

Michigan Senior Guide to Health Insurance

DIFS
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES



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65+ Senior Health Care

Medicare, Medicare Supplement and Medicare Advantage are considered to be “senior” health insurance products.

Medicare

Medicare is a federal government program providing health coverage to individuals who are:

- Age 65 and over.
- Eligible for Medicare Part B and receiving kidney dialysis treatments.
- Under age 65, disabled and have been receiving Social Security benefits for 24 months.

Part A – Hospital Coverage:

Medicare Part A Provides Hospital Coverage for Which Most People Are Automatically Eligible When Turning Age 65

- Part A is financed by taxes on employers and employees.
- Part A provides coverage for inpatient hospital care, hospice care, limited skilled nursing care and home health care. Co-pays, co-insurance and a deductible may apply to each of these services.
- Part A deductible will be charged each time there is a hospitalization, as long as there are 60 days between each episode.
  - » You pay a deductible and no co-insurance for days 1-60 each benefit period.
  - » You pay co-insurance for days 61-90 of each benefit period.
  - » Once the deductible is paid, Medicare will pay a share of the covered health care expenses and you are responsible for a share of the covered services.

Part B – Medical Coverage:

Medicare Part B Provides Coverage for Doctor and Outpatient Services and Is Optional to Purchase

- Part B is financed by individual monthly premiums, which are usually deducted from a person’s Social Security check.
- Medicare will pay 80% of covered health care costs and you are responsible for the remaining 20%.
- Some preventive services are covered with no charge, including a yearly “wellness visit.”
- Medicare deductibles and co-insurance amounts are adjusted on an annual basis.

More Information on Medicare

For more information on the Medicare program, visit **www.medicare.gov.** A "Frequently Asked Questions" section is available and covers many senior health care topics.

Medicare Supplement Policies

Medicare Supplement policies are designed to help pay for health care costs not paid by Medicare, including deductibles and co-insurance. The following is important to know about Medicare Supplement policies:

- They are often referred to as "Medigap" policies.
- They cover only one person. Spouses are responsible for obtaining their own coverage.
- The insured is responsible for paying the monthly premium.
- The policy is guaranteed renewable.
- The policy can be terminated only for nonpayment of premium or material misrepresentation. A material misrepresentation means you intentionally answered a question incorrectly on the application, and if the insurer would have known the correct answer, you would have been ineligible for the insurance plan or the plan would have been issued to you at a different premium.

Medicare Supplement Open Enrollment Period

The best time to purchase a Medicare Supplement policy is during your open enrollment period.

Your open enrollment period begins on the first day of the month in which you are both age 65 or older AND enrolled in Medicare Part B.

This period lasts six months, during which you can purchase any Medicare Supplement plan, even if you have a preexisting health condition.

If you apply for a Medicare Supplement policy after your six-month open enrollment period, you are subjected to the insurer's medical underwriting criteria and may be denied and/or rated based on your health conditions.

For more information about Medicare Supplement policies, review the "Seniors" section of DIFS' Health Insurance Consumer Assistance Program website at **www.michigan.gov/HICAP.**



Medicare Supplement Plans' Basic Core Benefits

Every Medicare Supplement plan includes the following:

- Hospitalization: Part A co-insurance plus coverage for 365 additional days after Medicare benefits end
- Medical Expenses: Part B co-insurance (generally 20% of Medicare-approved expenses) for hospital outpatient services
- Medicare Part A and B blood coverage: first three pints of blood per calendar year
- Medicare Part A hospice co-insurance

Medicare Supplement Standardized Plans

Plan A includes:

Only the basic core benefits

Plan B includes:

The basic core benefits and the Medicare Part A deductible

Plan C includes:

- Basic core benefits
- Medicare Part A deductible
- Skilled nursing facility care
- Medicare Part B deductible
- Medically necessary emergency care in a foreign country

Plan F includes:

- Basic core benefits
- Medicare Part A deductible
- Skilled nursing facility care
- Medicare Part B deductible
- 100% of Medicare Part B excess charges
- Medically necessary emergency care in a foreign country

High Deductible Plan F includes:

- All Plan F benefits
- While premiums are typically lower under the high deductible option, the insured is required to pay the deductible before the policy will cover your health claims
- The deductible for this plan changes annually

Plan G includes:

- Basic core benefits
- Medicare Part A deductible
- Skilled nursing facility care
- 100% of Medicare Part B excess charges
- Medically necessary emergency care in a foreign country

Plan K includes:

- Basic core benefits
- 50% of the cost-sharing for Medicare Part A covered hospice expenses
- First three pints of blood
- 50% of the Part B co-insurance after meeting the annual deductible
- Payment of the Part A and B deductibles, co-payments and co-insurance once the annual out-of-pocket spending limit is met
- Payment of the Part A and B deductibles, co-payments, and co-insurance once the annual out-of-pocket spending limit is met
- The deductible for this plan changes annually

Plan L includes:

- Basic core benefits
- 75% of the cost-sharing for Medicare Part A covered hospice expense
- First three pints of blood
- 75% of the Part B co-insurance after meeting the annual deductible
- 100% of the Part A and B deductibles, co-payments and co-insurance, once the annual out-of-pocket spending limit is met
- The deductible for this plan changes annually

Plan M includes:

- Basic core benefits
- 50% of the Medicare Part A deductible
- Skilled nursing facility care
- Medically necessary emergency care in a foreign country

Plan N includes:

- Basic core benefits
- Medicare Part A deductible
- Skilled nursing facility care
- Medically necessary emergency care in a foreign country
- 100% of the Part B co-insurance, except up to $20 co-payment for office visits and up to $50 for emergency department visits



Medicare Access and CHIP Reauthorization ACT of 2015

The Medicare Access and Chip Reauthorization Act of 2015 (MACRA) prohibits the sale of Medicare Supplement policies that cover Part B deductibles to individuals newly eligible for Medicare on or after January 1, 2020.

Plans C, F, and F with high deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

- Plan C is reassigned as Plan D and shall not provide coverage for any portion of the Medicare Part B deductible.
- Plan F is reassigned as Plan G and shall not provide coverage for any portion of the Medicare Part B deductible.
- Plan F with high deductible is reassigned as Plan G with high deductible and shall not provide coverage for any portion of the Medicare Part B deductible. The Medicare Part B deductible paid by the insured shall be considered an out-of-pocket expense in meeting the annual high deductible.

MACRA defines "newly eligible" individuals as anyone who:

- Attains age 65 on or after January 1, 2020.
- First becomes eligible for Medicare benefits due to age, disability or end-stage renal disease on or after January 1, 2020.

Medicare Select

A Medicare Select policy is a Medicare Supplement policy (Plan A through N) that conditions the payment of benefits, in whole or in part, on the use of network providers. Network providers are providers of health care that have entered into a written agreement with an insurer to provide benefits under a Medicare Select policy.

A Medicare Select policy cannot restrict payment for covered services provided by non-network providers in an emergency or for an unforeseen illness, injury, or a condition where it is not reasonable to obtain such services through a network provider. A Medicare Select insurer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy to the applicant. This disclosure shall include at least all of the following:

- An outline of coverage sufficient for the applicant to compare the coverage and premiums of the Medicare Select policy with other Medicare Supplement policies offered by the insurer or offered by other insurers.
- A description, including address, phone number, and hours of operation of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.
- A description of the restricted network provisions, including payments for co-insurance and deductibles, if providers other than network providers are utilized.
- A description of coverage for emergency and urgently needed care and other out-of-service area coverage
- A description of limitations on referrals to restricted network providers and to other providers.
- A description of the policyholder's rights to purchase any other Medicare Supplement policy or certificate otherwise offered by the insurer.
- A description of the Medicare Select insurer's quality assurance program and grievance procedure.
- At your request, under a Medicare Select policy, the health insurer must make available to you the opportunity to purchase a Medicare Supplement policy offered by the insurer that has comparable or lesser benefits that does not contain a restricted network provision. The health insurer shall make the policy available and cannot require evidence of insurability after the Medicare Supplement policy or certificate has been in force for six months.

Your Right to Return a Medicare Supplement Policy

The policy is your contract. You are responsible for reading your policy to understand the rights and duties of both you and the insurer.

If you are not satisfied with your Medicare Supplement policy, you may return it to the insurer within 30 days after you receive the policy to receive a full premium refund.

Replacing an Existing Medicare Supplement Policy With One From a Different Company

When deciding to replace your existing Medicare Supplement policy with one offered by a different company, do not cancel the current policy until the new policy has been received and reviewed.

It is your responsibility to understand the benefits of the new contract and decide if you want to keep it. Once your decision has been made, you are responsible for canceling the old policy.

Insurance agents selling a Medicare Supplement policy intending to replace an existing Medicare Supplement policy with a different insurer must provide the applicant with a Medicare Supplement coverage replacement notice.

Becoming Eligible for Medicaid While You Have a Medicare Supplement Policy

When becoming eligible for Medicaid while still enrolled in a Medicare Supplement policy, it is important to know the following:

- Benefits and premiums under a Medicare Supplement policy can be suspended at the insured's request for a period not to exceed 24 months.
- The insured must notify the insurer within 90 days of becoming eligible for Medicaid.
- The insurer must refund the portion of the premium attributable to the period of Medicaid eligibility, subject to an adjustment for paid claims.
- If you lose your entitlement to Medicaid, the Medicare Supplement policy should be automatically reinstated as of the date your Medicaid coverage ends. You must notify the insurer of the loss of coverage.

Treatment of Pre-Existing Conditions Under Medicare Supplement Policies

Under a Medicare Supplement policy, a pre-existing condition is a medical condition for which medical advice was given or treatment was recommended by or received from a physician within six months prior to the effective date of coverage.

A Medicare Supplement policy cannot use riders or endorsements to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

If a Medicare Supplement policy replaces another Medicare Supplement policy, the replacing insurer must waive any time periods applicable to pre-existing conditions including:

- Waiting periods
- Elimination periods
- Probationary periods in the new Medicare Supplement policy for similar benefits to the extent such time was spent under the original policy

Medicare Advantage Plans (MA)

MA plans replace original Medicare by providing all of Part A and Part B coverage. MA plans must cover all of the services that original Medicare covers except for hospice care.

MA plans are offered by private insurance companies approved by the federal government and are sometimes referred to as "Part C." It's important to note that MA plans:

- May require the use of network providers.
- May offer different co-payments, co-insurance, and deductibles than original Medicare.
- May offer extra benefits, including vision, hearing, or dental coverage.
- May include prescription drug coverage, also known as a Part D plan. (Read on for more information about Medicare prescription drug coverage.)
- These plans are not Medicare Supplement policies even though the plans cover similar benefits. For this reason, individuals do not need an MA plan and Medicare Supplement plan at the same time.

MA plans are regulated under the authority of the Centers for Medicare and Medicaid Services (CMS), a federal agency. The Michigan Department of Insurance and Financial Services (DIFS) does not have authority over MA plans; therefore, DIFS does not review or approve the contract language or the rates for MA plans. However, DIFS does license most of the health insurers that issue MA plans in Michigan.

Medicare Prescription Drug Coverage (Part D)

Medicare Part D coverage is a voluntary benefit available to everyone with Medicare and is offered by private insurance companies approved by the federal government. Health insurers offer a variety of Part D plan options, with different covered prescriptions and costs.

Prior to purchasing a plan, it is important to verify that your prescriptions are covered under the plan and what your financial responsibility will be. Important features about Part D monthly premiums and other plan costs are:

- Part D plans charge a monthly premium in addition to the Medicare Part B premium.
- MA plans offering Part D coverage may include a charge for the prescription drug coverage in the monthly premium.
- The amount you pay for Part D coverage may differ based on your income.
- Part D plans may have yearly deductibles that must be met before the plan begins to pay its share of covered medications.
- After the deductible has been met, the insured may be responsible for co-payments and co-insurance.

DIFS does not have authority over Medicare Part D plans; therefore, DIFS does not review or approve the contract language or the rates for Medicare Part D plans. However, DIFS does license most of the health insurers that issue Medicare Part D plans in Michigan.

MA and Medicare Part D Plans Through a Retiree or Group Health Plan

If you are covered under an employer group MA plan, Medicare Part D plan, or retiree health plan, any changes in the plan or coverage are determined by the employer.

Plan changes may occur only during open enrollment. It is important to know if your plan changed or if other plan options are available.

Questions regarding plan changes may be directed to your employer's human resources department, or use the contact number provided on any written communication received.

Open Enrollment for MA and Medicare Part D

You may only enroll, switch, or drop an MA or Medicare Part D plan during certain times of the year.

Once enrolled in an MA or Medicare Part D plan, enrollment must continue for the rest of the calendar year. There are limited circumstances in which these plans may be dropped or switched during the year.

For more information, visit **www.medicare.gov**, call 800-MEDICARE (800-633-4227) or the Michigan's State Health Insurance Assistance Program (SHIP) at 800-803-7174.

State Health Insurance Assistance Program (SHIP)

SHIP is a free health benefit counseling service for Medicare and Medicaid beneficiaries and their caregivers.

SHIP works to provide high quality and accessible health benefit information and counseling. Information regarding the programs and services available can be found on the Long Term Services and Supports website.

For more information, you can visit the State **Health Insurance Assistance Program (SHIP)** website or call 800-803-7174.

Filing a Complaint With DIFS

You do not always need an attorney to resolve most claim disputes with an insurer. Start with contacting the insurer's customer service department. Most insurers have toll-free telephone numbers located on the back of your insurance card.

If a satisfactory resolution is not received, ask about the insurer's appeal process or file a written complaint with the Michigan Department of Insurance and Financial Services (DIFS).

DIFS will send the insurer a copy of the complaint and ask them to explain its position. Insurers are required by law to respond to DIFS. We will review the facts to ensure the health insurer has complied with your contract language and all rules and regulations.

How to File a Complaint With DIFS

Complaints can be submitted as follows:

- **Online:** www.michigan.gov/DIFScomplaints
- **Email:** DIFScomplaints@michigan.gov
- **Fax:** 517-284-8837
- **Mail:** The Department of Insurance
  and Financial Services
  Office of Consumer Services
  PO Box 30220
  Lansing, MI 48909
- Contact DIFS toll-free at 877-999-6442 to request a complaint form be sent to you via mail, email or fax.

Health Care Provider Complaints

DIFS regulates the business of insurance transacted in Michigan. Our authority pertains to contracts issued in Michigan. DIFS accepts complaints from parties involved in the contract, such as the insured, policyholder or certificate holder. Because a health care provider is usually not a party to the health plan, DIFS generally does not accept complaints from providers. There are some exceptions to this rule.

DIFS will pursue appropriate complaints from providers acting as the authorized representative of a patient; however, written authorization from the patient or their legal representative must be included with the complaint.

DIFS will accept complaints from providers having problems with receiving timely payment for submitted claims without any errors or other issues. These claims are referred to as "clean claims" and must be paid within 45 days after they are received by the health plan. For more information on clean claims and to obtain the Clean Claim Report form, visit **www.michigan.gov/DIFS**.

If you have a provider-related billing dispute, these complaints can be submitted to the Michigan Attorney General Consumer Protection Division for review. The office can be reached toll-free at 877-765-8388 or **www.michigan.gov/AG**.

Glossary of Health Coverage and Medical Terms

This glossary has many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have the same meaning when used in your policy or plan and, in any such case, the policy or plan governs.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference (see Balance Billing).

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for charges not paid by your health insurance because the charges are higher than the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you the $30 difference.

Co-Insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-Payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for covered health care services before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services. The deductible may not apply to all services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance service for an emergency medical condition.

Emergency Room Care
Treatment you receive in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitative Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Service to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Treatment in a hospital that usually doesn't require an overnight stay.

In-Network Co-Insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-Network Co-Payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. [Check your policy to see if you can go to all providers who have contracted with your health insurance or plan or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.]

Out-of-Network Co-Insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-Payment
The fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – doctor of medicine or D.O. – doctor of osteopathic medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
A health insurance benefit that helps pay for prescription drugs and medications.

Prescription Drugs
A drug that by law requires a medical prescription.

Primary Care Physician
A physician (M.D. – doctor of medicine or D.O. – doctor of osteopathic medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – doctor of medicine or D.O. – doctor of osteopathic medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – doctor of medicine or D.O. – doctor of osteopathic medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical condition.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Treatment for an illness, injury or condition that is serious enough that a reasonable person would seek care right away but not so severe as to require emergency room care.

Updated Contact Information 6/2022

Important Contact Information

Michigan Department of Insurance and Financial Services (DIFS)

- Michigan.gov/DIFS
- Phone: 877-999-6442

Health Insurance Marketplace

- Healthcare.gov
- Phone: 800-318-2596

SHOP Marketplace

The Small Business Health Options Program (SHOP) Marketplace is a federally operated insurance marketplace where small businesses may shop for and compare group health coverage.

- Healthcare.gov/Small-Business
- Phone: 800-706-7893

Michigan Department of Health & Human Services (MDHHS)

Apply for Michigan health care programs like Medicaid, Healthy Michigan Plan and MiChild at:

- Michigan.gov/MiBridges
- Phone: 855-276-4627
- Michigan.gov/MDHHS
- Phone: 855-789-5610
- Michigan.gov/HealthyMiPlan
- Phone: 855-789-5610

Free Health Clinics

Free Clinics of Michigan (FCOM) is a network of volunteer-staffed free clinics that provide health care services to the uninsured or medically underserved in Michigan.

- FCOMi.org
- Phone 248-635-8695

U.S. Department of Labor – Employee Benefits Security Administration (USDOL)

The USDOL regulates self-funded health plans and the Consolidated Omnibus Budget Reconciliation Act (COBRA).

- DOL.gov/Agencies/EBSA
- Phone: 866-444-3272

Michigan Attorney General – Consumer Protection

Handles complaints and answers questions regarding provider billing issues.

- Michigan.gov/AG
- Phone: 877-765-8388



Don’t Know Where to Turn?

Health Insurance Consumer Assistance Program (HICAP)

The Health Insurance Consumer Assistance Program is operated by the Department of Insurance and Financial Services to help Michigan consumers with health insurance issues

- www.michigan.gov/HICAP
- Telephone: 877-999-6442

Medicare

Medicare provides health insurance for people age 65 or older, some under age 65 with disabilities, and those experiencing kidney failure.

- www.medicare.gov
- Telephone: 800-MEDICARE (800-633-4227)

Michigan’s State Health Insurance Assistance Program (SHIP)

SHIP provides free education and personalized assistance to people with Medicare and Medicaid, their families and caregivers.

- State Health Insurance Assistance Program (SHIP)
- Telephone: 800-803-7174



www.michigan.gov/difs

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