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[4]	In-Network	Out-of-Network[4]	In-Network Only
Deductible	$100/Individual $300/Family	$300/Individual $900/Family		$2,000/Individual $2,800/Individual 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 copay[1]	35%	10%	30%	$20 copay
Telehealth Visit	No charge[1] livehealthonline.com	No charge[1] livehealthonline.com	35%	10% 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
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	$2,000/Individual $6,000/Family		Included with Medical Out-of-Pocket Maximum		Included with Medical Out-of-Pocket Maximum
Pharmacy—Retail[3] (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 Order[3] (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).

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 second pair of glasses or contacts	Same allowance for second pair of glasses or contacts

Employee Contributions *(per month)*

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

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.

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