2022 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.

Medicaid and the Children's Health Insurance Program (CHIP)
The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows states to subsidize premiums for employer-provided group health coverage for eligible children, but it also imposes certain obligations on plan sponsors (employers).
The health plans must provide notice to all employees that their dependents may be eligible for state health insurance premium assistance. To view the full disclosure notice, visit the Resources page located on **www.marvellbenefits.com**.

Medicare Part D Notice
The prescription drug benefits provided under the plans have been reviewed and determined, according to Medicare Part D guidelines, that the prescription drug coverage is creditable. If you or a dependent is eligible for Medicare, you can contact HR to obtain a Creditable Coverage Notice. If you have questions about Medicare or Medicare Prescription Drug coverage, you can contact Medicare at (800) 633-4227 or **www.medicare.gov**. To view the full disclosure notice, visit the Resources page located on **www.marvellbenefits.com**.

Notice of HIPAA Privacy Practices
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.

HIPAA Notice of Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your dependents in the Marvell Semiconductor, Inc.'s plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage), 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 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.
To request special enrollment or obtain more information, contact Human Resources at (408) 222-3604.

Summary of Benefits and Coverage (SBC)
As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) were created to provide easy-to-understand descriptions of the medical plan coverage options available to you. SBC's 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 Resources page. Paper copies available upon request at (408) 222-3604.

Women's Health and 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' 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 hours 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.**

Patient Protection Notice
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.

More information can be found online at **www.marvellbenefits.com** under the Resources page.

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