2025 Medicare Experience Survey MEDICARE SURVEY INSTRUCTIONS

This survey asks about you and the health care you received <u>in the last six months</u>. Answer each question thinking about <u>yourself</u> and the times you got health care in person, by phone or by video call. Please take the time to complete this survey. Your answers are very important to us. Please return the survey with your answers in the enclosed postage-paid envelope to [Survey Vendor].

- If you changed your Medicare plan for 2025, answer the questions thinking about your experiences in the last 6 months of 2024.
- Answer <u>all</u> the questions by putting an "X" in the box to the left of your answer, like this:

🛛 Yes

- Be sure to read <u>all</u> the answer choices given before marking your answer.
- You are sometimes told not to answer some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this: [→If No, Go to Question 3]. See the example below:

EXAMPLE

1. Do you wear a hearing aid now?

Yes

 \boxtimes No \rightarrow If No, Go to Question 3

2. How long have you been wearing a hearing aid?

Less than one year

1 to 3 years

More than 3 years

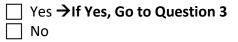
] I don't wear a hearing aid

3. In the last 6 months, did you have any headaches?

🔀 Yes 🗌 No

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. This applies to both mandatory and voluntary collections of information. The valid OMB control number for this information collection is **0938-0732 (expires TBD)**. The time required to complete this information collection is estimated to average **10 minutes**, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.

 Our records show that in 2024 your prescriptions were covered by the Medicare prescription drug plan named on the back page. Is that right?



- 2. Please write below the name of the Medicare prescription drug plan you had in 2024 and complete the rest of the survey based on the experiences you had with that plan. (Please print)
- In the last 6 months, did anyone from a doctor's office, pharmacy, or your prescription drug plan contact you:

		Yes	<u>No</u>
a.	To make sure you		
	filled or refilled a		
	prescription?		
b.	To make sure you		
	were taking medicine		

4. In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?

as directed?

 Never
 Sometimes
 Usually
 Always
 I did not use my prescription drug plan to get any medicines in the last 6 months 5. In the last 6 months, did you ever use your prescription drug plan to fill a prescription at your local pharmacy?

Yes
No →If No, Go to Question 7

- 6. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
 - Never
 Sometimes
 Usually
 Always
- In the last 6 months, did you ever use your prescription drug plan to fill a prescription by mail?



- 8. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
 - Never
 Sometimes
 Usually
 Always

- 9. Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?
 - 0 Worst prescription drug plan possible
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 Best prescription drug plan

About You

10. In general, how would you rate your overall health?

possible

- Excellent
 Very good
 Good
 Fair
- Poor
- **11**. In general, how would you rate your overall <u>mental or emotional</u> health?

	Excellent
	Very good
	Good
	Fair
\square	Poor

12. What language do you mainly speak at home?

English
Spanish
Chinese
Korean
Vietnamese
Some other language
\downarrow
Please print:

- **13.** In the last 6 months, did you spend one or more nights in a hospital?
 - ___ Yes ___ No
- **14**. In the last 6 months, did you delay or not fill a prescription because you felt you could not afford it?

Yes
No
My c
anvi

My doctor did not prescribe any medicines for me in the last 6 months **15**. Has a doctor <u>ever</u> told you that you had any of the following conditions?

	con	ditions?	-			completed?
			Yes	<u>No</u>		
	a.	A heart attack?				8 th grade or less
	b.	Angina or coronary				Some high school, but did not
		heart disease?				graduate
	c.	Hypertension				High school graduate or GED
		or high blood				Some college or 2-year degree
		pressure?				4-year college graduate
	d.	Cancer, <u>other than</u>				More than 4-year college
		<u>skin cancer</u> ?				degree
	e.	Emphysema, asthma,				
		or COPD (chronic			20 .	Are you of Hispanic or Latino origin
		obstructive pulmo-				or descent?
		nary disease)?				
	f.	Any kind of diabetes				Yes, Hispanic or Latino
		or high blood				No, not Hispanic or Latino
		sugar?				
					21 .	What is your race? Please mark
16.		you have serious difficu	lty			one or more.
	wal	king or climbing stairs?				
						American Indian or Alaska Native
		Yes				Asian
		No				Black or African-American
17	D • •					Native Hawaiian or other Pacific
17.		you have difficulty dres	sing or			Islander
	bati	ning?				White
		Voc			22 .	How many people live in your
		Yes No				household now, including
		INO .				yourself?
18	Rec	ause of a physical, men	tal or			
10.		otional condition, do yo				1 person
		culty doing errands alo				2 to 3 people
		isiting a doctor's office				4 or more people
		pping?	•			
					23.	Do you ever use the internet at
		Yes				home?
		No				
						Yes
						No No

19. What is the highest grade or level

of school that you have

24. May the Medicare Program follow up with you to learn more about your health care, or to invite you to a group discussion or interview on topics related to health care?

Yes
No

25. Did someone help you complete this survey?

26. How did that person help you? Please mark one or more.

Read the questions to me
Wrote down the answers I
gave
Answered the questions for r

Answered the questions for me

Translated the questions into my language

Helped in some other way

Yes
No → Thank you. Please
return the completed
survey in the postagepaid envelope.

Thank you.

Please return the completed survey in the postage-paid envelope.

[SURVEY VENDOR RETURN ADDRESS FOR MAIL PROCESSING]

Contract Name: _____

[OPTIONAL] You may also know your plan by one of the following: