# Benefits Program
# Required Legal Notices

As part of Marvell's compliance obligations, Marvell Semiconductor, Inc. must provide certain legal notices to its U.S. benefits eligible employees.

**THE REQUIRED DISCLOSURE NOTICES INCLUDED WITHIN THIS PACKET ARE:**

- Medicaid and the Children's Health Insurance Program (CHIP) Notice
- Medicare Part D Notice
- HIPAA Privacy and HIPAA Special Enrollment Rights
- Summaries of Benefits and Coverage (SBCs)
- Patient Protection Notice
- Women's Health and Cancer Rights Act
- Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act)
- Your Rights and Protections Against Surprises Medical Bills

**Marvell Semiconductor, Inc.**
**5488 Marvell Lane**
**Santa Clara, CA 95054**
**(408) 222-3604**

**Prepared on 09/15/2022**

# Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.**

| ALABAMA – Medicaid | CALIFORNIA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br><br>Phone: 1-855-692-5447 | Website:<br>Health Insurance Premium Payment (HIPP) Program<br>http://dhcs.ca.gov/hipp<br><br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **ALASKA – Medicaid** | **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br><br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br><br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx | Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br><br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br><br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br>Health Insurance Buy-In Program (HIBI):<br>https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program<br>HIBI Customer Service: 1-855-692-6442 |
| **ARKANSAS – Medicaid** | **FLORIDA – Medicaid** |
| Website: http://myarhipp.com/<br><br>Phone: 1-855-MyARHIPP (855-692-7447) | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br><br>Phone: 1-877-357-3268 |

| GEORGIA – Medicaid | MASSACHUSETTS – Medicaid and CHIP |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br><br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br><br>Phone: (678) 564-1162, Press 2 | Website: https://www.mass.gov/masshealth/pa<br><br>Phone: 1-800-862-4840<br>TTY: (617) 886-8102 |
| **INDIANA – Medicaid** | **MINNESOTA – Medicaid** |
| Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br><br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br><br>Phone 1-800-457-4584 | Website:<br><br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br><br>Phone: 1-800-657-3739 |
| **IOWA – Medicaid and CHIP (Hawki)** | **MISSOURI – Medicaid** |
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br><br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br><br>Hawki Phone: 1-800-257-8563<br>HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br><br>HIPP Phone: 1-888-346-9562 | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br><br>Phone: 573-751-2005 |
| **KANSAS – Medicaid** | **MONTANA – Medicaid** |
| Website: https://www.kancare.ks.gov/<br><br>Phone: 1-800-792-4884 | Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br><br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov |
| **KENTUCKY – Medicaid** | **NEBRASKA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br><br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br><br>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx<br><br>Phone: 1-877-524-4718<br><br>Kentucky Medicaid Website: https://chfs.ky.gov | Website: http://www.ACCESSNebraska.ne.gov<br><br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **LOUISIANA – Medicaid** | **NEVADA – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br><br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Medicaid Website: http://dhcfp.nv.gov<br><br>Medicaid Phone: 1-800-992-0900 |

| MAINE – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Enrollment Website:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br><br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br><br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br><br>Phone: -800-977-6740.<br>TTY: Maine relay 711 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br><br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **NEW JERSEY – Medicaid and CHIP** | **SOUTH DAKOTA - Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/<br><br>dmahs/clients/medicaid/<br><br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br><br>CHIP Phone: 1-800-701-0710 | Website: http://dss.sd.gov<br><br>Phone: 1-888-828-0059 |
| **NEW YORK – Medicaid** | **TEXAS – Medicaid** |
| Website: https://www.health.ny.gov/health_care/medicaid/<br><br>Phone: 1-800-541-2831 | Website: http://gethipptexas.com/<br><br>Phone: 1-800-440-0493 |
| **NORTH CAROLINA – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: https://medicaid.ncdhhs.gov/<br><br>Phone: 919-855-4100 | Medicaid Website: https://medicaid.utah.gov/<br><br>CHIP Website: http://health.utah.gov/chip<br><br>Phone: 1-877-543-7669 |
| **NORTH DAKOTA – Medicaid** | **VERMONT– Medicaid** |
| Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br><br>Phone: 1-844-854-4825 | Website: http://www.greenmountaincare.org/<br><br>Phone: 1-800-250-8427 |
| **OKLAHOMA – Medicaid and CHIP** | **VIRGINIA – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br><br>Phone: 1-888-365-3742 | Website: https://www.coverva.org/en/famis-select<br><br>https://www.coverva.org/en/hipp<br><br>Medicaid Phone: 1-800-432-5924<br>CHIP Phone: 1-800-432-5924 |
| **OREGON – Medicaid** | **WASHINGTON – Medicaid** |
| Website: http://healthcare.oregon.gov/Pages/index.aspx<br><br>http://www.oregonhealthcare.gov/index-es.html<br><br>Phone: 1-800-699-9075 | Website: https://www.hca.wa.gov/<br><br>Phone: 1-800-562-3022 |
| **PENNSYLVANIA – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website:<br>https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br><br>Phone: 1-800-692-7462 | Website: https://dhhr.wv.gov/bms/<br><br>http://mywvhipp.com/<br><br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |

| RHODE ISLAND – Medicaid and CHIP | WISCONSIN – Medicaid and CHIP |
|---|---|
| Website: http://www.eohhs.ri.gov/<br><br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br><br>Phone: 1-800-362-3002 |
| **SOUTH CAROLINA – Medicaid** | **WYOMING – Medicaid** |
| Website: https://www.scdhhs.gov<br><br>Phone: 1-888-549-0820 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br><br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

## Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

# Medicare Part D Notice

For employees enrolled in Anthem Blue Cross/BC Exclusive, Anthem Blue Cross/BC Preferred, Anthem Blue Cross HDHP/BC HDHP, Kaiser (California), Tufts (Massachusetts) and Cigna International

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**Important Notice from Marvell Semiconductor, Inc. About your Prescription Drug Coverage & Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Marvell Semiconductor, Inc. ("Marvell") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

**There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:**

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Marvell has determined that the prescription drug coverage offered by the Marvell Semiconductor Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

# Medicare Part D Notice

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**
If you decide to join a Medicare drug plan, your current Marvell coverage will not be affected. You can keep this coverage if you elect Part D and this plan may coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Marvell coverage, be aware that you and your dependents may not be able to get this coverage back.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**
You should also know that if you drop or lose your current coverage with **Marvell** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage:**
Contact the person on the following page for further information.

**NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Marvell** changes. You also may request a copy of this notice at any time.

# Medicare Part D Notice

**For More Information About Your Options Under Medicare Prescription Drug Coverage:**
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

**For more information about Medicare prescription drug coverage:**

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Date: **09/15/2022**

Name of Entity/Sender: **Marvell Semiconductor, Inc.**

Contact--Position/Office: **Human Resources**

Address: **5488 Marvell Lane, Santa Clara, CA 95054**

Phone Number: **(408) 222-3604**

# HIPAA Privacy and Special Enrollment Rights

## HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you wish to decline coverage for yourself or your eligible dependent(s), you will be required to complete the appropriate section on your election form. Please note that you or your dependent(s) must be enrolled in a benefit plan during the initial enrollment period in order to avoid being considered a Late Enrollee. You and/or your dependent(s) may qualify under a Late Enrollee Exception if you declined coverage during the initial enrollment period because you had other coverage under another employer's medical benefits plan and coverage under that employer's medical benefits plan ends. An employee or dependent who requests enrollment after the initial enrollment period will be considered to be a Late Enrollee unless the person qualifies under a Late Enrollee Exception.

This is a brief statement regarding your HIPAA special enrollment rights and does not fully explain these rights. You should read the insurance carrier's Summary Plan Description for a more detailed description of your HIPAA special enrollment rights.

**HIPAA and Privacy**

Marvell recognizes the confidentiality of you and your enrolled dependents' personal health information, and we are committed to keeping that information private. In addition to our commitment, the Federal Health Insurance Portability and Accountability Act (HIPAA) establishes privacy rules for individually identifiable health information. For a copy of the privacy notice, please contact the plan administrator at (408) 222-3604.

# Summaries of Benefits and Coverage and Patient Protection Notice

## Summaries of Benefits and Coverage (SBCs)

As part of the Affordable Care Act (ACA), Summaries of Benefits and Coverage (SBCs) were created to provide easy-to-understand descriptions of the medical plan coverage available to you. They are designed to help you better understand, compare and evaluate your medical plan choices.

You may find the SBCs for your medical plan choices as well as a helpful Glossary of Health Coverage and Medical Terms by going to the Marvell benefits portal at www.marvellbenefits.com and clicking on the Reference Center.

**Paper copies of the SBCs may be obtained upon request by contacting the plan administrator at (408) 222-3604**

## Patient Protection Notice

As The Tufts HMO Health Plan (MA) generally requires the designation of a primary care provider. You have the right to designate any primary care provider, including a pediatrician for your children, who participates in our network and who is available to accept you or your family members. You do not need prior authorization from Tufts or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

**For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Tufts Health Plan at (800) 462-0224.**

# Women's Cancer Rights and Newborns' Act

## Women's Health & Cancer Rights Act Notice

In accordance with the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), your coverage under the Marvell medical plans provides benefits for mastectomy-related services, including reconstruction and surgery to improve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Our medical plans will not restrict benefits if:

1. You or your dependent received benefits for a mastectomy, and;
2. You or your dependent elected breast reconstruction in connection with the mastectomy. Benefits will not be restricted provided that the breast reconstruction is performed in a manner determined in consultation with you or your dependent's physician and may include:
    - Reconstruction of the breast on which the mastectomy was performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

If you would like more information on WHCRA benefits, please contact the plan administrator at (408) 222-3604 or visit https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/whcra.pdf

## Newborns' & Mothers' Health Protection Act Notice

**Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act)**
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you would like more information on the Newborns' Act, please contact the plan administrator at (408) 222-3604 or visit https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/newborns-act.pdf

# Your Rights and Protections Against Surprise Medical Bills

***When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.***

## What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

## You are protected from balance billing for:

### Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

### Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

## When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - ◊ Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - ◊ Cover emergency services by out-of-network providers.
  - ◊ Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - ◊ Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, you may contact (800) 985-3059.
Visit www.cms.gov/nosurprises for more information about your rights under federal law.