# Mississippi State and School Employees' Health Insurance Plan Wellness/Preventive Coverage

| Wellness/Preventive Services and Screenings Covered at 100% | Birth to 2 years | Ages 3-11 years | Ages 12-17 | Female 18-34 | Male 18-39 | Female 35-39 | Male 40-49 | Female 40-49 | Male 50+ | Female 50+ |
|---|---|---|---|---|---|---|---|---|---|---|
| Wellness visits, preventive medicine evaluations or re-evaluations including blood pressure, dental caries screening, vision and hearing screening for age 3-5, and counseling as appropriate for risk factors, age or stage of development. | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Hemoglobin, hematocrit or CBC | 2 | | | 2 | | 2 | | 2 | | 2 |
| TB skin testing as needed | | | | | | | | | | |
| Diabetes screening (HbA1c) once per calendar year | | | | | | | | | | |
| Glucose once per calendar year (only for high-risk individuals) beginning at age 3 | | | | | | | | | | |
| Lipid profile once per calendar year | | | | 3 | 3 | | | | | |
| Pap smear once every three or five years | | | | 4 | | 4 | | 4 | | 4 |
| Pelvic and breast exam once per calendar year, included in wellness visit | | | 5 | 5 | | 5 | | 5 | | 5 |
| Sexually transmitted disease screenings (chlamydia infection [age 18-24], syphilis, gonorrhea) | | | | | | | | | | |
| HIV screening | | | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| Hepatitis B screening, for non-pregnant adolescents and adults at high-risk for infection | | | | | | | | | | |
| Hepatitis C (HCV) screening | | | | | | | | | 7 | 7 |
| Mammogram once per calendar year | | | | | | 8 | | 8 | | 8 |
| Osteoporosis in post-menopausal women screening | | | | | | | | | | 9 |
| Breast and ovarian cancer susceptibility, genetic risk assessment and BRCA mutation testing, once per lifetime | | | | | | | | | | |
| Flexible sigmoidoscopy once every five years or colonoscopy once every ten years or multi-target stool DNA test once every three years | | | | | | | 10 | 10 | 10 | 10 |
| Stool for occult blood once per calendar year | | | | | | | | | | |
| Lung cancer screening, once per year for adults age 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. | | | | | | | | | | |
| Abdominal aortic aneurysms screening men age 65-75, once per lifetime | | | | | | | | | | |

1. Eleven visits within the first 23 months of life; two visits per year age 2-3; one visit per year age 4-17; two visits per year age 18 and over.
2. Hemoglobin, hematocrit, CBC, only once between 6-24 months. Females, only performed if pregnant, once per pregnancy.
3. Lipid screenings begin at age 21.
4. Cervical cancer screening is recommended only for women age 21-65. Women age 21-29, screening should be done by a Pap test every 3 years. For women age 30-65, screening can be done by a Pap test every 3 years, a high-risk HPV test every 5 years, or a Pap test plus a high-risk HPV test every 5 years. Screening is not recommended for women younger than 21 years or older than 65 years (if they have had routine prior screening with negative results), or who have had their uterus and cervix removed.
5. Pelvic and breast exams are available for females beginning at age 12 if medically appropriate.
6. HIV screenings are for adolescents and adults age 15-65 years. Younger adolescents and older adults who are at increased risk should also be screened.
7. Hepatitis C screening is a one-time screening for adults born between 1945 and 1965.
8. A mammogram is recommended once every 2 years for women age 50-74 years.
9. Bone density studies are covered for women once every 2 years beginning at age 60.
10. Flexible sigmoidoscopy, colonoscopy, and multi-target stool DNA screenings begin at age 45. Additional screenings for individuals considered to be at high-risk for colorectal cancer may be covered under the medical portion of the Plan. A gastroenterology consult prior to a colonoscopy is not covered under a wellness visit. High-risk individuals are defined as someone with a:
    - Personal history of colorectal cancer polyps.
    - Known family history of colorectal cancer syndrome.
    - Strong family history of colorectal cancer or polyps in a first-degree relative younger than 60 or two first-degree relatives of any age. A first-degree relative is defined as a parent, sibling or child.

Beginning at the appropriate age, biometrics are required to be collected for a compliant wellness visit. All wellness services must be rendered by a network provider or facility.

Preventive Wellness Guidelines are based on recommendations from the following:

- U.S. Preventive Services Task Force (USPSTF)
- Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP)
- U.S. Health Resources & Services Administration (HRSA), Preventive Care and Screenings of Infants, Children and Women
- National Medical Societies

Call your primary care network provider to schedule your wellness visit. To locate a network provider, call 800-294-6307 or go to the "Provider Search" tab at http://KnowYourBenefits.dfa.ms.gov/provider-search/.

# Mississippi's State and School Employees' Health Insurance Plan

## Frequently Asked Questions

### Medical Plan

**Q. What is included in the AHS State Network?**

A. You can receive the maximum benefits available under the Plan if you choose to receive care from providers who participate in the Network. Participating providers include a variety of physicians, hospitals, facilities and medical service providers. For more information on the Plan or to view or download a copy of the Plan Document (PD), go to KnowYourBenefits.dfa.ms.gov and click on the "Publications" tab.

**Q. Why should I choose to receive medical care from a Network provider?**

A. Participating providers have agreed to accept pre-negotiated fees in exchange for their medical services. For you, this means that you are not responsible for any amounts over the allowable charge for covered services when you receive care from a participating provider.

**Q. How do I know if my doctor is participating in the Network?**

A. To find a participating provider, go to KnowYourBenefits.dfa.ms.gov and click "Find a Participating Provider." You can also go to https://www.myaccessblue.com/AHSProviderSearchWeb/#/ or contact the Network at (800) 294-6307.

**Q. What is an out-of-network review?**

A. This is the process of determining if the Plan will allow in-network level benefits for services provided by a non-participating provider. You should contact Kepro at (888) 801-1910 to request an out-of-network review.

**Q. If the Plan is not my primary source of health benefit coverage, how does my insurance coverage work?**

A. When a participant is covered by another group health plan, there may be some duplication in the coverage. To determine how plans coordinate benefits, one is considered "primary" and the other is considered "secondary." How this is decided is called Coordination of Benefits.

**Q. Where can I learn more about Coordination of Benefits?**

A. Refer to the Plan Document for additional information on how to determine which of your plan coverage options are considered "primary" or "secondary."

**Q. When I reach age 65, will my Plan coverage coordinate with my Medicare coverage?**

A. Yes. The Plan will coordinate with Medicare to provide you with health care benefit coverage. Information on coordination with Medicare is included in the PD.

**Q. What services require certification?**

A. The following services require certification and must be certified as medically necessary by Kepro prior to admission or treatment:

- Inpatient hospital admission – except routine maternity admissions
- Inpatient rehabilitation
- Residential Treatment Facility
- Inpatient bariatric surgical procedures
- Outpatient bariatric surgical procedures
- Private duty and home health nursing
- Solid organ and bone marrow/stem cell transplants
- Home infusion therapy
- Skilled Nursing Facility
- Long Term Acute Care Facility
- Hospice care
- Diabetic self-management training/education

Kepro must be contacted in advance of any anticipated non-emergency hospital admission and immediately following an emergency admission by calling (888) 801-1910. Failure to comply with notification requirements may result in financial penalties, reduction of benefits or even denial of benefits.

*Note: Certification is not required for those participants having Medicare or other primary coverage, unless the service is not covered by Medicare or other primary coverage. In this case, the service will be subject to the certification process through Kepro.*

**Q. What kind of coverage does the Plan provide for medical care in an emergency situation?**

A. Medical emergencies are defined as an unplanned event that may force you to seek prompt medical attention. Emergency care received from a non-participating provider will be paid at the in-network benefit level (for example, deductibles and coinsurance will be the same for visits to a hospital emergency room whether the hospital is in-network or out-of-network). However, the participant is still responsible for amounts charged by the non-participating provider that exceed the allowable charge.

## Prescription Drug Program

**Q. What is a Preferred Drug List (PDL) or Formulary?**

A. A list of preferred brand drugs or formulary is maintained by CVS Caremark, the pharmacy benefit manager (PBM). Drugs are chosen based on their clinical appropriateness and cost effectiveness. CVS Caremark may add drugs to the list at any time. Typically, deletions to the list will only occur on an annual basis. You can access a list of preferred drugs by going to Caremark.com or by contacting CVS Caremark Customer Care at (888) 996-0050.

**Q. What is a generic drug?**

A. Typically, generic drugs cost less than equivalent brand name drugs. Because the generic drug copayment is less, participants save money when purchasing generic drugs. Participants are encouraged to use generic drugs whenever allowed by their physician. To be covered by the Plan, a generic drug must:

- Contain the same active ingredients as the brand name drug (inactive ingredients may vary);
- Be identical in strength, form of dosage and the way it is taken;
- Demonstrate bioequivalence with the brand name drug; and
- Have the same indications, dosage recommendations and other label instructions (unless protected by patent or otherwise exclusive to the brand name).

**Q. What is a "non-preferred drug"?**

A. A "non-preferred drug" refers to those drugs that are available at the higher copay.

**Q. How can I find out if a drug is preferred?**

A. You can access a list of preferred drugs online at Caremark.com or by calling CVS Caremark Customer Care directly at (888) 996-0050.

**Q. What mail service will be used for the Plan?**

A. As part of the prescription drug program, you can enjoy the convenience of home delivery by using the CVS Caremark Mail Order Pharmacy program. You must register at Caremark.com or contact CVS Caremark Customer Care at (888) 996-0050.

To get started, register at Caremark.com or contact CVS Caremark Customer Care at (888) 996-0050.

**Q. What levels of coverage are available to me under the prescription drug program?**

A. The following chart outlines prescription drug copayments:

| | **Retail Pharmacy** | | **Home Delivery (CVS Caremark)** | |
|---|---|---|---|---|
| **Prescription Drug Type** | **1-30 Day Supply** | **31-60 Day Supply** | **61-90 Day Supply** | **90 Day Supply or Less** |
| Preferred Generic Drug | $12 | $24 | $36 | $24 |
| Non-preferred Generic Drug | $30 | $60 | $90 | $60 |
| Preferred Brand Drug | $45 | $90 | $135 | $90 |
| Non-Preferred Brand Drug | $100 | $200 | $300 | $200 |
| Specialty | $100 | N/A | N/A | N/A |

***Generic mandate applies to brand drugs purchased when a generic is available.** If a participant purchases a brand drug for which a generic equivalent is available, the participant will pay the difference in the cost of the brand name drug and the generic drug, plus the applicable brand copayment amount.

*Note: Participants in Base Coverage will be charged the full allowable charge for each 30-day supply until the annual deductible is met.*

## Filing a Claim

**Q. When do I need to file a medical claim?**

A. You need to file a claim when you receive care from a non-participating provider. Participating providers have agreed to file your claims for you. Before you can file a claim, you need to receive an itemized bill from your health care provider.

**Q. How do I file a medical claim?**

A. For care received from a non-participating provider, you first must receive the proper itemized bill from the provider and obtain a claim form from your personnel office or from Blue Cross & Blue Shield of Mississippi (BCBSMS). Be sure to read the instructions on the claim form carefully and complete the entire form to avoid delays in processing. Send your completed form, itemized bills and any other supporting documents, records and receipts to BCBSMS. Keep copies of all documents for your records.

**Q. With whom do I file a medical claim?**

A. You should mail your completed medical claim forms to:

**Blue Cross Blue Shield of Mississippi**
3545 Lakeland Drive
Flowood, MS 39232

**Q. How do I file a claim when the Plan is not my primary source of medical coverage?**

A. File a claim with your "primary" plan and request an Explanation of Benefits (EOB) from that plan. You then file the claim with your "secondary" plan, which in this case is the State and School Employees' Health Plan. When you file with the Plan, be sure to include a copy of your primary plan's EOB with your paperwork.

If Medicare is your primary coverage, you would use this same claims filing process when filing for secondary coverage under the Plan.

**Q. How can I get a claim form?**

A. For a claim form, contact BCBSMS at (800) 709-7881 or go to the BCBSMS website. You can also get a claim form through your personnel office.

**Q. When do I need to file a prescription drug claim?**

A. When you use a participating pharmacy, they will file a claim for you. If you use a non-participating pharmacy, you will need to file a completed claim form with CVS Caremark that includes your receipts from the pharmacy. Keep copies of the claim and receipts for your records.

**Q. What if I use a pharmacy that is not in the CVS Caremark network?**

A. If you choose to use a pharmacy that doesn't participate in the CVS Caremark retail network, you'll be charged the full cost for the medicine and you'll need to send a Claim Reimbursement Form to CVS Caremark. Under your plan, your reimbursement will be based on the cost you would have paid if you used a participating retail pharmacy, minus your applicable deductible and/or co-pay/co-insurance. Be sure to complete the entire claim form, attach the sales receipt showing the price you paid, and send them to CVS Caremark at the address on the form. Members can also submit reimbursement claims online from their Caremark.com account. To download a claim form, go to Caremark.com, login using your login credentials, and follow the link to print a form under the Plan & Benefits tab. Forms are also available by calling CVS Caremark Customer Care at (888) 996-0050.

**Q. With whom do I file a prescription drug claim?**

A. You should mail your completed prescription drug claim forms to:

**CVS Caremark**
P.O. Box 94467
Palatine, IL 60094-4467
888-996-0050

**Q. Is there a time limit for filing claims?**

A. Yes. There is a deadline for filing medical and prescription drug claims. All claims must be filed with BCBSMS or CVS Caremark within 12 months of the day you received services, prescriptions or supplies.

**Q. I would like to have a claim reviewed. How do I begin the appeals process?**

A. You have 180 days to submit a written request for a review after receiving notice of denial from BCBSMS or CVS Caremark. If you do not request a review within this timeframe, you will lose your right for a review. If you need more detailed information, you should refer to the PD. Here are some tips to help you file a claim.

- Keep all receipts from non-participating pharmacies and physicians.
- File your claim promptly.
- Use the correct form. (Remember, there are separate claim forms for medical and prescription drug benefits.)
- Complete the entire form.
- Make a copy of your completed form to keep for your own records.
- Mail the claim form to the correct address.

## Coinsurance, Copayment and Deductibles

**Q. What is a deductible?**

A. A deductible is the amount that you must pay each year before the Plan will begin to cover your health care expenses.

**2021 Select Coverage Medical Deductibles**

| Select Deductibles | In-Network | Out-of-Network |
|---|---|---|
| Calendar Year Deductible | $1,300 | $2,300 |
| Family Deductible | $2,600 | $4,600 |

**2021 Base Coverage Medical Deductibles**

| Base Deductibles | In-Network | Out-of-Network |
|---|---|---|
| Calendar Year Deductible – Individual Coverage | $1,800 | |
| Calendar Year Deductible – Family Coverage | $3,000 | |

**Q. What is the difference between coinsurance and copayments?**

A. Coinsurance is a percentage of the cost you pay for certain medical expenses, like doctors' visits. A copayment is a flat fee you pay for expenses such as prescription drugs.

**Q. How can I be sure to get the most out of my benefit dollar?**

A. The Plan can provide you with the highest benefit coverage when you receive medical care from a participating provider. Use a participating pharmacy or the CVS Caremark Mail Order Pharmacy for mail order prescriptions, and elect to fill your prescriptions using generic or preferred brand drugs whenever possible.

To get the most out of your benefit dollars, the Plan encourages you to:

- Receive care from participating providers.
- Certify appropriate medical services.
- Choose to fill your prescriptions using generic or preferred brand drugs whenever possible.
- Visit a participating pharmacy to fill your prescriptions or use the CVS Caremark Mail Order Pharmacy program for maintenance medications.
- File your claims promptly.

For questions about medical claims, call **Blue Cross & Blue Shield of Mississippi** (800) 709-7881

To certify a hospital admission or other service, call **Kepro** (888) 801-1910

For questions about prescription drug claims, call **CVS Caremark** (888) 996-0050

To find a participating provider, call **AHS State Network** (800) 294-6307

For general questions about the Plan, call the **Office of Insurance** (866) 586-2781

# CVS CAREMARK

CVS Caremark is the pharmacy benefit manager (PBM) for the Plan's prescription drug program. CVS Caremark currently processes prescription claims from participating pharmacies, mail order claims and paper claims filed by participants for approximately 103 million members across the country.

## CVS Caremark Resource Links

New Value Formulary *effective 7/01/2022*

- Value Formulary Flyer
- Value Formulary Quick Reference List
- CVS Caremark Value Formulary
- Medicines Not Listed on Value Formulary With Suggested Alternatives

## For Prescribers

- Value Formulary Medicines with Clinical Requirements
- Value Formulary Prescribers Guide

## Other Resources

- CVS Caremark Specialty Drug List
- CVS Caremark Mail Order Brochure
- Pharmacy Locator Tool

## Filing Claims for Over-the-Counter (OTC), at-home COVID-19 tests

- Notice regarding filing claims for OTC, at home Covid-19 tests
- OTC, at-home COVID-19 Test Reimbursement Claim Form
- OTC, at-home COVID-19 Test FAQs
- OTC, at-home COVID-19 Test Flyer

# MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN

## Health Insurance Portability and Accountability Act (HIPAA), Notice of Privacy Practices

***State and School Employees' Health Insurance Plan***

This Health Insurance Portability and Accountability Act, Notice of Privacy Practices (HIPAA) Notice describes how medical information about you may be used and disclosed and how you can get access to this information. This Notice is effective January 1, 2021.

**Please review this Notice carefully.**

This Notice relates to the State and School Employees' Health Insurance Plan only. This Notice does not apply to other covered programs offered by your employer such as dental, vision and flexible spending accounts. This Notice does not apply to non-covered programs such as life insurance and workers' compensation.

This Notice describes how the State and School Employees' Health Insurance Plan (Plan) may use and disclose Protected Health Information (PHI) and also explains your legal rights regarding this information. PHI is individually identifiable information about your past, present or future health or condition, health care services provided to you, or payment for health services.

The Plan is required by law to maintain the privacy of your PHI and to provide you with this Notice of the Plan's legal duties and privacy practices. The Plan is required to follow the privacy practices described in this Notice. This Notice is posted on the Plan's website at http://KnowYourBenefits.dfa.ms.gov. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time. If a change is made to this Notice, a revised Notice will be mailed to those individuals defined as "enrollees" in the *Plan Document*. The revised Notice will be posted on the Plan's website. You have the right to receive a printed copy of this Notice upon request. Contact information is included at the end of this notice.

**PERMITTED USES AND DISCLOSURES**

The examples of permitted uses and disclosures listed below are not provided as an all-inclusive list of the situations in which PHI may be used and disclosed by the Plan. However, the Plan will only use or disclose your PHI, without your written authorization in situations falling into one of these categories.

**Uses and Disclosures for Purposes of Treatment, Payment or Health Care Operations**

The Plan may use and disclose your PHI for the purposes of treatment, payment and health care operations. Examples of the uses and disclosures that the Plan may make under each purpose are listed below.

**Treatment:** Refers to the provision of health care by a doctor, hospital or other health care provider. The Plan generally does not use or disclose your PHI for treatment, but is permitted to do so if necessary. For example, the Plan may disclose to your treating specialty provider the name of your treating general medical provider so that the specialty provider may have the necessary medical records to evaluate your medical condition.

**Payment:** Refers to the activities that the Plan undertakes in the payment of claims for covered services received by Plan participants. Examples of uses and disclosures under this section include determination of medical necessity of a treatment or service, and what the allowable charge should be; determining if a treatment or

service is covered by the Plan; and sharing PHI with insurers in order to settle subrogation claims, and to perform coordination of benefits.

**Health Care Operations:** Refers to the basic functions necessary to operate the Plan. Examples of uses and disclosures under this section include the use of PHI to evaluate the performance of the Plan's vendors; the disclosure of PHI to provide disease management programs to participants with specific health conditions; the disclosure of PHI to vendors under contract with the Plan who provide consulting, actuarial, claims review and legal services to the Plan; the use and disclosure of PHI for general administrative functions such as responding to complaints or appeals; the use and disclosure of PHI for data and information management; and the use and disclosure of PHI for general data analysis used for planning, managing and evaluation purposes.

**Disclosures to the Plan's Business Associates**

The Plan may disclose your PHI to its business associates as part of contracted agreements to perform services for the Plan provided that the business associate agrees to protect the information.

**Disclosure for Health Related Products and Services**

The Plan or its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, the Plan's utilization management vendor may contact you regarding a disease management program.

**Disclosures to Other Covered Entities**

The Plan may disclose your PHI to other covered entities or business associates of those covered entities for the purposes of treatment, payment and certain health care operations. For example, the Plan may disclose PHI to another health plan in order to perform coordination of benefits.

**Other Uses and Disclosures Allowed Without Authorization**

The Plan may use and disclose PHI without your authorization in the following ways:

- To you as the covered individual;
- To a personal representative designated by you to receive PHI or a personal representative designated by law, such as the guardian ad litem for a minor or a person with power of attorney for health care;
- To the Secretary of Health and Human Services (HHS) or a duly designated employee of HHS as part of an investigation to determine the Plan's compliance with HIPAA;
- In response to a court order, subpoena, discovery request, or other lawful judicial or administrative proceeding or process;
- As required for federal, state and local law enforcement purposes;
- As required to comply with workers' compensation or other similar programs established by law;
- To a health oversight agency for activities authorized by law such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee benefit programs, other governmental regulatory programs and civil rights laws;
- As required to address certain matters of public interest as required or permitted by law. Examples include threats to the public health or national security matters; and

- To the State and School Employees Health Insurance Management Board, the Plan Sponsor, provided the appropriate language is included in the *Plan Document*, to carry out the payment and health care operations functions discussed above.

**USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION**

Other uses and disclosures of your PHI will only be made upon receiving your written authorization. If you have provided an authorization to the Plan, you may revoke your authorization at any time by providing written notice to the Plan. The Plan will honor a request to revoke as of the day it is received and to the extent that the Plan has not already used or disclosed your PHI.

**YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION**

The federal privacy regulations give you the right to make certain requests regarding your PHI.

**Right to be Notified of a Breach**

You have the right to be notified in the event that we (or a business associate) discover a breach of unsecured protected health information.

**Right to Request Restrictions**

You have the right to request that the Plan restrict its uses and disclosures of PHI in relation to treatment, payment and health care operations. Any such request must be made in writing and must state the specific restriction requested and to whom that restriction would apply. The Plan is not required to agree to a restriction that you request.

**Right to Request Confidential Communications**

You have the right to request that communications involving your PHI be provided to you at a certain location or in a certain way. Any such request must be made in writing. The Plan will accommodate any reasonable request if the normal method of communication would place you in danger and that danger is stated in your request.

**Right to Access Your Protected Health Information**

You have the right to inspect and copy your PHI maintained in a "designated record set" by the Plan. The designated record set consists of records used in making payment, claims adjudication, medical management and other operations. The Plan may ask that such requests be made in writing and may charge reasonable fees for producing and mailing the copies. The Plan may deny such requests in certain cases.

**Right to Request Amendment**

You have the right to request that your PHI created by the Plan and maintained in a designated record set be amended. Any such request must be made in writing and must include the reason for the request. If the Plan denies your request for amendment, you may file a written statement of disagreement. The Plan has the right to issue a rebuttal to your statement in which case a copy will be provided to you.

**Right to Receive an Accounting of Disclosures**

You have the right to receive an accounting of all disclosures of your PHI that the Plan has made if any. This accounting does not include disclosures for payment or health care operations or certain other purposes, or

disclosures to you or with your permission. Any such request must be made in writing and must include a time period, not to exceed six years. The Plan is only required to provide an accounting of disclosures made on or after April 14, 2003. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee.

All requests should be submitted in writing to the Department of Finance and Administration (DFA), Office of Insurance.

**COMPLAINTS**

You have the right to file a complaint if you think your privacy rights have been violated. You may file a complaint with the Plan by writing to the DFA, Office of Insurance, Attention: Privacy Officer at the address listed in this Notice. You may also file a complaint by writing to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

**PRIVACY CONTACT**

If you have any questions regarding this Notice, please contact:

Department of Finance and Administration
Office of Insurance
P.O. Box 24208
Jackson, MS 39225-4208
Phone 601-359-3411
Toll-free 866-586-2781