



California Consumer Privacy Act (CCPA) Privacy Notice

This California Consumer Privacy Act (“CCPA”) Privacy Notice applies solely to California residents and describes how MediExcel Health Plan collects, uses, and discloses personal information that is **NOT** governed by the Health Insurance Portability and Accountability Act (“HIPAA”).

Personal information that constitutes Protected Health Information (“PHI”) under HIPAA is governed by our HIPAA Notice of Privacy Practices.

Categories of Personal Information We Collect

In the past 12 months, we may have collected the following categories of personal information:

- Identifiers (e.g., name, email address, IP address)
- Internet or network activity (e.g., website interactions)
- Audio information (e.g., recorded customer service calls)
- Professional or employment-related information (for brokers, employers, or applicants)

Purposes for Collection

We collect personal information for purposes such as:

- Operating and improving our websites and services
- Communicating with members, brokers, and employers
- Marketing and advertising (where permitted by law)
- Security, fraud prevention, and compliance with legal obligations

Sharing of Personal Information

We may disclose personal information to:

- Service providers performing services on our behalf
- Vendors providing analytics, IT, or customer support services
- Government authorities when required by law

MediExcel Health Plan **DOES NOT** sell personal information as defined by the CCPA.

Your California Privacy Rights

California residents have the right to:

- Request access to personal information
- Request deletion of personal information (subject to exceptions)
- Request correction of inaccurate personal information
- Opt out of the sale or sharing of personal information
- Not be discriminated against for exercising these rights



How to Submit a Request

You may submit a request by:

- **Email:** memberservices@mediexcel.com
Subject: California Consumer Privacy Request

- **Mail:** MediExcel Health Plan
Attention: Privacy Officer
750 Medical Center Court, Suite 2
Chula Vista, CA 91911

We will need to confirm your identity before responding to your request(s).



California Consumer Privacy Request Form

This form is for California residents to submit requests under the California Consumer Privacy Act (CCPA/CPRA).

Requests involving Protected Health Information (PHI) regulated by HIPAA are handled under our HIPAA Privacy practices and may not be eligible for deletion under CCPA.

Identity & Verification Information:

First Name: _____ Last Name: _____

E-mail Address: _____ Telephone #: _____

California Residency Confirmation:

I confirm that I am a California resident.

Relationship to MediExcel Health Plan:

Member (ID # _____)

Former Member

Broker/Agent

Employer Representative (Group # _____)

Job Applicant

Other (please specify)

Type of Request:

Access personal information collected (*Subject to applicable legal exceptions. PHI regulated by HIPAA must be requested under HIPAA access rights.*)

Delete personal information (*We cannot delete information that is regulated by HIPAA, required for legal, regulatory, or security purposes, or necessary to complete transactions or provide services.*)

Website or online account information

Marketing or communications data

Call recordings

Other (please specify) _____



Correct personal information *(Requests to amend PHI are handled under HIPAA and may require additional documentation.)*

Current information on file:

Requested correction:

Opt Out of Sale or Sharing of Personal Information *(MediExcel Health Plan DOES NOT sell personal information for monetary consideration. Opting out may limit the use of analytics or technologies on our websites.)*

Submission & Confirmation:

Upon verification of your identity and request(s), we will make reasonable efforts to provide access, delete and/or correct inaccurate personal information we may have of you.

We will respond within the timeframe required by law and may contact you to obtain additional information.

I certify that the information provided is true and accurate. *(Please check)*

Signature

Date

Send Completed Form to:

Mail: MediExcel Health Plan
Attention: Privacy Officer
750 Medical Center Court,
Suite 2
Chula Vista, CA 91911

E-mail: memberservices@mediexcel.com
Subject: California Consumer Privacy Request