

**LOCKHEED MARTIN SPACE SYSTEMS COMPANY, MISSILES AND SPACE OPERATIONS
2008 IAM NEGOTIATIONS
RETIREE UNDER AGE 65 PREFERRED PROVIDER ORGANIZATION (PPO) SUMMARY COMPARISON**

BENEFIT	CURRENT RETIREE PPO – UNDER AGE 65 PLAN	PROPOSED RETIREE PPO – UNDER AGE 65 PLAN
Lifetime maximum per person	\$1,000,000 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.)	\$1,000,000 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: \$200 per person Family: \$400 (not to exceed \$200 per person)	Per person: \$500 per person Family: \$1,000 (not to exceed \$500 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 RETIREE PPO – UNDER AGE 65 PLAN The plan pays after the deductible	PROPOSED RETIREE PPO – UNDER AGE 65 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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