Marvell Benefits At-a-Glance

Medical Plan Details

	ANTHEM BLUE CROSS EXCLUSIVE	ANTHEM BLUE CROSS PREFERRED		ANTHEM BLUE CROSS HDHP		KAISER HMO (CA)
	In-Network Only	In-Network	Out-of-Network ⁴	In-Network	Out-of-Network ⁴	In-Network Only
Deductible	\$100/Individual \$300/Family	· · · · · · · · · · · · · · · · · · ·	ndividual Family	\$2,000/l \$2,800/Individual, u	ndividual up to \$4,000/Family	None
Percentage Co-Insurance	10%	20%	35%	10%	30%	None
Out-of-Pocket Maximum	\$2,000/Individual \$6,000/Family	\$2,000/Individual \$6,000/Family	\$4,000/Individual \$12,000/Family	\$5,000/Individual \$10,000/Family	\$5,000/Individual \$10,000/Family	\$1,500/Individual \$3,000/Family
Doctor's Office Visit	\$20 copay ¹	\$25 copay ¹	35%	10%	30%	\$20 copay
Specialist Office Visit	\$30 copay ¹	\$35 copay¹	35%	10%	30%	\$20 copay
Telehealth Visit	No charge ¹ livehealthonline.com	No charge ¹ livehealthonline.com	35%	No charge ¹ livehealthonline.com	30%	No charge KP.org
Urgent Care	\$20 copay ¹	\$25 copay ¹	35%	10%	30%	\$20 copay
Preventive Care Screening, Immunization, Radiology and Labs	No charge	No charge	35%	No charge	30%	No charge
X-ray and Advanced Imaging	10%	20%	35%	10%	30%	No charge
Lab	10%	20%	35%	10%	30%	No charge
Outpatient Surgery and Procedures	10%	20%	35%	10%	30%	\$20 copay
Emergency Room Services	10% after \$100 copay (copay waived if admitted)	20% after \$100 copay (copay waived if admitted)	20% after \$100 copay (copay waived if admitted)	10%	10%	\$100 copay (copay waived if admitted)
Inpatient Hospital ²	10%	20%	35% after \$250 copay	10%	30%	\$200 copay
Outpatient Behavioral Health Visit	\$20 copay/Individual ¹ \$20 copay/Group ¹	\$25 copay/Individual ¹ \$25 copay/Group ¹	35%	10%	30%	\$20 copay/Individual \$10 copay/Group
Chiropractor Visit	\$20 copay ¹ 30-visit maximum per year	20% 30-visit maximum per year	35% 30-visit maximum per year	10% 30-visit maximum per year	30% 30-visit maximum per year	\$15 copay 30-visit maximum per year (combined with acupuncture)
Acupuncture Visit	\$20 copay ¹ 30-visit maximum per year	20% 30-visit maximum per year	35% 30-visit maximum per year	10% 30-visit maximum per year	30% 30-visit maximum per year	\$15 copay 30-visit maximum per year (combined with chiropractor)
Physical, Speech and Occupational Therapy	10%	20%	35%	10%	30%	\$20 copay
PRESCRIPTION DRUGS						
Out-of-Pocket Maximum	\$2,000/Individual \$6,000/Family		ndividual /Family	Included w Out-of-Pock	ith Medical et Maximum	Included with Medical Out-of-Pocket Maximum
Pharmacy—Retail³ (30-day supply)	Tier 1: \$10 copay ¹ Tier 2: 10% (\$30 min./\$250 max.) ¹ Tier 3: 10% (\$50 min./\$250 max.) ¹ Tier 4: 10% (\$100 min./\$250 max.) ¹	Tier 1: \$10 copay ¹ Tier 2: 20% (\$30 min./\$250 max.) ¹ Tier 3: 20% (\$50 min./\$250 max.) ¹ Tier 4: 20% (\$100 min./\$250 max.) ¹	Tiers 1, 2, 3 and 4: 35% up to \$250 ¹	Tier 1: \$10 copay Tier 2: 10% (\$30 min./\$250 max.) Tier 3: 10% (\$50 min./\$250 max.) Tier 4: 10% (\$100 min./\$250 max.)	Tiers 1, 2, 3 and 4: 30% up to \$250	Generic: \$10 copay Brand: \$30 copay
Pharmacy—Mail Order³ (Anthem: 90-day supply)	Tier 1: \$20 copay ¹ Tier 2: 10% (\$60 min./\$500 max.) ¹ Tier 3: 10% (\$100 min./\$500 max.) ¹ Tier 4: 10% (\$200 min./\$500 max.) ¹	Tier 1: \$20 copay ¹ Tier 2: 20% (\$60 min./\$500 max.) ¹ Tier 3: 20% (\$100 min./\$500 max.) ¹ Tier 4: 20% (\$200 min./\$500 max.) ¹	Not covered	Tier 1: \$20 copay Tier 2: 10% (\$60 min./\$500 max.) Tier 3: 10% (\$100 min./\$500 max.) Tier 4: 10% (\$200 min./\$500 max.)	Not covered	2x copay for 100-day supply

1 Deductible does not apply. 2 Preauthorization required. 3 Coinsurance (including minimum and maximum allowed amounts) is per prescription. 4 Costs in excess of the plan's maximum allowed amount may apply (balance billing).

7 Delta Dental Plan Details

	DELTA DENTAL PPO PLAN		
	Delta Dental PPO, Delta Dental Premier and Out-of-Network		
Deductible	\$50/Person \$150/Family		
Benefit Maximum (calendar year)	Plan pays \$2,000/Person		
Diagnostic and Preventive Services* (oral exams, cleanings, X-rays)	No copay or deductible		
Basic Services (oral surgery, fillings, root canals, etc.)	You pay 20%		
Major Services (crowns, onlays, gum treatment, cast restorations, etc.)	You pay 50%		
Prosthodontics (bridges, full and partial dentures)	You pay 50%		
Dental Guards (once every three years)	You pay 50%, Plan pays \$500 maximum/Person		
Retainer Replacement (once every five years)	You pay 50%, Plan pays \$500 maximum/Person		
Implants**	You pay 50%, Plan pays \$2,000 calendar year maximum/Person		
Orthodontics (adults and children)	You pay 50%, Plan pays \$2,000 lifetime maximum/Person		
Reimbursement is based on PPO-contracted fees for PPO dentists, Premier-contracted fees for Premier dentists and enhanced-program allowance for out-of-network dentists.			

Balance billing may still apply for out-of-network dentists.

*Not subject to benefit maximum **Separate from benefit maximum

Vision Service Plan Details

BASE PLAN	In-Network	Out-of-Network			
Well-Vision Exams	Plan pays 100% after \$10 copay	Plan pays up to \$50 after \$10 copay			
Primary and Diabetic Eye Care Services	\$20 copay	Not covered			
Lenses and Frames Copay	\$25 copay	See limits below			
Contact Lenses Copay	\$25 copay	See limits below			
LENSES AND FRAMES (ONCE EVERY CALENDAR YEAR)					
Single-Vision Lenses	Plan pays 100%	Plan pays up to \$50			
Bifocal and Trifocal Lenses (Lined)	Plan pays 100%	Plan pays up to \$75 and \$100			
Standard Progressive Lenses	Plan pays 100%	Plan pays up to \$75			
Anti-Reflective Coating	\$30 copay	Not covered			
Adult and Child Polycarbonate Lenses	Plan pays 100%	Not covered			
Blue-Light-Filtering Lenses	Plan pays 100%	Not covered			
Frames	Plan pays up to \$200, plus 20% off any out-of-pocket cost Plan pays up to \$110 at Costco	Plan pays up to \$70			
CONTACT LENSES (IN LIEU OF LENSES AND FRAMES)					
Elective	Plan pays up to \$200 for contacts	Plan pays up to \$105 for contacts			
Necessary	Plan pays 100%	Plan pays up to \$210			
Laser Vision Correction (Lasik, Custom Lasik or PRK)	Plan pays up to \$1,000 per eye	Not covered			
BUY-UP					
Frames or Contacts	Same allowance for either additional contacts or a second pair of glasses	Same allowance for either additional contacts or a second pair of glasses			

Employee Contributions (per month)

MEDICAL PLAN					
ANTHEM BLUE CROSS EXCLUSIVE					
EE Only	\$134				
EE + Spouse/DP	\$348				
EE + Child(ren)	\$278				
EE + Family	\$464				
ANTHEM BLUE CROSS PREFERRED					
EE Only	\$173				
EE + Spouse/DP	\$456				
EE + Child(ren)	\$361				
EE + Family	\$607				
ANTHEM BLUE CROSS HDHP					
EE Only	\$68				
EE + Spouse/DP	\$175				
EE + Child(ren)	\$139				
EE + Family	\$235				
KAISER (CA)					
EE Only	\$105				
EE + Spouse/DP	\$275				
EE + Child(ren)	\$217				
EE + Family	\$365				

DENTAL PLAN					
DELTA DENTAL PPO PLAN					
EE Only	\$12				
EE + Spouse/DP	\$43				
EE + Child(ren)	\$35				
EE + Family	\$62				
VISION PLAN					
VSP (BASE PLAN)					
EE Only	\$6				
EE + Spouse/DP	\$21				
EE + Child(ren)	\$16				
EE + Family	\$28				
VSP (BASE + BUY-UP)					
EE Only	\$11				
EE + Spouse/DP	\$32				
EE + Child(ren)	\$26				
EE + Family	\$44				

This overview summarizes the Marvell Benefits Program. Full details of the benefits plans are contained in the official documents, which will govern in case of any discrepancies.