
- You may have someone help you fill out this Insert. If someone helps you fill it out, this person may need to complete *Section L - Authorized Representative Declaration*.

You can apply faster online at nheasy.nh.gov or HealthCare.gov.

You may need the following information to complete this Insert:

- Social Security numbers (or document numbers for any legal immigrants who need insurance);
- Employer and income information for everyone in your family (for example: paystubs, W-2 forms, or wage and tax statements);
- Policy numbers for any current health insurance; and
- Information about any job-related health insurance available to your family.

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law.

After you complete this Insert:

- You must return it to your local District Office along with DFA Form 800, *Application for Assistance*.
- If you don't have all the information we ask for, submit this Insert anyway along with your completed DFA From 800, *Application for Assistance*. We'll follow-up with you within 1–2 weeks.
- You'll get instructions on the next steps to complete your health coverage. If you don't hear from us in one to two weeks, call 1-800-852-3345 ext. 9700.

How you can get help with filling out this Insert:

- Over the phone: By calling Client Services at 1-800- 852-3345 ext. 9700.
- In person: There may be counselors in your area who can help. Call 1-800- 852-3345 ext. 9700 for more information.
- En Espanol: Llame a nuestro centro de ayuda gratis al 1-800- 852-3345 ext. 9700.

If you are applying for any other programs, such as Food Stamps, Cash, or Child Care, you must complete DFA Form 800, *Application for Assistance,* too. You can also apply for these programs on-line at www.nheasy.nh.gov.

Who do you need to include when filling out this Insert?

Tell us about all the family members who live with you. The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner if you have children in common or if he or she needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage if you have no children in common
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

SECTION A - HOUSEHOLD MEMBERS

Complete **Section A** starting with yourself, then follow with your spouse, and then tell us about each family member who lives with you or who you claim on your federal tax return. If you have more than 2 members in your household, copy this page and complete the information for those additional members on the copied page. You must then include all the copied page(s) with your application.

Person 1: First, middle, & last name:_____ ☐ Male ☐ Female

Relationship to you: **SELF** Date of Birth:_____/_____/_____ SSN _____--____--_____

Does this person plan to file a tax return NEXT YEAR? ☐Y ☐N

If so, will this person file jointly with a spouse? ☐Y ☐N

Name of spouse: _____

List any dependents claimed on this person's tax return: _____

_____

Will this person be claimed on someone else's tax return? ☐ Y ☐ N

If so, name of the tax filer? _____

Relationship to the tax filer? _____

Ethnicity (optional) White☐ Black or African American☐

Mexican☐ Mexican American☐ Chicano/a☐

Puerto Rican☐ Cuban☐ Other Hispanic/Latino☐

American Indian or Alaska Native☐ Samoan☐

Native Hawaiian☐ Guamanian or Chamorra☐

Filipino☐ Other Pacific Islander☐ Asian Indian☐

Korean☐ Chinese☐ Vietnamese☐ Japanese☐

Other Asian☐ Other: _____

Pregnant? ☐ Y ☐ N If yes, due date? _____/_____/_____ How many babies are expected, if known? _____

Does this person need health coverage? ☐ Y ☐ N (If no, stop here) Does this person live in a Nursing Facility? ☐ Y ☐ N

Does this person have a physical, mental or emotional health condition that causes limitation in activities? ☐ Y ☐ N

Is this person a U.S. citizen or national? ☐ Y ☐ N If no, does this person have eligible immigration status? ☐ Y ☐ N

Immigration document type: _____ Document # _____

Has this person lived in the U.S. since 1996? ☐ Y ☐ N

Is this person or this person's spouse or parent a veteran or on active duty in the U.S. military? ☐ Y ☐ N

Has this person incurred any unpaid medical bills over the last three months? ☐ Y ☐ N

Does this person live with a child under the age of 19, and is this person the main caretaker of the child? ☐ Y ☐ N

Is this person a full time student? ☐ Y ☐ N Was this person in foster care at age 18 or older? ☐ Y ☐ N

Person 2: First, middle, & last name:_____ ☐ Male ☐ Female

Relationship to you: _____ Date of Birth:_____/_____/_____ SSN _____--____--_____

Does this person plan to file a tax return NEXT YEAR? ☐Y ☐N

If so, will this person file jointly with a spouse? ☐Y ☐N

Name of spouse: _____

List any dependents claimed on this person's tax return: _____

_____

Will this person be claimed on someone else's tax return? ☐ Y ☐ N

If so, name of the tax filer? _____

Relationship to the tax filer? _____

Ethnicity (optional) White☐ Black or African American☐

Mexican☐ Mexican American☐ Chicano/a☐

Puerto Rican☐ Cuban☐ Other Hispanic/Latino☐

American Indian or Alaska Native☐ Samoan☐

Native Hawaiian☐ Guamanian or Chamorra☐

Filipino☐ Other Pacific Islander☐ Asian Indian☐

Korean☐ Chinese☐ Vietnamese☐ Japanese☐

Other Asian☐ Other: _____

Pregnant? ☐ Y ☐ N If yes, due date? _____/_____/_____ How many babies are expected, if known? _____

Does this person need health coverage? ☐ Y ☐ N (If no, stop here) Does this person live in a Nursing Facility? ☐ Y ☐ N

Does this person have a physical, mental or emotional health condition that causes limitation in activities? ☐ Y ☐ N

Is this person a U.S. citizen or national? ☐ Y ☐ N If no, does this person have eligible immigration status? ☐ Y ☐ N

Immigration document type: _____ Document # _____

Has this person lived in the U.S. since 1996? ☐ Y ☐ N

Is this person or this person's spouse or parent a veteran or on active duty in the U.S. military? ☐ Y ☐ N

Has this person incurred any unpaid medical bills over the last three months? ☐ Y ☐ N

Does this person live with a child under the age of 19, and is this person the main caretaker of the child? ☐ Y ☐ N

Is this person a full time student? ☐ Y ☐ N Was this person in foster care at age 18 or older? ☐ Y ☐ N

SECTION B - EMPLOYMENT

Complete **Section B** by telling us about each job a person in your household, or that you claim on your taxes, has had within in the past year. If you have more than 2 jobs to report, copy this page and complete the information for those jobs in **Section B** on the copied page. You must then include those pages with your application. If anyone is self-employed, put that information in **Section C** below, not here.

Job 1: Name of employee: _____

Employer name: _____

Employer address:_____ Phone # : (_____) _____--_____

City:_____ State: _____ Zip code:_____

Gross wages/tips (before deductions):$_____ ☐hourly ☐weekly ☐bi-weekly ☐monthly ☐twice a month ☐yearly

Average hours worked each WEEK: _____

In the past year did this person: ☐change jobs ☐stop working ☐start working fewer hours ☐none of these

If your income changes from month to month enter your yearly income below:

Total income this year: $_____ Total income next year (if you think it will be different): $_____

Job 2: Name of employee: _____

Employer name: _____

Employer address:_____ Phone # : (_____) _____--_____

City:_____ State: _____ Zip code:_____

Gross wages/tips (before deductions):$_____ ☐hourly ☐weekly ☐bi-weekly ☐monthly ☐twice a month ☐yearly

Average hours worked each WEEK: _____

In the past year did this person: ☐change jobs ☐stop working ☐start working fewer hours ☐none of these

If your income changes from month to month enter your yearly income below:

Total income this year: $_____ Total income next year (if you think it will be different): $_____

SECTION C - SELF-EMPLOYMENT

Complete **Section C** by telling us about any people in your household, or that you claim on your taxes, who have been self-employed within the past year. If you must report more than 2 people who have been self-employed, copy this page and complete the information for those people in **Section C** on the copied page. You must then include those pages with your application.

Self-Employment 1: Name of person who is self-employed: _____

Type of work: _____

How much net income (profits minus business expenses) will you get this month? $_____

Total income this year: $_____ Total income next year (if you think it will be different): $_____

Self-Employment 2: Name of person who is self-employed: _____

Type of work: _____

How much net income (profits minus business expenses) will you get this month? $_____

Total income this year: $_____ Total income next year (if you think it will be different): $_____

SECTION D - DEDUCTIONS

Complete **Section D** for each person in your household, or that you claim on your taxes, who claims any tax deductions, such as alimony or student loan interest. If you must report more than 2 people who file an income tax return and claim deductions, copy this page and enter those people's deductions in **Section D** on the copied page. You must then include those pages with your application.

Tax Filer 1: First and last name: _____

Type of deduction:_____ How much? $_____ How often? _____

Type of deduction:_____ How much? $_____ How often? _____

Tax filer 2: First and last name: _____

Type of deduction:_____ How much? $_____ How often? _____

Type of deduction:_____ How much? $_____ How often? _____

SECTION E – CURRENT HEALTH COVERAGE

You only need to answer the questions in **Section E** for people on this application who are applying for health coverage but also currently have other health coverage. If you have more than 2 additional types of health coverage to tell us about, copy this page and enter the additional health coverage information in **Section E** on the copied page. You must then include those pages with your application.

Health Coverage 1: Type of health coverage: ☐Medicaid ☐Children's Health Insurance Program (CHIP)

☐VA health care programs ☐Peace Corps ☐Medicare ☐TRICARE (don't check if you have direct care of Line of Duty)

☐Employer insurance Name of the health insurance:_____ Policy #:_____

If this is employer insurance, is this COBRA coverage? ☐Yes ☐No Is this a retiree health plan? ☐Yes ☐No

☐Other insurance Name of the health insurance:_____ Policy #:_____

If this is other insurance, is this a limited benefit plan (like a school accident policy)? ☐Yes ☐No

List all the people in your household who are covered under this health coverage: _____

_____

Health Coverage 2: Type of health coverage: ☐Medicaid ☐Children's Health Insurance Program (CHIP)

☐VA health care programs ☐Peace Corps ☐Medicare ☐TRICARE (don't check if you have direct care of Line of Duty)

☐Employer insurance Name of the health insurance:_____ Policy #:_____

If this is employer insurance, is this COBRA coverage? ☐Yes ☐No Is this a retiree health plan? ☐Yes ☐No

☐Other insurance Name of the health insurance:_____ Policy #:_____

If this is other insurance, is this a limited benefit plan (like a school accident policy)? ☐Yes ☐No

List all the people in your household who are covered under this health coverage: _____

_____

SECTION F - HEALTH COVERAGE OFFERED FROM A JOB

Complete **Section F** if anyone applying for health coverage on this application is offered health coverage from a job, even if the coverage is from someone else's job (such as through a spouse's job). Include health coverage that is currently offered, or will be offered within the next 3 months. **Take the Employer Coverage Tool (Section M), which is the last page of this Insert, to the employer who offers the health coverage to help you answer the questions in this Section. You only need to include this page when you send in your application, not the Employer Coverage Tool.**

Employer Coverage 1: Name of person who is offered health coverage: _____

What is this person's SSN? _____--_____--_____

Name of employer:_____ Employer phone #: (_____)--_____--_____

Employer address: _____

City: _____ State: _____ Zip: _____ Employer ID # (EIN): _____

Who can we contact about employee health coverage at this job? _____

Phone # (if different): (_____)--_____--_____ Email address:_____

If the employee is not currently eligible for health coverage, when can this person enroll in coverage? ____/____/____

List the names of anyone else who is eligible for coverage form this job: _____

_____

Does the employer offer a health plan that meets the minimum value standard*? ☐Yes ☐No

If the person who is offered health coverage opted for the lowest cost employee only plan** that meets the minimum value standard*, how much would this person have to pay in premiums? $_____ How often? _____

Will the employer make any of the following changes to the health plans offered for the new plan year (if known):

☐No longer offer health coverage. ☐Start offering health coverage.

☐Change the premium for the lowest-cost employee only plan** available that meets the minimum value standard*.

If the employer is starting to offer health coverage, or changing the premium for the lowest-cost employee only plan:

How much would be the premium for this plan? $_____How often? _____Date of change: _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

**The lowest cost employee only plan must reflect the maximum discount this person would receive if the employer offers any tobacco cessation programs, and this person did not receive any other discounts based on wellness programs.

Employer Coverage 2: Name of person who is offered health coverage: _____

What is this person's SSN? _____--_____--_____

Name of employer:_____ Employer phone #: (_____)--_____--_____

Employer address: _____

City: _____ State: _____ Zip: _____ Employer ID # (EIN): _____

Who can we contact about employee health coverage at this job? _____

Phone # (if different): (_____)--_____--_____ Email address:_____

If the employee is not currently eligible for health coverage, when can this person enroll in coverage? ____/____/____

List the names of anyone else who is eligible for coverage form this job: _____

_____

Does the employer offer a health plan that meets the minimum value standard*? ☐Yes ☐No

If the person who is offered health coverage opted for the lowest cost employee only plan** that meets the minimum value standard*, how much would this person have to pay in premiums? $_____ How often? _____

Will the employer make any of the following changes to the health plans offered for the new plan year (if known):

☐No longer offer health coverage. ☐Start offering health coverage.

☐Change the premium for the lowest-cost employee only plan** available that meets the minimum value standard*.

If the employer is starting to offer health coverage, or changing the premium for the lowest-cost employee only plan:

How much would be the premium for this plan? $_____How often? _____Date of change: _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

**The lowest cost employee only plan must reflect the maximum discount this person would receive if the employer offers any tobacco cessation programs, and this person did not receive any other discounts based on wellness programs.

SECTION G: For persons who will receive health care authorized by the Federally Facilitated Marketplace (FFM)

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the FFM to use income data, including information from tax returns. The FFM will send me a notice, let me make any changes, and I can opt out any time. **Yes, renew my eligibility automatically for the next:**

☐5 years (max) ☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use tax return information to renew my coverage.

SECTION H - INCARCERATED INDIVIDUALS

I understand that an individual who is incarcerated (detained or jailed) will not be eligible for health benefits until they are released. If I have included this person on this application, I must write that person's name below:

The following person is incarcerated_____and will be released_____

SECTION I - YOU MAY NEED TO COMPLETE ADDITIONAL SECTIONS

- If someone helped you complete this application, and you would like DHHS to be able to talk with this person concerning your eligibility for Medical Assistance, please complete **Section L**, "Authorized Representative Declaration", on page 6.
- If anyone listed on this application is an American Indian or Alaska Native, you must complete **Section K**, "American Indian or Alaska Native (AI/AN)," on page 5.
- If you need to obtain health information from your employer to complete **Section F** of this Insert, you can take **Section M**, "Employer Coverage Tool," to your employer to get the necessary information needed to complete that section of the application. The "Employer Coverage Tool" (Section M) does not need to be included in your application. It is there for you so you do not have to take your entire application into your place of employment.

SECTION J - FOR CERTIFIED APPLICATION COUNSELORS, NAVIGATORS, AGENTS, AND BROKERS ONLY

Complete **Section J** if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

Application start date: _____/_____/_____

First name, Middle name, Last name, & Suffix: _____

Organization name: _____ ID number (if applicable): _____

SECTION K - AMERICAN INDIAN OR ALASKA NATIVE (AI/AN)

Complete **Section K** if any family member(s) are American Indian or Alaska Native (AI/AN). AI/AN can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible. If your household has more than 2 AI/ANs, copy this page and enter those people in **Section K** on the copied page. You must then include those pages with your application.

AI/AN Person 1: First, middle, and last name: _____

Is this person a member of a federally recognized tribe? ☐Y ☐N

If yes, name of tribe: _____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐Y ☐N

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐Y ☐N

The following income sources may not be counted for Medicaid or the Children's Health Insurance Program (CHIP):

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

Did this person report income from the above sources on this application? ☐Y ☐N

If yes, how much income did this person report? $_____

How often is this income received? _____

AI/AN Person 2: First, middle, and last name: _____

Is this person a member of a federally recognized tribe? ☐Y ☐N

If yes, name of tribe: _____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐Y ☐N

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐Y ☐N

The following income sources may not be counted for Medicaid or the Children's Health Insurance Program (CHIP):

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

Did this person report income from the above sources on this application? ☐Y ☐N

If yes, how much income did this person report? $_____

How often is this income received? _____

SECTION L - AUTHORIZED REPRESENTATIVE DECLARATION

You may choose an authorized representative to help you with some or all of the requirements of applying for or getting Medical Assistance. An authorized representative is a friend, relative or other person who has a concern for your well-being. An authorized representative is a person you choose. We will not choose one for you. The person you choose must agree to help you. An agency cannot act as an authorized representative, but an individual at an agency can. An authorized representative must be an individual person.

An authorized representative may fill out an application form and other paperwork for you. They may also report changes in your income, resources, and other changes for you. They may receive your medical assistance ID card and other mail from us. You get to choose what you would like them to do for you or on your behalf by checking the boxes below.

AUTHORIZED REPRESENTATIVES DUTIES

Check off the things that you want the authorized representative to do for you:

☐ Get my application, forms, and other Department paperwork, and fill these forms out for me.

☐ Provide the Department with proof of my income, resources, and other case information, and report and verify changes in my case circumstances to the Department for me.

☐ Receive my notices from the Department.

☐ Receive my medical assistance ID card for me.

☐ Go to my eligibility interviews for me.

☐ Other:_____

CLIENT'S SIGNATURE

Please read the following statements carefully. Your signature below means you have read and understand these statements.

- I certify that I have read and understand the information on this form.
- I understand that I am responsible for any errors, omissions, or inaccurate information that my authorized representative reports to the Department.
- I understand that if my authorized representative uses my benefits without my permission, these benefits will not be replaced or reissued by the Department.
- I understand that the person I named as my authorized representative will continue to act for me unless I tell the Department in writing of a change.

_____ _____
Client's Signature Date

_____
Client's Printed Name

AUTHORIZED REPRESENTATIVE INFORMATION

Name of authorized representative_____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: (_____)--_____--_____

Describe your relationship to the authorized representative: _____

Representative's date of birth (Optional) _____--_____--_____ Agency name (if applicable)_____

AUTHORIZED REPRESENTATIVE'S SIGNATURE

I certify that I have read and understand the information on this form. I agree to accept the duties noted on this form and understand the following:

- I understand that I must give proof of my identity to act as an Authorized Representative.
- I understand that if I have been disqualified for a program violation, I cannot act as an Authorized Representative unless there is no one else suitable to represent this individual.
- I understand that the Department has the authority to discontinue my ability to act as an Authorized Representative if it is determined that I am not acting in the best interest of the household I am assisting.

_____ _____
Authorized Representative's Signature Date

_____
Authorized Representative's Printed Name

SECTION M - EMPLOYER COVERAGE TOOL

Use this tool in **Section M** to help answer questions in ***Section F*** - *Health Care Offered from a Job* about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse).

Write your name and Social Security number below and ask the employer to fill out the rest of the form.

Coverage Tool 1: Name of person who is offered health coverage: _____

What is this person's SSN? _____--_____--_____

Name of employer:_____ Employer phone #: (_____)--_____--_____

Employer address: _____

City: _____ State: _____ Zip: _____ Employer ID # (EIN): _____

Who can we contact about employee health coverage at this job? _____

Phone # (if different): (_____)--_____--_____ Email address:_____

If the employee is not currently eligible for health coverage, when can this person enroll in coverage? ____/____/____

Does the employer offer a health plan that covers an employee's spouse or dependent? ☐Yes ☐No

If yes, who will the health plan cover? ☐Spouse ☐Dependent

Does the employer offer a health plan that meets the minimum value standard*?☐Yes ☐No

If the person who is offered health coverage opted for the lowest cost employee only plan** that meets the minimum value standard*, how much would this person have to pay in premiums? $_____ How often? _____

Will the employer make any of the following changes to the health plans offered for the new plan year (if known):

☐No longer offer health coverage. ☐Start offering health coverage.

☐Change the premium for the lowest-cost employee only plan** available that meets the minimum value standard*.

If the employer is starting to offer health coverage, or changing the premium for the lowest-cost employee only plan:

How much would be the premium for this plan? $_____How often? _____Date of change: _____

Coverage Tool 2: Name of person who is offered health coverage: _____

What is this person's SSN? _____--_____--_____

Name of employer:_____ Employer phone #: (_____)--_____--_____

Employer address: _____

City: _____ State: _____ Zip: _____ Employer ID # (EIN): _____

Who can we contact about employee health coverage at this job? _____

Phone # (if different): (_____)--_____--_____ Email address:_____

If the employee is not currently eligible for health coverage, when can this person enroll in coverage? ____/____/____

Does the employer offer a health plan that covers an employee's spouse or dependent? ☐Yes ☐No

If yes, who will the health plan cover? ☐Spouse ☐Dependent

Does the employer offer a health plan that meets the minimum value standard*?☐Yes ☐No

If the person who is offered health coverage opted for the lowest cost employee only plan** that meets the minimum value standard*, how much would this person have to pay in premiums? $_____ How often? _____

Will the employer make any of the following changes to the health plans offered for the new plan year (if known):

☐No longer offer health coverage. ☐Start offering health coverage.

☐Change the premium for the lowest-cost employee only plan** available that meets the minimum value standard*.

If the employer is starting to offer health coverage, or changing the premium for the lowest-cost employee only plan:

How much would be the premium for this plan? $_____How often? _____Date of change: _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

**The lowest cost employee only plan must reflect the maximum discount this person would receive if the employer offers any tobacco cessation programs, and this person did not receive any other discounts based on wellness programs.