Kentucky Tobacco Health Plan Survey
(Adapted from the Colorado and Rhode Island Health Departments)

Name of Person Responding:
Title:
Business:
Address:
Phone:
E-Mail:
Health Plan Carrier:
Purchasing Group or Union:

# of Employers
# of Employees

Background: Please tell us about your health plan’s smoking cessation benefit coverage:

How many members does your plan serve in Kentucky ________________.
How many are fully insured accounts ______________________________.
How many are self-insured accounts ______________________________.

All employees are asked if they use tobacco and have their tobacco use documented annually.
_____yes, _____no

Communication Strategy: Please tell us how members become aware of and access your benefits:

How does your health plan communicate the cessation benefit to members?

Yes, through the following: _____Plan website, _____Employer mailing, _____Health Plan mailing, _____In-person, _____Member Services call center, _____Other

No, we do not communicate the cessation benefit to members _____.

How do members access the cessation benefit for pharmacy and counseling services?

Pharmacy: _____mail order pharmacy, _____prescription needed for all medications, _____other, please describe: _________________________________
Are there restrictions to your medication benefit:  _____yes,  _____no
describe_______________________________________________________________________

Counseling:  _____In network physician,  _____ Identification of HMO/PPO,  _____ other, please
describe: ______________________________________________________________________

Is benefit information available:  _____during enrollment to member,  _____during enrollment to
employer,  _____during renewal to member,  _____during renewal of employer

Collaboration Plan:  Has the plan referred members to Quit Now Kentucky Telephone Quitline or
www.QuitNowKentucky.org program to support its members?  _____ yes,  _____no.

Has the plan made additional tobacco cessation counseling services available to its members beyond
that provided by Quit Now Kentucky?  _____yes,  _____no

If yes, please indicate which services are provided:  _____in person counseling,  _____telephone
counseling,  _____web-based information,  _____web-based interactive cessation,  _____texting,
_____self- help materials,  _____ cessation services are provided in KY,  _____cessation services are
provided outside of KY

Are incentives available to your members for any of the following:  _____using services,
_____completing a cessation program,  _____ quitting tobacco use

Please describe:_______________________________________________________________

Tobacco Cessation Member Benefit:

Do you include tobacco cessation as a covered benefit in your health care coverage for employees?
_____ yes,  _____no

Has your plan made tobacco cessation counseling services available to its members?  _____yes,
_____no

Do you cover at least four counseling sessions?  _____ yes,  _____no, how many ___________

Has your plan made additional tobacco cessation pharmacotherapy options available to its
members?  _____yes,  _____no  What is covered: ________________________________

Do you provide medication coverage for at least two cessation attempts per year?  _____yes,
_____no, how many _________________________________________________________

Do you eliminate co-pays or deductibles for counseling and medication?  _____yes,  _____no
_____$5-$10,  _____$11-$15,  _____$16-$20,  _____$21-$25,  _____$26-$30

Do you have annual lifetime limits for your benefit package?  _____yes,  _____no
What percentage of members have used the benefit from time period (XXXX to XXXX) ____

<table>
<thead>
<tr>
<th>Prescription Service</th>
<th>Covered</th>
<th>Subject to deductible</th>
<th>Subject to coinsurance</th>
<th>Annual limits</th>
<th>Quantity limits</th>
<th>Age limits</th>
<th>Risk-based limits</th>
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</thead>
<tbody>
<tr>
<td>Varenicline/Chantix</td>
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<td>Bupropion SR/Wellbutrin, Zyban</td>
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<tr>
<td>Nicotine Inhaler</td>
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<tr>
<td>Nicotine nasal spray</td>
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<td>Comments</td>
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</table>

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<tr>
<th>Over the counter coverage</th>
<th>All fully insured</th>
<th>Fully insured as a buy-up</th>
<th>All individual</th>
<th>Individual as a buy-up</th>
<th>Member cost sharing required</th>
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</thead>
<tbody>
<tr>
<td>Nicotine Patch</td>
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<td>Nicotine Gum</td>
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<td>Nicotine Lozenge</td>
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<tr>
<td>Prescription required</td>
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<td>Length of treatment</td>
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<td>Comments</td>
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</table>

| Counseling Support | | | | | |
|--------------------|----------------|
| Counseling support covered | | | | | |
| What is covered     | | | | | |
| Length of treatment | | | | | |
| Co-pay              | | | | | |
| Deductible required | | | | | |
| Comments             | | | | | |

Please sign if willing for its name to be released in association with specific results of this survey: ______________________________________________________