

**LOCKHEED MARTIN AERONAUTICS COMPANY – MARIETTA  
2008 IAM NEGOTIATIONS  
POINT OF SERVICE (POS) SUMMARY COMPARISON**

<b>BENEFIT</b>	<b>CURRENT POS PLAN</b>	<b>PROPOSED POS PLAN</b>
Lifetime maximum per person	\$2,000,000 includes payments from all Company-sponsored plans and includes medical, prescription drugs, mental health and substance abuse benefits. (HMOs and network POS medical benefit payments are not included.)	\$2,000,000 includes payments from all Company-sponsored plans and includes medical, prescription drugs, mental health and substance abuse benefits. (HMOs and network POS medical benefit payments are not included.)
Calendar year deductible	Applies to <i>non-network</i> expenses only  Per person: \$500 per person  Family: \$1,500 (not to exceed \$500 per person)	Applies to <i>non-network</i> expenses only  Per person: \$750 per person  Family: \$2,250 (not to exceed \$750 per person)
Calendar year out-of-pocket (OOP) maximum	The OOP maximum excludes the deductible and other expenses and applies to most non-network expenses  Per person: \$5,000 per person  Family: \$10,000 (not to exceed \$5,000 per person)	The OOP maximum excludes the deductible and other expenses and applies to most non-network expenses  Per person: \$5,000 per person  Family: \$10,000 (not to exceed \$5,000 per person)
Inpatient hospital charges	Network: 100% after a \$100 inpatient copay Non-network: 70% after deductible	Network: 100% after a \$150 inpatient copay Non-network: 70% after deductible
Precertification required	Yes	Yes

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Emergency care	Network or non-network facility – must call PCP or claims administrator within 48 hours	Network or non-network facility – must call PCP or claims administrator within 48 hours
Hospital ER	100% after you pay a \$50 copay per visit (copay waived if admitted but inpatient copay will apply)	100% after you pay a \$75 copay per visit (copay waived if admitted but inpatient copay will apply)
Emergency care facility (including urgent care facilities)	100% after you pay a \$50 copay per visit (copay waived if admitted but inpatient copay will apply)	100% after you pay a \$75 copay per visit (copay waived if admitted but inpatient copay will apply)
Physician's office	100% after you pay a \$15 copay per visit	100% after you pay a \$20 Primary Care Physician or \$30 Specialist copay per visit
Reduced benefits if ER used for non-emergency care	Yes	Yes
Physician office visits	Network: 100% after you pay a \$15 copay per visit Non-network: 70% after deductible	Network: 100% after you pay a \$20 copay per visit Non-network: 70% after deductible
Specialist office visits	Network: 100% after you pay a \$15 copay per visit Non-network: 70% after deductible	Network: 100% after you pay a \$20 copay per visit Non-network: 70% after deductible
Diagnostic X-rays/laboratory	Network: 100% Non-network: 70% after deductible	Network: 100% Non-network: 70% after deductible
Routine physical exam (frequency limits apply)	Network: 100% after you pay a \$15 copay per visit Non-network: 70% after deductible	Network: 100% after you pay a \$20 copay per visit Non-network: 70% after deductible
Combined network and non-network age and frequency limit	Age 2 up to age 18 – one visit per calendar year Age 18 to age 65 – one visits every two calendar years Age 65 and older – one visit every calendar year	Age 2 up to age 18 – one visit per calendar year Age 18 to age 65 – one visits every two calendar years Age 65 and older – one visit every calendar year

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Well-child care after discharge from hospital (limits apply)	Network: 100% after you pay a \$15 copay per visit Non-network: 70% after deductible	Network: 100% after you pay a \$20 copay per visit Non-network: 70% after deductible
Combined network and non-network age and frequency limit	Up to age 1: seven visits Up to age 2: two visits	Up to age 1: seven visits Up to age 2: two visits
Physical, occupational and speech therapies (short-term treatment only)	Network: 100% after you pay a \$15 copay per visit  Non-network: 70% after deductible	Network: 100% after you pay a \$20 copay per visit Non-network: 70% after deductible
Maximum	Up to 60 visits per condition (combined network and non-network limits)	Up to 60 visits per condition (combined network and non-network limits)
Chiropractic care	Network: 100% after you pay a \$15 copay per visit  Non-network: 70% after deductible	Network: 100% after you pay a \$20 copay per visit Non-network: 70% after deductible
Maximum	Up to 20 visits per calendar year (combined network and non-network limits)	Up to 20 visits per calendar year (combined network and non-network limits)
Skilled nursing (or extended care) facility (Pre-certification required)	Network: 100% Non-network: 70% after deductible	Network: 100% Non-network: 70% after deductible
Maximum	Up to 120 days per calendar year (combined network and non-network day maximum with no more than 60 days for non-network facilities)	Up to 120 days per calendar year (combined network and non-network day maximum with no more than 60 days for non-network facilities)

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<p>Home health care program (Pre-certification required)</p> <p>Maximum</p>	<p>Network: 100% Non-network: 70% after deductible</p> <p>Up to 120 visits per calendar year (combined network and non-network maximum)</p>	<p>Network: 100% Non-network: 70% after deductible</p> <p>Up to 120 visits per calendar year (combined network and non-network maximum)</p>
<p>Organ and tissue transplants – inpatient</p>	<p>Network: 100% after a \$100 inpatient copay – only when care is received from one of the specialized network facilities approved for the transplant needed</p> <p>Non-network: 70% after deductible – all other facilities (including other network facilities)</p> <p>Includes coverage for donor searches with a maximum testing of 3 potential donors. (Combined network and non-network testing maximum applies.) For certain transplants, the claims administrator may approve additional donor searches in accordance with policy guidelines – prior authorization is required.</p>	<p>Network (Aetna): 100% after a \$150 inpatient copay – only when care is received from one of the specialized network facilities approved for the transplant needed</p> <p>Non-network (Aetna): 70% after deductible – all other facilities (including other network facilities)</p> <p>Network (CIGNA): 100% after a \$150 inpatient copay</p> <p>Non-network (CIGNA): 70% after deductible</p> <p>Includes coverage for donor searches with a maximum testing of 3 potential donors. (Combined network and non-network testing maximum applies.) For certain transplants, the claims administrator may approve additional donor searches in accordance with policy guidelines – prior authorization is required.</p>

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Hospice care (Pre-certification required)	Network: 100% Non-network: 70% after deductible	Network: 100% Non-network: 70% after deductible
Maximum	Combined network and non-network maximum of up to 210 days per calendar year	Aetna: Combined network and non-network maximum of up to 210 days per calendar year  CIGNA: Combined network and non-network maximum of up to 365 days per calendar year

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<b>Prescription drugs</b>		
At network retail pharmacies	For up to a 30-day supply, you pay a copay per prescription, per refill:	For up to a 30-day supply, you pay a copay per prescription, per refill:
Generic drugs	10% with a maximum \$25 copay	10% with a maximum \$25 copay
Brand-name drugs		
Preferred brand-name	30% with a maximum \$75 copay	30% with a maximum \$75 copay
Non-preferred brand-name	50% with no maximum copay	50% with no maximum copay
At non-network pharmacies	You pay for the prescription/refill and file a claim for reimbursement. Per prescription, per refill:	You pay for the prescription/refill and file a claim for reimbursement. Per prescription, per refill:
Generic drugs	50% of the cost of the drug	50% of the cost of the drug
Brand-name drugs	50% of the cost of the drug	50% of the cost of the drug
Mail order service	For up to a 90-day supply, you pay a copay per prescription, per refill:	For up to a 90-day supply, you pay a copay per prescription, per refill:
Generic drugs	10% with a maximum \$50 copay	10% with a maximum \$50 copay
Brand-name drugs		
Preferred brand-name	30% with a maximum \$150 copay	30% with a maximum \$150 copay
Non-preferred brand-name	50% with no maximum copay	50% with no maximum copay
Generic substitution	If you request a brand name when your physician permits a generic drug substitution, you will pay 10% of the generic cost plus the difference between the generic and brand-name cost	If you request a brand name when your physician permits a generic drug substitution, you will pay 10% of the generic cost plus the difference between the generic and brand-name cost

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<b>Mental health and substance abuse</b>		
Network benefits only	Yes	Yes
Pre-certification required	All inpatient and outpatient care <i>except routine office visits</i> must be approved in advance by the Mental Health and Substance Abuse claims administrator	All inpatient and outpatient care <i>except routine office visits</i> must be approved in advance by the Mental Health and Substance Abuse claims administrator
Separate calendar year deductible	None	None
Out-of-pocket maximum	None	None
Inpatient	<i>Network benefits only</i>	<i>Network benefits only</i>
Mental health	100% after a \$100 inpatient copay up to 60 days per calendar year	100% after a \$150 inpatient copay up to 60 days per calendar year
Substance abuse	100% after a \$100 inpatient copay up to 45 days per calendar year	100% after a \$150 inpatient copay up to 45 days per calendar year
Outpatient	<i>Network benefits only</i>	<i>Network benefits only</i>
Mental health	100% after a \$15 copay per visit; no visit maximum	100% after a \$20 copay per visit; no visit maximum
Substance abuse	100% after a \$15 copay per visit; no visit maximum	100% after a \$20 copay per visit; no visit maximum

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