Marvell**benefits** At-a-Glance

2023

Medical Plan Details

	ANTHEM BLUE CROSS EXCLUSIVE	ANTHEM BLUE CROSS PREFERRED		ANTHEM BLUE CROSS HDHP		KAISER HMO (CA)	TUFTS HMO (MA)
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Deductible	$100/Individual $300/Family	$300/Individual $900/Family		$2,000/Individual $2,800/Individual up to $4,000/Family		None	None
Percentage Co-Insurance	10%	20%	35%	10%	30%	None	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	$3,000/Individual $6,000/Family
Doctor's Office Visit	$20 copay*	$25 copay*	35%	10%	30%	$20 copay	$20 copay
Specialist Office Visit	$30 copay*	$35 copay*	35%	10%	30%	$20 copay	$35 copay
Telehealth Visit	No charge livehealthonline.com	No charge livehealthonline.com	35%	$59; No charge after deductible livehealthonline.com	30%	No charge KP.org	$20 copay teladoc.com
Urgent Care	$20 copay*	$25 copay*	35%	10%	30%	$20 copay	$20 copay
Preventive Care Screening, Immunization, Radiology and Labs	No charge	No charge	35%	No charge	30%	No charge	No charge
X-ray & Advanced Imaging	10%	20%	35%	10%	30%	No charge	No charge
Lab	10%	20%	35%	10%	30%	No charge	No charge
Outpatient Surgery & Procedures	10%	20%	35%	10%	30%	$20 copay	$500 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)	$150 copay (copay waived if admitted)
Inpatient Hospital**	10%	20%	35% after $250 copay	10%	30%	$200 copay	$500 copay
Behavioral Health Visit	10%	20%	35%	10%	30%	$20 copay/Individual $10 copay/Group	$20 copay
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
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	$20 copay
Physical, Speech & Occupational Therapy	10%	20%	35%	10%	30%	$20 copay	$35 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	Included with Medical Out-of-Pocket Maximum
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
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

**Deductible does not apply* ***Preauthorization required*

Delta Dental Plan Details

	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		Plan pays $3,000/Person
Diagnostic and Preventive Services (oral exams, cleanings, X-rays)*	No copay or deductible	Deductible applies	No copay or deductible
Basic Services (oral surgery, fillings, root canals, etc.)	You pay 20%		You pay 20%
Crowns, Onlays & Cast Restorations	You pay 50%		You pay 40%
Prosthodontics (bridges, full and partial dentures)	You pay 50%		You pay 40%
Dental Guards (once every three years)	You pay 50%, Plan pays $500 maximum/Person		You pay 50%, Plan pays $500 maximum/Person
Retainer Replacement (once every five years)	You pay 50%, Plan pays $500 maximum/Person		You pay 50%, Plan pays $500 maximum/Person
Implants	You pay 50%, Plan pays $2,000 lifetime maximum/Person		You pay 40%, Plan pays $3,000 annual maximum/Person
Orthodontics (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 Details

	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
Non-Prescription Sunglass 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	$113
EE + Spouse/DP	$294
EE + Child(ren)	$235
EE + Family	$392
ANTHEM BLUE CROSS PREFERRED	
EE Only	$139
EE + Spouse/DP	$366
EE + Child(ren)	$290
EE + Family	$487
ANTHEM BLUE CROSS HDHP	
EE Only	$59
EE + Spouse/DP	$152
EE + Child(ren)	$121
EE + Family	$204
KAISER (CA)	
EE Only	$82
EE + Spouse/DP	$213
EE + Child(ren)	$169
EE + Family	$283
TUFTS (MA)	
EE Only	$130
EE + Spouse/DP	$340
EE + Child(ren)	$290
EE + Family	$422
Medical Opt-Out Credit*	**$250**

* Premium payments are pre-tax. Medical opt-out credit is taxable. You can elect the medical opt-out credit and still be enrolled in all other benefits (dental, life insurance, FSA, etc.). The opt-out applies only to Marvell's Anthem, Kaiser and Tufts medical plans.

DENTAL PLAN	
DELTA DENTAL (BASE PLAN)	
EE Only	$12
EE + Spouse/DP	$42
EE + Child(ren)	$34
EE + Family	$61
DELTA DENTAL (BASE + BUY-UP)	
EE Only	$56
EE + Spouse/DP	$144
EE + Child(ren)	$120
EE + Family	$205

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

McGriff is Marvell's benefits administrator.

Contact the McGriff Benefits Information Center: (888) 754-6501, 6 a.m.–5 p.m. PT.

Email McGriff: marvellbenefits@mcgriffinsurance.com.

Visit **marvellbenefits.com** for more information.

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 coinsurance.

Allowed Amount: The maximum a health plan pays for services. If you go out-of-network, you will be responsible for any costs over the Allowed Amount.

Prescription tier: The way a health plan categorizes each prescription into different levels to determine cost.