Marvell Benefits At-a-Glance 2020

Medical Plans	ANTHEM BLUE CROSS EXCLUSIVE	ANTHEM BLUE CROSS PREFERRED		ANTHEM BLUE CROSS HDHP		KAISER HMO (CA)	TUFTS HMO (MA)	MVP PPO (NY, VT)	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only	In-Network	Out-of-Network
Deductible	$100/Individual $300/Family	$300/Individual $900/Family		$2,000/Individual $2,800/Individual up to $4,000/Family		None	None	$1,000/Individual $2,500/Family	$6,500/Individual $13,000/Family
Percentage Co-Insurance	10%	20%	35%	10%	30%	None	None	15%	40%
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	$3,000/Individual $6,000/Family	$3,000/Individual $7,500/Family	$13,000/Individual $26,000/Family
Doctor's Office Visits	$20 copay*	$25 copay*	35%	10%	30%	$20 copay	$20 copay	$30 copay*	40%
Specialist Office Visits	$30 copay*	$35 copay*	35%	10%	30%	$20 copay	$35 copay	$50 copay*	40%
Telemedicine Visits	No charge livehealthonline.com	No charge livehealthonline.com	35%	$59; 0% after deductible livehealthonline.com	30%	No charge KP.org	$20 teladoc.com	$30* myVisitNow.com	N/A
Urgent Care	$20 copay*	$25 copay*	35%	10%	30%	$20 copay	$20 copay	$30 copay*	40%
Preventive Care Screening, Immunization, Radiology and Labs	No charge	No charge	35%	No charge	30%	No charge	No charge	No charge	40%
Lab	Office: $20 copay* Outpatient: 10%	Office: $25 copay* Outpatient: 20%	35%	10%	30%	No charge	No charge	No charge	40%
X-Ray	Office: $20 copay* Outpatient: 10%	Office: $25 copay* Outpatient: 20%	35%	10%	30%	No charge	No charge	PCP: $30 copay* Spec: $50 copay* Outpatient: 15%	40%
Advanced Imaging MRI, CAT, PET	10%	20%	35%	10%	30%	No charge	No charge	PCP: $150 copay* Spec: $150 copay* Outpatient: 15%	40%
Outpatient Surgery & Procedures	10%	20%	35%	10%	30%	$20 copay	$500 copay	15%	40%
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)	$150 copay (copay waived if admitted)	$200 copay*	$200 copay*
Inpatient Hospital**	10%	20%	35% after $250 copay	10%	30%	$200 copay	$500 copay	15%	40%
Behavioral Health Visit	$20 copay*	$25 copay*	35%	10%	30%	$20 copay (individual) $10 copay (group)	$20 copay	$30 copay*	40%
Chiropractor Visit	$20 copay 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	$35 copay 12-visit maximum per year	$50 copay*	40%
Acupuncture Visit	$20 copay 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	Not covered	Not covered	Not covered
Physical, Speech & Occupational Therapy	10%	20%	35%	10%	30%	$20 copay	$35 copay	$50 copay*	40%
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	Included with Medical Out-of-Pocket Maximum	$2,000/Individual $4,000/Family	N/A
Pharmacy Retail	Tier 1: $10 copay* Tier 2: $30 copay* Tier 3: $50 copay* Tier 4: $100 copay*	Tier 1: $10 copay* Tier 2: $30 copay* Tier 3: $50 copay* Tier 4: $100 copay*	Member pays applicable copay + 50% of covered expense*	Tier 1: $10 copay Tier 2: $30 copay Tier 3: $50 copay Tier 4: $100 copay	Tier 1: 30% Tier 2: 30% Tier 3: 30% Tier 4: 30%	Generic: $10 copay Brand: $30 copay	Tier 1: $15 copay Tier 2: $30 copay Tier 3: $50 copay	Tier 1: $5 copay* Tier 2: $20 copay* Tier 3: $40 copay*	Not covered
Pharmacy Mail Order	2x copay for 90-day supply*	2x copay for 90-day supply*	Not covered	2x copay for 90-day supply	Not covered	2x copay for 100-day supply	2x copay for 90-day supply	2.5x copay for 90-day supply*	N/A

*Deductible does not apply
** Preauthorization required

TERMS TO KNOW

Deductible – The amount you pay each year before your plan starts to pay.

Co-Insurance – Your percentage of the costs after meeting your deductible.

Copay – A flat fee you pay for covered services like doctor visits.

Out-of-Pocket Maximum – The maximum amount you will pay out of your pocket for covered services for the plan year. This amount includes your deductible, copays and co-insurance.

Maximum Allowed Amount – Under all plans, out-of-network coverage is based on the plan's maximum allowed amounts. You will be responsible for any costs over the maximum allowed amount when going out-of-network.

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Delta Dental PPO

DELTA DENTAL PLAN	Dental Base Plan		Dental Buy-Up Plan
	Delta Dental PPO Network	Delta Dental Premier & Out-of-Network	Must use PPO In-network dentist only
Deductible	$50/Person $150/Family		$50/Person $150/Family
Benefit Maximum (calendar year)	Plan pays $2,000/Person		$3,000/Person
Diagnostic and Preventive Benefits (oral exams, cleanings, X-rays, etc.)*	No copay or deductible	Deductible applies	No copay or deductible
Basic Benefits (oral surgery, fillings, root canals, etc.)	You pay 20%		You pay 20%
Crowns, Inlays & Cast Restorations	You pay 50%		You pay 40%
Prosthodontic (bridges, full and partial dentures)	You pay 50%		You pay 40%
Implant	You pay 50% Plan pays $2,000 lifetime maximum/person		You pay 40% Plan pays $3,000 lifetime maximum/person
Orthodontic Benefits (adults and children)	You pay 50% Plan pays $2,000 lifetime maximum/person		You pay 40% Plan pays $3,000 lifetime maximum/person

Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and program allowance for non-Delta Dental dentists

* Not subject to benefit maximum

Vision Service Plan

VISION SERVICE 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	$60 copay	See limits below
LENSES & 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
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 $250 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

2020 EMPLOYEE CONTRIBUTIONS PER MONTH

DENTAL PLAN	
DELTA DENTAL (BASE PLAN)	
EE Only	$12.00
EE + Spouse	$42.00
EE + Child(ren)	$34.00
EE + Family	$61.00
DELTA DENTAL (BUY-UP PLAN)	
EE Only	$56.00
EE + Spouse	$144.00
EE + Child(ren)	$120.00
EE + Family	$205.00

VISION PLAN	
VSP (BASE PLAN)	
EE Only	$6.00
EE + Spouse	$21.00
EE + Child(ren)	$16.00
EE + Family	$28.00
VSP (BUY-UP PLAN)	
EE Only	$11.00
EE + Spouse	$32.00
EE + Child(ren)	$26.00
EE + Family	$44.00

MEDICAL PLAN	
ANTHEM BLUE CROSS EXCLUSIVE	
EE Only	$89.00
EE + Spouse	$233.00
EE + Child(ren)	$185.00
EE + Family	$310.00
ANTHEM BLUE CROSS PREFERRED	
EE Only	$106.00
EE + Spouse	$272.00
EE + Child(ren)	$222.00
EE + Family	$373.00
ANTHEM BLUE CROSS HDHP	
EE Only	$45.00
EE + Spouse	$117.00
EE + Child(ren)	$93.00
EE + Family	$157.00
KAISER (CA)	
EE Only	$82.00
EE + Spouse	$213.00
EE + Child(ren)	$169.00
EE + Family	$281.00
TUFTS (MA)	
EE Only	$78.00
EE + Spouse	$230.00
EE + Child(ren)	$182.00
EE + Family	$247.00
MVP PPO (NY, VT)	
EE Only	$80.00
EE + Spouse	$207.00
EE + Child(ren)	$167.00
EE + Family	$288.00
Medical Opt-Out Credit	**$250.00**

FINANCIAL PROTECTION

Short-Term Disability

Long-Term Disability and Buy-Up

Life and AD&D Insurance

Legal Plan

Critical Illness

FINANCIAL BENEFITS

401(k) Plan + Match

Employee Stock Purchase Plan

SUPPORTING MARVELL'S FAMILIES

Adoption and Surrogacy Benefits

Backup Child and Adult Care

Day Care Discount

Day Care FSA

Employee Assistance Program

Commuter Benefits

Care.com Membership

Senior Care Planning

Perks and Discounts

Tuition Reimbursement

Employee Referral Program

12 Weeks of Paid Bonding Leave

Rethink: Child Development Resources

MANAGE YOUR HEALTHCARE

- Health Savings Account (HSA)
- Healthcare FSA and Limited Healthcare FSA
- Engage Well-Being App
- LiveHealth Online: Medical, Kids, Allergy, Psychology, Psychiatry

When enrolled in the Anthem HDHP, Marvell will make a one-time, upfront contribution to your HSA:

- **$500 for employee-only coverage**
- **$1,000 for family coverage**

- Diabetes Prevention Program
- Autism Support Program
- 2nd.MD: Second Opinion Resource

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Precept is Marvell's benefits administrator.

Contact the Precept Benefits Information Center:

(888) 754-6501 | 6:00 a.m. to 5:00 p.m.

Pacific Time, Monday–Friday

Email Precept: **marvellbenefits@preceptgroup.com**

MARVELL BENEFITS

For more information on the Marvell Benefits Program, visit **www.marvellbenefits.com**

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