Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Report Identification Information For calendar plan year 2021 or fiscal plan year beginning 01/01/2021

Part I

SIGN **HERE**

Signature of DFE

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

12/31/2021

Enter name of individual signing as DFE

and ending

A This	return/report is for:	a multiemployer plan		lloyer plan (Filers checking this t mployer information in accordan		nns)
		x a single-employer plan	a DFE (specify	• •	oc with the form mondone	110.)
B This	return/report is:	the first return/report	the final return	/report		
	rotarri, roport io.	an amended return/report	a short plan ye	ear return/report (less than 12 mo	onths)	
C If the	plan is a collectively-barga	ained plan, check here	—		×	
D Chec	k box if filing under:	X Form 5558	automatic exte	nsion	the DFVC program	
		special extension (enter description	n)			
E If this	is a retroactively adopted	plan permitted by SECURE Act section	201, check here			
Part II	Basic Plan Inforr	nation —enter all requested information	on			1
	ne of plan	ATION OBOUR INQUES AND EDIAN EO	D EMBI 0VEE0 0E	TRANSFERDED OF ODG IN	1b Three-digit plan number (PN) ▶	512
	ARGAINING UNIT	ATION GROUP INSURANCE PLAN FO	R EMPLOYEES OF	TRANSFERRED GE OPS IN	1c Effective date of pla 01/01/1995	an
Mail City	n sponsor's name (employe ing address (include room or town, state or province,	2b Employer Identification Number (EIN) 52-1893632				
LOCKH	EED MARTIN CORPORA	TION			2c Plan Sponsor's telephone number 863-647-0370	
	OCKLEDGE DRIVE, CCT- SDA, MD 20817	-115			2d Business code (see instructions) 339900	
Caution	: A penalty for the late or	r incomplete filing of this return/repor	rt will be assessed	unless reasonable cause is es	stablished.	
		er penalties set forth in the instructions, ell as the electronic version of this return				
SIGN	Filed with outboring disciplination	d alastronia signatura	40/42/2022	DODEDT MUENINGLIGEE		
HERE	Filed with authorized/valid		10/12/2022	ROBERT MUENINGHOFF		
	Signature of plan admi	nistrator	Date	Enter name of individual signi	ng as pian administrator	
SIGN						
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 3329 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). 3329 a(1) Total number of active participants at the beginning of the plan year...... 6a(1) 3408 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 3408 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

13 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

		pursuant to	ERISA section 103(a)(2)				Inspection
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021				and en	ding 12/3	1/2021	
		GROUP INSURANCE PLAN F	OR EMPLOYEES OF	B Three plan	e-digit number (PN	N) •	512
TRANSFERRED GE OP:	S IN THE BAR	GAINING UNIT					
C Plan sponsor's name a LOCKHEED MARTIN CO		e 2a of Form 5500		· ·	yer Identific 1893632	ation Number (EIN)
		rning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		TH AMERICA					
	(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	(g) To
23-1503749	65498	LK 008348	1740		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	(a) Total amount of commissions paid (b) Total amount of fees paid						
	1847 0						
3 Persons receiving com	missions and f	ees. (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	ions or fees	were paid	
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE CAGO, IL 60674				
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	Э		(e) Organization code
	1847						3
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	Э		(e) Organization code

(a) 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
(a) 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.	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		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 7b and 7c(6))		/ 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)		
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		7			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

F	Part I	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	xpe	rience-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 Dental	С	: 🗌	Vision		d 🗌 Lif	fe insurance
	е	Temporary disability (accident and sickness)	f X Long-term disabilit	у д	ıΠ	Supplemental unemp	olovment	h ☐ Pr	escription drug
	i	Stop loss (large deductible)	j HMO contract	, s k		PPO contract	,	_ =	demnity contract
	. L	<u>-</u>	, I illino contidot		`Ш	1 1 0 contract		• 🗆	zonnity contract
	m	Other (specify)							
9	Evno	erience-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)		<u> </u>
	_	(4) Earned ((1) + (2) - (3))		9b(1)	······		9a(4)		
	b	Benefit charges (1) Claims paid			_				
		(2) Increase (decrease) in claim reserves(3) Incurred claims (add (1) and (2))					0h/2\		0
		(4) Claims charged					9b(3) 9b(4)		
	С	Remainder of premium: (1) Retention charges (or		•••••			35(4)		
	C	(A) Commissions	,	9c(1)(A)	. T				
		(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))	C
		(2) Dividends or retroactive rate refunds. (These	_	_	_		9c(2)		-
	d	Status of policyholder reserves at end of year: (1)		L			9d(1)		
	ű	(2) Claim reserves	•				9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no					9e		
10	_	nexperience-rated contracts:			<u>(-,-,</u>				
		Total premiums or subscription charges paid to ca	arrier				10a		610072
	b	If the carrier, service, or other organization incurre							-
		retention of the contract or policy, other than repo	, .			•	10b		
	Spe	cify nature of costs.							
P	Part I	V Provision of Information							
	_		ation noncessarity and	oto Califa	مان	лэ П	Yes	X No	
		I the insurance company fail to provide any informa		ete Schedi	ule	A (100	A INU	
14	∠ it th	ne 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

For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021			and en	ding 12/31/2021	
A Name of plan					B Three	e-digit	
		GROUP INSURANCE PLAN F	FOR E	EMPLOYEES OF	plan	number (PN)	512
TRANSFERRED GE OP	S IN THE BAR	GAINING UNIT					
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500			D Emplo	yer Identification Number	er (EIN)
LOCKHEED MARTIN CO	RPORATION				-	1893632	
		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:		Ţ,				J	
(a) Name of insurance ca	rrior						
LIFE INSURANCE COMP		TH AMEDICA					
Ell E IIVOOTATIVOE OOMI 7	ANT OF NOR	TTAMERIOA					
41 EIN	(c) NAIC	(d) Contract or		(e) Approximate nu		Policy or	contract year
(b) EIN	code	identification number		persons covered a policy or contrac		(f) From	(g) To
23-1503749	65498	LK 008358		36		01/01/2021	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	total c	commissions paid. Li	ist in line 3	the agents, brokers, and	I other persons in
<u> </u>	amount of com	missions paid			(b) To	otal amount of fees paid	
, ,						•	
3 Persons receiving com	missions and f	fees. (Complete as many entri	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) Amount of sales ar	nd base	Ę	ees a	and other commission	ns paid		
commissions pa		(c) Amount			(d) Purpose	е	(e) Organization code
	(a) Name	and address of the agent, broke	or or	other person to who	m commiss	ions or fees were naid	
	(a) Name	and address of the agent, broke	ei, oi	other person to who	II COITIITIISS	ions of fees were paid	
(b) Amount of sales ar	nd base	F	ees a	and other commission	ns paid		
commissions pa		(c) Amount			(d) Purpose	е	(e) Organization code
			1				İ

(a) 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
(a) 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		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 7b and 7c(6))		/ 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)		
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		7			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

	lort III	Welfare Benefit Contract Informa	ation						_
r	Part 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-ra	ated as a unit	t. Where co	entracts cover individual	
8	Benefit a	nd contract type (check all applicable boxes)				<u> </u>		<u> </u>	_
Ū	_	ealth (other than dental or vision)	b Dental	c	Vision			d ☐ Life insurance	
			<u> </u>					빌	
	=	mporary disability (accident and sickness)	f ∐ Long-term disabili			mental unem	pioyment	h Prescription drug	
		op loss (large deductible)	j HMO contract	K	PPO co	ontract		I Indemnity contract	
	m Ot	her (specify)							
									_
9	•	ce-rated contracts:		Г					
		iums: (1) Amount received		9a(1)					
		ncrease (decrease) in amount due but unpaid		9a(2)					
		ncrease (decrease) in unearned premium res		9a(3)			0-(4)		_
		arned ((1) + (2) - (3))			·····		9a(4)		0
		efit charges (1) Claims paid		(-)					
	` '	ncrease (decrease) in claim reserves ncurred claims (add (1) and (2))					0h/3\		0
							9b(3) 9b(4)		
	` ,	Claims charged					30(4)		
		(A) Commissions		9c(1)(A	١ .				
		(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 ir	cash, or	credited.)		9c(2)		
	d Stat	us of policyholder reserves at end of year: (1) Amount held to provide	benefits af	- ter retireme	nt	9d(1)		
	(2) (Claim reserves					9d(2)		
	(3) (Other reserves					9d(3)		
	e Divid	dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c	(2) .)		9e		
10	Nonexp	erience-rated contracts:							
	a Tota	al premiums or subscription charges paid to c	arrier				10a	107	85
	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep					10b		
	,	eature of costs.							
Р	art IV	Provision of Information							_
11	Did the	insurance company fail to provide any inform	nation necessary to comp	lete Sched	ule A?	П	Yes	X No	
		nswer to line 11 is "Yes," specify the informat				•			

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 LOCKHEED MARTIN CORPORATION GROUP INSURANCE PLAN F TRANSFERRED GE OPS IN THE BARGAINING UNIT				e-digit number (PN	N) •	512
TRANSPERRED GE OF	S IN THE BAI	RGAINING ONLI					
C Plan sponsor's name a	as shown on li	ne 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)
LOCKHEED MARTIN CO	RPORATION	I		52-	1893632		
		erning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							_
(a) Name of insurance ca		OF AMERICA					
	(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	(g) To
22-1211670	68241	43406-2	4126		01/01/2021	1	12/31/2021
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total	amount of cor	nmissions paid		(b) To	tal amount	of fees paid	
		542					0
3 Persons receiving com		fees. (Complete as many entrie					
		and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BEN	IEFITS 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
	542						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
		•					
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code

(a) 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
(a) 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 7b and 7c(6))			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	rt III Welfare Benefit Contract Informati	on				
ı a	If more than one contract covers the same gro		e same empl	over(s) or members of	the same er	nplovee organizations(s).
	the information may be combined for reporting					
	employees, the entire group of such individual	contracts with each ca	arrier may be	treated as a unit for pu	irposes of th	nis report.
8 B	Benefit and contract type (check all applicable boxes)					
		Dental	сГ	Vision		d X Life insurance
e		Long-term disabilit	_	Supplemental unemp		h ☐ Prescription drug
		=			Dioyineni	
I		HMO contract	K	PPO contract		I Indemnity contract
r	m ☐ Other (specify) ▶					
	experience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid		9a(2)			
	(3) Increase (decrease) in unearned premium reserv	/e	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)	
	C Remainder of premium: (1) Retention charges (on a	n 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					
	(G) Other retention charges					
	(H) Total retention	•			9c(1)(H)	0
	,					
	(2) Dividends or retroactive rate refunds. (These ar				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 i	nclude amount entered	d in line 9c(2)) .)	9e	
10	Nonexperience-rated contracts:					
•	a Total premiums or subscription charges paid to carr	ier			10a	315144
	b If the carrier, service, or other organization incurred	any specific costs in c	onnection wi	th the acquisition or		
,	retention of the contract or policy, other than reporte	ed in Part I, line 2 abov	e, report am	ount	10b	
٥	Specify nature of costs.					
Pa	rt IV Provision of Information					
	Did the insurance company fail to provide any informati	on necessary to compl	ete Schedule	e A?	Yes	X No
	If the answer to line 11 is "Yes," specify the information		Jonioudit			

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 $103(a)(2)$	١.			Inspection
For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/3	1/2021	
A Name of plan LOCKHEED MARTIN CO TRANSFERRED GE OP		GROUP INSURANCE PLAN F	OR EMPLOYEES OF		e-digit number (PI	N) •	512
TRANSFERRED GE OP	S IN THE BAR	GAINING UNIT					
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		rning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
22-1211670	68241	0023747-1	3136		01/01/202	1	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,	brokers, and o	ther persons in
(a) Total	amount of com	missions paid		(b) To	otal amount	of fees paid	
		1498					0
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	ions or fees	were paid	
MERCER HEALTH & BEN	IEFITS LLC		PAYSPHERE CIRCLE CAGO, IL 60674				
(b) Amount of sales a	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	1498						3
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
			·			·	
(b) Amount of sales a	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

(a) 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
(a) 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 7b and 7c(6))			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

_		Material Description of the Contract of t				
P	art	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 continuous employees, the entire group of such individual contracts with each care.	racts are e	experience-rated a	as a unit. Where cor	tracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)				
	а	Health (other than dental or vision) b Dental	c	Vision		Life insurance
				=		
	e	Temporary disability (accident and sickness) f Long-term disabilit				Prescription drug
	i	Stop loss (large deductible) j HMO contract	k	PPO contrac	t	I Indemnity contract
	m	Other (specify)				
	L					
9	Ехре	perience-rated contracts:				
	a i	Premiums: (1) Amount received	9a(1)		796800	
		(2) Increase (decrease) in amount due but unpaid	9a(2)		205105	
		(3) Increase (decrease) in unearned premium reserve	9a(3)			
		(4) Earned ((1) + (2) - (3))			9a(4)	1001905
	b		9b(1)		988073	
		(2) Increase (decrease) in claim reserves			45263	
		(3) Incurred claims (add (1) and (2))				1033336
		(4) Claims charged				1,00000
	С					
	C	(A) Commissions	9c(1)(A	1		
		` '	9c(1)(B	•		
		(B) Administrative service or other fees	9c(1)(C			
		(C) Other specific acquisition costs	9c(1)(D		64640	
		(D) Other expenses	9c(1)(E	•	-64610	
		(E) Taxes			28143	
		(F) Charges for risks or other contingencies	9c(1)(F)		5036	
		(G) Other retention charges		· ·	0.(4)(1)	04404
		(H) Total retention	-	_		-31431
		(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 af	fter retirement	9d(1)	
		(2) Claim reserves			9d(2)	200529
		(3) Other reserves			9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not include amount entered	l in line 9c	(2) .)	9е	
10	No	lonexperience-rated contracts:				
	а	Total premiums or subscription charges paid to carrier			10a	
	b	If the carrier, service, or other organization incurred any specific costs in co	onnection	with the acquisition	on or	
		retention of the contract or policy, other than reported in Part I, line 2 above			10b	
	Spe	ecify nature of costs.	-, торото			1
	•	•				
P	art l	IV Provision of Information				
					☐ Yes	No
11		id the insurance company fail to provide any information necessary to compl	ete Sched	lule A?	r es)	No
12	! If t	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)	١.			Inspection
For calendar plan year 202	21 or fiscal pl	an year beginning 01/01/2021		and en	ding 12/3	31/2021	
A Name of plan				B Thre	e-digit		
		N GROUP INSURANCE PLAN FO	OR EMPLOYEES OF	R EMPLOYEES OF plan number (PN)			512
TRANSFERRED GE OPS	S IN THE BAI	RGAINING UNIT		·	,	,	
C Plan sponsor's name a	s shown on li	ine 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)
LOCKHEED MARTIN CO				-	1893632	·	·
		erning Insurance Contract A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		OF AMERICA					
	<u> </u>	<u> </u>	(a) Approximate p	umbor of	<u> </u>	Policy or co	entract year
(b) EIN	(c) NAIC		(e) Approximate no persons covered a			Policy or co	•
(2) 2	code	identification number	policy or contract		(f) From		(g) To
22-1211670 68241		0023749-1	286		01/01/202	1	12/31/2021
2 Insurance fee and complete descending order of the		mation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of cor	nmissions paid		(b) To	otal amount	of fees paid	
		134					0
3 Persons receiving com		fees. (Complete as many entries					
	(a) Name	and address of the agent, broker	, 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 color or	nd book	Fe	es and other commissio	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	134						3
	(=) NI=====	and address of the arrest broken					
	(a) Name	and address of the agent, broker	, or other person to who	m commiss	ions or tees	were paid	
(b) Amount of sales ar	nd hase	Fe	es and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code

(a) 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
(a) 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 7b and 7c(6))			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	rt III	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	ing purposes if such cont	racts are expe	erience-rated as a un	it. Where co	ontracts cover in	
8	Benef	it and contract type (check all applicable boxes)			<u> </u>	•	· · · · · · · · · · · · · · · · · · ·	
	а ∏	Health (other than dental or vision)	b Dental	с□	Vision		d X Life insu	rance
	⊢					nloven ont		
,	e ∐ . □	Temporary disability (accident and sickness)	f Long-term disabili	- <u>-</u>	Supplemental unem	ipioymeni	h Prescript	_
	' 빌	Stop loss (large deductible)	j HMO contract	K _	PPO contract		I Indemnit	y contract
	m 📙	Other (specify)						
							1	
		ence-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		9b(1) 9b(2)				
	•	2) Increase (decrease) in claim reserves				9b(3)		0
		4) Claims charged				9b(4)		
	,	Remainder of premium: (1) Retention charges (o				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				9c(2)		
	d s	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		experience-rated contracts:	orrior			100		00010
	_	Total premiums or subscription charges paid to c				10a		90010
		f the carrier, service, or other organization incurnetention of the contract or policy, other than repo				10b		
;		fy nature of costs.	onca iii i ait i, iiiic 2 abov	c, report amo	, di it	100	I	
Pa	rt IV	Provision of Information						
<u>1</u> 1	Did t	he insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No	
		e answer to line 11 is "Yes," specify the informati						

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 CO TRANSFERRED GE OPS		GROUP INSURANCE PLAN FO	OR EMPLOYEES OF	B Three	e-digit number (PN	N) •	512
TRANSPERRED GE OF	O IN THE DAN	GAINING ONT					
C Plan sponsor's name a	C Plan sponsor's name as shown on line 2a of Form 5500			D Emplo	yer Identific	ation Number (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		rning Insurance Contract A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca PRUDENTIAL INSURANC		OF AMERICA					
			Policy or co	ontract year			
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
22-1211670	68241	0023748-1	1706		01/01/202	1	12/31/2021
2 Insurance fee and compute descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid			of fees paid				
636 0				0			
3 Persons receiving com	missions and	fees. (Complete as many entries	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	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674				
(b) Amount of sales ar	nd base	Ęε	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code
	636						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 ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code

(a) 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
(a) 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				
		-				
	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 7b and 7c(6)).	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	Welfare Benefit Contract Information 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 employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.						
0	D ('		with each carrier ma	iy be	treated as a unit for p	urposes of t	ліѕ героп.
	_	fit and contract type (check all applicable boxes)			٦		1 El
	а	Health (other than dental or vision) b Denta	I	С	Vision		d X Life insurance
	е	Temporary disability (accident and sickness) f Long-t	term disability	g	Supplemental unem	ployment	h Prescription drug
	i 🗌	Stop loss (large deductible) j HMO	contract	k	PPO contract		I Indemnity contract
	m \square	Other (specify)		_	_		_
	Ш	(1 - 7)					
9 [Experi	ience-rated contracts:			-		
	a Pr	remiums: (1) Amount received	9a(1)		437128	
	(2	2) Increase (decrease) in amount due but unpaid					
		3) Increase (decrease) in unearned premium reserve		3)			
	(4	4) Earned ((1) + (2) - (3))				9a(4)	437128
	b B	Benefit charges (1) Claims paid	9b(1	1)		443875	
	(2	2) Increase (decrease) in claim reserves	9b(2	2)		-6019	
	(3	3) Incurred claims (add (1) and (2))				9b(3)	437856
	(4	4) Claims charged				9b(4)	
	C R	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					
		(D) Other expenses				10364	
		(E) Taxes				10919	
		(F) Charges for risks or other contingencies	0-/4)			5001	_
		(G) Other retention charges				0.747711	00004
		(H) Total retention	_	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These amounts we				9c(2)	43634
		Status of policyholder reserves at end of year: (1) Amount held	•			9d(1)	
	(2	2) Claim reserves				9d(2)	87596
	,	(3) Other reserves				9d(3)	194297
40		Dividends or retroactive rate refunds due. (Do not include am	ount entered in line	9c(2)	<u>).)</u>	9e	
10		experience-rated contracts:					
	a 1	Total premiums or subscription charges paid to carrier				10a	
		f the carrier, service, or other organization incurred any specif				401-	
		retention of the contract or policy, other than reported in Part I ify nature of costs.	, line 2 above, repor	t amo	ount	10b	
	Specii	Ty Halure of costs.					
_		Duandalan af lafaman (fan					
Pa	art IV	Provision of Information					
11	Did t	the insurance company fail to provide any information necess	ary to complete Sch	edule	e A?	Yes	X No
12	If the	e answer to line 11 is "Yes," specify the information not provid	ed. 🕨				

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 20)21 or fiscal pla	n year beginning 01/01/2021		and en	nding 12/31/202	1	
A Name of plan				B Thre	e-digit		
LOCKHEED MARTIN CO TRANSFERRED GE OP		GROUP INSURANCE PLAN F	OR EMPLOYEES OF	plan	number (PN)	•	512
TRANSFERRED GE OF	3 IN THE BAK	GAINING UNIT					
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		D Emplo	yer Identification I	Number	(EIN)
LOCKHEED MARTIN CO				-	1893632		,
			_				
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:		a.r.aaa. ooaaa g.oapoa			portou on a omg.o	00.1000	
<u> </u>							
(a) Name of insurance ca		VODY					
CIGNA LIFE INSURANCE	CO. OF NEW	YORK					
	(c) NAIC	(d) Contract or	(e) Approximate n		Po	olicy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f) From	ı	(g) To
13-2556568	64548	NYD074268	604		01/01/2021		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) 10tai	amount of com	missions paid		(b) 10	otal amount of fees	s paiu	
3 Persons receiving com	nmissions and f	ees. (Complete as many entrie	s as needed to report all	nersons)			
T STOCKE TOOSIVING CON		and address of the agent, broke			sions or fees were	paid	
	. ,	<u> </u>					
(1) A		F	ees and other commissio	ns naid			
(b) Amount of sales a commissions page		(c) Amount		(d) Purpose			(e) Organization code
		, ,		` ' '			
	(a) Name a	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 hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code

(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	<u> </u>		(e)			
Fees and other commissions paid						
(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	(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			
(a) 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	(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				
		-				
	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 7b and 7c(6)).	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 III Welfare Benefit Contract Informati	on				
•	If more than one contract covers the same gro		e same empl	oyer(s) or members of	the same em	ployee organizations(s),
	the information may be combined for reporting					
	employees, the entire group of such individua	I contracts with each ca	arrier may be	treated as a unit for pu	irposes of th	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 a [Supplemental unemp	olovment I	n Prescription drug
	i Stop loss (large deductible)	HMO contract		PPO contract		I Indemnity contract
		T IIVIO GOTILIAGE	[I I Indemnity contract
	m ☐ Other (specify) ▶					
ο .	Consider a set of contracts.					
	Experience-rated contracts:		0-(4)			
	a 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)		00(4)	0
	(4) Earned ((1) + (2) - (3))				9a(4)	0
	b Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves				05/2)	0
	(3) Incurred claims (add (1) and (2))				9b(3)	0
	(4) Claims charged				9b(4)	
	C Remainder of premium: (1) Retention charges (on a	•	0=/4\/A\	T		
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			-
	(C) Other specific acquisition costs		9c(1)(D)			
	(D) Other expenses		9c(1)(E)			
	(E) Charges for sixty and the continuous					
	(F) Charges for risks or other contingencies					
	(G) Other retention charges				0c/1\/U\	0
	(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)	
40	e Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line 9c(2)) .)	9e	
10	Nonexperience-rated contracts:				- 40	
	a Total premiums or subscription charges paid to car				10a	136563
	b If the carrier, service, or other organization incurred	l any specific costs in c	onnection wi	th the acquisition or	10h	
	retention of the contract or policy, other than report Specify nature of costs.	ed in Part I, line 2 abov	e, report am	ount	10b	
	openity flatters of cools.					
_	Provision of laterase Con					
Pa	art IV Provision of Information					
	Did the insurance company fail to provide any informat		ete Schedule	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

This Form is Open to Public

		· ·	, , ,				шереенен
For calendar plan year 20	21 or fiscal plar	n year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan				B Thre	e-digit		
		GROUP INSURANCE PLAN F	OR EMPLOYEES OF		number (PN)	•	512
TRANSFERRED GE OP	S IN THE BAR	GAINING UNIT			,		
C Plan sponsor's name a	as shown on line	e 2a of Form 5500		D Emplo	oyer Identification N	lumber	(EIN)
LOCKHEED MARTIN CO	DRPORATION			52-	-1893632		
		ning Insurance Contra Individual contracts grouped					
1 Coverage Information:							_
(a) Name of insurance ca	arrier						
HAWAII MEDICAL SERVI	CE ASSOCIATI	ION					
	T				T		
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		Pol	icy or co	ontract year
(b) LIN	code	identification number	policy or contract		(f) From		(g) To
99-0040115	49948	C952	1	,	01/01/2021		12/31/2021
0							
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, brokers	s, and o	ther persons in
(a) Total	amount of comr	missions paid		(b) To	otal amount of fees	paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	es as needed to report all	nersons)			
T crooms receiving cent		and address of the agent, broke			cione or fees were n	aid	
	(a) Name a	ind address of the agent, broke	or, or other person to who	TH COMMINIS	sions of ices were p	Jaid	
43.4		F	ees and other commissio	ns naid			
(b) Amount of sales a commissions pa		(c) Amount	ces and other commission	(d) Purpos	Δ		(e) Organization code
Commissions pa	liu	(c) Amount		(d) i dipos	<u> </u>		(c) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were p	paid	
	ı						
(b) Amount of sales a	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
	<u> </u>		(e)			
Fees and other commissions paid						
(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	(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			
(a) 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	(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	(1) = 1, 1 1 1 1 1 1 1 1 1	te participa	tion 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)		1.0	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 7b and 7c(6)).	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 I	If more than one contract covers the same gro the information may be combined for reporting	up of employees of the purposes if such cont	racts are ex	xper	ience-rated as a unit	. Where co	ntracts cover in	ations(s), dividual
0		employees, the entire group of such individual	contracts with each ca	amer may b	e u	eated as a unit for pu	rposes or t	nis report.	
		nefit and contract type (check all applicable boxes)	п	_	_			-1 D	
	a _	Health (other than dental or vision)	Dental		Ш	Vision		d Life insur	
	е	Temporary disability (accident and sickness) f	Long-term disabilit	ty g	Ш	Supplemental unemp	loyment	h Prescripti	on drug
	i [Stop loss (large deductible)	X HMO contract	k		PPO contract		I Indemnity	contract
	m	Other (specify)							
	<u>L</u>								
9 [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 reserv	re	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	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			_				
		(G) Other retention charges		9c(1)(G))				
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These an	nounts were paid in	cash, or	cr	edited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	mount 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 in	nclude amount entered	d in line 9c((2) .).		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carr	ier				10a		21343
	b	If the carrier, service, or other organization incurred	any specific costs in c	onnection v	with	the acquisition or			
		retention of the contract or policy, other than reporte					10b		
	Spec	ecify nature of costs.							
Pa	art l'	IV Provision of Information							
11	Did	d the insurance company fail to provide any information	on necessary to compl	ete Schedu	ıle A	٨?	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

		parouant to	=:	<i>/</i> -		mspection
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and en	nding 12/31/2021	
A Name of plan LOCKHEED MARTIN CO TRANSFERRED GE OP		GROUP INSURANCE PLAN FO GAINING UNIT	OR EMPLOYEES OF		e-digit number (PN)	512
C Plan sponsor's name a	ORPORATION			52-	oyer Identification Numbe 1893632	
		ning Insurance Contrac Individual contracts grouped a				
Coverage Information:	ato Corrodato / t	. marriada contracto groupou e	ao a ant mir arto ir ana i	11 0411 50 10	portou on a onigio conoc	
(a) Name of insurance ca	arrier					
/L) FINI	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f) From	(g) To
23-7089668	53031	30077627	2869		01/01/2021	12/31/2021
descending order of the	e amount paid. amount of communications and fe (a) Name a	ees. (Complete as many entries nd address of the agent, broker	s as needed to report all	(b) To	otal amount of fees paid	(e) Organization code
commissions pa	ild	(c) Amount		(u) Fuipos	.	(e) Organization code
	(a) Name a	nd address of the agent, broker	or other person to who	m commiss	sions or fees were paid	
	(4) (4)	address of the agont, broker	, s. sais, pardon to wife		Si 1000 Word Pulu	
(b) Amount of sales an commissions pa		(c) Amount	es and other commission	ons paid (d) Purpos	e	(e) Organization code
	l l					•

(a) 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
(a) 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.	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		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 7b and 7c(6))		/ 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)		
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		7			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	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	expe	rience-rated as a unit	. Where co	entracts cover individual
8	Renefit	t and contract type (check all applicable boxes)						
Ü	_	Health (other than dental or vision)	b Dental		~ <u>~</u>	Vision		d ☐ Life insurance
								블
	e ∐	Temporary disability (accident and sickness)	f Long-term disabili	-		Supplemental unemp	ployment	h Prescription drug
	i 📙	Stop loss (large deductible)	j HMO contract	ŀ	K 📗	PPO contract		I Indemnity contract
	m 🗌	Other (specify)						
9	Experie	ence-rated contracts:						
	a Pre	emiums: (1) Amount received		9a(1)				
	(2)) Increase (decrease) in amount due but unpaid	t					
	(3)) Increase (decrease) in unearned premium res	serve	9a(3)			1	
	- ') Earned ((1) + (2) - (3))					. 9a(4)	0
		enefit charges (1) Claims paid		(-)				
	` ') Increase (decrease) in claim reserves					01 (0)	
) Incurred claims (add (1) and (2))					9b(3)	0
	` ') Claims charged(1) Betastion aboves (9b(4)	
	C R	emainder of premium: (1) Retention charges (c		00/4)/4				
		(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 .		9c(1)(F				_
		(G) Other retention charges						_
		(H) Total retention					9c(1)(H)	0
	(2	2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	С	redited.)	9c(2)	
		tatus of policyholder reserves at end of year: (1	_				9d(1)	
		2) Claim reserves					9d(2)	
	`	B) Other reserves					9d(3)	
	e D	ividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c	(2) .))	9e	
10	None	experience-rated contracts:						
	a To	otal premiums or subscription charges paid to o	arrier				10a	395731
		the carrier, service, or other organization incure etention of the contract or policy, other than rep					10b	
		y nature of costs.		-, търът				-
_		Draviaian of Information						
	art IV	Provision of Information						
11	Did th	ne insurance company fail to provide any inform	nation necessary to comp	lete Sched	dule	A?	Yes	X No
12	If the	answer to line 11 is "Yes," specify the informat	ion 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	021 or fiscal pla	n year beginning 01/01/2021		and en	nding 12/31/2021		
A Name of plan				B Thre	e-digit		
LOCKHEED MARTIN C TRANSFERRED GE OF		GROUP INSURANCE PLAN F	OR EMPLOYEES OF	plan	number (PN)	•	512
TRANSFERRED GE OF	O IN THE DAK	GAINING ONLI					
C Plan sponsor's name	as shown on lin	e 2a of Form 5500		D Emplo	oyer Identification N	lumber (EIN)
LOCKHEED MARTIN C	ORPORATION			52-	-1893632		
		rning Insurance Contracts. Individual contracts grouped					
1 Coverage Information:		a.a.a. ooaaa g.oupou			poou o u og.o	00.10441	
(a) Name of insurance c	arrier						
CIGNA HEALTH AND LIF		COMPANY					
	(a) NIAIC	(d) Contract or	(e) Approximate n	umber of	Pol	licy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract		(f) From	-	(g) To
59-1031071	67369	2500544,3341110	99		01/01/2021		12/31/2021
2 Insurance fee and condescending order of th		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers	s, and of	her persons in
	amount of com	missions paid		(b) To	otal amount of fees	paid	
		·					
3 Persons receiving cor	nmissions and f	ees. (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 p	oaid	
(la) Amazont of a class			ees and other commissio	ns paid			
(b) Amount of sales a commissions page		(c) Amount		(d) Purpos	е		(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	paid	_
	, ,		•		·		
(b) Amount of sales a	and base	F	ees and other commissio				
commissions pa	aid	(c) Amount		(d) Purpos	e		(e) Organization code

(a) 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
(a) 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.	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		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 7b and 7c(6))		/ 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)		
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		7			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

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 contract covers the same group of employees of the information may be combined for reporting purposes if such contract the information may be combined for reporting purposes if such contract the information is a such contract.	tracts are experience-rated as a uni	t. Where contracts cover individual
employees, the entire group of such individual contracts with each c	arrier may be treated as a unit for p	urposes 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 insurance
e Temporary disability (accident and sickness) f Long-term disabil	ity g Supplemental unem	ployment h Prescription drug
i Stop loss (large deductible) j HMO contract	k PPO 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)
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)
(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)	2 (4)(1)
(H) Total retention	_	9c(1)(H)
(2) Dividends or retroactive rate refunds. (These amounts were paid in		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)
e Dividends or retroactive rate refunds due. (Do not include amount entere	d in line 9c(2) .)	9e
10 Nonexperience-rated contracts:		
Total premiums or subscription charges paid to carrier		10a 31483
b If the carrier, service, or other organization incurred any specific costs in oretention of the contract or policy, other than reported in Part I, line 2 above Specify nature of costs.		10b
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		

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).

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▶ 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	nding 12/31/2021	•
A Name of plan				B Thre	e-digit	
		GROUP INSURANCE PLAN F	OR EMPLOYEES OF	plan	number (PN)	512
TRANSFERRED GE OP:	S IN THE BAR	GAINING UNIT				
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	oyer Identification Num	ber (EIN)
LOCKHEED MARTIN CO					1893632	
		rning Insurance Contra . Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
LIFE INSURANCE COMP		TH AMERICA				
Ell E INCOTOTIOE COMIT		TITAMEROA				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		Policy	or contract year
(b) LIN	code	identification number	policy or contract		(f) From	(g) To
23-1503749	65498	SDJ007632	317		01/01/2021	12/31/2021
2 Insurance fee and com	mission inform	ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, a	nd other persons in
descending order of the						
(a) Lotal a	amount of com	missions paid		(b) 10	otal amount of fees pai	<u>d</u>
0 =						
3 Persons receiving com		ees. (Complete as many entrie			sione or food were noid	<u> </u>
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions of fees were paid	·
(b) Amount of sales ar			ees and other commission			
commissions pa	ıd	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broke	or other person to who	m commiss	cione or fees were naid	
	(a) Name a	and address of the agent, broke	er, or other person to who	III COITIIII33	sions of fees were paid	
			ees and other commission	ns naid		
(b) Amount of sales ar commissions pa		(c) Amount	ees and other commission	(d) Purpos	e	(e) Organization code
σοπιπισσιστισ μα		(o) / milount		(±) i aipoo	<u> </u>	(c) Organization toda

(a) 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
(a) 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.	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		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 7b and 7c(6))		/ 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)		
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		7			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Pa	rt III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual	group of employees of th ing purposes if such con	tracts are	expe	erience-rated as a unit	. Where co	entracts cover individual	s),
8 E	Benefit a	nd contract type (check all applicable boxes)							
	а П Не	ealth (other than dental or vision)	b Dental		с	Vision		d Life insurance	
		emporary disability (accident and sickness)	f Long-term disabil		gΠ	1 1	olovment	h Prescription drug	
ì	. =		_ 📙	-		<u></u>	Dioyincin	- 📙	
		op loss (large deductible)	j		K _	PPO contract		I Indemnity contrac	τ
ı	m ∐ Ot	her (specify)							
	•	ce-rated contracts:		- 411	. 1				
6		iums: (1) Amount received		9a(1)					
		ncrease (decrease) in amount due but unpaid			_				
	` '	ncrease (decrease) in unearned premium res							
	_	Earned ((1) + (2) - (3))					. 9a(4)		0
		efit charges (1) Claims paid			_				
		ncrease (decrease) in claim reserves							
		ncurred claims (add (1) and (2))					9b(3)		0
	` '	Claims charged					9b(4)		
		nainder of premium: (1) Retention charges (o		- 4114					
		(A) Commissions		9c(1)(
		(B) Administrative service or other fees		9c(1)(l					
		(C) Other specific acquisition costs		9c(1)(
		(D) Other expenses		9c(1)(I					
		(E) Taxes		9c(1)(I	_				
		(F) Charges for risks or other contingencies		9c(1)(I					
		(G) Other retention charges					0-(4)(1)		
		(H) Total retention	_		_		9c(1)(H)		0
		Dividends or retroactive rate refunds. (These	<u></u>				9c(2)		
		us of policyholder reserves at end of year: (1					9d(1)		
	(2) (Claim reserves					9d(2)		
	()	Other reserves					9d(3)		
		dends or retroactive rate refunds due. (Do no	ot include amount entere	d in line 9	c(2).	.)	9e		
10		erience-rated contracts:							
	a Tota	al premiums or subscription charges paid to c	arrier				10a		71612
	rete	e carrier, service, or other organization incurr ntion of the contract or policy, other than repo nature of costs.					10b		
Pa	rt IV	Provision of Information							
		insurance company fail to provide any inform	nation necessary to comp	lete Sche	dule	А?	Yes	X No	
		nswer to line 11 is "Yes" specify the informati		3.2 00.10				<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

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)	١.			Inspection
For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/3	1/2021	
A Name of plan LOCKHEED MARTIN CO TRANSFERRED GE OP		GROUP INSURANCE PLAN F	OR EMPLOYEES OF		e-digit number (PN	N) •	512
TRANSFERRED GE OP	S IN THE BAK	GAINING UNIT					
C Plan sponsor's name a	as shown on lin	ne 2a of Form 5500		D Emplo	yer Identific	ation Number ((EIN)
LOCKHEED MARTIN CO	ORPORATION			52-	1893632		
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		INC					
a > =	(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	(g) To
94-1340523	00000	605635	1		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 o	ther persons in
(a) Total	amount of com	missions paid		(b) To	otal amount	of fees paid	
		9					0
3 Persons receiving com		ees. (Complete as many entrie					
		and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
CONDUENT SECURITIES	S, LLC		LEXINGTON AVE, 4TH F YORK, NY 10170	LOOR			
(b) Amount of sales a	nd hase	Fe	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	9						3
	(a) Name a	and address of the agent, broke	r. or other person to who	m commiss	ions or fees	were paid	
	(4)	g,	,,				
(b) Amount of sales a	nd hase	Fe	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

(a) 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
(a) 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 ϵ		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			
	•	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)		
)			
		(6)Total additions		7c(6)	0
	Ч	Total of balance and additions (add lines 7b and 7c(6)).		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 7e(5) from line 7d)		7f	0

Pa	If more than one contract covers the same growthe information may be combined for reporting employees, the entire group of such individual	up of employees of the purposes if such cont	racts are	expe	erience-rated as a uni	t. Where co	ntracts cover indiv	ions(s), ⁄idual
8	Benefit and contract type (check all applicable boxes)	_		_			_	
	a Health (other than dental or vision)	Dental	(C [Vision		d Life insuran	ce
	e ☐ Temporary disability (accident and sickness) f	Long-term disabili	ty 🤇	g 🗌	Supplemental unem	ployment	h Prescription	drug
	i Stop loss (large deductible)	X HMO contract		kΠ	PPO contract		I Indemnity c	ontract
	m ☐ Other (specify)			ш				
	III Utilet (Specify)							
9 F	Experience-rated contracts:							
	a Premiums: (1) Amount received		9a(1)					
	(2) Increase (decrease) in amount due but unpaid							
	(3) Increase (decrease) in unearned premium reserv		``					
	(4) Earned ((1) + (2) - (3))					. 9a(4)		0
	b Benefit charges (1) Claims paid							
	(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	n accrual basis)						
	(A) Commissions		9c(1)(A					
	(B) Administrative service or other fees		9c(1)(E					
	(C) Other specific acquisition costs		9c(1)(C	_				
	(D) Other expenses		9c(1)(E	-				
	(E) Taxes		9c(1)(E					
	(F) Charges for risks or other contingencies		0 (4)(6					
	(G) Other retention charges					00(4)(H)		0
	(H) Total retention			_		9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These am	—		_		9c(2)		
	d Status of policyholder reserves at end of year: (1) Ar	·				9d(1)		
	(2) Claim reserves					9d(2)		
	(3) Other reserves					9d(3)		
10	e Dividends or retroactive rate refunds due. (Do not in Nonexperience-rated contracts:	iciude amount entered	ı III IIII e 9 0	·(2).)	9e		
	Total premiums or subscription charges paid to carri	۵r				10a		2460
						IVa		2400
	b If the carrier, service, or other organization incurred retention of the contract or policy, other than reporte					10b		
,	Specify nature of costs.	a a,o = a o .	о, горолг		~			
_	ANA Broadeless of the Co							
Pa	art IV Provision of Information							
11	Did the insurance company fail to provide any information	on necessary to comp	lete Sched	dule	A?	Yes	X 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

OMB No. 1210-0110

2021

This Form is Open to Public

	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					1/2021			
A Name of plan LOCKHEED MARTIN CO	DR EMPLOYEES OF B Three-digit plan number (PN)			N) •	512			
TRANSFERRED GE OP:								
C Plan sponsor's name a LOCKHEED MARTIN CO		ne 2a of Form 5500		D Employer Identification Number (EIN) 52-1893632				
		rning Insurance Contra A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca		OF THE MID-ATLANTIC						
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or contract year		
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
52-0954463	95639	24776	2		01/01/202	1	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,	brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
		64					177	
3 Persons receiving com	missions 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	ions or fees	were paid		
BUCK GLOBAL, LLC			3OX 207640 LAS, TX 75320					
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
37		177	ANNUAL BOB				3	
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid		
CONDUENT SECURITIES	S, LLC		LEXINGTON AVE, 4TH F / YORK, NY 10017	LOOR				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid				
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code	
	27						3	
	ı							

(a) 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
(a) 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 ϵ		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)		
)			
		(6)Total additions		7c(6)	0
	Ч	Total of balance and additions (add lines 7b and 7c(6)).		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 7e(5) from line 7d)		7f	0

F	Part	III Welfare Benefit Contract Informatio If more than one contract covers the same grou the information may be combined for reporting a employees, the entire group of such individual of	p of employees of the ourposes if such cont	racts are	expe	erience-rated as a un	it. Where co	ontracts cover indi-	tions(s), vidual
•	Don		JOHNACIS WITH EACH CO	amer ma	y De i	ireated as a unit for p	ourposes or t	riis report.	
8	г	nefit and contract type (check all applicable boxes)	75			1		ا بن الم	
	а	Health (other than dental or vision)	Dental		с∐	Vision		d Life insurar	ice
	е	Temporary disability (accident and sickness) f	Long-term disabilit	ty	g	Supplemental unem	nployment	h Prescription	ı drug
	i	Stop loss (large deductible) j	X HMO contract		k 🗌	PPO contract		I Indemnity of	ontract
	m	Other (specify)							
	,	-							
9	Exp	erience-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	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)(
		(C) Other specific acquisition costs		9c(1)(
		(D) Other expenses		9c(1)(
		(E) Taxes		9c(1)(
		(F) Charges for risks or other contingencies		9c(1)(
		(G) Other retention charges					- (A) (B)		
		(H) Total retention			_		9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These ame	<u> </u>		_		9c(2)		
	d	Status of policyholder reserves at end of year: (1) Am	nount held to provide	benefits	after	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е_	,	clude amount entered	d in line 9	c(2).)	9e		
1(_	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrie	÷r				10a		9399
	b	If the carrier, service, or other organization incurred a					406		
	Sne	retention of the contract or policy, other than reported ecify nature of costs.	I in Part I, line 2 abov	e, report	amo	unt	10b		
	Орс	ony nature or cools.							
	art	IV Provision of Information							
							1 v.	₩ Na	
11		d the insurance company fail to provide any information		lete Sche	dule	A?	Yes	X No	
12	2 If t	the answer to line 11 is "Yes," specify the information r	ot provided.						