

# Marvell Benefits At-a-Glance

2025

## 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 <sup>4</sup>	In-Network	Out-of-Network <sup>4</sup>	In-Network Only
<b>Deductible</b>	\$100/Individual \$300/Family	\$300/Individual \$900/Family		\$2,000/Individual \$2,800/Individual up to \$4,000/Family		None
<b>Percentage Co-Insurance</b>	10%	20%	35%	10%	30%	None
<b>Out-of-Pocket Maximum</b>	\$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
<b>Doctor's Office Visit</b>	\$20 copay <sup>1</sup>	\$25 copay <sup>1</sup>	35%	10%	30%	\$20 copay
<b>Specialist Office Visit</b>	\$30 copay <sup>1</sup>	\$35 copay <sup>1</sup>	35%	10%	30%	\$20 copay
<b>Telehealth Visit</b>	No charge <sup>1</sup> livehealthonline.com	No charge <sup>1</sup> livehealthonline.com	35%	10% livehealthonline.com	30%	No charge KP.org
<b>Urgent Care</b>	\$20 copay <sup>1</sup>	\$25 copay <sup>1</sup>	35%	10%	30%	\$20 copay
<b>Preventive Care Screening, Immunization, Radiology and Labs</b>	No charge	No charge	35%	No charge	30%	No charge
<b>X-ray and Advanced Imaging</b>	10%	20%	35%	10%	30%	No charge
<b>Lab</b>	10%	20%	35%	10%	30%	No charge
<b>Outpatient Surgery and Procedures</b>	10%	20%	35%	10%	30%	\$20 copay
<b>Emergency Room Services</b>	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)
<b>Inpatient Hospital<sup>2</sup></b>	10%	20%	35% after \$250 copay	10%	30%	\$200 copay
<b>Behavioral Health Visit</b>	\$20 copay/Individual <sup>1</sup> \$20 copay/Group <sup>1</sup>	\$25 copay/Individual <sup>1</sup> \$25 copay/Group <sup>1</sup>	35%	10%	30%	\$20 copay/Individual \$10 copay/Group
<b>Chiropractor Visit</b>	\$20 copay <sup>1</sup> 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)
<b>Acupuncture Visit</b>	\$20 copay <sup>1</sup> 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)
<b>Physical, Speech and Occupational Therapy</b>	10%	20%	35%	10%	30%	\$20 copay
<b>PRESCRIPTION DRUGS</b>						
<b>Out-of-Pocket Maximum</b>	\$2,000/Individual \$6,000/Family	\$2,000/Individual \$6,000/Family		Included with Medical Out-of-Pocket Maximum		Included with Medical Out-of-Pocket Maximum
<b>Pharmacy—Retail<sup>3</sup> (30-day supply)</b>	<b>Tier 1:</b> \$10 copay <sup>1</sup> <b>Tier 2:</b> 10% (\$30 min./\$250 max.) <sup>1</sup> <b>Tier 3:</b> 10% (\$50 min./\$250 max.) <sup>1</sup> <b>Tier 4:</b> 10% (\$100 min./\$250 max.) <sup>1</sup>	<b>Tier 1:</b> \$10 copay <sup>1</sup> <b>Tier 2:</b> 20% (\$30 min./\$250 max.) <sup>1</sup> <b>Tier 3:</b> 20% (\$50 min./\$250 max.) <sup>1</sup> <b>Tier 4:</b> 20% (\$100 min./\$250 max.) <sup>1</sup>	<b>Tiers 1, 2, 3 and 4:</b> 35% up to \$250 <sup>1</sup>	<b>Tier 1:</b> \$10 copay <b>Tier 2:</b> 10% (\$30 min./\$250 max.) <b>Tier 3:</b> 10% (\$50 min./\$250 max.) <b>Tier 4:</b> 10% (\$100 min./\$250 max.)	<b>Tiers 1, 2, 3 and 4:</b> 30% up to \$250	<b>Generic:</b> \$10 copay <b>Brand:</b> \$30 copay
<b>Pharmacy—Mail Order<sup>3</sup> (Anthem: 90-day supply)</b>	<b>Tier 1:</b> \$20 copay <sup>1</sup> <b>Tier 2:</b> 10% (\$60 min./\$500 max.) <sup>1</sup> <b>Tier 3:</b> 10% (\$100 min./\$500 max.) <sup>1</sup> <b>Tier 4:</b> 10% (\$200 min./\$500 max.) <sup>1</sup>	<b>Tier 1:</b> \$20 copay <sup>1</sup> <b>Tier 2:</b> 20% (\$60 min./\$500 max.) <sup>1</sup> <b>Tier 3:</b> 20% (\$100 min./\$500 max.) <sup>1</sup> <b>Tier 4:</b> 20% (\$200 min./\$500 max.) <sup>1</sup>	Not covered	<b>Tier 1:</b> \$20 copay <b>Tier 2:</b> 10% (\$60 min./\$500 max.) <b>Tier 3:</b> 10% (\$100 min./\$500 max.) <b>Tier 4:</b> 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).

## Delta Dental Plan Details

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

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

## Vision Service Plan Details

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

# Employee Contributions *(per month)*

<b>MEDICAL PLAN</b>	
<b>ANTHEM BLUE CROSS EXCLUSIVE</b>	
EE Only	\$126
EE + Spouse/DP	\$328
EE + Child(ren)	\$262
EE + Family	\$437
<b>ANTHEM BLUE CROSS PREFERRED</b>	
EE Only	\$168
EE + Spouse/DP	\$443
EE + Child(ren)	\$350
EE + Family	\$589
<b>ANTHEM BLUE CROSS HDHP</b>	
EE Only	\$66
EE + Spouse/DP	\$170
EE + Child(ren)	\$135
EE + Family	\$228
<b>KAISER (CA)</b>	
EE Only	\$99
EE + Spouse/DP	\$258
EE + Child(ren)	\$204
EE + Family	\$343

<b>DENTAL PLAN</b>	
<b>DELTA DENTAL PPO PLAN</b>	
EE Only	\$12
EE + Spouse/DP	\$43
EE + Child(ren)	\$35
EE + Family	\$62
<b>VISION PLAN</b>	
<b>VSP (BASE PLAN)</b>	
EE Only	\$6
EE + Spouse/DP	\$21
EE + Child(ren)	\$16
EE + Family	\$28
<b>VSP (BASE + BUY-UP)</b>	
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.