Marvell Benefits At-a-Glance

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 ⁴	In-Network	Out-of-Network ⁴	In-Network Only	In-Network Only
Deductible	\$100/Individual \$300/Family	\$300/In \$900/		\$2,000/II \$2,800/Individual u	ndividual ip 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 ¹	\$25 copay ¹	35%	10%	30%	\$20 copay	\$20 copay
Specialist Office Visit	\$30 copay ¹	\$35 copay ¹	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 copay¹	\$25 copay ¹	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 and Advanced Imaging	10%	20%	35%	10%	30%	No charge	No charge
Lab	10%	20%	35%	10%	30%	No charge	No charge
Outpatient Surgery and 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 ²	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 (combined with acupuncture)	\$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 (combined with chiropractor)	\$20 copay
Physical, Speech and 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/I \$6,000	ndividual /Family	Included w Out-of-Pock	ith Medical et Maximum	Included with Medical Out-of-Pocket Maximum	Included with Medical Out-of-Pocket Maximum
Pharmacy—Retail³	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	Tier 1: \$15 copay Tier 2: \$30 copay Tier 3: \$50 copay
Pharmacy—Mail Order ³	2x retail cost for 90-day supply	2x retail cost for 90-day supply	Not covered	2x retail cost for 90-day supply	Not covered	2x copay for 100-day supply	2x copay for 90-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).

The Delta Dental Plan Details

	DENTAL BASE PLAN	DENTAL BUY-UP PLAN	
	Delta Dental PPO, Delta Dental Premier and Out-of-Network	Delta Dental PPO, Delta Dental Premier and Out-of-Network	
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	No copay or deductible	
Basic Services (oral surgery, fillings, root canals, etc.)	You pay 20%	You pay 20%	
Major Services (crowns, onlays, gum treatment, cast restorations, etc.)	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 enhanced-program allowance for out-of-network dentists. Balance billing may still apply for out-of-network dentists.

*Not subject to 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		
Plan pays up to \$200, plus 20% Frames 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 EXCLUSIV	E
EE Only	\$126
EE + Spouse/DP	\$328
EE + Child(ren)	\$262
EE + Family	\$437
ANTHEM BLUE CROSS PREFERRI	ED
EE Only	\$155
EE + Spouse/DP	\$408
EE + Child(ren)	\$323
EE + Family	\$543
ANTHEM BLUE CROSS HDHP	
EE Only	\$66
EE + Spouse/DP	\$170
EE + Child(ren)	\$135
EE + Family	\$228
KAISER (CA)	
EE Only	\$93
EE + Spouse/DP	\$242
EE + Child(ren)	\$192
EE + Family	\$322
TUFTS (MA)	
EE Only	\$153
EE + Spouse/DP	\$399
EE + Child(ren)	\$341
EE + Family	\$496

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

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.