## Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

A This return/report is for:

SIGN HERE

Signature of DFE

**Annual Report Identification Information** 

a multiemployer plan

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021

## Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

➤ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2021

This Form is Open to Public Inspection

and ending 12/31/2021

a multiple-employer plan (Filers checking this box must attach a list of

Enter name of individual signing as DFE

	·		participating e	mployer information in accordan	ce with the form instructio	ns.)
		x a single-employer plan	a DFE (specif	/)		
<b>B</b> This	return/report is:					
		an amended return/report	a short plan y	ear return/report (less than 12 mo	onths)	
C If the	plan is a collectively-barga	ained plan, check here			×	
<b>D</b> Chec	k box if filing under:	X Form 5558	automatic exte	ension	the DFVC program	
	•	special extension (enter descrip	tion)		_	
E If this	is a retroactively adopted	plan permitted by SECURE Act section	on 201, check here			
Part II	Basic Plan Inform	nation—enter all requested informa	ition			
1a Nam	ne of plan				1b Three-digit plan	594
LOCK	HEED MARTIN GROUP BI	ENEFITS PLAN			number (PN) ▶ <b>1c</b> Effective date of pl	
					01/01/1995	all
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					2b Employer Identification Number (EIN) 52-1893632	
LOCKHEED MARTIN CORPORATION					2c Plan Sponsor's telephone number 863-647-0370	
6801 ROCKLEDGE DRIVE, CCT-115 BETHESDA, MD 20817					2d Business code (see instructions)	
Caution	: A penalty for the late or	incomplete filing of this return/rep	ort will be assessed	unless reasonable cause is es	stablished.	
Under pe	enalties of perjury and othe	er penalties set forth in the instructions ell as the electronic version of this retu	s, I declare that I have	examined this return/report, inclu	uding accompanying sche	
SIGN HERE	Filed with authorized/valid	d electronic signature.	10/12/2022	ROBERT MUENINGHOFF		
ПЕКЕ	Signature of plan admir	nistrator	Date	Enter name of individual signi	ng as plan administrator	
SIGN HERE						
HERE	Signature of employer/	plan sponsor	Date	Enter name of individual signi	ng as employer or plan sp	onsor

Date

Form 5500 (2021) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN а Sponsor's name Plan Name 5 Total number of participants at the beginning of the plan year 106650 5 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 106650 a(1) Total number of active participants at the beginning of the plan year...... 6a(1) 105609 a(2) Total number of active participants at the end of the plan year ...... 6a(2)0 6b **b** Retired or separated participants receiving benefits....... 0 Other retired or separated participants entitled to future benefits ...... 6c 105609 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) ..... h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .. 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) ...... If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4D 4E 4F 4H 4L 4Q **9a** Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1)Insurance (1) Insurance (2) Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (3) Trust (3) Trust (4) General assets of the sponsor (4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules **b** General Schedules R (Retirement Plan Information) H (Financial Information) (1) (1) (2) I (Financial Information - Small Plan) (2) MB (Multiemployer Defined Benefit Plan and Certain Money

X

40 A (Insurance Information)

C (Service Provider Information)D (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

(3)

(4)

(5)

(6)

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

actuary

(3)

Form 5500 (2021) Page **3** 

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)	
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)	
If "Yes" is checked, complete lines 11b and 11c.	
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)	
11c Enter the Receipt Confirmation Code for the 2021 Form M-1 annual report. If the plan was not required to file the 2021 Form M-1 annual report, enter Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)	
Receipt Confirmation Code	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021			and en	ding 12/31/202	1	
A Name of plan					<b>B</b> Three	e-digit		
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN			plan	number (PN)	•	594
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500			<b>D</b> Emplo	yer Identification I	Number (	EIN)
LOCKHEED MARTIN CO	RPORATION				52-	1893632		
		rning Insurance Contra  L. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca	rrior							
AETNA HEALTH INC.	IIIei							
ALTNATILALITTING.								
/L) FIN	(c) NAIC	(d) Contract or		(e) Approximate nun		Po	olicy or co	ontract year
<b>(b)</b> EIN	code	identification number		persons covered at one policy or contract y		(f) From	l	<b>(g)</b> To
59-2411584	95088	0701220HNO		21		01/01/2021		12/31/2021
2 Insurance fee and coming descending order of the		ation. Enter the total fees and t	total	commissions paid. Lis	t in line 3	the agents, broke	rs, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid								
		·			1		•	
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as	s needed to report all po	ersons).			
	(a) Name a	and address of the agent, broke	er, or	r other person to whom	commiss	ions or fees were	paid	
(b) Amount of sales ar	nd base	F	ees a	and other commissions	paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
	(a) Name a	and address of the agent, broke	er, or	r other person to whom	commiss	ions or fees were	paid	
(b) Amount of sales ar	nd base	F	ees a	and other commissions	paid			
commissions pai		(c) Amount		(0	d) Purpose	Э		(e) Organization code
								1

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the previous year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

8 Benefit and contract type (check all applicable boxes)  a	
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription dru	
	ct
i  Stop loss (large deductible) j	
m ☐ Other (specify) ▶	
III Citief (Specify)	
9 Experience-rated contracts:	
a Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	0
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )	0
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	
(E) Taxes	
(F) Charges for risks or other contingencies	
(G) Other retention charges	
(H) Total retention	0
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
(2) Claim reserves 9d(2)	
(3) Other reserves	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	
a Total premiums or subscription charges paid to carrier	667554
	307334
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	
Specify nature of costs.	
Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	
12 If the answer to line 11 is "Yes," specify the information not provided.	

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#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021			and en	ding 12/31/2021		•
A Name of plan			<b>B</b> Three	e-digit				
LOCKHEED MARTIN GROUP BENEFITS PLAN					plan	number (PN)	•	594
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500			<b>D</b> Emplo	yer Identification N	umber (	EIN)
LOCKHEED MARTIN CO	RPORATION				52-	1893632		
		rning Insurance Contract  A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca KAISER FOUNDATION HE		OF WASHINGTON OPTIONS,	INC.					
	(a) NIAIC	(d) Contract or		(e) Approximate nu	mber of	Pol	icy or co	ntract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number		persons covered at policy or contract	end of	(f) From		<b>(g)</b> To
91-1467158	47055	6778600		50		01/01/2021		12/31/2021
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	total c	commissions paid. Li	st in line 3	the agents, brokers	s, and ot	her persons in
	amount of com	missions paid			<b>(b)</b> To	tal amount of fees	paid	
								_
3 Persons receiving com	missions and t	ees. (Complete as many entrie	es as	needed to report all p	persons).			
	(a) Name a	and address of the agent, broke	er, or	other person to whor	n commiss	ions or fees were p	aid	
(b) Amount of sales ar	nd base	F	ees a	and other commission	ns paid			
commissions pai	id	(c) Amount			(d) Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broke	er, or	other person to whor	n commiss	ions or fees were p	aid	
								_
(I) A	11	F	ees a	and other commission	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpose				(e) Organization code
		, ,		,	,			

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the previous year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	If more than one contract covers the same group of em the information may be combined for reporting purpose	s if such contracts are	е ехре	erience-rated as a unit	. Where co	ontracts cover individua	(s), al
0		employees, the entire group of such individual contracts	s with each camer ma	ay be	treated as a unit for pu	irposes or ti	піз героп.	
		nefit and contract type (check all applicable boxes)			1		<b>⊒</b> □	
	a _	Health (other than dental or vision) <b>b</b> Dent		c _	Vision		<b>d</b> Life insurance	
	е	Temporary disability (accident and sickness) <b>f</b> Long	j-term disability	g	Supplemental unemp	oloyment	<b>h</b> Prescription drug	g
	i [	Stop loss (large deductible) j X HMC	contract	k	PPO contract		I Indemnity contra	act
	m	Other (specify)						
	L							
9 i	Ехре	erience-rated contracts:						
	a F	Premiums: (1) Amount received	9a(1	1)				
		(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium reserve		3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	b	Benefit charges (1) Claims paid	9b(′	l)				
		(2) Increase (decrease) in claim reserves	9b(2	2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrua	l basis)					
		(A) Commissions	9c(1)	(A)				
		(B) Administrative service or other fees	9c(1)	(B)				
		(C) Other specific acquisition costs	9c(1)	(C)				
		(D) Other expenses	9c(1)	(D)				
		(E) Taxes	9c(1)	(E)				
		(F) Charges for risks or other contingencies						
		(G) Other retention charges	9c(1)	(G)				
		(H) Total retention				9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These amounts w	ere paid in cash, c	or c	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount he	eld to provide benefits	after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include ar	mount entered in line	9c(2).	.)	9e		
10	Nor	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a	1	295961
	b	If the carrier, service, or other organization incurred any spec	cific costs in connection	on witl	h the acquisition or			
	O	retention of the contract or policy, other than reported in Part ecify nature of costs.	I, line 2 above, repor	t amo	ount	10b		
_		Decision of Information						
Pa	art l'	IV Provision of Information						
11	Did	d the insurance company fail to provide any information neces	sary to complete Sch	edule	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information not provi	ded.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public

		parouarit to	=:::e::::e::::::::::::::::::::::::::::	•		mspection	
For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021		and en	nding 12/31/2021		
A Name of plan				<b>B</b> Thre	e-digit		
LOCKHEED MARTIN GROUP BENEFITS PLAN				plan	number (PN)	594	
					` '	•	
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Nu	mber (EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees.	and Con	nmissions Provid	e information for each contract	
		. Individual contracts grouped					
<u> </u>		3 - 1			,		
1 Coverage Information:							
(a) Name of insurance ca	rrier						
` '							
ANTHEM BLUE CROSS							
			(e) Approximate nu	ımher of	Polic	y or contract year	
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	persons covered a			<u> </u>	
` '	code	identification number	policy or contract	t year	(f) From	<b>(g)</b> To	
35-2145715	62825	173039-1,4,5	39		01/01/2021	12/31/2021	
00 2140710	02020	173033 1,4,3	33		01/01/2021	12/31/2021	
2 Incurance fee and com	mission informa	ation. Enter the total fees and to	tal commissions paid. Li	ict in line 3	the agents brokers	and other persons in	
descending order of the		ation. Enter the total lees and to	ital commissions paid. Li	ist iii iii le 5	the agents, brokers,	and other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
(a) rotare	arrioditi or com	Tilodiono pala		(6) 10	otal amount of ices p	aid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broker	, or other person to whor	n commiss	sions or fees were pai	id	
	` '	, , , , , , , , , , , , , , , , , , ,	•		•		
		Γ.	and other commission				
(b) Amount of sales ar			es and other commission				
commissions pai	d	(c) Amount		(d) Purpose		(e) Organization code	
	(a) Nama a	and address of the agent brokes			iono or foco were no	: d	
	(a) Name a	and address of the agent, broker	, or other person to whor	II COITIIIISS	sions of fees were par	iu	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Б	art III	Welfare Benefit Contract Informa	ation						
-	art III	If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are e	xperience-rate	d as a unit	. Where co	ntracts cover individua	(s), al
•	D C			amer may i	be freated as a	unit for pt	iiposes oi ti	піз терогі.	
8	_	t and contract type (check all applicable boxes)	_	_	П.,,,			a 🗆	
	а	Health (other than dental or vision)	<b>b</b> Dental		Vision			d Life insurance	
	е 📗	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Suppleme	ntal unem	oloyment	<b>h</b> Prescription dru	g
	i 🗌	Stop loss (large deductible)	j X HMO contract	k	PPO contr	act		I Indemnity contra	act
	m	Other (specify)							
9	Experie	ence-rated contracts:							
	<b>a</b> Pre	emiums: (1) Amount received		9a(1)					
	(2)	) Increase (decrease) in amount due but unpaid	t	9a(2)					
	(3)	) Increase (decrease) in unearned premium res	serve	9a(3)					
	(4)	) Earned ( <b>(1) + (2) - (3)</b> )					. 9a(4)		0
	<b>b</b> B	enefit charges (1) Claims paid		9b(1)					
	(2)	) Increase (decrease) in claim reserves		9b(2)					
	(3)	) Incurred claims (add (1) and (2))					9b(3)		0
	(4)	) Claims charged					9b(4)		
	<b>C</b> R	emainder of premium: (1) Retention charges (c	n an accrual basis)						
		(A) Commissions		9c(1)(A)					
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)					
		(D) Other expenses		9c(1)(D)					
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies .		9c(1)(F)					
		(G) Other retention charges			•		0-(4)(1)		
		(H) Total retention		_	_		9c(1)(H)		0
		2) Dividends or retroactive rate refunds. (These	_	_	_		9c(2)		
		tatus of policyholder reserves at end of year: (1					9d(1)		
	`	2) Claim reserves					9d(2)		
	,	3) Other reserves					9d(3)		
4.0		ividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c	<b>(2)</b> .)		9e		
10		experience-rated contracts:					40-		205404
		otal premiums or subscription charges paid to c					10a	1	325134
	re	the carrier, service, or other organization incur- etention of the contract or policy, other than rep					10b		
	Specify	y nature of costs.							
Р	art IV	Provision of Information							
		ne insurance company fail to provide any inform	nation necessary to comp	lete Schedi	ule A?	П	Yes	X No	
		answer to line 11 is "Yes," specify the informat		icie Guieui	uic A:				
		anower to line in is its, specify the illivilliat	IOIT HOL PIOVIGEG. 🗲						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public

			pursuant to	ERISA section 103(a)(2	).			Inspection	
For calendar	plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	iding 12/3	1/2021		
A Name of p	olan				<b>B</b> Thre	e-digit			
LOCKHEED	MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN	<b>N</b> )	594	
C Plan spon	sor's name a	s shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)	
LOCKHEED	MARTIN CO	RPORATION			52-1893632				
Part I			rning Insurance Contract.  A. Individual contracts grouped						
1 Coverage	Information:								
(a) Name of BLUE CROSS			ARE PLAN OF GEORGIA						
		(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year	
(b) EIN		code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
58-1638390 96962		96962	174524	1308	1308		1	12/31/2021	
		mission inform amount paid.	ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
	(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid		
3 Persons re	eceiving com	missions and	ees. (Complete as many entrie	es as needed to report all	persons).				
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
(b) Amou	nt of sales ar	nd base	F	ees and other commission	ns paid				
com	nmissions pai	d	(c) Amount		(d) Purpos	е		(e) Organization code	
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
		,	<b>y</b> ,				·		
(h) Am	nt of sales ar	nd book	F	ees and other commission	ns paid				
` '	nt of sales ar nmissions pai		(c) Amount		(d) Purpos	e		(e) Organization code	
			, ,					, , , , , , , , , , , , , , , , , , , ,	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art II	Welfare Benefit Contract Informati If more than one contract covers the same group the information may be combined for reporting employees, the entire group of such individual	oup of employees of the g purposes if such cont	racts are e	xpe	rience-rated as a unit	. Where co	ontracts cover	nizations(s), individual
8	Rene	efit and contract type (check all applicable boxes)				. cated as a a.m. ter pe			
	a 「	_	Dental	_	. П	Vision		<b>d</b> Life ins	curanco
	<u> </u>				_			브	
	e _	Temporary disability (accident and sickness)	Long-term disabili	_		Supplemental unemp	oloyment	h Prescri	iption drug
	i L	Stop loss (large deductible)	X HMO contract	k	<u>ا</u> ا	PPO contract		Indemr	nity contract
	m	Other (specify)							
		_							
9 i	хре	erience-rated contracts:							
	a P	Premiums: (1) Amount received		9a(1)					
	(	(2) Increase (decrease) in amount due but unpaid		9a(2)					
	(	(3) Increase (decrease) in unearned premium reser	ve	9a(3)					
	(	(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
	(	(2) Increase (decrease) in claim reserves		9b(2)					
	(	(3) Incurred claims (add (1) and (2))					9b(3)		0
	(	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	an accrual basis)						
		(A) Commissions		9c(1)(A	)				
		(B) Administrative service or other fees		9c(1)(B					
		(C) Other specific acquisition costs		9c(1)(C	_				
		(D) Other expenses		9c(1)(D	_				
		(E) Taxes			_				
		(F) Charges for risks or other contingencies			_				
		(G) Other retention charges		9c(1)(G	)		ı		
		(H) Total retention	<u></u>				9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These at	mounts were 🗌 paid ir	cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide	benefits af	ter	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c</b>	<b>(2)</b> .)	)	9e		
10	Nor	nexperience-rated contracts:					r		
	а	Total premiums or subscription charges paid to car	rier				10a		43683728
		If the carrier, service, or other organization incurred retention of the contract or policy, other than report					10b		
	Spec	cify nature of costs.	ed iii i ait i, iiile 2 abov	е, тероп а	11100	uiit	100		-
P	rt I	IV Provision of Information							
			ion nooncomuta assess	loto Col 1	مارر	<u>ла</u> П	Yes	X No	
		d the insurance company fail to provide any informat		ete Sched	uie .	A:	103	140	
12	If th	he answer to line 11 is "Yes," specify the information	not provided. 🕨						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

			parodantio					mspection		
For calendar p	olan year 202	21 or fiscal pla	n year beginning 01/01/2021		and	ending 12/31/2021				
A Name of plant					Вт	ree-digit				
LOCKHEED	MARTIN GR	OUP BENEFI	TS PLAN		pi	an number (PN)	•	594		
C Plan spons	or's name a	s shown on lir	ne 2a of Form 5500		D Fm	plover Identification N	lumber	(FIN)		
LOCKHEED N			10 Zu 01 1 01111 0000			D Employer Identification Number (EIN) 52-1893632				
2001412201						02 1000002				
Part I			rning Insurance Contract  A. Individual contracts grouped							
1 Coverage Ir	nformation:									
(a) Nome of in		rri o r								
(a) Name of ir			A BBO							
BLUE CROSS	BLUE SHIE	LD - GEORGI	A PPO							
		(c) NAIC	(d) Contract or		(e) Approximate number of	Pol	licy or c	contract year		
<b>(b)</b> EIN		code	identification number		persons covered at end of policy or contract year	(f) From		<b>(g)</b> To		
58-0469845		54801	174524		62	01/01/2021		12/31/2021		
2 Insurance for	ee and com	mission inform	ation. Enter the total fees and to	otal o	commissions naid. List in line	3 the agents, broker	s and o	other persons in		
		amount paid.	ation. Enter the total lees and to	otar	oommioolono pala. Elocurume	o the agents, broken	o, and t	Strict persons in		
	(a) Total a	amount of com	missions paid		(b)	Total amount of fees	paid			
3 Persons red	ceiving com	missions and	ees. (Complete as many entrie	es as	needed to report all persons	).				
		(a) Name	and address of the agent, broke	er, or	other person to whom comm	issions or fees were p	oaid			
				·000 (	and other commissions paid					
` '	it of sales ar missions pai		(c) Amount	003 6	(d) Purp	ose		(e) Organization code		
001111	moorono par		(e) / unounc		(4) 1 312			(b) Grgamzanon code		
		(a) Name	and address of the agent, broke	ar or	other person to whom comm	issions or face were r	naid			
		(a) Name	and address of the agent, broke	)i, Ui	other person to whom comin	13310113 OF TOCS WOTE P	Jaiu			
		1								
	t of sales ar			ees a	and other commissions paid			4		
comr	missions pai	d	(c) Amount		(d) Purp	ose		(e) Organization code		

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art III Welfare Benefit Contract Informat	ion					
•	If more than one contract covers the same gr		e same emp	loyer(s) or members	of the same en	nployee organizat	ions(s),
	the information may be combined for reporting						idual
	employees, the entire group of such individua	Il contracts with each ca	arrier may be	e treated as a unit for	purposes of th	is report.	
8	Benefit and contract type (check all applicable boxes)						
	a Health (other than dental or vision)	Dental	С	Vision		d Life insuran	ce
		Long-term disabili	L	Supplemental une	mplovment	h Prescription	drug
	i Stop loss (large deductible)	HMO contract	-	PPO contract	inploymon.	I Indemnity co	-
		HIVIO CONTIACT	ν.	A PPO Contract			лшасі
	m ☐ Other (specify) ▶						
						_	
9 1	Experience-rated contracts:						
	a Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid.		9a(2)				
	(3) Increase (decrease) in unearned premium rese	ve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		0
	<b>b</b> Benefit charges (1) Claims paid						
	(2) Increase (decrease) in claim reserves						
					0b/3)		0
	(3) Incurred claims (add (1) and (2))						
	(4) Claims charged				. 9b(4)		
	<b>c</b> Remainder of premium: (1) Retention charges (on	,	- (1)(1)				
	(A) Commissions		9c(1)(A)				
	(B) Administrative service or other fees		9c(1)(B)				
	(C) Other specific acquisition costs		9c(1)(C)				
	(D) Other expenses		9c(1)(D)				
	(E) Taxes		9c(1)(E)				
	(F) Charges for risks or other contingencies		9c(1)(F)				
	(G) Other retention charges		9c(1)(G)				
	(H) Total retention				. 9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These a	mounts were ☐ paid in	cash, or	credited.)			
	<b>d</b> Status of policyholder reserves at end of year: (1)						
	(2) Claim reserves	•					
	· /				<del></del>		
	(3) Other reserves						
40	e Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2	( <b>)</b> .)	. 9e		
10	Nonexperience-rated contracts:						
	<b>a</b> Total premiums or subscription charges paid to ca	rier			. <u>10a</u>		2028922
	<b>b</b> If the carrier, service, or other organization incurre						
	retention of the contract or policy, other than repor	ed in Part I, line 2 abov	e, report am	ount	. 10b		
	Specify nature of costs.						
Pa	art IV Provision of Information						
11	Did the insurance company fail to provide any informa	ion necessary to comp	lete Schedul	e A?	Yes	X No	
	If the answer to line 11 is "Yes," specify the information						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

			pursuant to	ENION Section 103(a)(2	.).			Inspection
For calendar	plan year 202	21 or fiscal pla	in year beginning 01/01/2021		and en	nding 12/31/2021		
A Name of p	lan				<b>B</b> Thre	e-digit		
LOCKHEED	MARTIN GR	OUP BENEF	TS PLAN			number (PN)	•	594
						,		
					_			
•			ne 2a of Form 5500		-	oyer Identification Nu	umber (I	EIN)
LOCKHEED	MARTIN CO	RPORATION			52-	-1893632		
	1 ( 1	· O		-1 O E				
Part I			rning Insurance Contra A. Individual contracts grouped					
4		ate Scriedule /	A. maividual contracts grouped	as a unii in Fans ii anu	ili cali be le	ported on a single s	scriedule	; A.
1 Coverage I	nformation:							
(a) Name of i	nsurance ca	rrier						
DELTA DENTA								
DELTA DENTA	AL OF CALII	OKNIA						
		(c) NAIC	(d) Contract or	(e) Approximate r	umber of	Poli	cy or co	ntract year
(b) E	IN	code	identification number	persons covered		(f) From		<b>(g)</b> To
				policy or contra	ct year	(,, -		(3)
94-1461312		00000	70715	160		01/01/2021		12/31/2021
•								
			ation. Enter the total fees and t	otal commissions paid. I	_ist in line 3	the agents, brokers	, and ot	her persons in
descending	descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid							
	(a) 10tai a	amount of con	imissions paid		(b) 10	otal amount of fees p	paid	
3 Persons re	eceiving com	missions and	fees. (Complete as many entrie	es as needed to report al	l persons).			
		(a) Name	and address of the agent, broke	er, or other person to who	om commiss	sions or fees were pa	aid	
		1						
(b) Amour	nt of sales ar	nd base	F	ees and other commission	ons paid			
com	missions pai	d	(c) Amount		(d) Purpos	е		(e) Organization code
		(a) Name	and address of the agent, broke	er, or other person to who	om commiss	sions or fees were na	aid	
		(4)		.,				
(h) Amour	nt of sales ar	nd hase	F	ees and other commission	ons paid			
	missions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	- 1: -::		` ,		. ,			., , ,

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	octs with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
		opeony materio or coole				
	_	T ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan.	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts mai				
•						
	а	(1) = 1,   1   1   1   1   1   1   1   1   1	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Б	art III	Welfare Benefit Contract Informa	ation					
	ait iii	If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are e	experie	ence-rated as a unit.	Where co	ntracts cover individual
8	Renefit	and contract type (check all applicable boxes)						
Ü		Health (other than dental or vision)	<b>b</b> X Dental	,	:□ v	/ision		d ☐ Life insurance
			<u> </u>					블
	e ∐ .	Temporary disability (accident and sickness)	f Long-term disabili			Supplemental unemp	oloyment	h Prescription drug
	i ∐ ;	Stop loss (large deductible)	j HMO contract	k	(   F	PPO contract		I Indemnity contract
	m	Other (specify)						
9	Experie	ence-rated contracts:		•				
	<b>a</b> Pre	emiums: (1) Amount received		9a(1)				
	(2)	) Increase (decrease) in amount due but unpaid	d					
	(3)	) Increase (decrease) in unearned premium res	erve	9a(3)				
		) Earned ( <b>(1) + (2) - (3)</b> )					9a(4)	0
		enefit charges (1) Claims paid		:				
	` ,	) Increase (decrease) in claim reserves					01 (0)	
		) Incurred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)	0
	` '	) Claims charged					9b(4)	
	C Re	emainder of premium: (1) Retention charges (c		00/41//	<u>.                                     </u>			
		(A) Commissions		9c(1)(A				
		(B) Administrative service or other fees		9c(1)(B 9c(1)(C				
		(C) Other specific acquisition costs(D) Other expenses		9c(1)(D				
		(E) Taxes		9c(1)(E	-			
		(F) Charges for risks or other contingencies .		9c(1)(F)				
		(G) Other retention charges						
		(H) Total retention					9c(1)(H)	0
	(2	<ul> <li>P) Dividends or retroactive rate refunds. (These</li> </ul>	_		_		9c(2)	
		tatus of policyholder reserves at end of year: (1	_	-			9d(1)	
		?) Claim reserves	•				9d(2)	
	`	d) Other reserves					9d(3)	
	,	ividends or retroactive rate refunds due. (Do n					9e	
10	None	xperience-rated contracts:						
	<b>a</b> To	otal premiums or subscription charges paid to o	arrier				10a	84573
		the carrier, service, or other organization incur-					10b	
		etention of the contract or policy, other than report y nature of costs.	orted in Fart I, line 2 abov	е, тероп а	iiiiouii	II	100	
D	art IV	Provision of Information						
				:			Vaa	V No
		ne insurance company fail to provide any inform		lete Sched	lule A	?	Yes	X No
12	If the	answer to line 11 is "Yes," specify the informat	on not provided. 🕨					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	iding 12/31/202	1	
A Name of plan				B Three-digit			
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	<u> </u>	594
C Plan sponsor's name as shown on line 2a of Form 5500				<b>D</b> Emplo	yer Identification I	Number (	EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
Info	• • • • • • • • •		-1 O F	10			
		rning Insurance Contra  A. Individual contracts grouped					
1 Coverage Information:		д			,		
(a) Name of insurance ca	rrier						
EYEMED VISION CARE							
a > ===	(c) NAIC	(d) Contract or	(e) Approximate n		Po	olicy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	ı	<b>(g)</b> To
43-0949844	71870	9657016	5184	5184			12/31/2021
		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, broke	rs, and o	ther persons in
descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid							
(a) rotare	(b) Fold difficult of commissions paid						
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).			
		and address of the agent, broke			ions or fees were	paid	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	se		(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were	paid	
							T
(b) Amount of sales and base Fees and other commissions paid							
commissions pai	d	(c) Amount		(d) Purpos	е		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			0000
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base		Organization	
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(h) Amount of calca and hace		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
oommooren para			
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(a)
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	octs with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
		opeony materio or coole				
	_	T ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan.	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts mai				
•						
	а	(1) = 1,   1   1   1   1   1   1   1   1   1	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

F	Part I	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reportification to the information of the informati	group of employees of the ng purposes if such cont	racts are	expe	rience-rated as a unit	. Where co	ontracts cover indiv	ons(s), idual
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	(	CX	Vision		<b>d</b> Life insurance	се
	еĪ	Temporary disability (accident and sickness)	f Long-term disabili	tv (	ıΠ	Supplemental unemp	olovment	h Prescription	drua
	i [	Stop loss (large deductible)	j HMO contract		k∏	PPO contract	,	I  Indemnity co	-
	. L	<u></u>	) [ Time contract	•	``⊔	11 O contract		· I machinity of	miraot
	m	Other (specify)							
9	Evne	rience-rated contracts:							
,		Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(1)	-				
		(3) Increase (decrease) in amount due but unpaid		9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	_	Benefit charges (1) Claims paid		9b(1)			<b>σ</b> α(+)		
	-	(2) Increase (decrease) in claim reserves							
		(3) Incurred claims (add (1) and (2))		` '			9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (or					0.0(1)		
		(A) Commissions	,	9c(1)(A	v) [				
		(B) Administrative service or other fees		9c(1)(E					
		(C) Other specific acquisition costs		9c(1)(C					
		(D) Other expenses		9c(1)(D					
		(E) Taxes		9c(1)(E					
		(F) Charges for risks or other contingencies		9c(1)(F					
		(G) Other retention charges							
		(H) Total retention					9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)			_		9d(1)		
	-	(2) Claim reserves	·				9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no					9e		
10	<b>)</b> No	nexperience-rated contracts:			, , ,	,	I.		
	а	Total premiums or subscription charges paid to ca	arrier				10a		641360
	b	If the carrier, service, or other organization incurre	ed any specific costs in c	onnection	with	the acquisition or			
	Cno	retention of the contract or policy, other than repo cify nature of costs.	orted in Part I, line 2 abov	e, report a	amou	unt	10b		
	ope -	my nataro di code.							
P	art I	V Provision of Information							
							Vac	V No	
		the insurance company fail to provide any inform		ete Sched	aule	Α?	Yes	X No	
12	2 If th	ne answer to line 11 is "Yes," specify the information	on not provided. 🕨						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public

		paredantie	=: ((a) (=)	•		inspection
For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
LOCKHEED MARTIN GR	OUP BENEFIT	TS PLAN		plan	number (PN)	<b>594</b>
				,	, ,	
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Nu	mber (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	-1893632	
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees,	and Con	nmissions Provid	le information for each contract
		. Individual contracts grouped				
1 Coverage Information:						
. cororago miorinazioni						
(a) Name of insurance ca	rrier					
HAWAII MEDICAL SERVIC	CE ASSOCIATI	ION				
	32713333mm					
	(c) NAIC	(d) Contract or	(e) Approximate no		Polic	cy or contract year
<b>(b)</b> EIN	code	identification number	persons covered a		(f) From	<b>(g)</b> To
			policy or contrac	t year	(,, -	(3)
99-0040115	49948	C952	169		01/01/2021	12/31/2021
		1				
		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers,	and other persons in
descending order of the	amount paid.					
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees p	paid
2 Paraona receiving com	missions and fe	ees. (Complete as many entries	a an acaded to report all	norcono)		
J Fersons receiving com					. ,	• •
	(a) Name a	and address of the agent, broker	r, or otner person to wno	m commiss	sions or tees were pa	lia
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid		
commissions pai	d	(c) Amount		(d) Purpos	е	(e) Organization code
	(a) Name a	and address of the agent, broker	r, or other person to who	m commiss	sions or fees were pa	IIG .
	ı					
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			0000
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base		Organization	
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(h) Amount of calca and hace		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
oommooren para			
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(a)
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	octs with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
		openity hatare or cooks				
	_	T ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan.	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts mai				
•						
	а	(1) = 1,   1   1   1   1   1   1   1   1   1	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art II	If more than one contract covers the same greather the information may be combined for reporting	oup of employees of the gurposes if such cont	racts are ex	хре	rience-rated as a unit	. Where co	ontracts cover in	zations(s), dividual
_		employees, the entire group of such individua	I contracts with each ca	arrier may b	oe t	reated as a unit for pu	irposes of t	nis report.	
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	Dental	С	Ш	Vision		<b>d</b> Life insur	ance
	e [	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	ty <b>g</b>		Supplemental unemp	oloyment	<b>h</b> Prescripti	on drug
	i [	Stop loss (large deductible)	X HMO contract	k		PPO contract		I Indemnity	contract
	m	Other (specify)	_					_	
	<u> </u>								
9 i	Ехре	erience-rated contracts:							
	а <sup>.</sup> Р	Premiums: (1) Amount received		9a(1)					
	(	(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reser		9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	_	Benefit charges (1) Claims paid		9b(1)					
	(	(2) Increase (decrease) in claim reserves		9b(2)					
	(	(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)			!	•		
		(A) Commissions	· i	9c(1)(A)	)				
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)					
		(D) Other expenses		9c(1)(D)	)				
		(E) Taxes		9c(1)(E)	)				
		(F) Charges for risks or other contingencies		9c(1)(F)					
		(G) Other retention charges		9c(1)(G)	)				
		(H) Total retention					9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid in	cash, or	С	redited.)	9c(2)		
		Status of policyholder reserves at end of year: (1) A	<u> </u>	<u></u>			9d(1)		
		(2) Claim reserves	·				9d(2)		
		(3) Other reserves					9d(3)		
		Dividends or retroactive rate refunds due. (Do not					9e		
10		nexperience-rated contracts:		,					
	а	Total premiums or subscription charges paid to car	rier				10a		2082501
	b	If the carrier, service, or other organization incurred	l any specific costs in c	onnection v	with	the acquisition or			
		retention of the contract or policy, other than report					10b		
	Spec	cify nature of costs.							
D-	ort I	IV Provision of Information							
	art I						V	. Na	
		d the insurance company fail to provide any informat		ete Schedu	ule .	A?	Yes	X No	
12	If th	he answer to line 11 is "Yes," specify the information	n not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

pursuant to ERISA section 103(a)(2).						Inspection		
For calendar plan year 20	21 or fiscal plar	n year beginning 01/01/2021		and en	iding 12/3	1/2021		
A Name of plan				<b>B</b> Three-digit				
LOCKHEED MARTIN GR	OUP BENEFIT	TS PLAN		plan	number (Pl	N) <b>•</b>	594	
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)	
LOCKHEED MARTIN CO	LOCKHEED MARTIN CORPORATION 52-1893632							
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca		NO.						
KAISER FOUNDATION HE	EALTH PLANT	NC						
# N = N .	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
94-1340523	00000	5-0002 & 605635	1447		01/01/202	1	12/31/2021	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
63739 0						0		
3 Persons receiving com		ees. (Complete as many entries						
		and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
CONDUENT SECURITIES	, LLC		XINGTON AVE, 4TH F ORK, NY 10170	LOOR				
(b) Amount of sales ar	nd hasa	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code	
	63739						3	
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
	(a) Hamo a	ind dadrood of the agent, broker,	or other percent to who		10110 01 1000	noro para		
<b>(b)</b> Amount of sales ar	nd hase	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	
·								
	A / N1 /							

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part								
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of			
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4				
		ent value of plan's interest under this contract in separate accounts at year e						
_		racts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier		6b				
	С	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d				
		retention of the contract or policy, enter amount						
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)				
	а	<del></del>	ate participation guaran					
		(3) guaranteed investment (4) other						
		(o) Sagranosa invocations (i) Saisi y						
	b	Palance at the end of the provious year		7b				
	C	Balance at the end of the previous year	7c(1)	/ D	0			
	C	(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		•						
		(0) T		70/6)	0			
	4	(6)Total additions		- \ _ \	0			
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(1)					
		(3) Transferred to separate account	7e(3)	<del></del>				
		(4) Other (specify below)	7e(4)					
		(4) Other (specify below)	70(4)					
		<b>7</b>						
		(5) Total deductions			0			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0			

Pa	art III W	elfare Benefit Contract Informa	ntion				
		nore than one contract covers the same		e same emp	olover(s) or members of	of the same er	nplovee organizations(s).
		information may be combined for report					
	em	ployees, the entire group of such individual	ual contracts with each ca	arrier may be	e treated as a unit for	purposes of th	nis report.
8	Benefit and c	ontract type (check all applicable boxes)					
	<b>a</b> Health	(other than dental or vision)	<b>b</b> Dental	С	Vision		d Life insurance
		prary disability (accident and sickness)	f Long-term disabili		Supplemental uner		h ☐ Prescription drug
	= '			_		прюуттеті	
		oss (large deductible)	j X HMO contract	K	PPO contract		I Indemnity contract
	<b>m</b> Other	(specify)					
<b>9</b> E	Experience-ra	ated contracts:					
	a Premiums	s: (1) Amount received		9a(1)			
	(2) Increa	ase (decrease) in amount due but unpaid	l	9a(2)			
	(3) Increa	ase (decrease) in unearned premium res	erve	9a(3)			
		ed ( <b>(1)</b> + <b>(2)</b> - <b>(3)</b> )				9a(4)	0
	_	charges (1) Claims paid					
		ase (decrease) in claim reserves					
	` '	red claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	0
		ns charged				9b(4)	
	` ,	der of premium: (1) Retention charges (o					
		Commissions	*	9c(1)(A)			
	` ,	Administrative service or other fees		9c(1)(B)			
	` ,	Other specific acquisition costs		9c(1)(C)			
	, ,	Other expenses		9c(1)(D)			
	, ,	Faxes		A (4)(=)			
		Charges for risks or other contingencies					
		Other retention charges				0o(1)(H)	0
	` ,	Fotal retention					
		lends or retroactive rate refunds. (These					
		f policyholder reserves at end of year: (1)	•				
	(2) Clain	n reserves				9d(2)	
	` '	r reserves				· · · ·	
	<b>e</b> Dividend	ds or retroactive rate refunds due. (Do no	ot include amount entere	d in line 9c(2	<b>2)</b> .)	. 9e	
10	Nonexperie	nce-rated contracts:					
	<b>a</b> Total pre	emiums or subscription charges paid to c	arrier			. 10a	18009177
	<b>b</b> If the ca	rrier, service, or other organization incurr	ed any specific costs in o	onnection w	ith the acquisition or		
	retention	n of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report am	nount	. 10b	
	Specify natur	e of costs.					
Pa	art IV P	rovision of Information					
		rance company fail to provide any inform	ation necessary to comp	lete Schedu	le A?	Yes	X No
		er to line 11 is "Yes," specify the informati		20.1044			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

pursuant to ERISA section 103(a)(2).							Inspection	
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021								
A Name of plan	า				<b>B</b> Thre	e-digit		
LOCKHEED MA	ARTIN GR	OUP BENEFI	TS PLAN		plan	number (Pl	N) •	594
C Plan sponsor	r's name as	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Numb	er (EIN)
LOCKHEED MA	ARTIN CO	RPORATION			52-	1893632		
			rning Insurance Contra  A. Individual contracts grouped					
1 Coverage Info	ormation:							
(a) Name of insu			NC					
		(c) NAIC	(d) Contract or	(e) Approximate n			Policy o	r contract year
(b) EIN		code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
94-1340523		00000	101200 & 233619	1621		01/01/202	1	12/31/2021
2 Insurance fee descending or			ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, an	d other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid								
58988 0								
3 Persons rece	iving comr		ees. (Complete as many entri					
		(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees	were paid	
CONDUENT SEC	CURITIES	, LLC		LEXINGTON AVE, 4TH F / YORK, NC 10170	LOOR			
(b) Amount o	of cales an	d hase	F	ees and other commissio	ns paid			
	ssions pai		(c) Amount		(d) Purpos	е		(e) Organization code
		58988						3
		(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees	were paid	
		(L) Hame	add. 666 61 11.6 age, 216	.,				
(b) Amount o	of calco on	d base	F	ees and other commissio	ns paid			
(b) Amount of sales and base commissions paid (c) Amo			(c) Amount		(d) Purpose			(e) Organization code
	·				•			

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part								
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of			
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4				
		ent value of plan's interest under this contract in separate accounts at year e						
_		racts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier		6b				
	С	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d				
		retention of the contract or policy, enter amount						
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)				
	а	<del></del>	ate participation guaran					
		(3) guaranteed investment (4) other						
		(o) Sagranosa invocations (i) Saisi y						
	b	Palance at the end of the previous year		7b				
	C	Balance at the end of the previous year	7c(1)	/ D	0			
	C	(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		•						
		(0) T		70/6)	0			
	4	(6)Total additions		- \ _ \	0			
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(1)					
		(3) Transferred to separate account	7e(3)	<del></del>				
		(4) Other (specify below)	7e(4)					
		(4) Other (specify below)	70(4)					
		<b>7</b>						
		(5) Total deductions			0			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0			

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	roup of employees of the ng purposes if such cont	racts are e	expe	erience-rated as a unit	. Where co	ontracts o	cover individual
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	C	; 🗌	Vision		<b>d</b> ∏ Li	ife insurance
	e	Temporary disability (accident and sickness)	f  Long-term disabili	ty <b>g</b>	ıĒ	Supplemental unemp	olovment	<b>h</b> □ P	rescription drug
	i [	Stop loss (large deductible)	j X HMO contract		,	PPO contract	,		demnity contract
	. L		, A Time contract	•	`⊔	11 O dominado		- □	definity defination
	m	Other (specify)							
9		rience-rated contracts:							
9				00(1)				_	
		Premiums: (1) Amount received		9a(1) 9a(2)	+			_	
		(2) Increase (decrease) in amount due but unpaid		9a(2)				_	
		(3) Increase (decrease) in unearned premium rese					02(4)		
	_	(4) Earned ((1) + (2) - (3))		9b(1)	<u>-</u>		9a(4)		
	b	Benefit charges (1) Claims paid						_	
		(2) Increase (decrease) in claim reserves					0b/2\		0
		(3) Incurred claims (add (1) and (2))					9b(3) 9b(4)		
	•	(4) Claims charged					30(4)		
	С	, , , , , , , , , , , , , , , , , , , ,	•	9c(1)(A	<b>.</b>			_	
		(A) Commissions		9c(1)(A				_	
		(B) Administrative service or other fees		9c(1)(C				_	
		(D) Other expenses		9c(1)(D	_				
		(E) Taxes		9c(1)(E)	_				
		(F) Charges for risks or other contingencies		9c(1)(F)	_				
		(G) Other retention charges			_				
		(H) Total retention					9c(1)(H	`	C
		(2) Dividends or retroactive rate refunds. (These	_	-				<del>'</del>	
	٨		<b>—</b> ·	<u>L</u>			9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•				9d(1)		
		(2) Claim reserves					9d(2)		
	е	(3) Other reserves					9d(3)		
10	_	Dividends or retroactive rate refunds due. (Do no nexperience-rated contracts:	i include amount enteret	ı iii iiile <b>9C</b>	·( <b>∠</b> ).	)	9e		
		Total premiums or subscription charges paid to ca	arrior				10a		18894679
							IVa		10034073
	<b>b</b> Sne	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo- cify nature of costs.	, ,			•	10b		
Р	art I	V Provision of Information							
11	Dic	the insurance company fail to provide any informa	ation necessary to compl	lete Sched	lule	A?	Yes	X No	
12	lf th	ne answer to line 11 is "Yes," specify the information	on not provided.	·	_				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

			pursuant to	ERISA Section 103	(a)(2).			Inspection
For calendar	plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and	d ending 12/	31/2021	
A Name of p	lan				В т	hree-digit		
LOCKHEED	MARTIN GR	OUP BENEFI	TS PLAN		F.	olan number (P	N) •	594
C Plan spon	sor's name a	s shown on lir	ne 2a of Form 5500		<b>D</b> En	nployer Identifi	cation Number	(EIN)
LOCKHEED MARTIN CORPORATION						52-1893632		
Part I			rning Insurance Contract.  A. Individual contracts grouped					
1 Coverage	Information:							
(a) Name of it			OF COLORADO					
<i>a</i>		(c) NAIC	(d) Contract or	(e) Approxim			Policy or c	ontract year
(b) E	EIN	code	identification number	persons cove policy or co		f (f	) From	<b>(g)</b> To
84-0591617		95669	35881		1720	01/01/202	21	12/31/2021
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.								
(a) Total amount of commissions paid (b) Total amount of fees paid								
<b>3</b> Damas as						- \		
3 Persons re	eceiving com		fees. (Complete as many entrice and address of the agent, broke				a wara naid	
				ees and other comn				Τ
	nt of sales ar nmissions pai		(c) Amount	ees and other comin	(d) Pur	noco		(e) Organization code
COIT	iiiiissions pai	id	(c) Amount		<b>(u)</b> 1 ui	розе		(e) Organization code
		(a) Name	and address of the agent, broke	r, or other person to	whom comr	nissions or fee	s were paid	
(h) Amou	nt of sales ar	nd hase	F	ees and other comn	nissions paid			
` '	ini di sales al imissions pai		(c) Amount		<b>(d)</b> Pur	pose		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part								
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of			
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4				
		ent value of plan's interest under this contract in separate accounts at year e						
_		racts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier		6b				
	С	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d				
		retention of the contract or policy, enter amount						
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)				
	а	<del></del>	ate participation guaran					
		(3) guaranteed investment (4) other						
		(o) Sagranosa invocations (i) Saisi y						
	b	Palance at the end of the previous year		7b				
	C	Balance at the end of the previous year	7c(1)	/ D	0			
	C	(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		•						
		(0) T		70/6)	0			
	4	(6)Total additions		- \ _ \	0			
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(1)					
		(3) Transferred to separate account	7e(3)	<del></del>				
		(4) Other (specify below)	7e(4)					
		(4) Other (specify below)	70(4)					
		<b>7</b>						
		(5) Total deductions			0			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0			

Pa	art I	II	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a un	it. Where co	ontracts cove	
8	Rene	əfit ər	nd contract type (check all applicable boxes)						-
	_	_		<b>b</b> Dental	۰	Vision		d ☐ Life in	ouronoo
	a [	_	alth (other than dental or vision)	<u> </u>	<u> </u>			=	surance
	e L	Те	mporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	h Preso	ription drug
	i	Sto	op loss (large deductible)	j X HMO contract	k _	PPO contract		I Indem	nity contract
	m	Ot	her (specify)						
	_								
9 E	Ехре	erienc	e-rated contracts:						
	a F	rem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)					
		(	(A) Commissions		9c(1)(A)				
		(	B) Administrative service or other fees		9c(1)(B)				
		(	C) Other specific acquisition costs		9c(1)(C)				
		(	D) Other expenses		9c(1)(D)				
		(	E) Taxes		9c(1)(E)				
		(	F) Charges for risks or other contingencies .		9c(1)(F)				
		(	G) Other retention charges		9c(1)(G)		1		
		(	H) Total retention				9c(1)(H)	)	0
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	State	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		(3) (	Other reserves				9d(3)		
	е	Divid	dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b>	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		18861456
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or			
	_	reter	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	cify n	ature of costs.						
Ps	rt I	V	Provision of Information						
				otion nooneen to econo	loto Cobodul-	. Д	Yes	X No	
			insurance company fail to provide any inform		iete Scheaule	9 A (	100	A INO	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided. 🕨					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		pursuant to	ERISA section 103(a)(2)				Inspection
For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/3	1/2021	
A Name of plan LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		B Three plan	e-digit number (PN	N) <b>•</b>	594
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)
LOCKHEED MARTIN CORPORATION 52-1893632							
		rning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		TH AMERICA					
	(a) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ntract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
23-1503749	65498	LK 008348	50636		01/01/202	1	12/31/2021
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total amount of commissions paid (b) Total amount of fees paid							
47962 0							
3 Persons receiving com		ees. (Complete as many entrie					
	(a) Name a	and address of the agent, broke	•	m commiss	ions or fees	were paid	
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674				
(b) Amount of sales ar	nd hase	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	47962						3
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the previous year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Part III  Welfare Benefit Contract Information  If more than one contract covers the same group of employees of the the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes.	racts are experience-	rated as a unit. Where co	ntracts cover individual
employees, the entire group of such individual contracts with each ca	arrier may be treated	as a unit for purposes of the	nis report.
8 Benefit and contract type (check all applicable boxes)			. 🗔
a ☐ Health (other than dental or vision) b ☐ Dental	<b>C</b> Vision		<b>d</b> Life insurance
e Temporary disability (accident and sickness) f X Long-term disabili	ty <b>g</b> 🗌 Supple	emental unemployment	<b>h</b> Prescription drug
i Stop loss (large deductible) j HMO contract	<b>k</b> 🗌 PPO c	contract	I Indemnity contract
m ☐ Other (specify) ▶			
9 Experience-rated contracts:			
a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		_
(3) Increase (decrease) in unearned premium reserve	9a(3)		_
(4) Earned ((1) + (2) - (3))		9a(4)	0
<b>b</b> Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		_
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were paid in	cash, or Credited.		
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide			+
(2) Claim reserves		· · · · ·	
(3) Other reserves			+
Dividends or retroactive rate refunds due. (Do not include amount entered			
10 Nonexperience-rated contracts:	3 III IIII e 3C(2)	Je	
a Total premiums or subscription charges paid to carrier		10a	15845082
			13043002
b If the carrier, service, or other organization incurred any specific costs in c retention of the contract or policy, other than reported in Part I, line 2 abov Specify nature of costs.			
epocity reactions of sociols.			
Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to comp	lete Schedule A?	☐ Yes	X No
12 If the answer to line 11 is "Yes" specify the information not provided	ioto odriedule A!		

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2021

pursuant to ERISA section 103(a)(2).						Inspection	
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021							
A Name of plan				<b>B</b> Three	e-digit		
LOCKHEED MARTIN GR	ROUP BENEFIT	ΓS PLAN		plan	number (Pl	<b>1</b> )	594
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:		-					
(a) Name of insurance ca		H AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu	ımber of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
23-1503749	65498	LK 018358	2107		01/01/202	1	12/31/2021
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount	of fees paid	
		3043					0
3 Persons receiving com		ees. (Complete as many entries					
		nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
MERCER HEALTH & BEN	EFITS LLC		AYSPHERE CIRCLE GO, IL 60674				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	3043						3
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
				_			

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the previous year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art III Welfare Benefit Contract Informati	on				
•	If more than one contract covers the same gro		e same empl	loyer(s) or members of	the same em	ployee organizations(s),
	the information may be combined for reporting					
	employees, the entire group of such individua	contracts with each ca	arrier may be	treated as a unit for pu	irposes of the	is report.
8	Benefit and contract type (check all applicable boxes)					
	a Health (other than dental or vision)	Dental	С	Vision		Life insurance
	e X Temporary disability (accident and sickness) f	Long-term disabili	tv <b>a</b> l	Supplemental unemp	olovment <b>I</b>	n Prescription drug
	i Stop loss (large deductible)	HMO contract		PPO contract		I  Indemnity contract
		1 IIVIO CONTIGOT	·. [	1 1 0 dominant		
	m ☐ Other (specify) ▶					
ο .	Consider as asked contrasts.					
	Experience-rated contracts:		0-(4)	1		
	a Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid					
	(3) Increase (decrease) in unearned premium reser				00(4)	0
	(4) Earned ((1) + (2) - (3))				9a(4)	U
	<b>b</b> Benefit charges (1) Claims paid					
	(2) Increase (decrease) in claim reserves				0h/2\	0
	(3) Incurred claims (add (1) and (2))				9b(3) 9b(4)	0
	(4) Claims charged				3D(4)	
		•	00/1\/A\			
	(A) Commissions		9c(1)(A) 9c(1)(B)			
	(B) Administrative service or other fees		9c(1)(C)			
	(C) Other specific acquisition costs(D) Other expenses		9c(1)(D)			
	(E) Taxes		0 (4)(E)			
	(F) Charges for risks or other contingencies					
	(G) Other retention charges					
	(H) Total retention				9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These at					
					9c(2)	
	d Status of policyholder reserves at end of year: (1) A	·			9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
10	Dividends or retroactive rate refunds due. (Do not	nciude amount entered	ın iine <b>90(2</b>	<i>]</i> .)	9e	
10	Nonexperience-rated contracts:	rio r			100	405446
	Total premiums or subscription charges paid to car				10a	485446
	<b>b</b> If the carrier, service, or other organization incurred retention of the contract or policy, other than report				10b	
	Specify nature of costs.	ed in Fait i, line 2 abov	e, report am	Ourit	100	
	-,,					
Г.	out IV Drawinian of Information					
	art IV Provision of Information				V [	7 N-
	Did the insurance company fail to provide any informat		lete Schedul	e A?	Yes	No
12	If the answer to line 11 is "Yes," specify the information	not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		parouant to	2:::0::000::0::100(4)(2)	•		inspection	
For calendar plan year 202	21 or fiscal plai	n year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan B Three-digit							
LOCKHEED MARTIN GROUP BENEFITS PLAN				plan	number (PN)	594	
			· ·	, ,			
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Num	nber (EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	-1893632		
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees,	and Con	nmissions Provide	information for each contract	
		. Individual contracts grouped					
1 Coverage Information:						_	
- Covorago information.							
(a) Name of insurance ca	rrier						
LIFE INSURANCE COMPA	ANY OF NORT	H AMERICA					
	arr or more	TT/III/ERIO/R					
	(c) NAIC	(d) Contract or	(e) Approximate nu	ımber of	Policy	or contract year	
<b>(b)</b> EIN	code	identification number	persons covered a		(f) From	<b>(g)</b> To	
			policy or contract	t year	(.,	(9)	
23-1503749	65498	LK 008358	8626		01/01/2021	12/31/2021	
		ation. Enter the total fees and to	tal commissions paid. Li	st in line 3	the agents, brokers, a	and other persons in	
descending order of the	amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid						id	
2 Daragna receiving com	missions and f	and (Complete as many entries	a ac mandad to report all	naraana)			
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	and address of the agent, broker	r, or other person to whor	n commiss	sions or fees were paid	<u> </u>	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpos	е	(e) Organization code	
	(a) Name a	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees were paid	d	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code	
- 1							
						1	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Ps	art I	II	Welfare Benefit Contract Informa	ation					
	••••	•	If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a un	it. Where co	ontracts cover	
8	Bene	efit ar	nd contract type (check all applicable boxes)			·		· · · · · · · · · · · · · · · · · · ·	
	аГ	_	alth (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life ins	urance
	_ _	_		<u>=</u>	<u> </u>	<u>.</u>			
	e	_		f Long-term disabili		Supplemental unem	ployment	h Prescri	_
	i	Sto	op loss (large deductible)	j  HMO contract	k _	PPO contract		I Indemn	ity contract
	m	Ot	her (specify)						
<b>9</b> E	Expe	rienc	e-rated contracts:						
	a F	Premi	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) Ir	crease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Bene	efit charges (1) Claims paid		9b(1)				
		(2) Ir	crease (decrease) in claim reserves		9b(2)				
		(3) Ir	curred claims (add (1) and (2))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	ainder of premium: (1) Retention charges (o	n an accrual basis)					
		(	A) Commissions		9c(1)(A)				
		(	B) Administrative service or other fees		9c(1)(B)				
		(	C) Other specific acquisition costs		9c(1)(C)				
		(	D) Other expenses		9c(1)(D)				
		(	E) Taxes		9c(1)(E)				
			F) Charges for risks or other contingencies .		9c(1)(F)				
			G) Other retention charges						
		,	H) Total retention	_	_		9c(1)(H)	)	0
		(2) E	Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	Stati	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) C	Claim reserves				9d(2)		
		(3) C	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b>	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		3382447
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or			
	<b>^</b>	reter	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	city n	ature of costs.						
Pa	rt I	٧	Provision of Information						
				ation necessary to seem	loto Sobodulo	. Д	Yes	X No	
			insurance company fail to provide any inform		iete Scheaule	9 A f	100	/\ INU	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021							
A Name of plan				<b>B</b> Three	e-digit		
LOCKHEED MARTIN GR	ROUP BENEFIT	TS PLAN		plan	number (PN	<b>N</b> )	594
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		ning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca PRUDENTIAL INSURANCE		OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	entract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
22-1211670	68241	23747-1	96111		01/01/202	1	12/31/2021
2 Insurance fee and com- descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount	of fees paid	
	45912 0						
3 Persons receiving com		ees. (Complete as many entrie					
		ind address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674				
(h) Amount of colon or	nd book	Fe	ees and other commission	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose				(e) Organization code
	45912						3
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
	<u> </u>		1						
(In) Assessment of a standard the second		Fees and other commissions paid	(e)						
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code						
commissions paid			COGC						
			•						
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
		Francisco de alban accomplication (1)							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						
•									
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid							
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid							
		Fees and other commissions paid	(e)						
(b) Amount of sales and base			Organization						
commissions paid	(c) Amount	(d) Purpose	code						
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
	<u> </u>		1						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						
(-) No.									
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid							
		Face and other commissions naid	(0)						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Р	art II	Welfare Benefit Contract Information  If more than one contract covers the same group of employees of th the information may be combined for reporting purposes if such con- employees, the entire group of such individual contracts with each c	tracts are	exp	erience-rated as a ur	nit. Where c	ontracts cover	
8	Dono		amer ma	y De	treated as a unit for	purposes or	ппо тероп.	
0		efit and contract type (check all applicable boxes)			1		al 🔽	
	a	Health (other than dental or vision) b Dental		c _	Vision		<b>d</b> X Life ins	
	е	Temporary disability (accident and sickness) <b>f</b> Long-term disabil	ity	g	Supplemental uner	mployment	<b>h</b> Prescri	ption drug
	i 🗌	Stop loss (large deductible) j HMO contract		k	PPO contract		I Indemn	ity contract
	m	Other (specify)						
9	Exper	rience-rated contracts:						
	<b>a</b> P	Premiums: (1) Amount received	9a(1	)		24416394	<u>.                                    </u>	
	(	(2) Increase (decrease) in amount due but unpaid	9a(2	)		6285063	<u> </u>	
	,	(3) Increase (decrease) in unearned premium reserve				T		
		(4) Earned ((1) + (2) - (3))						30701457
		Benefit charges (1) Claims paid		_		30277594		
		(2) Increase (decrease) in claim reserves				1387011		
		(3) Incurred claims (add (1) and (2))						31664605
	,	(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual basis)	00/41/	A \			_	
		(A) Commissions	9c(1)(					
		(B) Administrative service or other fees	9c(1)( 9c(1)(				_	
		(D) Other expenses	9c(1)(	_		-1979863		
		(E) Taxes	9c(1)(			862404		
		(F) Charges for risks or other contingencies	9c(1)(	_		154311		
		(G) Other retention charges				101011		
		(H) Total retention		•		. 9c(1)(H	)	-963148
	(	(2) Dividends or retroactive rate refunds. (These amounts were $\[ \bigcap$ paid in	n cash, oi	٠П ،	credited.)	9c(2)		
		Status of policyholder reserves at end of year: (1) Amount held to provide		_				
		(2) Claim reserves						6144821
		(3) Other reserves						
	e	Dividends or retroactive rate refunds due. (Do not include amount entere	d in line 9	c(2)	.)			
10	Non	nexperience-rated contracts:						
	<b>a</b> .	Total premiums or subscription charges paid to carrier				. 10a		
		If the carrier, service, or other organization incurred any specific costs in or retention of the contract or policy, other than reported in Part I, line 2 above				. 10b		
		cify nature of costs.						
D	art I\	V Provision of Information						
			1-1- 0 1	4. 1	Г Г	Yes	X No	
11		the insurance company fail to provide any information necessary to comp	iete Sche	aule	A/	162	^ INU	
12	If th	ne answer to line 11 is "Yes," specify the information not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		pursuant to	ERISA section 103(a)(2)	-			Inspection	
For calendar plan year 20	21 or fiscal pla	an year beginning 01/01/2021		and en	ding 12/3	1/2021		
A Name of plan				<b>B</b> Three	e-digit			
LOCKHEED MARTIN GR	ROUP BENEF	ITS PLAN		plan	number (PN	<b>1</b> ) •	594	
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	1893632			
		rning Insurance Contract  A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca		OF AMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To	
22-1211670	68241	23748-1	48243		01/01/2021	1	12/31/2021	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.								
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid							
17998 0								
3 Persons receiving com		fees. (Complete as many entrie						
		and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid		
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE CAGO, IL 60674					
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code	
	17998						3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
(a) Name and address of the agent, broker, or other person to when commissions of rees were paid								
<b>(b)</b> Amount of sales a	ad base	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
							-	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
	<u> </u>		1						
(In) Assessment of a standard the second		Fees and other commissions paid	(e)						
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code						
commissions paid			COGC						
			•						
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
		Francisco de alban accomplication (1)							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						
•									
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid							
		Fees and other commissions paid	(e)						
(b) Amount of sales and base			Organization						
commissions paid	(c) Amount	(d) Purpose	code						
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
	<u> </u>		1						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						
(-) No.									
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid							
		Face and other commissions naid	(0)						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

P	art I	Welfare Benefit Contract Information If more than one contract covers the same group of employed the information may be combined for reporting purposes if semployees, the entire group of such individual contracts with	such contracts are	exp	erience-rated as a unit.	Where co	ontracts	cover individual
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) <b>b</b> Dental		С	Vision		d X L	ife insurance
	еĪ	Temporary disability (accident and sickness) <b>f</b> Long-terr	n disability	g	Supplemental unemp	lovment	h∏F	rescription drug
	: [		-		<u>-</u>	io y i i i o i i i		
	' <u> </u>		itract	r [	PPO contract		1   II	ndemnity contract
	m	Other (specify)						
9	•	erience-rated contracts:	0.74					
		Premiums: (1) Amount received		•		12361870		
		(2) Increase (decrease) in amount due but unpaid		•				
		(3) Increase (decrease) in unearned premium reserve		•		00/4)		12361870
	-	(4) Earned ((1) + (2) - (3))				9a(4) 12552683		12301070
		Benefit charges (1) Claims paid		_		-170220		
		(2) Increase (decrease) in claim reserves				9b(3)		12382463
		(3) Incurred claims (add (1) and (2))			T .	9b(3) 9b(4)		12302403
		(4) Claims charged		•••••	·····	30(4)		
	C	(A) Commissions	- 443	<b>(A)</b>			_	
		(B) Administrative service or other fees					_	
		(C) Other specific acquisition costs	0 (4)					
		(D) Other expenses	0 (4)			293094	_	
		(E) Taxes	0-/4\/			308805		
		(F) Charges for risks or other contingencies	- (1)			141420		
		(G) Other retention charges						
		(H) Total retention				9c(1)(H)	)	743319
		(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, o	r X	credited.)	9c(2)		1233961
	d	Status of policyholder reserves at end of year: (1) Amount held to			F	9d(1)		
	-	(2) Claim reserves	•			9d(2)		2477207
		(3) Other reserves			<del> </del>	9d(3)		5494684
	е	Dividends or retroactive rate refunds due. (Do not include amour			F	9e		
10	No	nexperience-rated contracts:			. ,			
	а	Total premiums or subscription charges paid to carrier				10a		
	b	If the carrier, service, or other organization incurred any specific or retention of the contract or policy, other than reported in Part I, linuity nature of costs.				10b		
	art I						<u> </u>	
11	Did	d the insurance company fail to provide any information necessary	to complete Scho	edule	e A?	Yes	X No	
12	) If +L	he answer to line 11 is "Vee" appoint the information not provided	<b>.</b>					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2021

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/3	31/2021		
A Name of plan				<b>B</b> Three	e-digit			
LOCKHEED MARTIN GE	ROUP BENEFI	ITS PLAN		plan	number (PI	N) •	594	
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	1893632			
		rning Insurance Contract  A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca		OF AMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
22-1211670	68241	23749-1	8080	01/01/2021		1	12/31/2021	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.								
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid							
3781 0								
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).				
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid		
MERCER HEALTH & BEN	IEFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674					
(b) Amount of sales a	ad basa	Fe	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	
	3781						3	
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales a	nd hase	Fe	ees and other commissio	ns paid_				
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
	<u> </u>		1						
(In) Assessment of a standard the second		Fees and other commissions paid	(e)						
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code						
commissions paid			COGC						
			•						
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
		Francisco de alban accomplication (1)							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						
•									
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid							
		Fees and other commissions paid	(e)						
(b) Amount of sales and base			Organization						
commissions paid	(c) Amount	(d) Purpose	code						
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid							
	<u> </u>		1						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						
(-) No.									
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid							
		Face and other commissions naid	(0)						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art l	III Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reporting employees, the entire group of such individua	oup of employees of the purposes if such conf	tracts are	expe	erience-rated as a uni	it. Where co	ntracts cover inc	
8	Rene	nefit and contract type (check all applicable boxes)		a			a.p0000 0. t.		
	a 「		Dental		٦٦	Vision		<b>d</b> X Life insura	nco
	느		<b>=</b>						
	e	Temporary disability (accident and sickness)	Long-term disabili	-	_ =	Supplemental unem	ployment	h Prescription	on drug
	i	Stop loss (large deductible)	HMO contract		k _	PPO contract		I Indemnity	contract
	m [	Other (specify)							
9	Expe	erience-rated contracts:							
		Premiums: (1) Amount received		9a(1)	_				
		(2) Increase (decrease) in amount due but unpaid							
		(3) Increase (decrease) in unearned premium reser					2 (1)		
	_	(4) Earned ((1) + (2) - (3))					. 9a(4)		0
	b	<b>5</b> ( ) 1		/	-				
		(2) Increase (decrease) in claim reserves					01 (0)		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
	_	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on		00/11/	۸١				
		(A) Commissions		9c(1)(					
		(B) Administrative service or other fees(C) Other specific acquisition costs		9c(1)(l					
		(D) Other expenses		9c(1)(I					
		(E) Taxes		9c(1)(I					
		(F) Charges for risks or other contingencies		0 (4)(					
		(G) Other retention charges		A (4) (					
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These a	_		_		9c(2)		
	d	Status of policyholder reserves at end of year: (1) A			_		9d(1)		
	_	(2) Claim reserves	·				9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not					9e		
10	No	onexperience-rated contracts:			. ,	,			
	а	Total premiums or subscription charges paid to car	rier				10a		2545473
	b	If the carrier, service, or other organization incurred	I anv specific costs in o	connection	n with	n the acquisition or			
		retention of the contract or policy, other than report					10b		
	Spe	ecify nature of costs.							
Pa	art I	IV Provision of Information							
11	Dic	d the insurance company fail to provide any informat	ion necessary to comp	lete Sche	dule	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information	not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		pursuant to	ERISA section 103(a)(2)				Inspection		
For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/3	1/2021			
A Name of plan				<b>B</b> Three	e-digit				
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN	<b>V</b> )	594		
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number	(EIN)		
LOCKHEED MARTIN CO	RPORATION			52-	1893632				
		rning Insurance Contract. Individual contracts grouped a							
1 Coverage Information:									
(a) Name of insurance ca		OF AMERICA							
(a) Approximate number of Policy or contract year							ontract year		
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f)	From	<b>(g)</b> To		
22-1211670	68241	43406-2	116696		01/01/2021	1	12/31/2021		
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.									
(a) Total amount of commissions paid (b) Total amount of fees paid									
15329 0									
3 Persons receiving com		ees. (Complete as many entries							
	(a) Name a	and address of the agent, broker	•	m commiss	ions or fees	were paid			
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674						
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code		
	15329						3		
	(a) Name a	and address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid			
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpose			(e) Organization code		
							L		

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the su	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

P	art I	Welfare Benefit Contract Informati	on					
- '		If more than one contract covers the same gro the information may be combined for reporting	up of employees of the					
		employees, the entire group of such individua	contracts with each ca	rrier may be	e treated as a unit for p	ourposes of t	his report.	
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	Dental	c	Vision		<b>d</b> X Life insurance	
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	y <b>g</b> [	Supplemental uner	nployment	<b>h</b> Prescription drug	g
	i [	Stop loss (large deductible)	HMO contract	k [	PPO contract		I Indemnity contra	ıct
	m	Other (specify)	_		_		_	
		_						
9	Expe	erience-rated contracts:						
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	F .	9a(2)				
		(3) Increase (decrease) in unearned premium reserv	To the second se	9a(3)				
		(4) Earned ((1) + (2) - (3))	_			9a(4)		0
	_	Benefit charges (1) Claims paid	F	9b(1)		• • • • • • • • • • • • • • • • • •		
		(2) Increase (decrease) in claim reserves	T .	9b(2)				
		(3) Incurred claims (add (1) and (2))	<u>-</u>			9b(3)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	·	0-(4)(A)	1			
		(A) Commissions	ħ.	9c(1)(A)				
		(B) Administrative service or other fees	l l	9c(1)(B)				
		(C) Other specific acquisition costs	ħ.	9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes	ħ.	9c(1)(E)				
		(F) Charges for risks or other contingencies	F	9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These ar	nounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide I	penefits afte	er retirement			
		(2) Claim reserves				- · · · ·		
		(3) Other reserves						
		Dividends or retroactive rate refunds due. (Do not						-
10		nexperience-rated contracts:			<b>,</b>			
		Total premiums or subscription charges paid to care	ier			10a	8	912208
	_					100		012200
		If the carrier, service, or other organization incurred retention of the contract or policy, other than report				10b		
	Spec	cify nature of costs.	eu iii Fait i, iiile 2 above	e, report air	iourit	100		
	Орос	ony nature of cools.						
D.	art l'	V Provision of Information						
					- A0	1 Vaa	X No	
11		I the insurance company fail to provide any informati		ete Schedul	le A?	Yes	X No	
12	If th	ne answer to line 11 is "Yes," specify the information	not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		paredant to	=: :: <b>0</b> ; : 000:::0:: :00(a)(=):	•		mspection
For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
LOCKHEED MARTIN GR	ROUP BENEFI	TS PLAN		plan	number (PN)	<b>594</b>
				· ·	, ,	
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Nu	mber (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	-1893632	
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees,	and Con	nmissions Provid	e information for each contract
		. Individual contracts grouped a				
1 Coverage Information:						
1 Cororago imoninationi						
(a) Name of insurance ca	rrier					
UNITED HEALTHCARE O	F MS INC					
	(c) NAIC	(d) Contract or	(e) Approximate nu		Polic	cy or contract year
<b>(b)</b> EIN	code	identification number	persons covered a		(f) From	<b>(g)</b> To
			policy or contract	year	()	(3)
63-1036817	95716	65083	107		01/01/2021	12/31/2021
		1				
		ation. Enter the total fees and to	tal commissions paid. Li	st in line 3	$the \ agents, \ brokers,$	and other persons in
descending order of the	amount paid.					
(a) Total a	amount of comi	missions paid		<b>(b)</b> To	otal amount of fees pa	aid
2 Dereche receiving com	missions and f	ees. (Complete as many entries	as peeded to report all	norcono)		
J Persons receiving com		· · · · · · · · · · · · · · · · · · ·		· · · · · ·		.,
	(a) Name a	and address of the agent, broker	, or other person to whor	n commiss	sions or fees were pa	ıa
	<u> </u>					
(b) Amount of sales ar	nd base	Fe	es and other commissior	ns paid		
commissions pai	id	(c) Amount		(d) Purpose		
	(a) Name a	and address of the agent, broker	, or other person to whor	n commiss	sions or fees were pa	ıa
	<u> </u>					
(b) Amount of sales ar	nd base	<u> </u>	es and other commissior	ns paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the su	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	II	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a un	it. Where co	ontracts cove	
8	Bene	efit ar	nd contract type (check all applicable boxes)			·		<u> </u>	
	a Γ	_	alth (other than dental or vision)	<b>b</b> Dental	c۲	Vision		<b>d</b> ☐ Life in	surance
	_ _	_		<u>=</u>	<u> </u>	<u>.</u>		=	
	e	_		f Long-term disabili		Supplemental unem	ployment	h Presc	-
	i L	Sto	op loss (large deductible)	j X HMO contract	k _	PPO contract		I Indem	nity contract
	m	Ot	her (specify)						
								•	
<b>9</b> E	Expe	erienc	e-rated contracts:						
	a F	Premi	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
			ncrease (decrease) in unearned premium res		9a(3)		1		
		(4) E	arned ((1) + (2) - (3))				. 9a(4)		0
	b	Bene	efit charges (1) Claims paid		9b(1)			_	
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		0
		. ,	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)	Г				
		,	A) Commissions		9c(1)(A)				
		,	B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)			_	
		,	D) Other expenses		9c(1)(D)			_	
		,	E) Taxes		9c(1)(E)			_	
			F) Charges for risks or other contingencies .		9c(1)(F)			_	
			G) Other retention charges				0-(4)(11)		
		,	H) Total retention	_	_		9c(1)(H)	)	0
			Dividends or retroactive rate refunds. (These	_	-		9c(2)		
	d		us of policyholder reserves at end of year: (1	•			9d(1)		
		` '	Claim reserves				9d(2)		
	_	` '	Other reserves				9d(3)		
40			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e		
10			erience-rated contracts:				40		0000504
	_		Il premiums or subscription charges paid to c				10a		2208501
	b		e carrier, service, or other organization incurr				10b		
	Sne	reter cify n	ntion of the contract or policy, other than repo ature of costs.	orted in Part I, line 2 abov	e, report amo	ount	100		
	Орс	Ony 11	atare or coole.						
D-	ve I	V	Provision of Information						
	rt I								
			insurance company fail to provide any inform		lete Schedule	A?	Yes	X No	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan LOCKHEED MARTIN GR	ROUP BENEFI	TS PLAN			e-digit number (PN)	594	
C Plan sponsor's name a		e 2a of Form 5500			oyer Identification Nur 1893632	mber (EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca UPMC HEALTH PLAN INC							
# N = IN I	(c) NAIC	(d) Contract or	(e) Approximate nu		Polic	y or contract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To	
25-2813536	95216	8451	208		01/01/2021	12/31/2021	
2 Insurance fee and coming descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers,	and other persons in	
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees p	aid	
3 Persons receiving com		ees. (Complete as many entrie					
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions of fees were par		
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpos	e	(e) Organization code	
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were pa	id	
			·		·		
<b>(b)</b> Amount of sales ar	nd base	Ę	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the su	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	Welfare Benefit Contract Information If more than one contract covers the same group the information may be combined for reporting pu employees, the entire group of such individual cor	of employees of the rposes if such contr	acts are ex	хре	rience-rated as a unit	. Where co	ontracts c	over individual
8	Pone		illacis will each ca	inei may k	ו סכ	reated as a utilit for po	iiposes oi t	піз тероп	
		nefit and contract type (check all applicable boxes)	Devial	_	П	A Carlana		ين □ ن	
	a _	Health (other than dental or vision)	Dental		=	Vision		브	e insurance
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disability	y <b>g</b>	Ш	Supplemental unemp	oloyment	<b>h</b> $\square$ Pr	escription drug
	i [	Stop loss (large deductible) j X	HMO contract	k		PPO contract		I Inc	demnity contract
	m	Other (specify)							
	_	<u> </u>							
<b>9</b> [	Ехре	erience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserve		9a(3)					
		(4) Earned ((1) + (2) - (3))	<u>-</u>				9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
		(2) Increase (decrease) in claim reserves		9b(2)					
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on an a	ccrual basis)						
		(A) Commissions		9c(1)(A)	)				
		(B) Administrative service or other fees	F	9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)	)				
		(D) Other expenses		9c(1)(D)	)				
		(E) Taxes		9c(1)(E)	)				
		(F) Charges for risks or other contingencies		9c(1)(F)					
		(G) Other retention charges		9c(1)(G)	)				
		(H) Total retention					9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These amou	ints were paid in	cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amo	unt held to provide b	enefits aft	ter ı	retirement	9d(1)		
		(2) Claim reserves	•				9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not inclu	ude amount entered	in line 9c(	( <b>2)</b> .)		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrier.					10a		4190895
	b	If the carrier, service, or other organization incurred any	y specific costs in co	onnection v	with	the acquisition or			
		retention of the contract or policy, other than reported in					10b		
	Spe	ecify nature of costs.							
P	rt l'	IV Provision of Information							
							V	V N-	
		d the insurance company fail to provide any information		ete Schedu	ule .	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information not	provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		parodantio	<u> </u>			inspection
For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	594
			-		,	•
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Nur	nber (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	-1893632	
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees, a	and Con	nmissions Provide	e information for each contract
		. Individual contracts grouped				
1 Coverage Information:						
- Covorago information.						
(a) Name of insurance ca	rrier					
LIFE INSURANCE COMPA	ANY OF NORT	H AMERICA				
	arr or more	TT III ETTION				
	(c) NAIC	(d) Contract or	(e) Approximate nu	mber of	Policy	y or contract year
<b>(b)</b> EIN	code	identification number	persons covered at		(f) From	<b>(g)</b> To
			policy or contract	year	(7)	(3)
23-1503749	65498	SDJ007632	2093		01/01/2021	12/31/2021
		ation. Enter the total fees and to	tal commissions paid. Lis	st in line 3	the agents, brokers,	and other persons in
descending order of the	amount paid.					
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees pa	aid
2 Damana masabidan sam		(Computate on money autic				
3 Persons receiving com		ees. (Complete as many entries				<del> </del>
	(a) Name a	and address of the agent, broker	r, or other person to whon	n commiss	sions or fees were pai	d
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		
commissions pai	id	(c) Amount		(d) Purpose		(e) Organization code
	(a) Name a	and address of the agent, broker	r, or other person to whon	n commiss	sions or fees were pai	<u>d</u>
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code
- 1			`			

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	If more than one contract covers the same group o the information may be combined for reporting purp	poses if such contra	acts are ex	cper	rience-rated as a unit	Where co	ontracts c	over individual
0		employees, the entire group of such individual cont	tracts with each cai	rrier may b	e tr	eated as a unit for pu	rposes of the	nis report	•
	_	nefit and contract type (check all applicable boxes)							
	a _	ᅼ ` ' ᆜ	Dental		Ш	Vision			e insurance
	e X	X Temporary disability (accident and sickness) <b>f</b> I	Long-term disability	/ g	Ш	Supplemental unemp	loyment	h Pre	escription drug
	i	Stop loss (large deductible) j	HMO contract	k		PPO contract		I Ind	lemnity contract
	m	Other (specify)							
	L	<b>-</b>							
9 i	хре	erience-rated contracts:							
	a P	Premiums: (1) Amount received		9a(1)					
	(	(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserve		9a(3)					
		(4) Earned ((1) + (2) - (3))	_				9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
	(	(2) Increase (decrease) in claim reserves		9b(2)					
	(	(3) Incurred claims (add (1) and (2))					9b(3)		0
	(	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on an ac	crual basis)						
		(A) Commissions		9c(1)(A)					
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)					
		(D) Other expenses		9c(1)(D)					
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies		9c(1)(F)					
		(G) Other retention charges		9c(1)(G)					
		(H) Total retention					9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These amoun	nts were paid in	cash, or	cr	edited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amou	nt held to provide b	enefits afte	er r	etirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include	de amount entered	in line 9c(2	<b>2)</b> .).		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrier					10a		418795
	b	If the carrier, service, or other organization incurred any	specific costs in co	nnection w	vith	the acquisition or			
		retention of the contract or policy, other than reported in					10b		
	Spec	ecify nature of costs.							
Pa	rt l'	IV Provision of Information							
<u>11</u>	Did	d the insurance company fail to provide any information no	ecessary to comple	ete Schedu	ıle /	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information not p	provided.				·		

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 202	For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021							
A Name of plan				<b>B</b> Thre	B Three-digit			
LOCKHEED MARTIN GR	ROUP BENEF	ITS PLAN		plan	number (PN)	•	594	
C Plan sponsor's name a	e chown on lir	20 22 of Form 5500		D Emplo	oyer Identification N	umbor (	EINI)	
LOCKHEED MARTIN CO		le 2a di Folili 3300		1	-1893632	ullibel (	LIIV)	
LOCKITEED WARTIN CO	ECONTILLED WANTIN CONTONATION							
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:							_	
(a) Name of insurance ca								
CIGNA LIFE INSURANCE	CO. OF NEW	YORK						
	(c) NAIC	(d) Contract or	(e) Approximate r	number of	Poli	icy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered policy or contra		(f) From		<b>(g)</b> To	
13-2556568	64548	NYD074268	5381		01/01/2021		12/31/2021	
2 Insurance fee and coming descending order of the		nation. Enter the total fees and t	otal commissions paid.	List in line 3	the agents, brokers	s, and of	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report al	l persons).				
		and address of the agent, broke			sions or fees were p	aid		
	` '	<b>y</b> .	•					
(b) Amount of sales ar			ees and other commission		·			
commissions pai	id	(c) Amount		(d) Purpos	e		(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	om commiss	sions or fees were p	aid		
(h) Amazouri - ( 1	(b) Amount of color and base Fees and other commissions paid							
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code	
22	-	(-)		,			( ) - gamasaan oodo	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Ps	art I	Ш	Welfare Benefit Contract Informa	ation					
		•	If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a un	it. Where co	ontracts cove	
8	Bene	efit ar	nd contract type (check all applicable boxes)			·		<u> </u>	
	аГ	_	alth (other than dental or vision)	<b>b</b> Dental	сГ	Vision		d ☐ Life in	surance
	ᆫ			<u>=</u>	<u> </u>			=	
	e			f Long-term disabili		Supplemental unem	ployment	h Presc	-
	i L	Sto	op loss (large deductible)	j  HMO contract	k _	PPO contract		I Indem	nity contract
	m	Otl	her (specify)						
<b>9</b> E	Expe	erienc	e-rated contracts:						
	a F	Premi	iums: (1) Amount received		9a(1)				
		(2) In	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) In	crease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				. 9a(4)		0
	b	Bene	efit charges (1) Claims paid		9b(1)				
		(2) In	crease (decrease) in claim reserves		9b(2)				
		(3) In	curred claims (add (1) and (2))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	ainder of premium: (1) Retention charges (o	n an accrual basis)					
		(	A) Commissions		9c(1)(A)				
		(	B) Administrative service or other fees		9c(1)(B)				
		(	C) Other specific acquisition costs		9c(1)(C)				
		(	D) Other expenses		9c(1)(D)				
		(	E) Taxes		9c(1)(E)				
			F) Charges for risks or other contingencies .		9c(1)(F)				
		,	G) Other retention charges						
		•	H) Total retention	_	_		9c(1)(H)	)	0
		(2) D	Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	Stati	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) C	Claim reserves				9d(2)		
		(3) C	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b>	.)	9e		
10	No	nexpe	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		1526604
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	th the acquisition or			
	<b>.</b>	reter	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	city n	ature of costs.						
Pa	rt I	٧	Provision of Information						
		-	insurance company fail to provide any inform	ation necessary to seem	loto Sobodulo	. Д2	Yes	X No	
					ete Scheaule	; A!	103	A INO	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided. 🕨					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		paredant to	=: :: <del>=</del> : : : : : : : : : : : : : : : : : : :				ispection
For calendar plan year 202	21 or fiscal plai	n year beginning 01/01/2021	T	and en	nding 12/31/2021		
A Name of plan				<b>B</b> Thre	e-digit		
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	•	594
					, ,		
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Nu	ımber (E	IN)
LOCKHEED MARTIN CO	RPORATION				-1893632	,	,
200111222111111111100							
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage Fees	and Con	nmissions Provid	de inform	nation for each contract
		. Individual contracts grouped					
	ato Corrodato 7	marriada contracto greapea	ao a ant in r ano n ana n	r carr bo ro	portou on a onigio o	onoddio	7.0
1 Coverage Information:							
(a) Name of incurance on	~~i ~ ~						
(a) Name of insurance ca							
METROPOLITAN LIFE INS	SURANCE CO	MPANY					
		T	(a) Ammunimanta mu		Dolla		atroot voor
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			by or cor	ntract year
(b) LIN	code	identification number	policy or contract		(f) From		<b>(g)</b> To
				. y ou.	0.1/0.1/0.001		10/01/0001
13-5581829	65978	1840000	13		01/01/2021		12/31/2021
						<del></del>	
		ation. Enter the total fees and to	tal commissions paid. Li	st in line 3	the agents, brokers,	, and oth	er persons in
descending order of the							
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Damana masabidan sam		(Camplete as many autois		\			
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees were pa	aid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose				(e) Organization code
commissions par	<u>u</u>	(c) / uniouni		(u) i uipose			(J) G.gamzanon Godo
	(a) Name a	and address of the agent, broke	r. or other person to whor	n commiss	sions or fees were pa	aid	
	(4)		,				
	ı	_					
(b) Amount of sales ar	nd base	<u> </u>	es and other commission				
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
							_

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

P	Part III Welfare Benefit Contract Information		
	If more than one contract covers the same group of employee the information may be combined for reporting purposes if such employees, the entire group of such individual contracts with a	ich contracts are experience-rated as a unit. Where con	tracts cover individual
8	Benefit and contract type (check all applicable boxes)		
	a ☐ Health (other than dental or vision) b ☐ Dental	C Vision	X Life insurance
	e ☐ Temporary disability (accident and sickness) f ☐ Long-term		Prescription drug
	i Stop loss (large deductible)	- <u> </u>	I  Indemnity contract
		act R FFO contract	Indemnity contract
	m ☐ Other (specify)		
9	Experience-rated contracts:		
9	a Premiums: (1) Amount received	02(1)	
	(2) Increase (decrease) in amount due but unpaid		
	(3) Increase (decrease) in unearned premium reserve	`	
	(4) Earned ((1) + (2) - (3))		0
	<b>b</b> Benefit charges (1) Claims paid		
	(2) Increase (decrease) in claim reserves	21 (2)	
	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )	, ,	0
	(4) Claims charged		
	c Remainder of premium: (1) Retention charges (on an accrual basis	s)	
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees		
	(C) Other specific acquisition costs		
	(D) Other expenses		
	(E) Taxes	0 (4)(=)	
	(F) Charges for risks or other contingencies		
	(G) Other retention charges	-	0
	(H) Total retention		0
	(2) Dividends or retroactive rate refunds. (These amounts were		_
	<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to p		
	(2) Claim reserves		
	(3) Other reserves  Prividends or retroactive rate refunds due. (Do not include amount		
10	<ul> <li>Dividends or retroactive rate refunds due. (Do not include amount</li> <li>Nonexperience-rated contracts:</li> </ul>	entered in line <b>9c(2)</b> .)	
	Total premiums or subscription charges paid to carrier	10a	1020
			1020
	b If the carrier, service, or other organization incurred any specific co retention of the contract or policy, other than reported in Part I, line		
	Specify nature of costs.		
D	Part IV Provision of Information		
			l No
11			No
12	2 If the answer to line 11 is "Yes," specify the information not provided.	<b>&gt;</b>	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2021

			ERISA section 103(a)(2)		lion	Inis Foi	m is Open to Public Inspection
For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and en	nding 12/3	1/2021	•
A Name of plan LOCKHEED MARTIN GI	A Name of plan  LOCKHEED MARTIN GROUP BENEFITS PLAN				e-digit number (PN	ı) <b>&gt;</b>	594
•	C Plan sponsor's name as shown on line 2a of Form 5500  LOCKHEED MARTIN CORPORATION  D Employer Identification Number ( 52-1893632					(EIN)	
		rning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		ΓΗ AMERICA					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	ontract year
(b) LIN	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
23-1503749	65498	LK 100000	94		01/01/2021		12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, b	orokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
	55 0						
3 Persons receiving com	nmissions and t	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees	were paid	
MERCER HEALTH & BEN	NEFITS LLC		PAYSPHERE CIRCLE CAGO, IL 60674				
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	55						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees	were paid	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

_	Malfara Danelit Contract Information			
P	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the	he same employer(s) or members	of the same employe	e organizations(s)
	the information may be combined for reporting purposes if such cor	ntracts are experience-rated as a	unit. Where contracts	cover individual
	employees, the entire group of such individual contracts with each			
8	Benefit and contract type (check all applicable boxes)			
	a ☐ Health (other than dental or vision) b ☐ Dental	<b>c</b> Vision	d 🔲 ⊔	ife insurance
	e X Temporary disability (accident and sickness) f ☐ Long-term disabi	ility <b>g</b> Supplemental une	employment <b>h</b> F	Prescription drug
	i Stop loss (large deductible) j HMO contract	<b>k</b> ☐ PPO contract	I ∏ ı	ndemnity contract
	m ☐ Other (specify)	_	_	
9	Experience-rated contracts:			
-	a Premiums: (1) Amount received	9a(1)		
	(2) Increase (decrease) in amount due but unpaid			
	(3) Increase (decrease) in unearned premium reserve	<del>- ` ` '  </del>		
	(4) Earned ((1) + (2) - (3))		9a(4)	0
	<b>b</b> Benefit charges (1) Claims paid			
	(2) Increase (decrease) in claim reserves	21 (2)		
	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )		9b(3)	0
	(4) Claims charged		9b(4)	
	C Remainder of premium: (1) Retention charges (on an accrual basis)		( )	
	(A) Commissions	9c(1)(A)		
	(B) Administrative service or other fees			
	(C) Other specific acquisition costs	0. (4)(0)		
	(D) Other expenses	9c(1)(D)		
	(E) Taxes	9c(1)(E)		
	(F) Charges for risks or other contingencies	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)		
	(H) Total retention		9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were paid	in cash, or credited.)	9c(2)	
	<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide	<u>—</u>		-
	(2) Claim reserves			-
	(3) Other reserves		2 1/2	
	e Dividends or retroactive rate refunds due. (Do not include amount entere			
10	Nonexperience-rated contracts:			
	a Total premiums or subscription charges paid to carrier		10a	8817
	<b>b</b> If the carrier, service, or other organization incurred any specific costs in	connection with the acquisition or		
	retention of the contract or policy, other than reported in Part I, line 2 abo			
	Specify nature of costs.			
Р	Part IV Provision of Information			
11		nlete Schedule A2	☐ Yes X No	
		piete Scriedule A?		
12	2 If the answer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021			and en	ding 12/31/202	1	
A Name of plan					B Three-digit			
LOCKHEED MARTIN GROUP BENEFITS PLAN				plan	number (PN)	•	594	
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500			<b>D</b> Emplo	yer Identification I	Number (	EIN)
LOCKHEED MARTIN CO	RPORATION				52-	1893632		
Informati	• • • • • • • •		- 1 4	O	1 0			
		rning Insurance Contra  A. Individual contracts grouped						
1 Coverage Information:	<u></u>				0000.07		0011000	<u> </u>
(a) Name of insurance ca	rrior							
LIFE INSURANCE COMPA		TH AMERICA						
	(-) NIAIO	(A) Contract on		(e) Approximate nu	mber of	Po	olicy or co	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number		persons covered at policy or contract	end of	(f) From		<b>(g)</b> To
23-1503749	65498	TDI001120		94		02/01/2020		01/31/2021
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	otal	commissions paid. Lis	st in line 3	the agents, broke	rs, and o	ther persons in
9	•	nmissions paid			<b>(b)</b> To	otal amount of fees	s paid	
		·						
3 Persons receiving com	missions and	fees. (Complete as many entrie	es a	s needed to report all p	ersons).			
	(a) Name	and address of the agent, broke	er, o	or other person to whom	commiss	ions or fees were	paid	
(b) Amount of sales ar	nd base	F	ees	and other commission	s paid			
commissions pa	id	(c) Amount		(d) Purpose				(e) Organization code
	(a) Name					: <b>f</b>		
	(a) Name	and address of the agent, broke	er, o	or other person to whom	1 COMMISS	ions or rees were	paid	
(b) Amount of sales ar	nd hase	F	ees	and other commission	s paid			
commissions pa		(c) Amount			d) Purpose	e		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art I	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such cor	ne same ei	nplo	yer(s) or members of erience-rated as a unit	the same e	employee organizations(s), ontracts cover individual
		employees, the entire group of such individual contracts with each					
8	Bene	nefit and contract type (check all applicable boxes)					_
	a [	Health (other than dental or vision) <b>b</b> Dental		c 🗌	Vision		<b>d</b> Life insurance
	e 🛚	X Temporary disability (accident and sickness) <b>f</b> Long-term disabi	lity	gΠ	Supplemental unemp	oloyment	h Prescription drug
	i Γ	Stop loss (large deductible) j HMO contract		k∏	PPO contract		I ☐ Indemnity contract
	m [				I.		<b>—</b>
	∟						
<b>9</b> 1	xpe	perience-rated contracts:					
	a F	Premiums: (1) Amount received	9a(1)				
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium reserve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)	0
	b	Benefit charges (1) Claims paid	9b(1)	)			
	(	(2) Increase (decrease) in claim reserves	9b(2)	)			
		(3) Incurred claims (add (1) and (2))				9b(3)	0
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on an accrual basis)					
		(A) Commissions	9c(1)(/	١)			
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs		_			
		(D) Other expenses					
		(E) Taxes		_			
		(F) Charges for risks or other contingencies					
		(G) Other retention charges	9c(1)(0	3)		T	
		(H) Total retention		_		9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These amounts were paid	in cash, or		credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	e benefits a	after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not include amount entere	ed in line 9	c(2).	)	9e	
10	Nor	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carrier				10a	29280
		If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 aborecify nature of costs.				10b	
Pa	art l'	IV Provision of Information					
							——————————————————————————————————————
11	Did	id the insurance company fail to provide any information necessary to com	olete Sche	dule	A?	Yes	X No
12	If th	the answer to line 11 is "Yes," specify the information not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	iding 12/31/202	1	•
A Name of plan				<b>B</b> Three-digit			
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	<u> </u>	594
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification N	Number	(EIN)
LOCKHEED MARTIN CO				-	1893632		(=····)
		rning Insurance Contra Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrior						
AMERICAN HERITAGE LI		CE COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of	Po	licy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From		<b>(g)</b> To
59-0781901	60534	G0846	3		01/01/2021		12/31/2021
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, broker	rs, and o	ther persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees	s paid	
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).			
•		and address of the agent, broke			ions or fees were	paid	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name a	and address of the agent, broke	or other person to who	m commiss	ions or fees were	naid	
	(a) Name a	and address of the agent, broke	er, or other person to who	III COITIIII33	ions or rees were	paiu	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

P	Part III Welfare Benefit Contract Information		
•	If more than one contract covers the same group of employee	ees of the same employer(s) or members of the same employee organ	izations(s),
	the information may be combined for reporting purposes if such	uch contracts are experience-rated as a unit. Where contracts cover i	ndividual
	employees, the entire group of such individual contracts with	n each carrier may be treated as a unit for purposes of this report.	
8	Benefit and contract type (check all applicable boxes)		
	a ☐ Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☒ Life insu	rance
	e ☐ Temporary disability (accident and sickness) f ☐ Long-term	n disability $oldsymbol{g}$ $oldsymbol{oldsymbol{G}}$ Supplemental unemployment $oldsymbol{h}$ $oldsymbol{h}$ Prescrip	tion drug
	i Stop loss (large deductible) j HMO contra	tract $\mathbf{k} \ \square$ PPO contract $\mathbf{l} \ \square$ Indemni	ty contract
	m ☐ Other (specify) ▶		
9	Experience-rated contracts:		
_	a Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid		
	(3) Increase (decrease) in unearned premium reserve		
	(4) Earned ((1) + (2) - (3))		0
	<b>b</b> Benefit charges (1) Claims paid		
		21 (2)	
	(2) Increase (decrease) in claim reserves		0
	(4) Claims charged		
	c Remainder of premium: (1) Retention charges (on an accrual basis		
	(A) Commissions	· · · · ·	
	(B) Administrative service or other fees	0.(4)(0)	
	(C) Other specific acquisition costs	0.(4)(D)	
	(D) Other expenses	0-(4)(F)	
	(E) Taxes	0. (4)(=)	
	(F) Charges for risks or other contingencies		
	(G) Other retention charges		
	(H) Total retention		0
	(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, or credited.)	
	<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to p	provide benefits after retirement	
	(2) Claim reserves	9d(2)	
	(3) Other reserves	9d(3)	
	e Dividends or retroactive rate refunds due. (Do not include amount		
10	Nonexperience-rated contracts:		
	a Total premiums or subscription charges paid to carrier	10a	1271
	<b>b</b> If the carrier, service, or other organization incurred any specific co		
	retention of the contract or policy, other than reported in Part I, line		
	Specify nature of costs.		
	•		
P	Part IV Provision of Information		
11	1 Did the insurance company fail to provide any information necessary to	to complete Schedule A? Yes X No	
12	2 If the answer to line 11 is "Yes," specify the information not provided.	<b>•</b>	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	nding 12/31/2021		•
A Name of plan				B Three-digit			
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	<u> </u>	594
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	oyer Identification N	Jumher (	FIN)
LOCKHEED MARTIN CO		C 2a 0i i 0iiii 0000		-	-1893632	varriber (	LIIV)
LOOKI ILLD WATER TO	iti Olutiloit						
		rning Insurance Contra Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrior						
DAVIS VISION, INC.	illei						
	(c) NAIC	(d) Contract or	(e) Approximate no	umber of	Pol	licy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From		<b>(g)</b> To
11-3051991	93440	001,002,C02,C0B	3934		01/01/2021		12/31/2021
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers	s, and ot	ther persons in
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees	paid	
							_
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).			
<u> </u>		and address of the agent, broke			sions or fees were p	oaid	
							Г
(b) Amount of sales ar			ees and other commissio				
commissions pai	d	(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were p	oaid	
	`,'	<u> </u>					
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
<u> </u>							

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	roup of employees of the ng purposes if such cont	racts are	expe	rience-rated as a unit	. Where co	ontracts cover i	izations(s), ndividual
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	(	CX	Vision		<b>d</b> Life insu	rance
	е	Temporary disability (accident and sickness)	f  Long-term disabili	tv (	g∏	Supplemental unemp	olovment	h Prescrip	tion drua
	i [	Stop loss (large deductible)	j  HMO contract		k∏	PPO contract	,	= =	ty contract
	. L		, I illino contract	'	., □	110 dontidot			y contract
	m	Other (specify)							
9	Evno	rience-rated contracts:							
9	•			00/1)	. 1				
		Premiums: (1) Amount received		9a(1) 9a(2)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium rese					02/4)		
	_	(4) Earned ((1) + (2) - (3))		9b(1)		•••••	9a(4)		
	b	Benefit charges (1) Claims paid							
		(2) Increase (decrease) in claim reserves		` '			0h/2\		0
		(3) Incurred claims (add (1) and (2))					9b(3) 9b(4)		
	•	(4) Claims charged					3D(4)		
	С	, , , , , , , , , , , , , , , , , , , ,	•	00/1)//	· · ·				
		(A) Commissions		9c(1)(A 9c(1)(E					
		(B) Administrative service or other fees		9c(1)(C					
		(D) Other expenses		9c(1)(E					
		(E) Taxes		9c(1)(E	_				
		(F) Charges for risks or other contingencies		9c(1)(F					
		(G) Other retention charges			_				
		(H) Total retention					9c(1)(H)	\	0
		(2) Dividends or retroactive rate refunds. (These	_		_			<b>/</b>	
	لم		<b>—</b> ·		ш		9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•				9d(1)		
		(2) Claim reserves					9d(2)		
	_	(3) Other reserves					9d(3)		
10	e Na	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 90	C(2).	)	9e		
10		nexperience-rated contracts:	arria r				100		267422
		Total premiums or subscription charges paid to ca					10a		367133
	b Sne	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo- cify nature of costs.	, ,			•	10b		
P	art I	V Provision of Information							
11	Dic	I the insurance company fail to provide any informa	ation necessary to compl	ete Sche	dule	A?	Yes	X No	
		ne answer to line 11 is "Yes," specify the information							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

			pursuant to	ERISA section 103(a)(2	).			Inspection
For calendar	plan year 202	21 or fiscal pla	in year beginning 01/01/2021		and en	ding 12/3	1/2021	
A Name of p	lan				<b>B</b> Thre	e-digit		
LOCKHEED	MARTIN GR	OUP BENEFI	EFITS PLAN		plan	plan number (PN)		594
C Plan spons	sor's name a	s shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number	(EIN)
LOCKHEED	MARTIN CO	RPORATION			52-	1893632		
Part I			rning Insurance Contract  A. Individual contracts grouped					
1 Coverage	Information:							
(a) Name of i			OF THE NORTHWEST					
		(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
(b) E	EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
93-0798039		95540	21201	8		01/01/2021	1	12/31/2021
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
	(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons re	eceiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amou	nt of sales ar	nd base	F	ees and other commission	ns paid			_
	nmissions pai		(c) Amount		(d) Purpose			(e) Organization code
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
							·	
(b) Ama	nt of sales ar	nd hoos	F	ees and other commission	ns paid			
` '	nt of sales ar Imissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	- 1		, ,					, , , , , , , , , , , , , , , , , , , ,

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	If more than one contract covers the same group of employ the information may be combined for reporting purposes if	such contracts are	expe	erience-rated as a unit	. Where co	ontracts cover i	nizations(s), ndividual
0		employees, the entire group of such individual contracts wi	ith each carrier may	be i	treated as a unit for pu	irposes or ti	nis report.	
	_	enefit and contract type (check all applicable boxes)					a 🗆	
	a _	Health (other than dental or vision) b Dental		Ե∐	Vision		d Life insu	
	е	Temporary disability (accident and sickness) <b>f</b> Long-ter	rm disability	g 📗	Supplemental unemp	oloyment	<b>h</b> Prescrip	tion drug
	i [	Stop loss (large deductible) j 🛛 HMO co	ntract	k 🗌	PPO contract		I Indemni	ty contract
	m	Other (specify)						
	L							
<b>9</b> [	Ехре	perience-rated contracts:						
	a F	Premiums: (1) Amount received	9a(1)					
		(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium reserve	9a(3)					
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	b	Benefit charges (1) Claims paid	9b(1)					
		(2) Increase (decrease) in claim reserves	9b(2)					
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual ba	asis)					
		(A) Commissions	9c(1)(/	۱)				
		(B) Administrative service or other fees	2 (1) (1					
		(C) Other specific acquisition costs	9c(1)(0	<b>;</b> )				
		(D) Other expenses	9c(1)(I	))				
		(E) Taxes	9c(1)(E	Ξ)				
		(F) Charges for risks or other contingencies	9c(1)(F	-)				
		(G) Other retention charges	9c(1)(0	3)				
		(H) Total retention				9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, or	C	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held t	to provide benefits a	after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amou	unt entered in line 9	c(2).	)	9e		
10	Noi	Ionexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a		75920
	b	If the carrier, service, or other organization incurred any specific	costs in connection	with	n the acquisition or			
		retention of the contract or policy, other than reported in Part I, li				10b		
	<b>O</b> po.	pecify nature of costs.						
Pa	art I	IV Provision of Information						
11	Did	oid the insurance company fail to provide any information necessar	y to complete Sche	dule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the information not provided			<u> </u>			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		parouant to	= : :: 0, : 000 :: 0: 100 (a) (=)	•		ilispection	
For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan				<b>B</b> Thre	e-digit		
LOCKHEED MARTIN GR	ROUP BENEFI	TS PLAN		plan	n number (PN)	594	
				,	` '		
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Nur	mber (EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	-1893632		
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees,	and Con	nmissions Provide	e information for each contract	
		. Individual contracts grouped a					
1 Coverage Information:							
1 Cororago imormationi							
(a) Name of insurance ca	rrier						
KAISER FOUNDATION HE	FAI TH PI AN (	OF GEORGIA					
(c) NAIC (d) Contract or				Policy	y or contract year		
<b>(b)</b> EIN	code	identification number	persons covered a		(f) From	<b>(g)</b> To	
			policy or contrac	t year	( )	(3)	
58-1592076	96237	10306	149		01/01/2021	12/31/2021	
	l						
		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers,	and other persons in	
descending order of the	amount paid.	Ţ					
(a) Total amount of commissions paid (b) Total amount of fees paid							
2 Dereche receiving com	missions and f	ees. (Complete as many entries	a as pooded to report all	noroona)			
J Persons receiving com		` ' '	·		. , .		
	(a) Name a	and address of the agent, broker	r, or other person to who	m commiss	sions or fees were pai	la .	
(b) Amount of sales ar	nd base		es and other commission				
commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code	
	(=) NI=======	and address of the amount harden					
	(a) Name a	and address of the agent, broker	r, or other person to who	m commiss	sions or fees were pai	la .	
(b) Amount of sales ar	nd base	<u>Fe</u>	es and other commission				
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the previous year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	Welfare Benefit Contract Information If more than one contract covers the same ground the information may be combined for reporting employees, the entire group of such individual of the contract of the contract in the cont	up of employees of the purposes if such cont	racts are ex	xpe	rience-rated as a unit.	. Where co	ntracts cover ind	ations(s), ividual
8	Done		Contracts with each ca	anner may k	ו סכ	eated as a drift for pu	iiposes oi ti	riis report.	
	_	nefit and contract type (check all applicable boxes)	Пред	_	П	A Calana		al 🗆 1.76. Salama	
	a _	Health (other than dental or vision)			_	Vision		<b>d</b> ∐ Life insura	
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	ty <b>g</b>	Ш	Supplemental unemp	loyment	<b>h</b> Prescription	n drug
	i [	Stop loss (large deductible) j	X HMO contract	k		PPO contract		I Indemnity	contract
	m	Other (specify)							
	<u> </u>								
<b>9</b> [	Ехре	erience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserve	ə	9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
		(2) Increase (decrease) in claim reserves		9b(2)					
		(3) Incurred claims (add (1) and (2))	············				9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on ar	n accrual basis)			•			
		(A) Commissions		9c(1)(A)	)				
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)	)				
		(D) Other expenses		9c(1)(D)	) [				
		(E) Taxes		9c(1)(E)	)				
		(F) Charges for risks or other contingencies		9c(1)(F)					
		(G) Other retention charges		9c(1)(G)	)				
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These am	ounts were paid in	cash, or	CI	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Ar	nount held to provide	benefits aft	_ ter r	etirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not in	clude amount entered	d in line 9c(	( <b>2)</b> .)		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrie	ər				10a		1356453
	b	If the carrier, service, or other organization incurred a	any specific costs in c	onnection v	with	the acquisition or			
		retention of the contract or policy, other than reported					10b		
	Орек	ecify nature of costs.							
Pá	art l'	IV Provision of Information							
11	Did	d the insurance company fail to provide any information	n necessary to compl	ete Schedu	ule /	Α?	Yes	X No	· · · · · ·
		the answer to line 11 is "Yes," specify the information is				<u> </u>			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2021

,			ERISA section 103(a)(2)		luori	This Fo	rm is Open to Public Inspection
For calendar plan year 20	21 or fiscal pla	in year beginning 01/01/2021		and er	nding 12/31	1/2021	
A Name of plan LOCKHEED MARTIN GR	OI ID BENEEI	TS DI AN			ee-digit	n <b>k</b>	594
EGORITEED WARTIN OF	COOL DEIVELL	TOTLAN		pian	number (PN	i) <b>F</b>	004
C Plan sponsor's name a	as shown on lin	ne 2a of Form 5500		<b>D</b> Emplo	over Identifica	ation Number	(EIN)
LOCKHEED MARTIN CO					-1893632		
		rning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:						-	
(a) Name of insurance ca		OF THE MID ATLANTIC					
RAISER FOUNDATION II	T	T THE WILD-ATEANTIC	(a) Approximate pu	umbar af		Policy or o	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a	t end of	(f)	From	(g) To
52-0954463	95639	24776	policy or contract	policy or contract year			12/31/2021
					01/01/2021		
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, t	orokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
	19828 54768						
3 Persons receiving com		fees. (Complete as many entrie					
	(a) Name a	and address of the agent, broke	•	n commiss	sions or fees	were paid	
BUCK GLOBAL LLC			OX 207640 .AS, TX 75320				
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount	ı	(d) Purpos	se		(e) Organization code
	11475	54768	ANNUAL BOB				3
	(a) Name a	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees	were paid	
CONDUENT SECURITIES		450 L	EXINGTON AVE, 4TH FI			·	
42.4		Fi	ees and other commission	ns paid			
(b) Amount of sales a commissions pa		(c) Amount		(d) Purpos	se		(e) Organization code
	8353						3
							1

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the previous year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	If more than one contract covers the same grouthe information may be combined for reporting	up of employees of the purposes if such conti	racts are e	хре	rience-rated as a unit	. Where co	ontracts cover individ	ons(s), dual
8	2000	employees, the entire group of such individual of	Contracts with each ca	illei illay i	Je i	realed as a utilition pu	iposes oi t	nis report.	
		nefit and contract type (check all applicable boxes)	□ poutal	_	П	A Carlana		<b>d</b> □ 126.2	_
	a _	Health (other than dental or vision)			_	Vision		<b>d</b> Life insurance	
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	y <b>g</b>	Ш	Supplemental unemp	loyment	<b>h</b> Prescription of	drug
	i [	Stop loss (large deductible) j	X HMO contract	k		PPO contract		I Indemnity con	ntract
	m	Other (specify)							
	<u> </u>	<b>_</b>							
<b>9</b> [	Ехре	erience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserve	÷	9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
		(2) Increase (decrease) in claim reserves		9b(2)					
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on ar	n accrual basis)						
		(A) Commissions		9c(1)(A)	)				
		(B) Administrative service or other fees		9c(1)(B)	)				
		(C) Other specific acquisition costs		9c(1)(C)					
		(D) Other expenses		9c(1)(D)	_				
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies		9c(1)(F)	_				
		(G) Other retention charges		9c(1)(G)	)				
		(H) Total retention					9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These am	ounts were paid in	cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Ar	nount held to provide	benefits aft	ter ı	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not in	clude amount entered	l in line <b>9c(</b>	<b>(2)</b> .)		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrie	er				10a		2910642
	b	If the carrier, service, or other organization incurred a	any specific costs in c	onnection v	with	the acquisition or			
		retention of the contract or policy, other than reported					10b		
	Spec	ecify nature of costs.							
Pa	rt l	IV Provision of Information							
<u>1</u> 1	Did	d the insurance company fail to provide any information	n necessary to compl	ete Schedu	ule .	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information i	not provided.						·

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	nding 12/31/2021		•
A Name of plan				<b>B</b> Three-digit			
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	•	594
C Plan sponsor's name a	C Plan sponsor's name as shown on line 2a of Form 5500				yer Identification Nu	mber (I	EIN)
LOCKHEED MARTIN CO	LOCKHEED MARTIN CORPORATION 52-1893632						
		rning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:					•		
(a) Name of insurance ca		COMPANY					
CIGNA HEALTH AND LIFE	INSURANCE	COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate r		Polic	y or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered policy or contra		(f) From		<b>(g)</b> To
59-1031071	67369	2500544/3341110	5002		01/01/2021		12/31/2021
2 Insurance fee and come descending order of the		ation. Enter the total fees and t	otal commissions paid.	_ist in line 3	the agents, brokers,	and ot	ner persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and t	ees. (Complete as many entrie	es as needed to report al	l persons).			
	(a) Name a	and address of the agent, broke	er, or other person to who	om commiss	sions or fees were pa	id	
(b) Amount of sales ar	nd hase	F	ees and other commission	ons paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	om commiss	sions or fees were pa	id	
(b) Amount of sales ar	nd base	F	ees and other commission	ons paid			
commissions pai	id	(c) Amount		(d) Purpos	e		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part		Salvada a salaa	ale a surface as a surface of the state of t	46
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the previous year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	If more than one contract covers the same group of employer the information may be combined for reporting purposes if su	ich contracts are	expe	erience-rated as a unit	. Where co	ontracts cover in	izations(s), ndividual
0		employees, the entire group of such individual contracts with	each camer may	y be	ireated as a unit for pu	irposes or t	nis report.	
		nefit and contract type (check all applicable boxes)			l		a 🗆	
	a _	Health (other than dental or vision) <b>b</b> X Dental		с <u> </u>	Vision		<b>d</b> Life insu	
	е	Temporary disability (accident and sickness) <b>f</b> Long-term	disability	g	Supplemental unemp	oloyment	<b>h</b> Prescrip	tion drug
	i [	Stop loss (large deductible) j HMO contr	ract	k	PPO contract		I Indemnit	y contract
	m	Other (specify)						
	L							
9 i	Ехре	perience-rated contracts:						
	a F	Premiums: (1) Amount received	9a(1)	)				
		(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium reserve		)				
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	b	Benefit charges (1) Claims paid	9b(1)	)				
		(2) Increase (decrease) in claim reserves	9b(2)	)				
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual basis	s)					
		(A) Commissions	9c(1)(	A)				
		(B) Administrative service or other fees	- (1) (					
		(C) Other specific acquisition costs	9c(1)(0	C)				
		(D) Other expenses	9c(1)(I	D)				
		(E) Taxes	9c(1)(I	E)				
		(F) Charges for risks or other contingencies	9c(1)(I	F)				
		(G) Other retention charges	9c(1)(	G)				
		(H) Total retention				9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, or	. 🗌	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to	provide benefits	 after	retirement	9d(1)		
		(2) Claim reserves	·			9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amount	entered in line 9	c(2).	)	9e		
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a		1956147
	b	If the carrier, service, or other organization incurred any specific co	osts in connection	n witl	h the acquisition or			
		retention of the contract or policy, other than reported in Part I, line				10b		
	Spe	ecify nature of costs.						
_		IV Duovision of Information						
Pa	rt I	IV Provision of Information						
11	Did	id the insurance company fail to provide any information necessary t	o complete Sche	dule	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information not provided.	<b>•</b>					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 202	For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021							
A Name of plan				<b>B</b> Thre	, i			
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	<u> </u>	594	
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification N	Jumber (	EIN)	
LOCKHEED MARTIN CO				1	1893632	(	,,	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of incurrence on	rrior						_	
(a) Name of insurance ca VISION SERVICE PLAN	mei							
VISION SERVICE PLAIN								
(1) FIN	(c) NAIC	(d) Contract or	(e) Approximate n		Po	licy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From		<b>(g)</b> To	
23-7089668	53031	30077627	72218		01/01/2021		12/31/2021	
2 Insurance fee and coming descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, broker	s, and of	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).				
g		and address of the agent, broke			sions or fees were p	paid		
	, ,		•					
(b) Amount of sales ar		(c) Amount	ees and other commission	ees and other commissions paid (d) Purpose			(e) Organization code	
commissions pai	u	(C) Amount		(u) Fulpos	Е		(e) Organization code	
	(a) Name a	and address of the agent, broke	or other person to who	m commiss	cione or fees were r	naid		
	(a) Name a	and address of the agent, broke	or, or other person to who	III COITIIII33	sions of ices were p	Jaiu		
							Т	
(b) Amount of sales ar			ees and other commission					
commissions pai	d	(c) Amount		(d) Purpos	e		(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art III Welfare Benefit Contract Informat	ion				
	If more than one contract covers the same gro		e same empl	over(s) or members of	the same en	nplovee organizations(s).
	the information may be combined for reporting					
	employees, the entire group of such individua	I contracts with each ca	arrier may be	e treated as a unit for pu	irposes of th	is report.
8	Benefit and contract type (check all applicable boxes)					
		Dental	c	Vision		d Life insurance
		Long-term disabili	_	Supplemental unemp		h ☐ Prescription drug
					Dioyineni	
	i Stop loss (large deductible)	HMO contract	κլ	PPO contract		I Indemnity contract
	m ☐ Other (specify) ▶					
	Experience-rated contracts:			I		
	a Premiums: (1) Amount received		9a(1)			_
	(2) Increase (decrease) in amount due but unpaid		9a(2)			_
	(3) Increase (decrease) in unearned premium reser	ve	9a(3)			
	(4) Earned ( <b>(1) + (2) - (3)</b> )				9a(4)	0
	<b>b</b> Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	0
	(4) Claims charged				9b(4)	
	c Remainder of premium: (1) Retention charges (on	an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			_
	(F) Charges for risks or other contingencies		9c(1)(F)			_
	(G) Other retention charges					
	(H) Total retention				9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These a				9c(2)	
	d Status of policyholder reserves at end of year: (1) A				9d(1)	
	(2) Claim reserves	•			9d(2)	
	(3) Other reserves				9d(3)	
	e Dividends or retroactive rate refunds due. (Do not				9a(3) 9e	
10	Nonexperience-rated contracts:	include amount entered	111 1111e <b>3C(2</b>	<i>]</i> .)	36	
10	<b>a</b> Total premiums or subscription charges paid to car	rior			10a	11296926
					100	11230323
	<b>b</b> If the carrier, service, or other organization incurred retention of the contract or policy, other than report	any specific costs in c ed in Part I line 2 abov	onnection w	ount	10b	
	Specify nature of costs.	od ii i dit i, iiio 2 doov	o, roport arri	ourit.		
	• •					
D-	art IV Provision of Information					
				п п	Voc.	V No
	Did the insurance company fail to provide any informat		ete Schedul	e A?	Yes	No
12	If the answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

		1		-		inspection	
For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021		and en	nding 12/31/2021		
A Name of plan				<b>B</b> Thre	e-digit		
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	n number (PN)	594	
					, ,		
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Nu	mber (EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	-1893632		
on a separa	ate Schedule A	. Individual contracts grouped a	as a unit in Parts II and II	I can be re	ported on a single So	chedule A.	
1 Coverage Information:							
(a) Name of insurance ca	rrier						
PRUDENTIAL INSURANC	E COMPANY (	OF AMERICA					
	Γ	1	(2) A manassismata na		Dollo	v. or contract voor	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			y or contract year	
(b) Ent	code	identification number	policy or contract		(f) From	<b>(g)</b> To	
22-1211670	68241	43406-1	105609		01/01/2021	12/31/2021	
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	st in line 3	the agents, brokers,	and other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
(b) Total amount of commissions paid							
_							
3 Persons receiving com		ees. (Complete as many entries		· · · · · · · · · · · · · · · · · · ·			
	(a) Name a	and address of the agent, broker	, or other person to whor	n commiss	sions or fees were pa	id	
	Г						
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpos	е	(e) Organization code	
	(a) Name a	ind address of the agent, broker	r, or other person to whor	n commiss	sions or fees were pa	ıd	
	ı						
(b) Amount of sales ar	nd base	<u> </u>	es and other commission				
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code	
				·			

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individua	oup of employees of the g purposes if such cont	racts are ex	креі	rience-rated as a unit	. Where co	ntracts cover indi	ations(s), vidual
8	Bene	efit and contract type (check all applicable boxes)					<u> </u>	•	
	a □	_	<b>b</b> Dental	c	П	Vision		<b>d</b> Life insurar	nce
	<u> </u>	<b>-</b>    -			=				
	e _		Long-term disabili	_	_	Supplemental unemp	oloyment	h Prescriptio	
	i	Stop loss (large deductible)	HMO contract	k	Ш	PPO contract		I Indemnity	contract
	m X	Other (specify) TRAVEL AD&D							
		-							
9 1	Ехреі	erience-rated contracts:							
	<b>a</b> P	Premiums: (1) Amount received		9a(1)					
	(	(2) Increase (decrease) in amount due but unpaid .		9a(2)					
	(	(3) Increase (decrease) in unearned premium rese	rve	9a(3)					
	(	(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
	(	(2) Increase (decrease) in claim reserves		9b(2)					
	(	(3) Incurred claims (add (1) and (2))					9b(3)		0
	(	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)						
		(A) Commissions		9c(1)(A)					
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)	_				
		(D) Other expenses		9c(1)(D)	_				
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies		9c(1)(F)					
		(G) Other retention charges		9c(1)(G)					
		(H) Total retention	_		-		9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid ir	cash, or	cr	edited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits aft	er r	etirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c(</b> 2	<b>2)</b> .)		9e		
10	Nor	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to ca	rrier				10a		885262
		If the carrier, service, or other organization incurre							
	Cnaa	retention of the contract or policy, other than repor cify nature of costs.	ted in Part I, line 2 abov	e, report an	nou	ınt	10b		
Pa	art I	V Provision of Information							
11	Did	I the insurance company fail to provide any informa	tion necessary to compl	ete Schedu	ıle /	Α?	Yes	X No	
		he answer to line 11 is "Yes," specify the information						<del></del>	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2021

		pursuant to	ERISA section 103(a)(2)				Inspection
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and en	ding 12/3	31/2021	
A Name of plan				<b>B</b> Thre	e-digit		
LOCKHEED MARTIN GR	ROUP BENEFIT	TS PLAN			number (PI	N) •	594
				,	,		
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	cation Number (	EIN)
LOCKHEED MARTIN CORPORATION 52-1893632							
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:						-	
(a) Name of insurance ca		DF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
22-1211670	68241	24444 - GUL	63319		01/01/202	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and of	her persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount	of fees paid	
112772 1288383						288383	
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	nd address of the agent, broker	, or other person to whor	m commiss	ions or fees	were paid	
MARSH USA, INC			AVENUE OF THE AMER YORK, NY 10036	RICAS			
(b) Amount of sales ar	ad book	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
0		ì	THIRD PARTY ADMINISTRATION FEES			5	
	(a) Nama a	nd address of the agent broker	or other person to when	m commics	iono or food	wore poid	
MEDOED HEALTH A DEN		nd address of the agent, broker		II COIIIIIISS	ions or rees	were paid	
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	112772			, , , , , ,			3

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

D. (III. Walfara Danelit Contract Information			
Part III Welfare Benefit Contract Information  If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such comployees, the entire group of such individual contracts with each of the information may be combined for reporting purposes if such contracts with each of the individual contracts with each of the individual contracts.	ntracts are experience-rated as	a unit. Where contract	s cover individual
8 Benefit and contract type (check all applicable boxes)			
a ☐ Health (other than dental or vision) b ☐ Dental	<b>c</b> Vision	d 🛚	Life insurance
e Temporary disability (accident and sickness) f Long-term disability	<u> </u>		Prescription drug
	* = * = * :	unemployment II	
i  Stop loss (large deductible) j  HMO contract	<b>k</b> ☐ PPO contract	· 📙	Indemnity contract
m ☐ Other (specify) ▶			
9 Experience-rated contracts:			
a Premiums: (1) Amount received		68137669	
(2) Increase (decrease) in amount due but unpaid			
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ((1) + (2) - (3))			68137669
<b>b</b> Benefit charges (1) Claims paid		64128434	
(2) Increase (decrease) in claim reserves		2138028	
(3) Incurred claims (add (1) and (2))			66266462
(4) Claims charged		9b(4)	66266462
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis)	[]		
(A) Commissions			
(B) Administrative service or other fees	0-(4)(0)	1288383	
(C) Other specific acquisition costs	0 (4)(D)		
(D) Other expenses	0-(4)(5)	2108862	
(E) Taxes		2054366	
(F) Charges for risks or other contingencies	0 (4)(0)	519663	
(G) Other retention charges	•	00(4)(U)	5071274
(H) Total retention	_	````	5971274
(2) Dividends or retroactive rate refunds. (These amounts were paid		<del></del>	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide			
(2) Claim reserves			33280396
(3) Other reserves			9032940
e Dividends or retroactive rate refunds due. (Do not include amount enter	ed in line 9c(2).)	9e	
10 Nonexperience-rated contracts:		10	
Total premiums or subscription charges paid to carrier		10a	
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 abord Specify nature of costs.		n or 10b	
Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to com	plete Schedule A?	Yes X N	)
12 If the angular to line 11 is "Vee" appoint the information not provided			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

pursuant to ERISA section 103(a)(2).						Inspection	
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021							
A Name of plan				<b>B</b> Three	e-digit		
LOCKHEED MARTIN GR	ROUP BENEFI	TS PLAN		plan	number (Pl	N) •	594
C Plan sponsor's name as shown on line 2a of Form 5500  D Employer Identification Number (EIN							EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca		E COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
59-0781901	60534	G0846	44338		01/01/202	1	12/31/2021
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
2485610 196165							
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
BUCK GLOBAL, LLC			OX 207640 .AS, TX 75320-7640				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	2107941	196165	SUPPLEMENTAL COMP	PENSATION	N		3
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
CONDUENT SECURITIES		450 L	EXINGTON AVE, 4TH F YORK, NY 10017			·	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	377669						3
							l

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	cts with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year e	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				_
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	_	Time of contract. (4) Time dividual religion (2) Time defended				
	е	Type of contract: (1) individual policies (2) group deferred	annully			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai				
•				tion guarantee		
	а	(,) = (,) = (,) = (,) = (,) = (,)	te participa	lion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 7 5	0
	C		7c(2)			
		(2) Dividends and credits				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Tatal additions			7c(6)	0
	a	(6)Total additions				0
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			7d	
	е	Deductions:	7 - (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

P	art	Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individua	oup of employees of th g purposes if such con	tracts are	expe	erience-rated as a un	t. Where co	ntracts cover ind	utions(s), ividual
8	Ren	enefit and contract type (check all applicable boxes)							
•	a 「	,, ,	Dental		۰Π	Vision		d Life insura	nco
	L	<u>'</u>	<u>=</u>		느				
	е	Temporary disability (accident and sickness)	Long-term disabili			Supplemental unem	ployment	h Prescriptio	n drug
	i	Stop loss (large deductible)	HMO contract		k 📗	PPO contract		I Indemnity	contract
	m	X Other (specify) ► CRITICAL ILLNESS & ACCID	ENT						
9	Ехре	perience-rated contracts:							
	a I	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid.							
		(3) Increase (decrease) in unearned premium reser					1		
		(4) Earned ((1) + (2) - (3))					. 9a(4)		0
	b	0 ( )		/					
		(2) Increase (decrease) in claim reserves					01 (0)		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
	_	(4) Claims charged					9b(4)		
	С	1 ()		00/11//	۸۱				
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees		9c(1)(E					
		(D) Other expenses		9c(1)([					
		(E) Taxes		9c(1)(E	•				
		(F) Charges for risks or other contingencies		0 (4)(5	_				
		(G) Other retention charges		0 (4)(4					
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These a	_		_		9c(2)		
	d				_		9d(1)		
	_	(2) Claim reserves	·				9d(2)		
		(3) Other reserves					9d(3)		
	е						9e		
10	No	Ionexperience-rated contracts:			. ,	,	<b>U</b>		
	а	Total premiums or subscription charges paid to car	rier				10a		16030295
	b	If the carrier, service, or other organization incurred	d any specific costs in o	connection	n with	n the acquisition or			
		retention of the contract or policy, other than report					10b		
	Spe	pecify nature of costs.							
Pa	art l	IV Provision of Information							
11	Dic	old the insurance company fail to provide any informat	ion necessary to comp	lete Sche	<u>dule</u>	A?	Yes	X No	
12	If t	the answer to line 11 is "Yes," specify the information	n not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

OMB No. 1210-0110

2021

,			ERISA section 103(a)(2)		uion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	21 or fiscal pla	an year beginning 01/01/2021		and e	nding 12/3	1/2021	
A Name of plan LOCKHEED MARTIN GR	ROUP BENEFI	TS PLAN			ee-digit n number (PN	l) <b>•</b>	594
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	oyer Identifica	ation Number	(EIN)
LOCKHEED MARTIN CO	RPORATION			52	-1893632		
		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		CE COMPANY					
	T	1	(e) Approximate nu	ımbor of	T	Policy or o	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	(g) To
59-0781901	60534	93714	10000	t year	01/01/2021		12/31/2021
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, I	orokers, and o	other persons in
	amount of com	nmissions paid		<b>(b)</b> T	otal amount o	of fees paid	
1335768 335768						335768	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commis	sions or fees	were paid	
BUCK GLOBAL, LLC			3OX 207640 LAS, TX 75320				
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	se		(e) Organization code
	1127555	335768	SUPPLEMENTAL COMP	PENSATIO	N		3
	(a) Name	and address of the agent, broke	er, or other person to who	m commis	sions or fees	were paid	
CONDUENT SECURITIES		450	LEXINGTON AVE, 4TH F V YORK, NY 10017			·	
(b) Amount of sales a	nd hase		ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	se		(e) Organization code
	208213						3

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part I			ale a surface as a surface of the su	46	
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	rt II	Welfare Benefit Contract Informa	ition					
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ng purposes if such cont	racts are expe	erience-rated as a un	it. Where co	ontracts cover in	
8	3ene	fit and contract type (check all applicable boxes)			<u> </u>	•	· · · · · · · · · · · · · · · · · · ·	
	а	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		d ☐ Life insur	ance
						nloven ont		
,	e		f Long-term disabilit	- <u>-</u>	Supplemental unem	ipioymeni	h Prescript	_
	' <u> </u>	Stop loss (large deductible)	j HMO contract	K _	PPO contract		I X Indemnity	/ contract
	m _	Other (specify)						
		rience-rated contracts:		2 (1)				
•		remiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res		9a(3)		00(4)		0
	_ `	(4) Earned ((1) + (2) - (3))		9b(1)		9a(4)		0
		Benefit charges (1) Claims paid(2) Increase (decrease) in claim reserves		9b(1) 9b(2)				
	,	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		0
		(4) Claims charged				9b(4)		
	,	Remainder of premium: (1) Retention charges (or				0.5(1)		
		(A) Commissions	•	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	)	0
	(	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d :	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
	(	(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2).	.)	9e		
10		nexperience-rated contracts:	arriar			100		6660224
	_	Total premiums or subscription charges paid to co				10a		6660331
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo				10b		
;		cify nature of costs.	inted in Fait 1, iiile 2 abov	c, report amo	, di it	100		
Pa	rt I\	V Provision of Information						
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No	
12	If th	e answer to line 11 is "Yes," specify the information	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public

		paroualit to	=:::e::::e::::::::::::::::::::::::::::	•		ilispection
For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	594
					, ,	
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Nur	nber (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632	
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage, Fees.	and Con	nmissions Provide	e information for each contract
		. Individual contracts grouped a				
<u> </u>		Ŭ i				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
` ,		MDANIXLIOA				
JOHN HANCOCK LIFE IN	SURANCE CO	MPANY USA				
			(e) Approximate nu	ımber of	Policy	y or contract year
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	persons covered a			
` '	code	identification number	policy or contract	t year	(f) From	<b>(g)</b> To
01-0233346	65838	28260	5237		01/01/2021	12/31/2021
01-0200040	00000	20200	3237		01/01/2021	12/31/2021
2 Incurance fee and com	mission inform	ation. Enter the total fees and to	tal commissions paid. Li	ict in line 3	the agents brokers	and other persons in
descending order of the		ation. Enter the total lees and to	ital commissions paid. Li	13t III III IC 3	the agents, brokers, a	and other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
(b) Total amount of commissions paid						
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all	persons).		
	(a) Name a	and address of the agent, broker	or other person to whor	n commiss	ions or fees were pai	 d
	. ,	, , , , , , , , , , , , , , , , , , ,	,		'	
		Γ.	and other commission	aa naid		
(b) Amount of sales ar			es and other commission			<del></del>
commissions pai	d	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name -				: <b>f</b>	۵
	(a) Name a	and address of the agent, broker	r, or other person to whor	n commiss	sions or rees were par	<u>a</u>
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code
				. ,		(-, - )

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part I			ale a surface as a surface of the su	46	
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pa	art I	Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individua	oup of employees of the g purposes if such cont	racts are e	хре	rience-rated as a unit	. Where co	ontracts cover in	zations(s), idividual
8	Bene	efit and contract type (check all applicable boxes)				·	•	· · · · · · · · · · · · · · · · · · ·	
	аГ	_	<b>b</b> Dental	c	П	Vision		<b>d</b> Life insur	ance
	-				_				
	e	_ ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	f Long-term disabili	_	_	Supplemental unemp	oloyment	h Prescript	
	i _	Stop loss (large deductible)	HMO contract	k		PPO contract		I Indemnit	y contract
	m 🛚	Other (specify) LONG TERM CARE							
9 E	xpe	erience-rated contracts:							
	a P	Premiums: (1) Amount received		9a(1)					
	(	(2) Increase (decrease) in amount due but unpaid.		9a(2)					
	(	(3) Increase (decrease) in unearned premium rese	rve	9a(3)			T		
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
	(	(2) Increase (decrease) in claim reserves		9b(2)			T		
	(	(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)						
		(A) Commissions		9c(1)(A)					
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)	_				
		(D) Other expenses		9c(1)(D)	_				
		(E) Taxes		9c(1)(E)	_				
		(F) Charges for risks or other contingencies			_				
		(G) Other retention charges		9c(1)(G)	)		T		
		(H) Total retention		····· <u>-</u>			9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These a	amounts were 📗 paid in	cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits aft	ter i	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line 9c(	<b>(2)</b> .)	)	9e		
10	Nor	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to ca	rrier				10a		7634802
	b	If the carrier, service, or other organization incurre	d any specific costs in c	onnection v	with	the acquisition or			
	_	retention of the contract or policy, other than repor	ted in Part I, line 2 abov	e, report ar	moı	unt	10b		
	Spec	cify nature of costs.							
Pa	rt l'	V Provision of Information							
<u>1</u> 1	Did	the insurance company fail to provide any informa	tion necessary to compl	ete Sched	ule .	A?	Yes	X No	
		ne answer to line 11 is "Yes," specify the information							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2021

This Form is Open to Public

		parouarit to	Ξ. (α) (Ξ)	•			inspection	
For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021	T	and en	nding 12/31/2021			
A Name of plan				<b>B</b> Thre	e-digit	ļ		
LOCKHEED MARTIN GR	OUP BENEFI	TS PLAN		plan	number (PN)	•	594	
				·	, ,			
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification No	umber (	EIN)	
LOCKHEED MARTIN CO					1893632	,	,	
Part I Informat	ion Concer	ning Insurance Contrac	t Coverage Fees	and Con	nmissions Provi	de infor	mation for each contract	
		. Individual contracts grouped a						
		g			,		<u></u>	
1 Coverage Information:								
(a) Name of insurance ca	rrior							
` ,								
METROPOLITAN LIFE INS	SURANCE CO	MPANY						
			(a) Approximate pu	mbor of	Poli	cv or cc	ontract year	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			cy or co	•	
(b) Liiv	code	identification number	policy or contract		(f) From	ļ	<b>(g)</b> To	
40.5504000	05070	05540		. <i>y</i> = =	04/04/0004		40/04/0004	
13-5581829	65978	35512	1126		01/01/2021	ļ	12/31/2021	
2					4			
		ation. Enter the total fees and to	ital commissions paid. Li	st in line 3	the agents, brokers	, and ot	ner persons in	
	descending order of the amount paid.							
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and fo	ees. (Complete as many entries	s as needed to report all I	nersons)				
3 Tersons receiving com		1			·	-1-1		
	(a) Name a	and address of the agent, broker	r, or other person to whor	n commiss	sions or rees were pa	aid		
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpos	е	ļ	(e) Organization code	
•		•					, , ,	
						ļ		
						ļ		
	(a) Name a	and address of the agent, broker	r, or other person to whor	n commiss	sions or fees were pa	aid		
	Fees and other commissions paid							
(b) Amount of sales ar								
commissions pai	d	(c) Amount		(d) Purpos	e		(e) Organization code	
						ļ		
						ļ		

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(In) Assessment of a standard the second		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			COGC
			•
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Francisco de alban accomplication (1)	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	<u> </u>		1
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(-) No.			
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions naid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part I			ale a surface as a surface of the state of t	46	
		Where individual contracts are provided, the entire group of such individual this report.	iqual contracts with ea	on carrier may be treated as a un	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
_		racts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-	nnection with the acqui	sition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate ac	counts)	
	а	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pá	art	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of thing purposes if such con	tracts are e	expe	rience-rated as a un	it. Where co	ntracts cover i	
8	Ren	enefit and contract type (check all applicable boxes)							
	a 「		<b>b</b> Dental		· 🗆	Vision		d ☐ Life insu	ırance
	L		<b>=</b>		느				
	e [	Temporary disability (accident and sickness)	f Long-term disabili	•	_	Supplemental unem	ipioyment	h Prescrip	_
	1	Stop loss (large deductible)	j   HMO contract		(	PPO contract		I Indemni	y contract
	m	Other (specify) LONG TERM CARE							
								_	
9 1	Ехре	perience-rated contracts:							
	a I	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid							
		(3) Increase (decrease) in unearned premium res					0-(4)		
	L	(4) Earned ((1) + (2) - (3))			·····		9a(4)		0
	b	3 ( ) 1		/->				_	
		(2) Increase (decrease) in claim reserves					01- (0)		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
	_	(4) Claims charged					9b(4)		
	С	1 ( )		00/1)//	<b>\</b>			_	
		(A) Commissions		9c(1)(A 9c(1)(B					
		(B) Administrative service or other fees (C) Other specific acquisition costs		9c(1)(C					
		(D) Other expenses		9c(1)(D	_			_	
		(E) Taxes		9c(1)(E	-			_	
		(F) Charges for risks or other contingencies .		a (4)(=					
		(G) Other retention charges		A (4)(A					
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These	_		_		9c(2)		
	d			,			9d(1)		
	u	(2) Claim reserves	•				9d(2)		
		(3) Other reserves					9d(3)		
	е						9e		
10		lonexperience-rated contracts:			` , ,	,			
			arrier				10a		1132879
	b	If the carrier, service, or other organization incur	ed any specific costs in o	connection	with	the acquisition or			
	-	retention of the contract or policy, other than repo					10b		
	Spe	pecify nature of costs.							
Pa	art l	IV Provision of Information							
11	Dic	Did the insurance company fail to provide any inform	ation necessary to comp	lete Sched	lule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the informati							
		and an arrange to mile in its root, opening the information							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2021

This Form is Open to Public

pursuant to ERISA section 103(a)(2).							
For calendar plan year 202	21 or fiscal plar	n year beginning 01/01/2021		and en	ding 12/3	1/2021	
A Name of plan				<b>B</b> Three-digit			
LOCKHEED MARTIN GR	ROUP BENEFIT	TS PLAN		plan	number (PI	1) 🕨	594
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		ning Insurance Contract  Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		DF WASHINGTON					
	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
91-0511770	95672	1924400	66		01/01/202	1	12/31/2021
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	tal amount	of fees paid	
		2005					0
3 Persons receiving com		ees. (Complete as many entries					
		and address of the agent, broker,	or other person to whom	n commiss	ions or fees	were paid	
CONDUENT SECURITIES	s, LLC		XINGTON AVE, 4TH FL ORK, NY 10017	OOR			
(b) Amount of sales ar	nd hase	Fee	s and other commission	s paid			
commissions pa		(c) Amount	(0	d) Purpose	Э		(e) Organization code
	2005						3
	(a) Name a	and address of the agent, broker,	or other person to whom	n commiss	ions or fees	were paid	
	, ,					·	
(b) Amount of sales ar	nd hase	Fee	s and other commission	s paid			
commissions pa		(c) Amount	(	d) Purpose	= <u></u>		(e) Organization code
			,	•			

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	<u> </u>		1		
(In) Assessment of a standard the second		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commissions paid			COGC		
			•		
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
		Francisco de alban accomplication (1)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
•					
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid			
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid			
		Fees and other commissions paid			
(b) Amount of sales and base			(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	<u> </u>		1		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(-) No.					
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Face and other commissions naid	(0)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	octs with each carrier may	y be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
		openity hatare or cooks				
	_	T ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan.	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts mai				
•						
	а	,,,, =	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

**7**f

0

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

P	art III Welfare Benefit Contract Informat	ion					
•	If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s),						
	the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual					idual	
	employees, the entire group of such individua	I contracts with each ca	arrier may be	treated as a unit for p	ourposes of th	is report.	
8	Benefit and contract type (check all applicable boxes)						
	a Health (other than dental or vision)	Dental	С	Vision		d Life insurance	e
		Long-term disabili	_	Supplemental unem	nplovment	h Prescription	drua
		X HMO contract		PPO contract	ipioyiiioii	I  Indemnity co	-
		HINO CONTIACT	N.	] PPO contract		■ Indemnity co	IIIIaci
	m ☐ Other (specify)						
9	Experience-rated contracts:						
	a Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid.		9a(2)				
	(3) Increase (decrease) in unearned premium rese	ve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		0
	<b>b</b> Benefit charges (1) Claims paid		9b(1)				
	(2) Increase (decrease) in claim reserves		9b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)		0
	(4) Claims charged				9b(4)		
	c Remainder of premium: (1) Retention charges (on						
	(A) Commissions	,	9c(1)(A)			_	
	(B) Administrative service or other fees		9c(1)(B)				
	(C) Other specific acquisition costs		9c(1)(C)				
	(D) Other expenses		9c(1)(D)			_	
	(E) Taxes		9c(1)(E)				
	(F) Charges for risks or other contingencies						
	(G) Other retention charges						
	(H) Total retention				9c(1)(H)		0
	` '						
	(2) Dividends or retroactive rate refunds. (These a						
	<b>d</b> Status of policyholder reserves at end of year: (1)	•			9d(1)		
	(2) Claim reserves				9d(2)		
	(3) Other reserves				9d(3)		
	e Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c(2</b> )	<u>).)</u>	9e		
10	Nonexperience-rated contracts:						
	a Total premiums or subscription charges paid to cal	rier			10a		582890
	<b>b</b> If the carrier, service, or other organization incurred	d any specific costs in c	onnection wi	th the acquisition or			
	retention of the contract or policy, other than report	ed in Part I, line 2 abov	e, report am	ount	10b		
	Specify nature of costs.						
Р	ort IV Provision of Information						
	art IV Provision of Information				l v	7 Na	
	Did the insurance company fail to provide any informa		ete Schedule	e A?	Yes	No	
12	If the answer to line 11 is "Yes," specify the information	n not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2021

		pursuant to E	RISA section 103(a)(2)	).			Inspection	
For calendar plan year 20	21 or fiscal plar	n year beginning 01/01/2021		and en	nding 12/3	1/2021		
A Name of plan  LOCKHEED MARTIN GROUP BENEFITS PLAN					e-digit number (PI	N) •	594	
C Plan sponsor's name a		e 2a of Form 5500		-	oyer Identific -1893632	ation Number (	EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca	urrier							
4. FIN	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
20-4632340	00000	18447-0001-001	25280		01/01/202	1	12/31/2021	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid							
		283452					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid		
BUCK GLOBAL, LLC			X 207640 S, TX 75320					
(b) Amount of sales a	nd base	Fee	s and other commissio	ns paid				
commissions pa		(c) Amount	nount		(d) Purpose		(e) Organization code	
243345						3		
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid		
CONDUENT SERVICE, LI	_C		XINGTON AVE, 4TH F ORK, NY 10017	LOOR				
(b) Amount of sales a	nd base	Fee	s and other commissio	ns paid				
commissions pa				(d) Purpose			(e) Organization code	
	40107						3	
For Donomyork Doductio	n Act Notice	can the Instructions for Form F	500			Cohoo	Iula A (Farm FE00) 2024	

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	<u> </u>		1		
(In) Assessment of a standard the second		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commissions paid			COGC		
			•		
(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
		Francisco de alban accomplication (1)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
•					
(a) No.	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
(a) Ivai	The and address of the agent, broker	, or other person to whom commissions or rees were paid			
		Fees and other commissions paid			
(b) Amount of sales and base			(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	<u> </u>		1		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(-) No.					
(a) Nai	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Face and other commissions naid	(0)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

	_				
ı	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with cook corrier ma	v ha traatad	as a unit for numerous of
		this report.	ridual contracts with each camer ma	y be liealeu	as a unit for purposes or
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year $\epsilon$		5	
_		tracts With Allocated Funds:			
Ŭ	a	State the basis of premium rates			
	u	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
		•		6c	
	۲ C	Premiums due but unpaid at the end of the year		00	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount		6d	
		Specify nature of costs			
		Specify flattate of cools 7			
	•	Turn of contract. (4) \(\Pi\) in dividual policies \(\((\Pi\)\) \(\Pi\) are used of force	al manufact		
	е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	nating plan, check here		
7	Con	rracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)		
	а		ate participation guarantee		
	_				
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account	` '		
		(5) Other (specify below)	7c(5)		
		<b>)</b>			
		(6)Total additions		7c(6)	0
	Ч	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	
		Deductions:		70	
	C		7e(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	7e(2) 7e(3)		
		(3) Transferred to separate account			
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )		7f	0

P	art	Welfare Benefit Contract Information If more than one contract covers the same group of employ the information may be combined for reporting purposes if employees, the entire group of such individual contracts wi	uch contracts are experience-rated as a unit	t. Where conf	tracts cover individual
8	Ben	enefit and contract type (check all applicable boxes)			
	а	Health (other than dental or vision) <b>b</b> Dental	<b>c</b> Vision	C	Life insurance
	е	Temporary disability (accident and sickness) <b>f</b> Long-ter	n disability <b>g</b> Supplemental unemp	ployment <b>r</b>	Prescription drug
	iΓ	Stop loss (large deductible) j HMO co	- <u>-</u>		Indemnity contract
	m [			•	
	[	Other (specify) F LEGAL			
9	=xne	perience-rated contracts:			
_	•	Premiums: (1) Amount received	9a(1)		
		(2) Increase (decrease) in amount due but unpaid			
		(3) Increase (decrease) in unearned premium reserve	· · ·		
		(4) Earned ((1) + (2) - (3))		9a(4)	0
	b			1 Ja(+)	•
		(2) Increase (decrease) in claim reserves		0b/3)	0
		(3) Incurred claims (add (1) and (2))		9b(3)	U
	_	(4) Claims charged(4) Paterties the second control to		9b(4)	
	С	. , , , , , , , , , , , , , , , , , , ,			
		(A) Commissions	` ' ' '		
		(B) Administrative service or other fees	0. (4)(0)		
		(C) Other specific acquisition costs			
		(D) Other expenses	0-(4)(5)		
		(E) Taxes	0 (4)(=)		
		(F) Charges for risks or other contingencies			
		(G) Other retention charges			
		(H) Total retention	_	9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, or credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held t	provide benefits after retirement	9d(1)	
		(2) Claim reserves		9d(2)	
		(3) Other reserves		9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not include amou	t entered in line <b>9c(2)</b> .)	9e	
10	No	Nonexperience-rated contracts:			
	а	Total premiums or subscription charges paid to carrier		10a	2549178
	b	If the carrier, service, or other organization incurred any specific	osts in connection with the acquisition or		
	-	retention of the contract or policy, other than reported in Part I, li		10b	
	Spe	pecify nature of costs.			
P	art i	t IV Provision of Information			
				Voc V	l No
		Did the insurance company fail to provide any information necessar		Yes X	No
12	If t	f the answer to line 11 is "Yes," specify the information not provided	<b>&gt;</b>		