

**LOCKHEED MARTIN AERONAUTICS COMPANY – MARIETTA
2008 IAM NEGOTIATIONS
PREFERRED PROVIDER ORGANIZATION (PPO) SUMMARY COMPARISON**

| BENEFIT | CURRENT PPO PLAN | PROPOSED PPO PLAN |
|---|---|---|
| Lifetime maximum per person | \$2,000,000 includes payments from all current and prior Company-sponsored plans, including medical, prescription drugs, mental health and substance abuse benefits, except as specifically excluded. (HMOs and network POS network medical benefit payments are not included.) | \$2,000,000 includes payments from all current and prior Company-sponsored plans, including medical, prescription drugs, mental health and substance abuse benefits, except as specifically excluded. (HMOs and network POS network medical benefit payments are not included.) |
| Calendar year deductible | Per person: \$500 per person Family: \$1,500 (not to exceed \$500 per person) | 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 certain other expenses Per person Network: \$2,500 Non-network: \$5,000 Family Network: \$2,500 per person; \$5,000 maximum Non-network: \$5,000 per person; \$10,000 maximum | The OOP maximum excludes the deductible and certain other expenses Per person Network: \$2,500 Non-network: \$5,000 Family Network: \$2,500 per person; \$5,000 maximum Non-network: \$5,000 per person; \$10,000 maximum |

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| BENEFIT | CURRENT PPO PLAN The plan pays after the deductible | PROPOSED PPO PLAN The plan pays after the deductible |
|---|--|--|
| Inpatient hospital charges | Network: 90% Non-network: 80% | Network: 90% Non-network: 70% |
| Precertification required | Yes, for inpatient hospital and certain outpatient treatments/procedures | Yes, for inpatient hospital and certain outpatient treatments/procedures |
| Emergency care | | |
| In a hospital or urgent care facility ER | Network: 90% Non-network: 90% | Network: 90% Non-network: 90% |
| Reduced benefit for non-emergency use of an emergency room | Yes | Yes |
| Pre-certification required | No, unless admitted | No, unless admitted |
| Physician office visits | Network: 90% Non-network: 80% | Network: 90% Non-network: 70% |
| Diagnostic X-rays/laboratory | Network: 90% Non-network: 80% | Network: 90% Non-network: 70% |
| Routine physical exam annual well woman exam including Pap smear and routine mammogram (age and frequency limits apply) | Network: 100% no deductible Non-network: 100% no deductible | Network: 100% no deductible Non-network: 100% no deductible |
| Routine nursery care for newborn child before mother's discharge from hospital | Network: 90% Non-network: 80% | Network: 90% Non-network: 70% |

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| Well-child care after discharge from hospital (limits apply based on age of child) | Network: 100% no deductible Non-network: 100% no deductible | Network: 100% no deductible Non-network: 100% no deductible |
| Physical, occupational and speech therapies (short-term treatment only) Maximum | Network: 90% Non-network: 80% Up to 60 visits per condition (combined network and non-network limits) | Network: 90% Non-network: 70% Up to 60 visits per condition (combined network and non-network limits) |
| Chiropractic care | Network: 90% Non-network: 80% Up to 20 visits per calendar year (combined network and non-network limits) | Network: 90% Non-network: 70% Up to 20 visits per calendar year (combined network and non-network limits) |
| Skilled nursing (or extended care) facility (Pre-certification required) Maximum | Network: 90% Non-network: 80% Up to 120 days per calendar year (combined network and non-network day maximum) | Network: 90% Non-network: 70% Up to 120 days per calendar year (combined network and non-network day maximum) |
| Home health care program (Pre-certification required) Maximum | Network: 90% Non-network: 80% Up to 120 visits per calendar year (combined network and non-network maximum) | Network: 90% Non-network: 70% Up to 120 visits per calendar year (combined network and non-network maximum) |

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|--|--|--|
| Organ and tissue transplants – inpatient | <p>Network: 90% – only when care is received from one of the specialized network facilities approved for the transplant needed</p> <p>Non-network: 80% – 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: 90% – only when care is received from one of the specialized network facilities approved for the transplant needed</p> <p>Non-network: 70% – 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> |
| Hospice care (Pre-certification required) | <p>Network: 90% Non-network: 80%</p> <p>Combined network and non-network maximum of up to 210 days per calendar year</p> | <p>Network: 90% Non-network: 70%</p> <p>No day maximum – Compassionate Care Program</p> |

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|------------------------------|---|---|
| Prescription drugs | | |
| 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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|--|---|---|
| Mental health and substance abuse | | |
| 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 |
| Inpatient | <i>Network benefits only</i> | <i>Network benefits only</i> |
| Mental health | 90% up to 60 days per calendar year | 90% up to 60 days per calendar year |
| Substance abuse | 90% up to 45 days per calendar year | 90% up to 45 days per calendar year |
| Outpatient | <i>Network benefits only</i> | <i>Network benefits only</i> |
| Mental health | 90% – unlimited visits for medically necessary care | 90% – unlimited visits for medically necessary care |
| Substance abuse | 90% – unlimited visits for medically necessary care | 90% – unlimited visits for medically necessary care |

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