#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

 Part I
 Annual Report Identification Information

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

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2021

This Form is Open to Public Inspection

and ending 12/31/2021

Enter name of individual signing as DFE

A This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box multiple-employer information in accordance with						ne )
		X a single-employer plan	a DFE (specify		ce with the form instruction	115.)
<b>B</b> This	return/report is:	the first return/report	the final return	report		
		an amended return/report	a short plan ye	ar return/report (less than 12 mo	onths)	
C If the	plan is a collectively-barga	ained plan, check here			X	
<b>D</b> 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		<b>nation</b> —enter all requested informatio	n			T
	ne of plan	ATION COOLD INCLIDANCE DI AN FOI	D DETIDED EMDLO	VEEC	<b>1b</b> Three-digit plan number (PN) ▶	591
LOCK	TEED MARTIN CORPORA	ATION GROUP INSURANCE PLAN FOR	RETIRED EMPLO	YEES	1c Effective date of pl 01/01/1993	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 (seinstructions) 339900	e 
Caution	: A penalty for the late or	incomplete filing of this return/repor	t will be assessed	unless reasonable cause is est	tablished.	
Under pe	enalties of perjury and othe	er penalties set forth in the instructions, I ell as the electronic version of this return	declare that I have	examined this return/report, inclu	iding accompanying sche	
SIGN HERE	Filed with authorized/valid	d electronic signature.	10/13/2022	ROBERT MUENINGHOFF		
	Signature of plan admi	nistrator	Date	Enter name of individual signin	ng as plan administrator	
SIGN HERE						
HERE	Signature of employer/	plan sponsor	Date	Enter name of individual signin	ng as employer or plan sp	onsor
SIGN						

Date

Signature of DFE

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 47800 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). 0 a(1) Total number of active participants at the beginning of the plan year...... 6a(1) 0 a(2) Total number of active participants at the end of the plan year ...... 6a(2)46656 6b **b** Retired or separated participants receiving benefits....... 0 Other retired or separated participants entitled to future benefits ...... 6c 46656 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 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) X **H** (Financial Information) (1) (1)

(2)

(3)

(4)

(5)

(6)

X

X

X

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(2)

(3)

actuary

I (Financial Information - Small Plan)

**D** (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

C (Service Provider Information)

49 A (Insurance Information)

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

		parodantio			ilispection
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021	a	nd ending 12/31/2021	
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO		Three-digit plan number (PN)	591
C Plan sponsor's name a	ORPORATION			Employer Identification Nul 52-1893632	
		ning Insurance Contrac  Individual contracts grouped a			
1 Coverage Information:	<u></u>	. mamada oomada gibapoa d		zo roportoù en a omigio et	
(a) Name of insurance ca					
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate numbe		y or contract year
<b>(b)</b> EIN	code	identification number	persons covered at end policy or contract year	(t) From	<b>(g)</b> To
23-2169745	95109	172310;172312	7	01/01/2021	12/31/2021
descending order of the		ation. Enter the total fees and to		line 3 the agents, brokers, <b>(b)</b> Total amount of fees p	· 
(4) 1014	<u></u>	oo.oo paia		( <b>2</b> )	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all perso	ons).	
-	(a) Name a	nd address of the agent, broker	, or other person to whom cor	nmissions or fees were pa	id
(b) Amount of sales a	nd base		es and other commissions pa		
commissions paid (c) Amount			(d) P	urpose	(e) Organization code
	(a) Name a	nd address of the agent, broker	, or other person to whom cor	nmissions or fees were pa	id
(b) Amount of sales a	nd base	Fe	es and other commissions pa	id	
commissions pa		(c) Amount	<b>(d)</b> P	urpose	(e) Organization code

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

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

Pá	art I	Welfare Benefit Contract Informati If more than one contract covers the same group the information may be combined for reporting employees, the entire group of such individua	oup of employees of the purposes if such cont	racts are	expe	rience-rated as a un	it. Where co	ntracts cover indi	
8	Bono	nefit and contract type (check all applicable boxes)	T COTTIACIS WITH CACIT C	arrier may	DC 1	reated as a drift for p	urposes or ti	по торот.	
	_		N □ Dontol		<b>.</b> $\Box$	Vicion		d 🗆 Life incurer	
	a [		Dental		느	Vision		<b>d</b> ∐ Life insurar	
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabili	ty (	3 🗌	Supplemental unem	ployment	h Prescription	า drug
	i	Stop loss (large deductible)	X HMO contract	l	<b>(</b>	PPO contract		I Indemnity of	ontract
	m	Other (specify)							
9 1	Ехре	erience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid							
		(3) Increase (decrease) in unearned premium reser							
	_	(4) Earned ((1) + (2) - (3))			<u>.</u>		. 9a(4)		0
		0 ( )		(-)					
		(2) Increase (decrease) in claim reserves					01 (0)		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	,	0-/4\/4					
		(A) Commissions		9c(1)(A 9c(1)(E					
		(B) Administrative service or other fees		9c(1)(C					
		(D) Other expenses		9c(1)(E					
		(E) Taxes		9c(1)(E	•				
		(F) Charges for risks or other contingencies		A (4)/=	_				
		(G) Other retention charges		0 (4)(6					
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These at			_		9c(2)		
	d	Status of policyholder reserves at end of year: (1) A					9d(1)		
	_	(2) Claim reserves	•				9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not					9e		
10	Noi	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to car	rier				10a		39668
	b	If the carrier, service, or other organization incurred	I any specific costs in o	connection	with	n the acquisition or			
	_	retention of the contract or policy, other than report	ed in Part I, line 2 abov	e, report a	amo	unt	10b		
	Spe	ecify nature of costs.							
D-	\p4	IV Provision of Information							
	art I					🗔	V	V N-	
		d the insurance company fail to provide any informat		lete Sched	dule	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information	not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/31/2021	•
A Name of plan				<b>B</b> Thre	e-digit	
LOCKHEED MARTIN CO	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591	
EMPLOTEES						
C Plan sponsor's name a	s shown on lin	ne 2a of Form 5500		<b>D</b> Emplo	yer Identification Numb	er (EIN)
LOCKHEED MARTIN CO					1893632	,
		rning Insurance Contra  A. Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
AETNA HEALTH INC FL						
, terror real real real real real real real rea						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		Policy of	or contract year
(b) LIN	code	identification number	policy or contract		(f) From	<b>(g)</b> To
59-2411584	95088	0701220HNO	4		01/01/2021	12/31/2021
		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, an	d other persons in
descending order of the		missions noid		(b) T	atal amount of food nois	
(a) 10tal a	amount of com	imissions paid		( <b>b)</b> 10	otal amount of fees paid	<u> </u>
<b>3</b> Damana wasabidan asaa		(a.a. (Camalata aa manu antii				
3 Persons receiving com		fees. (Complete as many entrice and address of the agent, broke			ions or foos wore paid	
	(a) Name a	and address of the agent, broke	or, or other person to who	III COITIITI33	ions of fees were paid	
(b) Amount of sales ar		(c) Amount	ees and other commissions paid (d) Purpose			(e) Organization code
commissions pa	iu	(C) Amount		(u) Fulpos	<u> </u>	(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid	
	(*/		, ,			
	T		ees and other commissio	ns naid		
(b) Amount of sales ar commissions pa		(c) Amount	oco ana omer commissio	(d) Purpos	e	(e) Organization code
commissions pa		(4)		(2) . 41,000	<del>-</del>	(c) organization code

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

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

Pa	art l	III Welfare Benefit Contract Information If more than one contract covers the same group the information may be combined for reporting employees, the entire group of such individual	oup of employees of the purposes if such cont	tracts are	expe	erience-rated as a un	it. Where co	ntracts cover indi	
8	Ren	nefit and contract type (check all applicable boxes)							
	a 「		Dental		ر □	Vision		d Life insurar	000
	L		=						
	е	Temporary disability (accident and sickness)	Long-term disabili	-		Supplemental unem	ployment	h Prescriptio	n drug
	i L	Stop loss (large deductible)	X HMO contract		k 💹	PPO contract		I Indemnity	contract
	m [	Other (specify)							
9	Ехрє	perience-rated contracts:							
	a I	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid			_				
		(3) Increase (decrease) in unearned premium reser					2 (1)		
		(4) Earned ((1) + (2) - (3))					. 9a(4)		0
	b	<b>5</b> ( ) 1		/	_				
		(2) Increase (decrease) in claim reserves					01 (0)		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
	_	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a		00/11//					
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees		9c(1)(0	_				
		(D) Other expenses		9c(1)([					
		(E) Taxes		9c(1)(E	_				
		(F) Charges for risks or other contingencies		0 (4)(5					
		(G) Other retention charges		0 (4)(4					
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These a	_		_		9c(2)		
	d	Status of policyholder reserves at end of year: (1) A			_		9d(1)		
	_	(2) Claim reserves	•				9d(2)		
		(3) Other reserves					9d(3)		
	е						9e		
10	No	onexperience-rated contracts:			. ,	,			
	а	Total premiums or subscription charges paid to car	rier				10a		93120
	b	If the carrier, service, or other organization incurred	l anv specific costs in o	connection	with	n the acquisition or			
		retention of the contract or policy, other than report					10b		
	Spe	ecify nature of costs.							
Pa	art I	IV Provision of Information							
<u>11</u>	Dic	id the insurance company fail to provide any informat	ion necessary to comp	lete Sche	<u>dule</u>	A?	Yes	X No	
12	If ti	the answer to line 11 is "Yes," specify the information	not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

2021

		· ·	. , , ,			
For calendar plan year 20	21 or fiscal plar	n year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
	ORPORATION	GROUP INSURANCE PLAN F	OR RETIRED		number (PN)	591
EMPLOYEES			•	` ,		
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numb	er (EIN)
LOCKHEED MARTIN CO	DRPORATION			52-	-1893632	
		ning Insurance Contra				
on a separ	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and I	II can be re	ported on a single Sche	dule A.
1 Coverage Information:						
(a) Name of incomes as						
(a) Name of insurance ca						
AETNA HEALTH INC G	A SR HMO					
			(e) Approximate n	ımher of	Policy o	r contract year
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	persons covered a		-	
	code	identification number	policy or contrac	t year	(f) From	<b>(g)</b> To
58-1649568	95094	172310;172312	278		01/01/2021	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, and	d other persons in
(a) Total	amount of comi	missions paid		<b>(b)</b> To	otal amount of fees paid	
3 D						
Persons receiving corr		ees. (Complete as many entrie				_
	(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			ees and other commissions paid			(2) Conseries tien and
commissions pa	aid	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	
						_
(b) Amount of sales a	nd hase	F	ees and other commissio	ns paid		
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code
		` ,		. ,		, , , , , , , , , , , , , , , , , , , ,

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

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

0

P	art I	Ш	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a un	it. Where co	ontracts cove	
8	Bene	efit aı	nd contract type (check all applicable boxes)				<u>'</u>	<u> </u>	
_	a 「	_	ealth (other than dental or vision)	<b>b</b> Dental	c۲	Vision		d ☐ Life in	surance
	느	_		브	<u>-</u>				
	e	_		f Long-term disabili		Supplemental unem	ployment	h Presci	_
	i L	Sto	op loss (large deductible)	j X HMO contract	k _	PPO contract		I Indem	nity contract
	m	Ot	her (specify)						
<b>9</b> 1	Ехре	erienc	ce-rated contracts:						
	a i	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)					
		(	(A) Commissions		9c(1)(A)				
		(	(B) Administrative service or other fees		9c(1)(B)				
		(	(C) Other specific acquisition costs		9c(1)(C)				
		(	(D) Other expenses		9c(1)(D)				
		(	(E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies .		9c(1)(F)				
			(G) Other retention charges						
			(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 after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		(3)	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	Il premiums or subscription charges paid to c	arrier			10a		1682981
	b		e carrier, service, or other organization incurr						
	O	rete	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	city n	ature of costs.						
Pa	art I	V	Provision of Information						
<u>1</u> 1	Dic	the	insurance company fail to provide any inform	ation necessary to comp	ete Schedule	A?	Yes	X No	
			swer 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

			. , , ,			шересиен
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
	RPORATION (	GROUP INSURANCE PLAN F	OR RETIRED		number (PN)	591
EMPLOYEES					, ,	
C Plan sponsor's name a	is shown on line	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Num	nber (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	-1893632	
		ning Insurance Contra				
	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and I	I can be re	ported on a single Sch	nedule A.
1 Coverage Information:						
(a) Name of incurance of	rri o r					
(a) Name of insurance ca						
AETNA HEALTH INC VA	A SR HMO					
			(e) Approximate no	ımber of	Policy	or contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a			
	code	identification number	policy or contract year		(f) From	<b>(g)</b> To
23-2169745	95109	19528	1		01/01/2021	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, a	and other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		•				
<b>3</b> Damana wasabilan asaa		(Camanlata an manus antrio				
3 Persons receiving com		ees. (Complete as many entrie				
	(a) Name a	nd address of the agent, broke	er, or otner person to wno	m commiss	sions or fees were paid	<u> </u>
			ees and other commissio	no poid		
(b) Amount of sales ar			ees and other commissio	•		(2) Organization and
commissions pa	Ia	(c) Amount		(d) Purpos	<u>e</u>	(e) Organization code
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	d
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid		
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code
- <u>-                                  </u>						,,,

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

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

0

P	art I	II	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	érience-rated as a un	it. Where co	ontracts cover	
8	Rene	əfit ər	nd contract type (check all applicable boxes)					<b>-</b>	-
_	_	_		<b>b</b> Dental	٦	Vision		d ☐ Life ins	uranaa
	a [	_	alth (other than dental or vision)	<u> </u>	<u> </u>			브	
	e L	Те	mporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	h Prescri	ption drug
	i L	Sto	op loss (large deductible)	j X HMO contract	k	PPO contract		I Indemn	nity contract
	m	Ot	her (specify)						
	_								
9 i	Ехре	erienc	e-rated contracts:						
	a F	rem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)					
		(	(A) Commissions		9c(1)(A)				
		(	B) Administrative service or other fees		9c(1)(B)				
		(	(C) Other specific acquisition costs		9c(1)(C)				
		(	D) Other expenses		9c(1)(D)				
		(	E) Taxes		9c(1)(E)				
		(	F) Charges for risks or other contingencies .		9c(1)(F)				
		(	G) Other retention charges		9c(1)(G)				
		(	H) Total retention				9c(1)(H)	)	0
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	State	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		(3) (	Other reserves				9d(3)		
	е	Divid	dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b>	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		8694
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or			
	_	reter	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	cify n	ature of costs.						
Pa	rt I	V	Provision of Information						
11	Did	l the	insurance company fail to provide any inform	ation necessary to comp	lete Schedule	e A?	Yes	X No	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

		parodantio	=:		mspection	
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021	and	l ending 12/31/2021		
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO		hree-digit olan number (PN)	591	
C Plan sponsor's name a	ORPORATION			nployer Identification Numbe 52-1893632		
			t Coverage, Fees, and Cas a unit in Parts II and III can be			
1 Coverage Information:	<u> </u>	. mamada oomada gibapoa d		or a single cone		
(a) Name of insurance ca						
/L) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of		contract year	
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To	
23-2169745	95109	19528	6	01/01/2021	12/31/2021	
descending order of the		Т	tal commissions paid. List in line	e 3 the agents, brokers, and	I other persons in	
(a) Total	amount or com	mosions paid	(5	Total amount of fees paid		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all persons	3).		
	(a) Name a	nd address of the agent, broker	, or other person to whom comm	nissions or fees were paid		
(b) Amount of sales a	nd base		es and other commissions paid			
commissions pa	id	(c) Amount	<b>(d)</b> Purş	oose	(e) Organization code	
	(a) Name a	nd address of the agent, broker	, or other person to whom comn	nissions or fees were paid	•	
	(-)		,			
(b) Amount of sales a	nd base	Fe	es and other commissions paid			
commissions pa		(c) Amount	(d) Purp	(e) Organization code		

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

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

0

F	Part I	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	roup of employees of the ng purposes if such cont	racts are ex	perience-rated a	s a unit.	Where co	ntracts cover ir	
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision			<b>d</b> Life insu	rance
	е	Temporary disability (accident and sickness)	f  Long-term disabili	ty <b>g</b>	Supplementa	l unempl	ovment	h Prescript	ion drua
	i	Stop loss (large deductible)	j X HMO contract	, s k					y contract
	. L	<u>-</u>	, A Time contract	•					, commune
	m	Other (specify)							
9	Evne	erience-rated contracts:							
,	•	Premiums: (1) Amount received		9a(1)				_	
		(2) Increase (decrease) in amount due but unpaid		9a(1)				_	
		(3) Increase (decrease) in unearned premium rese		9a(3)				_	
		(4) Earned ((1) + (2) - (3))					9a(4)		
	_	Benefit charges (1) Claims paid		9b(1)			σα(+)		
		(2) Increase (decrease) in claim reserves						_	
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (or				L	35(4)		
	Ū	(A) Commissions	•	9c(1)(A)					
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)					
		(D) Other expenses		9c(1)(D)					
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies		9c(1)(F)					
		(G) Other retention charges							
		(H) Total retention			•		9c(1)(H)		C
		(2) Dividends or retroactive rate refunds. (These	_	_	=	-	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	<b>—</b> ·	<u> </u>	_	-	9d(1)		
	ű	(2) Claim reserves	•			F	9d(2)	+	
		(3) Other reserves				-	9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no					9e		
10	_	nexperience-rated contracts:			<b>-,</b>	1			
		Total premiums or subscription charges paid to ca	arrier			Г	10a		38938
	b	If the carrier, service, or other organization incurre				F			
		retention of the contract or policy, other than repo	, ,				10b		
	Spe	cify nature of costs.				_			
P	Part I	V Provision of Information							
	_			lata Calaa I	.1- 02		Yes	X No	
		I the insurance company fail to provide any informa		ete Schedu	ле А?		162	X No	
12	∠ If 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	nding 12/31/202	1		
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	ORPORATION	GROUP INSURANCE PLAN F	OR RETIRED		e-digit number (PN)	•	591	
2 20 / 220								
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identification I	Number (	EIN)	
LOCKHEED MARTIN CO	ORPORATION			52-	1893632			
Part I Informa	tion Concer	ning Insurance Contra	ct Coverage Fees	and Con	nmissions Prov	vide infor	mation for each contract	
		. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca								
(c) NAIC (d) Contract or			(e) Approximate nu		Po	olicy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year		(f) From		<b>(g)</b> To	
52-1270921	95287	019528	2		01/01/2021		12/31/2021	
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, broker	rs, and o	ther persons in	
(a) Total	amount of com	missions paid		<b>(b)</b> To	otal amount of fees	s paid		
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).				
	(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		F	ees and other commission	ns paid				
commissions pa	iid	(c) Amount		(d) Purpos	e		(e) Organization code	
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were	paid		
(b) Amount of sales a	nd hase	F	ees and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	

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

F	Part	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		4		
		rent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:			1	
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con-				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
		openity hatare or cooks				
	_	T ( ( ( ( ( )				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan.	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts mai				
•						
	а	,,,, =	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
			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	II	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are expe	érience-rated as a un	it. Where co	ontracts co	
8	Rene	əfit ər	nd contract type (check all applicable boxes)						
	_	_		<b>b</b> Dental	٦	Vision		<b>d</b> ☐ Life	ingurance
	a [	_	alth (other than dental or vision)	<u>=</u>	<u> </u>			=	insurance
	e L	Те	mporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	<b>h</b> ∐ Pres	scription drug
	i L	Sto	op loss (large deductible)	j X HMO contract	k	PPO contract		l Inde	emnity contract
	m	Ot	her (specify)						
	_								
9 E	Ехре	erienc	e-rated contracts:						
	a F	rem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		0
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)					
		(	(A) Commissions		9c(1)(A)				
		(	B) Administrative service or other fees		9c(1)(B)				
		(	C) Other specific acquisition costs		9c(1)(C)				
		(	D) Other expenses		9c(1)(D)				
		(	E) Taxes		9c(1)(E)				
		(	F) Charges for risks or other contingencies .		9c(1)(F)				
		(	G) Other retention charges		9c(1)(G)		1		
		(	H) Total retention				9c(1)(H)	)	0
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	credited.)	9c(2)		
	d	State	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		(3) (	Other reserves				9d(3)		
	е	Divid	dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b> .	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		14209
	b	If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	h the acquisition or			
	_	reter	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	cify n	ature of costs.						
D-	rt I	V	Provision of Information						
	rt I								
<u>11</u>	Did	l the	insurance company fail to provide any inform	ation necessary to comp	ete Schedule	A?	Yes	X No	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021			and en	ding 12/31/2021		•		
A Name of plan				В	Three	e-digit				
	PROPRATION	GROUP INSURANCE PLAN F	OR RE	ETIRED	plan	number (PN)		591		
EMPLOYEES										
C Plan sponsor's name a	C Plan sponsor's name as shown on line 2a of Form 5500				Emplo	yer Identification Numb	ber (E	EIN)		
LOCKHEED MARTIN CO	RPORATION					1893632				
			4.0							
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
1 Coverage Information:										
(a) Name of insurance ca	rrier									
AETNA HEALTH INC SO		SR HMO								
	1									
(b) EIN	(c) NAIC	(d) Contract or		<ul><li>(e) Approximate numb persons covered at er</li></ul>		-	or cor	ntract year		
(5) EIIV	code	identification number		policy or contract year		(f) From		( <b>g</b> ) To		
52-1270921	95287	019528		31		01/01/2021		12/31/2021		
2 Insurance fee and com	mission inform	ation. Enter the total fees and t	total cor	mmissions paid. List i	n line 3	the agents, brokers, ar	nd oth	ner persons in		
descending order of the			1							
(a) Total a	amount of com	missions paid			<b>(b)</b> To	tal amount of fees paid	<u> </u>			
3 Persons receiving com		ees. (Complete as many entrie								
	(a) Name a	and address of the agent, broke	er, or ot	ther person to whom co	ommiss	ions or fees were paid				
(b) Amount of sales ar			ees an	d other commissions p	_					
commissions pa	id	(c) Amount		(d)	Purpose	9	$\dashv$	(e) Organization code		
	(a) Name a	and address of the agent, broke	er. or ot	ther person to whom c	ommiss	ions or fees were paid				
	(*)		,							
(h) A		F	ees an	nd other commissions p	paid					
(b) Amount of sales ar commissions pa		(c) Amount	200 011	•	Purpose	9		(e) Organization code		
- 1		. ,			*					

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

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	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		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	,,,, =	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
			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 group of employ the information may be combined for reporting purposes if	such contracts are	expe	erience-rated as a unit	. Where co	ntracts cover indiv	ions(s), vidual
0		employees, the entire group of such individual contracts wi	ith each camer ma	y be	treated as a unit for pu	irposes or ti	nis report.	
	_	nefit and contract type (check all applicable boxes)					a 🗆	
	a _	Health (other than dental or vision) <b>b</b> Dental		c∐	Vision		<b>d</b> Life insuran	
	е	Temporary disability (accident and sickness) <b>f</b> Long-tel	rm disability	g	Supplemental unemp	oloyment	<b>h</b> Prescription	drug
	i [	Stop loss (large deductible) j 🗵 HMO co	ontract	k 🗌	PPO contract		I Indemnity c	ontract
	m	Other (specify)						
	L							
9 i	Ехре	perience-rated contracts:						
	a F	Premiums: (1) Amount received	9a(1	)				
		(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium reserve		)				
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	_							
		(2) Increase (decrease) in claim reserves	9b(2	)				
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual ba	asis)					
		(A) Commissions	9c(1)(	A)				
		(B) Administrative service or other fees	- (1)					
		(C) Other specific acquisition costs	9c(1)(	C)				
		(D) Other expenses	9c(1)(	D)				
		(E) Taxes	9c(1)(	E)				
		(F) Charges for risks or other contingencies	9c(1)(	F)				
		(G) Other retention charges	9c(1)(	G)				
		(H) Total retention				9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, or	· 🗌 d	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held t	to provide benefits	after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amou	unt entered in line 9	c(2).	)	9e		
10	Noi	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a		287022
	b	If the carrier, service, or other organization incurred any specific	costs in connection	n with	n the acquisition or			
		retention of the contract or policy, other than reported in Part I, li				10b		
	<b>O</b> po.	ecify nature of costs.						
Pa	art I	IV Provision of Information						
11	Did	id the insurance company fail to provide any information necessar	y to complete Sche	dule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the information not provided			·· L		L_I	

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	=:			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 EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO		B Thre	591	
C Plan sponsor's name a	RPORATION			52-	oyer Identification Number 1893632	<u> </u>
		ning Insurance Contract Individual contracts grouped a				
1 Coverage Information:					,	- <del>-</del>
(a) Name of insurance ca						
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate num		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered at e		(f) From	<b>(g)</b> To
06-6033492	95234	0701220	46		01/01/2021	12/31/2021
descending order of the		ation. Enter the total fees and tot	ral commissions paid. List		the agents, brokers, and otal amount of fees paid	other persons in
3 Persons receiving com		ees. (Complete as many entries nd address of the agent, broker,			sions or foos wors poid	
(b) Amount of sales a			es and other commissions			
commissions pa		(c) Amount	(d	) Purpos	е	(e) Organization code
	(a) Name a	nd address of the agent, broker,	, or other person to whom	commiss	sions or fees were paid	
(b) Amount of sales a	nd base	Fee	es and other commissions	paid		
commissions pa		(c) Amount	(d	) Purpos	e	(e) Organization code

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

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	dual contra	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		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	,,,, =	te participa	tion guarantee		
		(3) guaranteed investment (4) dother				
		<del>-</del>				
	b	Balance at the end of the previous year			7b	0
	C	Additions: (1) Contributions deposited during the year	7c(1)		1.0	0
	C					
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(C)Total additions			70(6)	0
	لہ	(6)Total additions			7c(6)	
	_	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).	г		7d	0
	е	Deductions:	- (4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
			7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
		(5) Total deductions			7e(5)	0

0

F	Part I	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	group of employees of the ng purposes if such cont	racts are ex	xperie	ence-rated as a unit.	Where co	ontracts cover in	
8	Ben	efit and contract type (check all applicable boxes)							
	a	Health (other than dental or vision)	<b>b</b> Dental	С	;	/ision		<b>d</b> Life insura	ance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>	ı 🗖 s	Supplemental unemp	lovment	h Prescripti	on drua
	i [	Stop loss (large deductible)	j  HMO contract	k		PPO contract	,	I Indemnity	_
	. L	=			. П.	1 o dominado		aay	contract
	m	Other (specify)							
9	Evno	erience-rated contracts:							
9		Premiums: (1) Amount received		9a(1)					
	a	(2) Increase (decrease) in amount due but unpaid		9a(1)					
		(3) Increase (decrease) in unearned premium resi		9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	_	Benefit charges (1) Claims paid	i	9b(1)	<u> </u>		3a(+)		
	D	(2) Increase (decrease) in claim reserves							
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)		0
		(4) Claims charged					9b(3) 9b(4)		
	С	Remainder of premium: (1) Retention charges (or					3D( <del>1</del> )		
	C	(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	_	_	_	i	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	<b>—</b> ·	<u> </u>		·	9d(1)		
	u	(2) Claim reserves	·				9d(1)		
		(3) Other reserves				İ	9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no				ŀ	9e		
10	_	nexperience-rated contracts:	inolade amount entered	2 III IIII 0 00(	( <b>-</b> )·/···		- 30		
.,	a	Total premiums or subscription charges paid to ca	arrier			[	10a		797203
		If the carrier, service, or other organization incurre				İ			
	<b>b</b> Spe	retention of the contract or policy, other than repocify nature of costs.	, .				10b		
P	art I	V Provision of Information						_	
11	<b>l</b> Dic	the insurance company fail to provide any informa	ation necessary to compl	ete Schedu	ule A	?	Yes	X No	
12	2 If ti	ne answer to line 11 is "Yes," specify the information	on not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

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

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

2021

		· ·	, , ,					
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>B</b> Three-digit				
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED		number (PN)	591		
EMPLOYEES					, ,			
_								
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Num	nber (EIN)		
LOCKHEED MARTIN CO	DRPORATION			52-	-1893632			
		rning Insurance Contract. Individual contracts grouped						
1 Coverage Information:		<u>J</u>			,			
(a) Name of insurance ca	arrier							
AETNA HEALTH INC SO	OUTHEAST PA	SR HMO						
	T				Dallar.			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		Policy	or contract year		
(b) LIIV	code	identification number	policy or contract		(f) From	<b>(g)</b> To		
23-2169745	95109	019528	29		01/01/2021	12/31/2021		
2		-Car Fatandha tatal fara and t		tat to the o	the energy backers a	and other managers to		
descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, a	and other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid								
` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `		'		. ,	·			
2 Damana manising and		(Camplete es manu antrio						
3 Persons receiving com		ees. (Complete as many entrie						
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	1		
		F	ees and other commission	ne naid				
(b) Amount of sales an commissions pa		(c) Amount	ccs and other commission	(d) Purpos	Δ	(e) Organization code		
commissions pa	liu	(c) Amount		(u) 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 paid	<u> </u>		
(b) Amount of sales ar			ees and other commission					
commissions pa	iid	(c) Amount		(d) Purpos	е	(e) Organization code		

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

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

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	roup of employees of the ng purposes if such cont	racts are e	xpe	rience-rated as a unit	. Where co	ontracts co	
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	С	;	Vision		<b>d</b> Life	insurance
	e	Temporary disability (accident and sickness)	f  Long-term disabili	ty <b>g</b>	ıП	Supplemental unemp	olovment	h Pre	scription drug
	i	Stop loss (large deductible)	j X HMO contract	, s k		PPO contract	,	_ =	emnity contract
	. L		, A Time contract	• • • • • • • • • • • • • • • • • • • •	`Ш	110 contract		• 🔲ac	minty contract
	m	Other (specify)							
9	Evno	rience-rated contracts:							
9				00/1)					
		Premiums: (1) Amount received		9a(1) 9a(2)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium rese					02/4)		0
	_	(4) Earned ((1) + (2) - (3))		9b(1)	······	•••••	9a(4)		
	b	Benefit charges (1) Claims paid							
		(2) Increase (decrease) in claim reserves					0b/2\		0
		(3) Incurred claims (add (1) and (2))					9b(3) 9b(4)		
	•	(4) Claims charged					30(4)		
	С	, , , , , , , , , , , , , , , , , , , ,	•	9c(1)(A)	\ T				
		(A) Commissions		9c(1)(A)				_	
		(B) Administrative service or other fees		9c(1)(C)				_	
		(D) Other expenses		9c(1)(D)	_				
		(E) Taxes		9c(1)(E)	_				
		(F) Charges for risks or other contingencies		9c(1)(F)	_				
		(G) Other retention charges			_				
		(H) Total retention					9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These	_	_	_			<u>'</u>	
	٨		<b>—</b> ·	<u> </u>			9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•				9d(1)		
		(2) Claim reserves					9d(2)		
	е	(3) Other reserves					9d(3)		
10	_	Dividends or retroactive rate refunds due. (Do no nexperience-rated contracts:	i include amount entered	in line <b>sc</b>	<b>(2)</b> .)	)	9e		
		Total premiums or subscription charges paid to ca	rrior				10a		254746
							IVa		254740
	<b>b</b> Spe	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo- cify nature of costs.	, ,			•	10b		
P	art I	V Provision of Information						_	
11	Dic	the insurance company fail to provide any informa	ation necessary to compl	ete Sched	ule	A?	Yes	X No	
12	2 If 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

		F				mspection
For calendar plan year 202	21 or fiscal plan	year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	RPORATION (	GROUP INSURANCE PLAN FO	DR RETIRED		e-digit number (PN)	591
C Plan sponsor's name as	RPORATION			52-	oyer Identification Number 1893632	·
		ning Insurance Contrac  Individual contracts grouped a				
1 Coverage Information:					portou on a omgre conse	
(a) Name of insurance car AETNA HEALTH INC TX						
(I-) [IN]	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
(b) EIN	code	identification number	'	persons covered at end of policy or contract year		<b>(g)</b> To
76-0189680	95490	172310;172312	249		01/01/2021	12/31/2021
descending order of the (a) Total a	amount paid. Imount of comr	·		<b>(b)</b> To	the agents, brokers, and	other persons in
3 Persons receiving comm		ees. (Complete as many entries and address of the agent, broker			sions or foos wore paid	
<b>(b)</b> Amount of sales and commissions paid	d base		es and other commission			(e) Organization code
	(a) Name a	nd address of the agent, broker	, or other person to whor	n commiss	sions or fees were paid	
(b) Amount of sales and	d base	Fe	es and other commission	ns paid		
commissions paid	d	(c) Amount	ı	(d) Purpos	е	(e) Organization code

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

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

Pa	art I	If more than one contract covers the same ground the information may be combined for reporting	up of employees of the purposes if such cont	racts are e	хре	rience-rated as a unit	. Where co	ontracts co	rganizations(s), ver individual
0		employees, the entire group of such individual	contracts with each ca	arrier may t	oe t	reated as a unit for pu	irposes or t	nis report.	
		nefit and contract type (check all applicable boxes)	Пъ	_	П			- I	
	a _	Health (other than dental or vision)	Dental		Ш	Vision		느	insurance
	e	Temporary disability (accident and sickness) <b>f</b>	Long-term disabili	ty <b>g</b>	Ш	Supplemental unemp	oloyment	h Pres	scription drug
	i [	Stop loss (large deductible) j	X HMO contract	k		PPO contract		I Inde	mnity contract
	m	Other (specify)							
	L	<b>_</b>							
9 i	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		9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	_	Benefit charges (1) Claims paid		9b(1)					
		(2) Increase (decrease) in claim reserves		9b(2)					
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on 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		9c(1)(F)					
		(G) Other retention charges		9c(1)(G)	)				
		(H) Total retention					9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These arr	nounts were paid in	cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Ar	mount held to provide	benefits aft	ter ı	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not in	nclude amount entered	d in line 9c(	<b>(2)</b> .)		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carri	er				10a		1079649
	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 Schedi	ule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the information		-		<u> </u>			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

		parouant to	=:			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 EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO	DR RETIRED		e-digit number (PN)	591
C Plan sponsor's name a	ORPORATION			52-	oyer Identification Numbe 1893632	
		ning Insurance Contrac  Individual contracts grouped a				
1 Coverage Information:	<u> </u>	. manada oo mada gi oapoa c			portou on a onigio ocinou	
(a) Name of insurance ca						
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f) From	<b>(g)</b> To
35-2145715	62825	173039H043	15		01/01/2021	12/31/2021
descending order of the		ation. Enter the total fees and to	tal commissions paid. L		the agents, brokers, and otal amount of fees paid	other persons in
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).		
	(a) Name a	nd address of the agent, broker	, or other person to who	n commiss	sions or fees were paid	
(b) Amount of sales a			es and other commission	•		
commissions paid		(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name a	nd address of the agent, broker	, or other person to who	n commiss	sions or fees were paid	
(b) Amount of sales a	nd base	Fe	es and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code
		-				

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

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

Pa	art I	If more than one contract covers the same group the information may be combined for reporting p	o of employees of the urposes if such contr	acts are ex	xper	rience-rated as a unit	Where co	ontracts cover	nizations(s), individual
_		employees, the entire group of such individual co	ontracts with each ca	rrier may b	e tr	reated as a unit for pu	rposes of t	nis report.	
8	Bene	nefit and contract type (check all applicable boxes)	7						
	a	Health (other than dental or vision) <b>b</b>	Dental	С	Ш	Vision		<b>d</b> Life ins	urance
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	y <b>g</b>		Supplemental unemp	loyment	<b>h</b> Prescri	otion drug
	i [	Stop loss (large deductible) j 🛚 🗙	HMO contract	k		PPO contract		I Indemn	ity contract
	m	Other (specify)	_					<u> </u>	
	<u>L</u>								
9 i	Ехре	erience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserve	T T	9a(3)					
		(4) Earned ((1) + (2) - (3))	_				9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
		(2) Increase (decrease) in claim reserves		9b(2)					
		(3) Incurred claims (add (1) and (2))	·····				9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on an	accrual basis)			•			
		(A) Commissions		9c(1)(A)	)				
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)					
		(D) Other expenses		9c(1)(D)					
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies	<u> </u>	9c(1)(F)	_				
		(G) Other retention charges		9c(1)(G)	)				
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These amo	unts were paid in	cash, or	cr	edited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amo	ount held to provide I	enefits 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 inc	lude amount entered	in line 9c(	<b>2)</b> .)		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrier					10a		128809
	b	If the carrier, service, or other organization incurred ar							
	O	retention of the contract or policy, other than reported ecify nature of costs.	in Part I, line 2 above	e, report an	nou	ınt	10b		
Pa	art l'	IV Provision of Information							
11	Did	d the insurance company fail to provide any information	necessary to comple	ete Schedu	ıle /	٩?	Yes	X No	
		the answer to line 11 is "Yes," specify the information no							

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

			, , , ,			шересиен
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>B</b> Thre	e-digit	
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591
EMPLOYEES						<u>.</u>
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Num	nber (EIN)
LOCKHEED MARTIN CO	DRPORATION			52-	-1893632	
		ning Insurance Contra				
on a separ	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and II	II can be re	ported on a single Sch	nedule A.
1 Coverage Information:						
( ) N ( )						
(a) Name of insurance ca	arrier					
ANTHEM, INC - CA HMO						
			(e) Approximate nu	ımher of	Policy	or contract year
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	persons covered a			
	code	identification number	policy or contrac	t year	(f) From	<b>(g)</b> To
35-2145715	62825	173039	2		01/01/2021	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, a	and other persons in
(a) Total	amount of comi	missions paid		<b>(b)</b> To	otal amount of fees pa	id
2.5		(0 1.	1 14 4 11	`		
3 Persons receiving com		ees. (Complete as many entrie				<del></del> -
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	1
(b) Amount of sales a			ees and other commission	•		<del></del>
commissions pa	ıld	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	b
		-	•		•	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid		
commissions paid (c) Amount (d) Purpose (e) Organization cod						
22	-	\','		· · · · · · · · · · · · · · · · · · ·		(5) 5 5 5 5 5 6 5 6 6 6 6 6 6 6 6 6 6 6 6

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

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

Pa	art I	II	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	racts are exp	érience-rated as a un	it. Where co	ontracts co	
8	Bene	efit ar	nd contract type (check all applicable boxes)			•		<u> </u>	
	a 「	_	alth (other than dental or vision)	<b>b</b> Dental	c۲	Vision		d ∏ Life	insurance
	_ _	_		<u>=</u>	<u> </u>			=	
	e L			f Long-term disabili		Supplemental unem	ployment	=	scription drug
	i [	Sto	op loss (large deductible)	j X HMO contract	k _	PPO contract		I Inde	emnity contract
	m	Ot	her (specify)						
<b>9</b> E	Expe	erienc	e-rated contracts:						
	a F	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	l	9a(2)				
			ncrease (decrease) in unearned premium res		9a(3)		1		
		(4) E	arned ((1) + (2) - (3))				. 9a(4)		0
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)		T		
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		0
			laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)					
		,	A) Commissions		9c(1)(A)				
		,	B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)				
			D) Other expenses		9c(1)(D)				
		,	E) Taxes		9c(1)(E)				
			F) Charges for risks or other contingencies .		9c(1)(F)				
			G) Other retention charges				0 - (4) (11)		
		,	H) Total retention	_	_		9c(1)(H)	<u> </u>	0
			Dividends or retroactive rate refunds. (These	_	-		9c(2)		
	d		us of policyholder reserves at end of year: (1	•			9d(1)		
		` '	Claim reserves				9d(2)		
	_	` '	Other reserves				9d(3)		
40			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e		
10			erience-rated contracts:				40		40700
	_		Il premiums or subscription charges paid to c				10a		48706
	b		e carrier, service, or other organization incurr				10h		
	Sne	reter cify n	ntion of the contract or policy, other than repo ature of costs.	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Opc	City II	ature or costs.						
D:	we I	v I	Provision of Information						
	art I		Provision of Information						
11	Dic	l the	insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A?	Yes	X No	
12	If th	ne an	swer to line 11 is "Yes," specify the informati	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

		parouarit to	=:		mspection
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021	and	l ending 12/31/2021	
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO		hree-digit lan number (PN)	591
C Plan sponsor's name a		e 2a of Form 5500		nployer Identification Number 52-1893632	er (EIN)
		ning Insurance Contract. Individual contracts grouped a			
1 Coverage Information:					
(a) Name of insurance ca		ARE PLAN OF GEORGIA, INC			
# N = N 1	(c) NAIC	(d) Contract or	(e) Approximate number o		contract year
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To
58-1638390	96962	174524	5	01/01/2021	12/31/2021
descending order of the	amount paid.	ation. Enter the total fees and tot	·		I other persons in
(a) Total	amount of comr	nissions paid	(b)	Total amount of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons	s).	
-	(a) Name a	nd address of the agent, broker,	, or other person to whom comm	nissions or fees were paid	
(b) Amount of sales a			es and other commissions paid		
commissions pa	id	(c) Amount	<b>(d)</b> Purp	oose	(e) Organization code
	(a) Name a	nd address of the agent, broker,	, or other person to whom comm	nissions or fees were paid	
(b) Amount of sales a	nd base	Fee	es and other commissions paid		
commissions pa	iid	(c) Amount	(d) Purp	oose	(e) Organization code

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

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

P	Part III Welfare Benefit Contract Inform	ation				
	If more than one contract covers the same		e same empl	over(s) or members of	the same en	nplovee organizations(s).
	the information may be combined for repor					
	employees, the entire group of such individ	lual 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)	<b>b</b> Dental	сГ	Vision		d Life insurance
	e Temporary disability (accident and sickness)	f ☐ Long-term disabili	_	Supplemental unemp		<b>h</b> ☐ Prescription drug
		<u>=</u>			Dioyineni	
	i Stop loss (large deductible)	j X HMO contract	ĸ	PPO contract		I Indemnity contract
	m ☐ Other (specify) ▶					
<b>9</b> E	Experience-rated contracts:					
	a Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	0
	<b>b</b> Benefit charges (1) Claims paid					
	(2) Increase (decrease) in claim reserves					_
	(3) Incurred claims (add (1) and (2))				9b(3)	0
	(4) Claims charged				9b(4)	
	C Remainder of premium: (1) Retention charges (c					
	(A) Commissions	,	9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		0 (4)(0)			-
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		0-/4\/5\			-
	(F) Charges for risks or other contingencies					-
	(G) Other retention charges					-
					9c(1)(H)	0
	(H) Total retention					0
	(2) Dividends or retroactive rate refunds. (These				9c(2)	
	<b>d</b> Status of policyholder reserves at end of year: (*	•			9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
	<b>e</b> Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line <b>9c(2</b> )	<u>).)</u>	9e	
10	Nonexperience-rated contracts:					
	a Total premiums or subscription charges paid to	carrier			10a	231789
	<b>b</b> If the carrier, service, or other organization incur	red any specific costs in o	connection wi	th the acquisition or		
	retention of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report am	ount	10b	
	Specify nature of costs.					
Pa	Part IV Provision of Information					
11	Did the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	э А?	Yes	No
	If the answer to line 11 is "Yes," specify the informat				L	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

			, , , ,	1		шересиен
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>B</b> Thre	e-digit	
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591
EMPLOYEES	EMPLOYEES					·
				_		
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		-	yer Identification Num	nber (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632	
		ning Insurance Contra				
	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and I	ii can be re	ported on a single Sci	nedule A.
1 Coverage Information:						
(a) Name of insurance ca	rrior					
` '						
CIGNA HEALTHCARE OF	· AZ					
	(a) NIAIC	(d) Contract or	(e) Approximate n	umber of	Policy	or contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f) From	<b>(g)</b> To
		10011111001111001	policy or contrac	t year	(1)	(9)
86-0334392	95125	4225	24		01/01/2021	12/31/2021
_						
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, a	and other persons in
(a) Total	amount of comi	missions paid		<b>(b)</b> To	otal amount of fees pa	iid
2 Paraona receiving com	missions and f	ees. (Complete as many entrie	o as pooded to report all	noroono)		
Fersons receiving com		and address of the agent, broke			iona or food word nois	
	(a) Name a	illu address of the agent, broke	er, or other person to who	III COITIIIISS	sions or fees were paid	<u> </u>
		F	ees and other commissio	ne naid		
(b) Amount of sales an commissions pa		(c) Amount	ces and other commission	(d) Purpos	Δ	(e) Organization code
commissions pa	iiu	(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 paid	d
	ı					
(b) Amount of sales a	nd base	F	ees and other commissio	ns paid		
commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code

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

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

0

Р	art III Welfare Benefit Contract Informat	ion					
•	If more than one contract covers the same gr		e same empl	oyer(s) or members o	f the same en	nployee organizat	ions(s),
	the information may be combined for reporting						idual
	employees, the entire group of such individua	I contracts with each ca	arrier may be	treated as a unit for p	ourposes of th	is report.	
8	Benefit and contract type (check all applicable boxes)						
	a Health (other than dental or vision)	Dental	С	Vision		<b>d</b> Life insuran	ce
		Long-term disabili	_	Supplemental unen	nplovment	<b>h</b> Prescription	drua
		X HMO contract		PPO contract	ipioyinoni	I Indemnity co	-
		HIVIO CONTIACT	ν.[	] PPO contract			лшасі
	m ☐ Other (specify)						
						1	
9	Experience-rated contracts:						
	a Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid.		9a(2)				
	(3) Increase (decrease) in unearned premium rese	ve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		0
	<b>b</b> Benefit charges (1) Claims paid		9b(1)				
	(2) Increase (decrease) in claim reserves						
					0b/3\		0
	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
	(4) Claims charged				9b(4)		
	<b>c</b> Remainder of premium: (1) Retention charges (on	,	- (1)(1)				
	(A) Commissions		9c(1)(A)				
	(B) Administrative service or other fees		9c(1)(B)				
	(C) Other specific acquisition costs		9c(1)(C)				
	(D) Other expenses		9c(1)(D)				
	(E) Taxes		9c(1)(E)				
	(F) Charges for risks or other contingencies		9c(1)(F)				
	(G) Other retention charges		9c(1)(G)				
	(H) Total retention				9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These a	mounts were ☐ paid ir	cash, or	credited.)			
	<b>d</b> Status of policyholder reserves at end of year: (1)						
		•					
	(2) Claim reserves				9d(2)		
	(3) Other reserves				` '		
	e Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c(2</b> )	<b>)</b> .)	9e		
10	Nonexperience-rated contracts:						
	<b>a</b> Total premiums or subscription charges paid to call	rier			10a		86242
	<b>b</b> If the carrier, service, or other organization incurred	d any specific costs in c	onnection wi	th the acquisition or			
	retention of the contract or policy, other than report	ed in Part I, line 2 abov	e, report am	ount	10b		
	Specify nature of costs.						
P	art IV Provision of Information						
11	Did the insurance company fail to provide any informa	ion necessary to comp	ete Schedule	e A?	Yes	X No	
	If the answer to line 11 is "Yes," specify the information			_	<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

For calendar plan year 20	21 or fiscal pla	an year beginning 01/01/2021		and er	nding 12/31/2021	•	
A Name of plan				<b>B</b> Thre	<b>B</b> Three-digit		
	RPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	n number (PN)	591	
EMPLOYEES							
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	oyer Identification Num	ber (EIN)	
LOCKHEED MARTIN CO					-1893632	(=)	
		rning Insurance Contra  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrior						
EYEMED VISION CARE	inei						
ETEMED VIOLON OAKE							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate persons covered		Policy	or contract year	
<b>(b)</b> EIN	code	identification number	policy or con		(f) From	<b>(g)</b> To	
43-0949844	71870	9660556 & SUBS	:	209	01/01/2021	12/31/2021	
2 Insurance fee and com	mission inform	nation. Enter the total fees and t	otal commissions paid	d. List in line 3	the agents, brokers, a	nd other persons in	
descending order of the	amount paid.		· -				
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid						
3 Persons receiving com		fees. (Complete as many entrie					
	(a) Name	and address of the agent, broke	er, or other person to	vhom commiss	sions or fees were paid		
(b) Amount of sales ar	nd base		ees and other commis				
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code	
	(-) NI	and address of the areat backs					
	(a) Name	and address of the agent, broke	er, or other person to	vnom commiss	sions or fees were paid		
(b) Amount of sales ar			ees and other commis	•			
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code	

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

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

0

Pa	art I	Welfare Benefit Contract Information If more than one contract covers the same group of employee the information may be combined for reporting purposes if employees, the entire group of such individual contracts we	f such contracts are	ехре	erience-rated as a unit	. Where co	ntracts cover individ	ns(s), ual
8	Rone	nefit and contract type (check all applicable boxes)	viiii caoii caiiici iiia	y DC	ireated do a unit for pe	1100000 01 1	по горога	
	_	_		<b>~</b> ∇	Vision		<b>d</b> ☐ Life insurance	
	a _				Vision			
	е	Temporary disability (accident and sickness) <b>f</b> Long-te	erm disability	g _	Supplemental unemp	oloyment	<b>h</b> Prescription d	rug
	i	Stop loss (large deductible) j HMO co	ontract	k	PPO contract		I Indemnity con	tract
	m	Other (specify)						
	<u> </u>							
<b>9</b> [	хре	erience-rated contracts:						
	a F	Premiums: (1) Amount received	9a(1	)				
		(2) Increase (decrease) in amount due but unpaid	9a(2	2)				
		(3) Increase (decrease) in unearned premium reserve		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	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 b	asis)					
		(A) Commissions	9c(1)(	(A)				
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs	9c(1)(	(C)				
		(D) Other expenses	9c(1)(	D)				
		(E) Taxes	9c(1)(	<b>E</b> )				
		(F) Charges for risks or other contingencies	9c(1)(	(F)				
		(G) Other retention charges	9c(1)(	(G)				
		(H) Total retention				9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, o	r 🗌 c	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held	to provide benefits	after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amo	unt entered in line	9c(2).	)	9e		
10	Nor	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a		17532
	b	If the carrier, service, or other organization incurred any specific	c costs in connection	n with	n the acquisition or			
		retention of the contract or policy, other than reported in Part I,				10b		
	Spec	ecify nature of costs.						
P	rt l'	IV Provision of Information						
			m. ta aama/alata 0 l	- al1		Yes	X No	
		d the insurance company fail to provide any information necessa		eaule	Α:	1 69	X No	
12	If th	the answer to line 11 is "Yes," specify the information not provide	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

This Form is Open to Public Inspection

For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and er	nding 12/31/2021	•
A Name of plan				<b>B</b> Thre		
	ORPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591
EMPLOYEES						
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numb	er (EIN)
LOCKHEED MARTIN CO					1893632	,
		rning Insurance Contract. Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
		OF WASHINGTON OPTIONS,	INC.			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		-	r contract year
(5) EIIV	code	identification number	policy or contract		(f) From	<b>(g)</b> To
91-1467158	47055	6778600	1		01/01/2021	12/31/2021
		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, and	d other persons in
descending order of the amount paid.  (a) Total amount of commissions paid				(b) T	otal amount of fees paid	
(a) Total amount of commissions paid						
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	nersons)		
T Cladia receiving com		and address of the agent, broke			sions or fees were paid	
	(**/		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
(1) A		F	ees and other commissio	ns naid		
(b) Amount of sales ar commissions pa		(c) Amount	ces and outer commission	(d) Purpos	e	(e) Organization code
<b>.</b>		, ,		` ' '		,, ,
	(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 ar	nd base	F	ees and other commissio	ns paid		
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code
	l l					1

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

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

0

Pa	art II	If more than one contract covers the same gro the information may be combined for reporting	oup of employees of the purposes if such cont	racts are e	xpe	rience-rated as a unit	. Where co	ontracts cov	ganizations(s), er individual
0		employees, the entire group of such individua	Contracts with each ca	amer may i	be t	reated as a unit for pu	irposes or t	nis report.	
		efit and contract type (check all applicable boxes)	. 🗆	_	. —			a 🗆	
	a _	Health (other than dental or vision)	Dental		; ∐	Vision			nsurance
	e	Temporary disability (accident and sickness) <b>f</b>	Long-term disabili	ty <b>g</b>	ıШ	Supplemental unemp	oloyment	<b>h</b> Pres	cription drug
	i [	Stop loss (large deductible)	X HMO contract	k		PPO contract		I Inder	mnity contract
	m	Other (specify)							
	<u> </u>								
<b>9</b> [	хре	erience-rated contracts:							
	a P	Premiums: (1) Amount received		9a(1)					
	(	(2) Increase (decrease) in amount due but unpaid		9a(2)					
	(	(3) Increase (decrease) in unearned premium reser	ve	9a(3)					
	(	(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
	(	(2) Increase (decrease) in claim reserves		9b(2)					
	(	(3) Incurred claims (add (1) and (2))					9b(3)		0
	(	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	an accrual basis)						
		(A) Commissions		9c(1)(A	)				
		(B) Administrative service or other fees		9c(1)(B	)				
		(C) Other specific acquisition costs		9c(1)(C	)				
		(D) Other expenses		9c(1)(D	_				
		(E) Taxes			_				
		(F) Charges for risks or other contingencies			_				
		(G) Other retention charges		9c(1)(G	)				
		(H) Total retention					9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These are	mounts were paid ir	n cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	Amount held to provide	benefits af	ter i	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c</b>	<b>(2)</b> .)	)	9e		
10	Nor	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to car	rier				10a		14856
		If the carrier, service, or other organization incurred					10b		
	Spec	retention of the contract or policy, other than report cify nature of costs.	eu iii Fait i, iiile 2 abov	е, тероп а	11100	uiit	100		
Pa	rt I	V Provision of Information							
			ion noonoon, to occur	loto Coba-l	ula	<u>ла</u> П	Yes	X No	
		d the insurance company fail to provide any informat		iete Sched	uie .	A:	1 53		
12	If th	he answer to line 11 is "Yes," specify the information	not provided. 🕨						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base and address of the agent, broker, or other person to whom commissions or fees were paid			parodant to	=:	•		mspection
C Plan sponsor's name as shown on line 2a of Form 5500 C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) 52-1893632  Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information: (a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF WASHINGTON  (b) EIN	For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and en	nding 12/31/2021	
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  KAISER FOUNDATION HEALTH PLAN OF WASHINGTON  (b) EIN (c) NAIC (d) Contract or identification number code (e) Approximate number of persons covered at end of policy or contract year persons covered at end of policy or contract year (f) From (g) To policy or contract year (h) From (h) To policy or contract	LOCKHEED MARTIN CO	ORPORATION (	GROUP INSURANCE PLAN FO	OR RETIRED			591
on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  KAISER FOUNDATION HEALTH PLAN OF WASHINGTON  (b) EIN (c) NAIC code Identification number of identification number of persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons or covered at end of policy or contract year persons or covered at end of policy or contract year persons or descending order of the amount paid.  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (e) Organization code	LOCKHEED MARTIN CO	ORPORATION			52-	1893632	
1 Coverage Information:  (a) Name of insurance carrier  KAISER FOUNDATION HEALTH PLAN OF WASHINGTON  (b) EIN (c) NAIC code (d) Contract or identification number of persons covered at end of policy or contract year (f) From (g) To persons covered at end of policy or contract year (h) From (g) To persons covered at end of policy or contract year (h) From (g) To persons covered at end of policy or contract year (h) From (g) To persons covered at end of policy or contract year (h) From (g) To persons covered at end of policy or contract year (h) From (g) To persons contract year (h) From (g) To persons contract year (h) From (g) To persons or fees end commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code  (b) Amount of sales and base Fees and other commissions or fees were paid							
(a) Name of insurance carrier  KAISER FOUNDATION HEALTH PLAN OF WASHINGTON  (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year (t) From (g) To 91-0511770 95672 1069000 28 01/01/2021 12/31/2021  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		<u> </u>	a.ruada. comunacto groupou a			portou on a omigro como	
(b) EIN (c) Note code identification number persons covered at end of policy or contract year policy or contract year 1069000 28 01/01/2021 12/31/2021  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(a) Name of insurance ca		PF WASHINGTON				
Second   Identification number   Identification numb	ALV EIN	(c) NAIC	(d) Contract or			Policy or	contract year
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base and address of the agent, broker, or other person to whom commissions or fees were paid	(b) EIN	code identification number persons covered at end of			(f) From	<b>(g)</b> To	
descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and address of the agent, broker, or other person to whom commissions or fees were paid	91-0511770	95672 1069000 28			01/01/2021	12/31/2021	
(b) Amount of sales and base Fees and other commissions paid	descending order of the  (a) Total  3 Persons receiving com  (b) Amount of sales an	amount paid. amount of communications and fe (a) Name a	nissions paid ees. (Complete as many entries nd address of the agent, broker,	as needed to report all, or other person to who	(b) To	sions or fees were paid	(e) Organization code
(b) Amount of sales and base Fees and other commissions paid							
(b) Amount of sales and base		(a) Name a	nd address of the agent, broker,	, or other person to who	m commiss	sions or fees were paid	
(b) Amount of sales and base							
	(b) Amount of sales a	nd base	Fee	es and other commission	ns paid		
	` ,		(c) Amount		(d) Purpos	e	(e) Organization code

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

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

0

Pa	Welfare Benefit Contract Information If more than one contract covers the same ground the information may be combined for reporting employees, the entire group of such individual of the same process.	up of employees of the purposes if such cont	racts are	expe	rience-rated as a uni	t. Where co	ntracts cover ind	ations(s), ividual
8	Benefit and contract type (check all applicable boxes)	_					_	
	<b>a</b> Health (other than dental or vision)	Dental	(	c 🗌	Vision		<b>d</b> Life insura	nce
	e ☐ Temporary disability (accident and sickness) <b>f</b>	Long-term disabili	ty 🧐	эΠ	Supplemental unem	ployment	<b>h</b> Prescription	n drug
	i Stop loss (large deductible)	HMO contract		kΠ	PPO contract		I Indemnity	contract
	m ☐ Other (specify) ▶			ш				
	III Utilei (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 reserve		<del>``</del>					
	(4) Earned ((1) + (2) - (3))					. 9a(4)		0
	<b>b</b> Benefit charges (1) Claims paid							
	(2) Increase (decrease) in claim reserves		9b(2)					
	(3) Incurred claims (add (1) and (2))					9b(3)		0
	(4) Claims charged					9b(4)		
	c Remainder of premium: (1) Retention charges (on an	n accrual basis)						
	(A) Commissions		9c(1)(A	١)				
	(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					0 (4)(1)		
	(H) Total retention	_		_		9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These am	_		_		9c(2)		
	<b>d</b> Status of policyholder reserves at end of year: (1) Ar	·				9d(1)		
	(2) Claim reserves					9d(2)		
	(3) Other reserves					9d(3)		
40	e Dividends or retroactive rate refunds due. (Do not in	clude amount entered	d in line 90	c(2).	)	9e		
10	Nonexperience-rated contracts:					40-		040000
	<b>a</b> Total premiums or subscription charges paid to carrie					10a		219963
	b If the carrier, service, or other organization incurred a					10b		
	retention of the contract or policy, other than reported Specify nature of costs.	u in Part I, line 2 abov	e, report a	amo	unt	100		
	Dravisian of Information							
Pa	art IV Provision of Information					r		
11	. , , , , , , , , , , , , , , , , , , ,		lete Sched	dule	A?	Yes	X No	
12	If the answer to line 11 is "Yes," specify the information is	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 plar	n year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan				<b>B</b> Thre	e-digit		
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591	
EMPLOYEES							
0 -:				<b>D</b>			
C Plan sponsor's name a		e 2a of Form 5500		-	yer Identification Nur	nber (EIN)	
LOCKHEED MARTIN CO	DRPORATION			52-	1893632		
Dout I Informat	tion Consor	mina Incurance Centre	ot Coverage Fees	and Can	nmissions Deside	- information for each con-	
		rning Insurance Contract. Individual contracts grouped					tract
	ato Coriodaio 7	marriada comitacto groupou	ao a anicin'i ano n'ana i		ported on a onigio co	Tioddio 7 t.	
1 Coverage Information:							
(a) Name of insurance ca	ırrier						
HAWAII MEDICAL SERVI	CE ASSOCIAT	ION					
/L\	(c) NAIC	(d) Contract or	(e) Approximate n		Policy	y or contract year	
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year		(f) From	<b>(g)</b> To	
99-0040115	49948	C952	13	•	01/01/2021	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 other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						aid	
·		•					
2 Darsana resoluting som	mississe and f	and (Camplete as many entrie	a a naadad ta ranart all	noroona\			
3 Persons receiving com		ees. (Complete as many entrie			.:	٠	
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or rees were par	u	
(h) Amount of color of		F	ees and other commissio	ns paid			
(b) Amount of sales an commissions pa		(c) Amount		(d) Purpos	e	(e) Organization of	code
		(1)		(1)	-	(4) 4 34 4 4	
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were pai	<u>a</u>	
	1	E	ees and other commissio	ns naid			
(b) Amount of sales a			cos and other commissio	(d) Purpos	Α	(a) Organization	codo
commissions pa	iu	(c) Amount		(u) Fulpos	<u> </u>	(e) Organization (	Joue

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

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

acts are experience-rated as a unit	
<b>c</b> ☐ Vision	<b>d</b> Life insurance
<b>=</b>	불
· · · · · · · · · · · · · · · · · · ·	<u>.                                    </u>
<b>K</b> ☐ PPO contract	I ☐ Indemnity contract
- : : · · · · · · · · · · · · · · · · ·	
\ /	2 (1)
	9a(4) 0
	21 (2)
	9b(3) 0
	9b(4)
0.743743	
<u>'</u>	9c(1)(H) 0
	9c(2)
	9d(1)
	9d(2)
	9d(3)
in line <b>9c(2)</b> .)	9e
	40,4000
	<b>10a</b> 164692
•	10b
ete Schedule A?	Yes X No
	e same employer(s) or members of racts are experience-rated as a unit for purious of the same employer (s) or members of the racts are experience-rated as a unit for purious of the same employer (s) or members of the racts are experience-rated as a unit for purious of the same employer (s) or members of the racts are experienced as a unit for purious or members of the racts are experienced as a unit for purious or members of the racts are experienced as a unit for purious or part of the same employer (s) or members of the racts are experienced as a unit for purious or part of the same employer (s) or members of the racts are experienced as a unit for purious or part of the same employer (s) or members of the racts are experienced as a unit for purious or part of the same employer (s) or members of the racts are experienced as a unit for purious or part of the same employer (s) or members of the same employer (s) or m

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 plar	year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan  B Three-digit							
	GROUP INSURANCE PLAN F	OR RETIRED		number (PN)	591		
EMPLOYEES				•	, ,		
_							
C Plan sponsor's name a	is shown on line	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Num	nber (EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		ning Insurance Contraction Individual contracts grouped					
1 Coverage Information:		Ţ,			,		
(a) Name of insurance ca	rrier						
HEALTH NET - NORTHER	RN CA SR HMC	)					
	1	T	T		T = ::		
/b) FINI	(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	<b>(g)</b> To	
95-4402957	95800	57534	60	- <b>,</b>	01/01/2021	12/31/2021	
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, a	and other persons in	
(a) Total a	amount of comr	nissions paid		<b>(b)</b> To	otal amount of fees pa	iid	
3 Porsons receiving com	missions and fo	ees. (Complete as many entrie	e as pooded to report all	norcone)			
J 1 ersons receiving com		nd address of the agent, broke			iona or food ware nois	J	
	(a) Name a	nd address of the agent, broke	er, or other person to who	III COIIIIIISS	sions or lees were paid	ı	
			ees and other commissio	ne poid			
(b) Amount of sales ar		(c) Amount	(d) Purpose			(a) Organization code	
commissions pa	iu	(C) Amount		(u) Puipos	<del>U</del>	(e) Organization code	
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	d	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code	
- <u>-                                  </u>						,, ,	

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

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

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 ting purposes if such cont	racts are e	xperience-rate	d as a unit	t. Where co	ntracts cover individua	s(s), al
8	Popofit			arrior may i	oc treated as a	dilicitor po	arpooco or ti	по торота	
O	_	t and contract type (check all applicable boxes)	_	_				<b>⊿</b> □ 126. 3	
	а	Health (other than dental or vision)	<b>b</b> Dental		Vision			d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Suppleme	ntal unem <sub>l</sub>	ployment	<b>h</b> Prescription dru	ıg
	i 🔲	Stop loss (large deductible)	j X HMO contract	k	PPO contr	act		I Indemnity contr	act
	m	Other (specify)							
9	Experie	ence-rated contracts:							
	<b>a</b> Pre	emiums: (1) Amount received		9a(1)					
	(2)	) Increase (decrease) in amount due but unpaid	b	9a(2)					
	(3)	) Increase (decrease) in unearned premium res	serve	9a(3)					
	(4)	) Earned ( <b>(1) + (2) - (3)</b> )					9a(4)		0
	<b>b</b> B	enefit charges (1) Claims paid		9b(1)					
	(2)	) Increase (decrease) in claim reserves		9b(2)					
	(3)	) Incurred claims (add (1) and (2))					9b(3)		0
	` '	) Claims charged					9b(4)		
	C R	emainder of premium: (1) Retention charges (c	n an accrual basis)		_				
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees		9c(1)(B)					
		(C) Other specific acquisition costs		9c(1)(C)					
		(D) Other expenses		9c(1)(D)					
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies .		9c(1)(F)					
		(G) Other retention charges			•		0-(4)(11)		
		(H) Total retention			_		9c(1)(H)		0
		2) Dividends or retroactive rate refunds. (These	_		_		9c(2)		
		tatus of policyholder reserves at end of year: (1					9d(1)		
	`	2) Claim reserves					9d(2)		
	,	3) Other reserves					9d(3)		
40		ividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c	<b>(2)</b> .)		9e		
10		xperience-rated contracts:					40		470000
		otal premiums or subscription charges paid to c					10a		472632
	re	the carrier, service, or other organization incur etention of the contract or policy, other than rep					10b		
	Specify	y nature of costs.							
ь	art IV	Provision of Information							
							Vaa	V Na	
		ne insurance company fail to provide any inform		lete Sched	ule 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

EMPLOYEES PRAIT HUMBER (FTV)	591 IN)
LOCKHEED MARTIN CORPORATION GROUP INSURANCE PLAN FOR RETIRED  EMPLOYEES  plan number (PN)  5	
0.51	IN)
C Plan sponsor's name as shown on line 2a of Form 5500  LOCKHEED MARTIN CORPORATION  D Employer Identification Number (EIN 52-1893632	
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.	
1 Coverage Information:	
(a) Name of insurance carrier HEALTH NET - SOUTHERN CA	
(c) NAIC (d) Contract or (e) Approximate number of Policy or contract or	tract year
(b) EIN (d) Contract of persons covered at end of policy or contract year (f) From	<b>(g)</b> To
95-4402957 95800 5030 & SUBS 3 01/01/2021	12/31/2021
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose	(e) Organization code
(a) Name 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 code

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

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

Pa	rt II	Welfare Benefit Contract Informa	ntion					
		If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	ing purposes if such cont	racts are expe	erience-rated as a un	it. Where co	ontracts cover in	
8	3ene	fit and contract type (check all applicable boxes)			<u> </u>	<u> </u>	· · · · · · · · · · · · · · · · · · ·	
	а ∏	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insu	rance
	ㅁ					nloven ont	블	
,	e ∐ . □		f Long-term disabilit	- <u>-</u>	Supplemental unem	ipioymeni	h Prescript	_
	' <u>U</u>	Stop loss (large deductible)	j X HMO contract	K _	PPO contract		I Indemnit	y contract
	m _	Other (specify)						
							1	
		rience-rated contracts:						
•		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)		
		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 :	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	d in line 9c(2).	.)	9e		
10		experience-rated contracts:	o rri o r			100		F0760
	_	Total premiums or subscription charges paid to c				10a		52768
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
;		ify nature of costs.	orted in Fait 1, line 2 abov	c, report amo	, di it	100	I	
Pa	rt I\	Provision of Information						
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No	
12	If the	e answer to line 11 is "Yes," specify the informati	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and er	nding 12/31/2021	•
A Name of plan				B Three-digit		
LOCKHEED MARTIN CO	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591	
EMPLOTEES						
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numl	per (EIN)
LOCKHEED MARTIN CO					·1893632	( )
		rning Insurance Contra  L. Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
HEALTH NET - SOUTHER		)				
TIERETTINET GOOTTE	·					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate persons covered		Policy	or contract year
(b) LIN	code	identification number	policy or contr		(f) From	<b>(g)</b> To
95-4402957	95800	57534	13	32	01/01/2021	12/31/2021
2 Insurance fee and com	mission inform	ation. Enter the total fees and t	otal commissions paid.	List in line 3	the agents, brokers, ar	nd other persons in
descending order of the						
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees paid	<u>d</u>
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 w	nom commiss	sions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commiss	ions paid		
commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code
						<u> </u>
	(a) Name a	and address of the agent, broke	er, or other person to wi	nom commiss	sions or fees were paid	
(b) Amount of sales ar			ees and other commiss			
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code

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

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

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information in the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes.	tracts are experience-rated as a uni	it. Where contracts cover individual
employees, the entire group of such individual contracts with each c	arrier may be treated as a unit for p	rurposes of this report.
8 Benefit and contract type (check all applicable boxes)		. 🗖
a ☐ Health (other than dental or vision) b ☐ Dental	<b>C</b> Vision	<b>d</b> Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability	ity <b>g</b> Supplemental unem	nployment <b>h</b> Prescription drug
i ☐ Stop loss (large deductible) j ☒ HMO contract	<b>k</b> 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>b</b> Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))		9b(3)
(4) Claims charged		9b(4)
<b>c</b> 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)	10.4040
(H) Total retention	_	9c(1)(H)
(2) Dividends or retroactive rate refunds. (These amounts were paid in		9c(2)
<b>d</b> 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 <b>9c(2)</b> .)	9e
10 Nonexperience-rated contracts:		
Total premiums or subscription charges paid to carrier		<b>10a</b> 446030
b If the carrier, service, or other organization incurred any specific costs in cretention 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).

#### 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	=:			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 EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO	DR RETIRED	B Thre	e-digit number (PN)	591
C Plan sponsor's name a	ORPORATION			52-	oyer Identification Number 1893632	<u> </u>
		ning Insurance Contrac  Individual contracts grouped a				
1 Coverage Information:		<u> </u>			J	
(a) Name of insurance ca	arrier					
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f) From	<b>(g)</b> To
41-1693838	95766	2181	16		01/01/2021	12/31/2021
descending order of the		ation. Enter the total fees and to	tal commissions paid. Lis		the agents, brokers, and otal amount of fees paid	other persons in
3 Persons receiving com		ees. (Complete as many entries nd address of the agent, broker			sions or foos wore paid	
(b) Amount of sales a		<u> </u>	es and other commission			
commissions pa		(c) Amount	(	d) Purpos	е	(e) Organization code
	(a) Name a	nd address of the agent, broker	, or other person to whon	n commiss	sions or fees were paid	
(b) Amount of sales a	nd base	Fe	es and other commission	s paid		
commissions pa		(c) Amount	(	d) Purpos	e	(e) Organization code

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

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

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information may be combined for reporting purposes if such contract to the information is a such contract t	racts are experience-rated a	is a unit. Where contracts cov	
employees, the entire group of such individual contracts with each ca	arrier may be treated as a ur	nit for purposes of this report.	
8 Benefit and contract type (check all applicable boxes)	_		
a ☐ Health (other than dental or vision) b ☐ Dental	C Vision	<b>d</b> ∐ Life i	nsurance
e Temporary disability (accident and sickness) f Long-term disabili	ty <b>g</b> Supplementa	ıl unemployment $oldsymbol{h}$ Preso	cription drug
i Stop loss (large deductible) j X HMO contract	k ☐ PPO contract	t I Inden	nnity contract
m ☐ Other (specify) ▶	_	_	
9 Experience-rated contracts:			
a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
<b>b</b> Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
C Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	<u>.</u>	9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were paid in	n cash, or credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after retirement	9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered	d in line <b>9c(2)</b> .)	9e	
10 Nonexperience-rated contracts:			
Total premiums or subscription charges paid to carrier		10a	73875
<b>b</b> If the carrier, service, or other organization incurred any specific costs in cretention of the contract or policy, other than reported in Part I, line 2 above			
Specify nature of costs.	•	<u> </u>	
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).

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

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

2021

This Form is Open to Public Inspection

		· ·	, , , ,			
For calendar plan year 20	)21 or fiscal plai	n year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
	ORPORATION	GROUP INSURANCE PLAN F	OR RETIRED		number (PN)	591
EMPLOYEES				•	, ,	
C Plan sponsor's name	as shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Num	nber (EIN)
LOCKHEED MARTIN CO	ORPORATION			52-	-1893632	
		rning Insurance Contract. Individual contracts grouped				
1 Coverage Information:		. Individual contracts grouped	as a unit in Faits it and i	ii can be re	ported on a single Sci	ledule A.
1 Coverage Information.						
(a) Name of insurance ca	arrier					
KAISER FOUNDATION H	EALTH PLAN I	NC				
# N = IN I	(c) NAIC	(d) Contract or	(e) Approximate n		Policy	or contract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To
94-1340523	00000	582-100;101	338	, , , , ,	01/01/2021	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, a	and other persons in
(a) Total	amount of com	missions paid		<b>(b)</b> To	otal amount of fees pa	id
3 Persons receiving com	nmissions and f	ees. (Complete as many entrie	es as needed to report all	nersons)		
T CISONS ICCCIVING CON		and address of the agent, broke			rions or foos word naid	1
	(a) Name a	ind address of the agent, broke	er, or other person to who	III COIIIIII33	sions of fees were paid	
(h) A a a - a - a - a - a - a - a - a		F	ees and other commissio	ns paid		
(b) Amount of sales a commissions page		(c) Amount	(d) Purpose			(e) Organization code
COMMINICONO PO	ald .	(o) / unodin		( <b>u</b> ) 1 dipose		(b) Grgariization ocac
	•					
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	<u> </u>
	1					
(b) Amount of sales a	nd base	F	ees and other commissio	ns paid		
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code

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

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

0

Pa	rt II	Welfare Benefit Contract Informa	ation					
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ing purposes if such cont	racts are expe	erience-rated as a un	it. Where co	ontracts cover in	
8	3ene	fit and contract type (check all applicable boxes)			<u> </u>	· ·	· · ·	
	аГ	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		d Life insura	ance
	<u> </u>		<u>=</u>	<u> </u>	1	nlov moont	블	
,	e		f Long-term disability		Supplemental unem	ipioymeni	h Prescripti	-
	' <u> </u>	Stop loss (large deductible)	j X HMO contract	K_	PPO contract		I Indemnity	contract
	m _	Other (specify)						
		rience-rated contracts:						
•		remiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res		9a(3)		00(4)		0
	_ '	(4) Earned ((1) + (2) - (3))		9b(1)		9a(4)		0
		Benefit charges (1) Claims paid(2) Increase (decrease) in claim reserves						
	,	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		0
		(4) Claims charged				9b(4)		
	,	Remainder of premium: (1) Retention charges (or				0.5(1)		
		(A) Commissions	, in the second of the second	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b> .	.)	9e		
10		nexperience-rated contracts:	orrior			100		4040504
		Total premiums or subscription charges paid to co				10a		4843584
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo				10b		
;		cify nature of costs.	orted in Fart I, line 2 abov	c, report arrio	, di it	100		
Pa	rt I\	V Provision of Information					_	
11	Did	the insurance company fail to provide any inform	ation necessary to compl	lete Schedule	A?	Yes	X No	
12	If th	e answer to line 11 is "Yes," specify the information	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION  D Employer Identification Number (EIN) 52-1893632  Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  (AISER FOUNDATION HEALTH PLAN INC  (b) EIN (c) NAIC code (d) Contract or identification number of persons covered at end of policy or contract year (g) To	For calendar plan year 20	021 or fiscal pla	in year beginning 01/01/2021		and er	nding 12/31/2021		
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION  Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  (AISER FOUNDATION HEALTH PLAN INC  (b) EIN (c) NAIC Code Identification number policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons in descending order of the amount peld.  2 Insurance fee and commission information. Enter the total fees and total commissions paid. (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	A Name of plan			<b>B</b> Thre	e-digit			
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION  Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of Insurance carrier  (AISER FOUNDATION HEALTH PLAN INC  (b) EIN (c) NAIC (dd) Contract or identification number persons covered at end of policy or contract year persons covered at end of policy or contract year of persons covered at end of policy or contract year of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base (c) Amount process and other commissions paid (d) Purpose (e) Organization code  (b) Amount of sales and base Fees and other commissions paid  (c) Amount of sales and base Fees and other commissions paid		GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591		
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  (AISER FOUNDATION HEALTH PLAN INC  (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year  (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year  (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year  (a) Total amount of commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name 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 code  (b) Amount of sales and base Fees and other commissions or fees were paid	EMPLOTEES							
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  (AISER FOUNDATION HEALTH PLAN INC  (b) EIN (c) NAIC code Identification number of code Identification number of persons covered at end of policy or contract year persons covered at end of policy or contract year of the amount paid.  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (b) Amount of sales and base	C Plan sponsor's name	as shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	yer Identification Nun	mber (EIN)	
on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  (AISER FOUNDATION HEALTH PLANINC  (b) EIN  (c) NAIC  (c) NAIC  (d) Contract or identification number  (e) Approximate number of persons covered at end of policy or contract year  (f) From  (g) To  12/31/2021  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base  Fees and other commissions or fees were paid	LOCKHEED MARTIN CO	ORPORATION			52-	1893632		
1 Coverage Information:  (a) Name of insurance carrier  (AISER FOUNDATION HEALTH PLAN INC  (b) EIN  (c) NAIC code  (d) Contract or identification number  (e) Approximate number of persons covered at end of policy or contract year  (p) From  (q) To  (q) To  (d) Contract or identification number  (e) Approximate number of persons covered at end of policy or contract year  (g) To  (h-1340523  (o) 0000  (a) S82-165,4697  (b) Amount of the amount paid.  (c) Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base  (c) Amount  (d) Purpose  (e) Organization code								act
(b) EIN (c) NAIC code identification number persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year policy or contract year policy or contract year policy or contract year (f) From (g) To 41340523 00000 582-165,4697 339 01/01/2021 12/31/2021  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	1 Coverage Information:		<u> </u>			,		
(b) EIN (c) NAIC code identification number persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons in the second policy or contract year persons in the persons in the propose of the amount policy.  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(a) Name of insurance of	arrier						
(c) NAIC code identification number (e) Approximate number of persons covered at end of policy or contract year persons covered at end of policy or contract year (f) From (g) To 4-1340523 0000 582-165,4697 339 01/01/2021 12/31/2021  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			INC					
(b) EIN (C) NIC code identification number persons covered at end of policy or contract year policy or contract year 01/01/2021 12/31/2021  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	TO HOLINI OCH DANNON I							
4-1340523 00000 582-165;4697 339 01/01/2021 12/31/2021  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(b) EIN	(c) NAIC				Policy	y or contract year	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base and address of the agent, broker, or other person to whom commissions or fees were paid	(b) LIN	code	identification number			(f) From	<b>(g)</b> To	
descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base and address of the agent, broker, or other person to whom commissions or fees were paid	94-1340523	00000	582-165;4697		339	01/01/2021	12/31/2021	
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base (e) Organization code			ation. Enter the total fees and t	otal commissions	paid. List in line 3	the agents, brokers, a	and other persons in	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base  Fees and other commissions or fees were paid	(a) Total	amount of com	missions paid		(b) Total amount of fees paid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base  Fees and other commissions or fees were paid								
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base	3 Persons receiving con	nmissions and t	fees. (Complete as many entrie	es as needed to r	eport all persons).			
(a) Name 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		(a) Name	and address of the agent, broke	er, or other person	n to whom commiss	sions or fees were paid	d	
(a) Name 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								
(a) Name 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								
(a) Name 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								
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base    Co Amount	(b) Amount of sales a	ind base	F	ees and other commissions paid				
(b) Amount of sales and base Fees and other commissions paid			(c) Amount		(d) Purpos	е	(e) Organization co	de
(b) Amount of sales and base Fees and other commissions paid								
(b) Amount of sales and base Fees and other commissions paid								
(b) Amount of sales and base Fees and other commissions paid		(a) Nama	and address of the agent broke	or other person	a to whom commiss	sions or foos wors poi		
(b) Amount of sales and base		(a) Name	and address of the agent, broke	er, or other persor	T to whom commiss	ions or rees were pair	<u>u</u>	
(b) Amount of sales and base								
(b) Amount of sales and base								
	(b) Amount of sales a	ind base	Ę	ees and other co	mmissions paid			
			(c) Amount		(d) Purpos	е	(e) Organization co	de

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

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

0

P	the information may be combined for reporting purposes if	eyees of the same employer(s) or members of the same employee organizations(s), is such contracts are experience-rated as a unit. Where contracts cover individual with each carrier may be treated as a unit for purposes of this report.	
8	Benefit and contract type (check all applicable boxes)		
	a ☐ Health (other than dental or vision) b ☐ Dental	<b>c</b> ☐ Vision <b>d</b> ☐ Life insurance	
	e ☐ Temporary disability (accident and sickness) <b>f</b> ☐ Long-te	rm disability <b>g</b> Supplemental unemployment <b>h</b> Prescription drug	
	i ☐ Stop loss (large deductible) j ☒ HMO co		
		T I much mity contract	
	m ☐ Other (specify)		
_	Fire animonal material anathrapta.		
9	Experience-rated contracts:  a Premiums: (1) Amount received	00(4)	
	(2) Increase (decrease) in amount due but unpaid		
	(3) Increase (decrease) in unearned premium reserve		0
	<b>b</b> Benefit charges (1) Claims paid	33(1)	Ť
	(2) Increase (decrease) in claim reserves	21 (2)	
	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )		0
	(4) Claims charged	/	Ť
	C Remainder of premium: (1) Retention charges (on an accrual ba		
	(A) Commissions	2 (4)(2)	
	(B) Administrative service or other fees	- (1)(-)	
	(C) Other specific acquisition costs	0.(4)(0)	
	(D) Other expenses	0. (4)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies		
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention	9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, or credited.) 9c(2)	
	<b>d</b> Status of policyholder reserves at end of year: (1) Amount held		
	(2) Claim reserves	9d(2)	
	(3) Other reserves	9d(3)	
	e Dividends or retroactive rate refunds due. (Do not include amor	unt entered in line 9c(2).)	
10	Nonexperience-rated contracts:		
	a Total premiums or subscription charges paid to carrier		12
	<b>b</b> If the carrier, service, or other organization incurred any specific retention of the contract or policy, other than reported in Part I, Specify nature of costs.		
P	Part IV Provision of Information		
11	1 Did the insurance company fail to provide any information necessal	ry to complete Schedule A? Yes X No	
12	2. If the anguer to line 11 is "Vee " angeity the information not provide		

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

		parodantio	=:	,.		mspection
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO	DR RETIRED		e-digit number (PN)	591
C Plan sponsor's name a	ORPORATION			52-	oyer Identification Number	
		ning Insurance Contract. Individual contracts grouped a				
1 Coverage Information:		<u> </u>				
(a) Name of insurance ca		NC				
/LA FINI	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To
94-1340523	95708	101200;114302	172		01/01/2021	12/31/2021
descending order of the	e amount paid. amount of com	nissions paid ees. (Complete as many entries		<b>(b)</b> To	the agents, brokers, and	other persons in
T crodits receiving con		nd address of the agent, broker		•	sions or fees were paid	
	1	Fe	es and other commissic	ne naid		
(b) Amount of sales a commissions pa		(c) Amount	es and other commission	(d) Purpose (e) Organization of		
20		(0)		(4)	<u> </u>	(7) 0.96
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	sions or fees were paid	
(b) Amount of sales a	nd base	Fe	es and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code

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

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

0

Pá	art l	III Welfare Benefit Contract Informati If more than one contract covers the same grunder the information may be combined for reporting employees, the entire group of such individual	oup of employees of the purposes if such cont	tracts are	expe	rience-rated as a uni	t. Where co	ntracts cover in	
8	Bone	nefit and contract type (check all applicable boxes)	roomiaata with caon of	arrier may	50 (	reated as a arm for p	arposco or tr	по торот.	
	_		N Dontol		<b>.</b> $\Box$	Vicion		d 🗆 Life incom	
	a [		Dental		느	Vision		d Life insura	
	e L	Temporary disability (accident and sickness)	Long-term disabili	•		Supplemental unem	ployment	h Prescripti	on drug
	i	Stop loss (large deductible)	X HMO contract	I	<b>(</b>	PPO contract		I Indemnity	contract
	m	Other (specify)							
9 1	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 reser	ve	9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
		(2) Increase (decrease) in claim reserves							
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a	an accrual basis)						
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees		9c(1)(E	_				
		(C) Other specific acquisition costs		9c(1)(C	_				
		(D) Other expenses		9c(1)(D	•				
		(E) Taxes		9c(1)(E	_				
		(F) Charges for risks or other contingencies							
		(G) Other retention charges		9c(1)(G	i)		T = 4.5.45.5		
		(H) Total retention	_		_		9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid ir	n cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	Amount held to provide	benefits a	fter	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entere	d in line 90	(2).	)	9e		
10	No	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to car	rier				10a		2429266
	b	If the carrier, service, or other organization incurred							
	C	retention of the contract or policy, other than report	ed in Part I, line 2 abov	e, report a	amo	unt	10b		
	Spe	ecify nature of costs.							
Pa	art I	IV Provision of Information							
11	Dic	d the insurance company fail to provide any informat	ion necessary to comp	lete Sched	dule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the information		23				<u></u> 1	
	n u	and another to line it is a specify the illicitiation	providou.						

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

			, , ,			поросион	
For calendar plan year 20	)21 or fiscal plai	n year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan				<b>B</b> Thre	e-digit		
	ORPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	n number (PN)	591	
EMPLOYEES							
0 -:				<b>D</b>		(=)	
C Plan sponsor's name		e 2a of Form 5500		1	oyer Identification Number	er (EIN)	
LOCKHEED MARTIN CO	DRPORATION			52-	-1893632		
Dort I Informa	tion Concor	ning Incurance Contro	ot Coverage Fees	and Car	nmiccione Decide in	farmation for each contract	
		rning Insurance Contra Individual contracts grouped					
•	ato conocato i	marriada contracto groupou	ac a ant not are n and i		ported on a single cone	uuio 7 1.	
1 Coverage Information:							
(a) Name of insurance ca	arrier						
KAISER FOUNDATION H	EALTH PLAN I	NC					
/L\	(c) NAIC	(d) Contract or	(e) Approximate n		Policy o	r contract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To	
94-1340523	95708	114302-65	536	•	01/01/2021	12/31/2021	
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, and	d other persons in	
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid						
		•					
2 Paraona resoluting com	missions and f	ees. (Complete as many entrie	as as pooded to report all	noroona)			
Fersons receiving con		and address of the agent, broke			sione or food were noid		
	(a) Name a	ind address of the agent, broke	er, or other person to who	III COITIITIISS	sions of fees were paid		
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code	
•		,		` ' '		., .	
	(a) Nama a	and address of the agent broke	ar ather nersen to who		sione or food were noid		
	(a) Name a	and address of the agent, broke	er, or other person to who	III COIIIIIISS	sions of fees were paid		
(la) A management of a sil	and because	F	ees and other commission	ns paid			
(b) Amount of sales a commissions page		(c) Amount		(d) Purpos	ie.	(e) Organization code	
oominioonono pe		(o) / amount		( <del>4)</del> . uipos	· <del>·</del>	(G) Organization code	

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

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

0

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same of 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 co	rganizations(s), ver individual
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	С	; □	Vision		<b>d</b> Life	insurance
	е	Temporary disability (accident and sickness)	f  Long-term disabili	ty <b>g</b>	ıП	Supplemental unemp	olovment	<b>h</b> ☐ Pre	scription drug
	i [	Stop loss (large deductible)	j X HMO contract	າ s k		PPO contract	,	_ =	emnity contract
	. L	<u></u>	, A Time contract	-,	`Ш	110 contract		• []ac	oning contract
	m	Other (specify)							
9	Evno	prionog rated contracts:							
Э	•	rience-rated contracts:		00/1)					
		Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)				_	
		(3) Increase (decrease) in unearned premium rese		9a(3)			00/4)		
	_	(4) Earned ((1) + (2) - (3))			Т		9a(4)		
	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)		U
	_	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (or	,	0-/4\/A				_	
		(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					00/41/11		
		(H) Total retention	_	_			9c(1)(H)	)	
	_	(2) Dividends or retroactive rate refunds. (These	<b>—</b> ·	L			9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•				9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line 9c	<b>(2)</b> .)	)	9e		
10		nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to ca	arrier				10a		1537548
	b	If the carrier, service, or other organization incurrer retention of the contract or policy, other than repo				•	10b		
		cify nature of costs.							
Р	art I	V Provision of Information							
11	Dic	the insurance company fail to provide any informa	ation necessary to compl	lete Sched	ule	A?	Yes	X No	
12	lf th	ne answer to line 11 is "Yes," specify the information	on not provided.						. <u></u>

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

		parodantio	=:	,.		mspection
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 LOCKHEED MARTIN CO EMPLOYEES	ORPORATION	GROUP INSURANCE PLAN FO	DR RETIRED		e-digit number (PN)	591
C Plan sponsor's name a	ORPORATION			52-	oyer Identification Number 1893632	·
		ning Insurance Contrac  Individual contracts grouped a				
1 Coverage Information:					<u> </u>	
(a) Name of insurance ca		DF COLORADO				
# N = N	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To
84-0591617	95669	2001-006;-008	312		01/01/2021	12/31/2021
descending order of the	amount paid.	ation. Enter the total fees and to	tal commissions paid. L			other persons in
(a) Total	amount of comi	missions paid		<b>(b)</b> To	otal amount of fees paid	
3 Persons receiving com	missions and fe	Lees. (Complete as many entries	s as needed to report all	persons).		
-		and address of the agent, broker		•	sions or fees were paid	
(b) Amount of sales a			es and other commission			
				(d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	sions or fees were paid	
(b) Amount of sales a	nd base	Fe	es and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code

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

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

Pa	art I	If more than one contract covers the same grouthe information may be combined for reporting	p of employees of the ourposes if such cont	racts are ex	xper	ience-rated as a unit	Where co	ntracts cov	ganizations(s), ver individual
0		employees, the entire group of such individual of	contracts with each ca	amer may b	e ir	eated as a unit for pu	rposes or t	nis report.	
		nefit and contract type (check all applicable boxes)	7	_				a 🗆	
	a _	Health (other than dental or vision)			Ш'	Vision			insurance
	e	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	y <b>g</b>	Ш	Supplemental unemp	loyment	h Pres	scription drug
	i [	Stop loss (large deductible) j	X HMO contract	k		PPO contract		I nde	mnity contract
	m	Other (specify)							
	L								
9 i	Ехре	erience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserve		9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
		(2) Increase (decrease) in claim reserves		9b(2)					
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on an	accrual basis)			•			
		(A) Commissions		9c(1)(A)	)				
		(B) Administrative service or other fees		9c(1)(B)	)				
		(C) Other specific acquisition costs		9c(1)(C)					
		(D) Other expenses		9c(1)(D)					
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies		9c(1)(F)					
		(G) Other retention charges		9c(1)(G)	)				
		(H) Total retention					9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These ame	ounts were paid in	cash, or	cr	edited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Am	nount held to provide	benefits aft	er re	etirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not in	clude amount entered	in line <b>9c(</b>	<b>2)</b> .).		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrie	er				10a		4071683
	b	If the carrier, service, or other organization incurred a	any specific costs in c	onnection v	with	the acquisition or			
		retention of the contract or policy, other than reported					10b		
	Spec	ecify nature of costs.							
Pa	art l'	IV Provision of Information							
<u>11</u>	Did	d the insurance company fail to provide any informatio	n necessary to compl	ete Schedu	ıle A	٨?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information r	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

		·	, , ,			opeeu.e	
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>B</b> Thre	e-digit		
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591	
EMPLOYEES							
0 -:				<b>D</b>		(=)	
C Plan sponsor's name a		e 2a of Form 5500		-	oyer Identification Number	er (EIN)	
LOCKHEED MARTIN CO	DRPORATION			52-	-1893632		
Dout I Informat	tion Consor	ming Incurance Control	ot Coverage Fees	and Car	nmiccione Dustida in	favoration for each contract	
		ning Insurance Contract.  Individual contracts grouped					
	ato Coriodaio 7	marriada contracto groupou	ao a anicin'i ano ii ana i		ported on a single cone.	3410 7 1.	
1 Coverage Information:							
(a) Name of insurance ca	ırrier						
KAISER FOUNDATION H	EALTH PLAN C	OF COLORADO					
/b) FINI	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		Policy or	contract year	
(b) EIN	code	identification number	policy or contract		(f) From	<b>(g)</b> To	
84-0591617	95669	2001-006	26		01/01/2021	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	d other persons in	
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid						
		·			•		
2 Paraona receiving com	missions and f	ees. (Complete as many entrie	on an anadad to report all	noroona)			
Fersons receiving com		and address of the agent, broke			viona or food word noid		
	(a) Name a	illu address of the agent, broke	si, or other person to write	III COITIITIISS	sions of fees were paid		
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
1		,		` ' '			
	(a) Nama a	and address of the exect broke	ur or other nersen to who		sione or food were noid		
	(a) Name a	and address of the agent, broke	er, or other person to wrice	III COIIIIIISS	sions of fees were paid		
(In) A		F	ees and other commission	ns paid			
(b) Amount of sales an commissions pa		(c) Amount	COO GITG CATTOT COMMINICATION	(d) Purpos	e	(e) Organization code	
COMMINISSIONS PA	iu .	(c) Amount		(a) i dipos	<u> </u>	(c) Organization code	
						<u> </u>	

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

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

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	roup of employees of the ng purposes if such cont	racts are e	xpe	rience-rated as a unit	. Where co	ontracts	cover individual
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	С	; □	Vision		d∏L	ife insurance
	e	Temporary disability (accident and sickness)	f  Long-term disabili	ty <b>g</b>	ıП	Supplemental unem	olovment	h∏F	Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	, s k		PPO contract	,		ndemnity contract
	. L		, A Time contract		`Ш	11 0 dominade		- Ш	identification of the contract
	m [	Other (specify)							
9	Evne	rience-rated contracts:							
3		Premiums: (1) Amount received		9a(1)				_	
		(2) Increase (decrease) in amount due but unpaid		9a(1)				_	
		(3) Increase (decrease) in unearned premium rese		9a(3)				_	
		(4) Earned ((1) + (2) - (3))					9a(4)		
	_	Benefit charges (1) Claims paid		9b(1)	Τ.		Ja(+)		
	D	(2) Increase (decrease) in claim reserves						_	
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)		0
		(4) Claims charged(4)					9b(3) 9b(4)		
	С	Remainder of premium: (1) Retention charges (or					30(4)		
	C	, , , , , , , , , , , , , , , , , , , ,	•	9c(1)(A	١ .				
		(A) Commissions		9c(1)(B				_	
		(B) Administrative service or other fees		9c(1)(C)				_	
		(D) Other expenses		9c(1)(D)	_				
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies		9c(1)(F)	_				
		(G) Other retention charges						_	
		(H) Total retention					9c(1)(H	·	
		(2) Dividends or retroactive rate refunds. (These	_	_				<del>'</del>	
	لم		<b>—</b> ·	L			9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•				9d(1)		
		(2) Claim reserves					9d(2)		
	_	(3) Other reserves					9d(3)		
10	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	i include amount entered	in line 9C	(2).	)	9e		
10		nexperience-rated contracts:	unio n				100		110405
		Total premiums or subscription charges paid to ca					10a		112405
	<b>b</b> Sne	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo- cify nature of costs.	, ,				10b		_
Р	art I	V Provision of Information							
11	Dic	the insurance company fail to provide any informa	ation necessary to compl	ete Sched	ule	A?	Yes	X No	
12	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

For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021			and en	iding 12/31/2021	•
A Name of plan					<b>B</b> Three-digit		
	RPORATION	GROUP INSURANCE PLAN F	FOR F	RETIRED	plan	number (PN)	591
EMPLOYEES							
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500			<b>D</b> Emplo	yer Identification Number	er (EIN)
LOCKHEED MARTIN CO						1893632	,
		rning Insurance Contra Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
KAISER FOUNDATION HE		OF GEORGIA					
	1						
(b) EIN	(c) NAIC	(d) Contract or		<ul><li>(e) Approximate nur persons covered at</li></ul>		_	contract year
(5) Env	code	identification number		policy or contract		(f) From	<b>(g)</b> To
58-1592076	96237	4822		81		01/01/2021	12/31/2021
		ation. Enter the total fees and t	total c	commissions paid. Lis	t in line 3	the agents, brokers, and	d other persons in
descending order of the			1		/b) T		
(a) Total amount of commissions paid (b) Total amount of fees paid							
2 Doronno ropojujna som	missions and f	ees. (Complete as many entrie		naadad ta ranart all n	o********		
3 Persons receiving com		and address of the agent, broke				ions or fees were naid	
	(a) Hamo	and address of the agont, broke	01, 01	Carlot porcon to whom		none of feet were para	
				and other commissions	noid		
(b) Amount of sales ar commissions pa		(c) Amount	662	and other commissions	d) Purpos	(e) Organization code	
commissions pa	iu	(b) / unounc			<b>a)</b> : a.poo	<u> </u>	(c) organization code
	(a) Name a	and address of the agent, broke	er, or	other person to whom	commiss	ions or fees were paid	
		-		•			
(h) A		F	ees a	and other commissions	s paid		
(b) Amount of sales ar commissions pa		(c) Amount	3000		d) Purpos	e	(e) Organization code
		, ,		,	, , , , ,		(1) 2 3

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

F	Part		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	<del></del>	ate participation guaran		
		(3) guaranteed investment (4) other			
		(o) Sagranosa invocations (i) Saisi y			
	b	Palance at the end of the provious year		7b	
	C	Balance at the end of the previous year	7c(1)	/ D	0
	C	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(0) T		70/6)	0
	4	(6)Total additions		- \ _ \	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		/ u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(1)		
		(3) Transferred to separate account	7e(3)	<del></del>	
		(4) Other (specify below)	7e(4)		
		(4) Other (specify below)	70(4)		
		<b>7</b>			
		(5) Total deductions			0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

Pá	art I	If more than one contract covers the same group of the information may be combined for reporting purp	oses if such contrac	cts are exp	erience-rated as a unit	. Where cor	ntracts cover individual
		employees, the entire group of such individual contr	acts with each carri	er may be	treated as a unit for pu	irposes of th	is report.
8	Bene	nefit and contract type (check all applicable boxes)		_	7		. —
	a	Health (other than dental or vision) <b>b</b> [] C	Dental	c	Vision	(	d Life insurance
	e	Temporary disability (accident and sickness) <b>f</b> L	ong-term disability	g	Supplemental unemp	oloyment	h Prescription drug
	i [	Stop loss (large deductible) j 🛛	IMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)			_		_
	<u>L</u>						
9 i	Ехре	erience-rated contracts:					
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserve		9a(3)			
		(4) Earned ((1) + (2) - (3))	<u></u>			9a(4)	0
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	0
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on an acc	crual basis)				
		(A) Commissions	g	c(1)(A)			
		(B) Administrative service or other fees		c(1)(B)			
		(C) Other specific acquisition costs	9	c(1)(C)			
		(D) Other expenses	9	c(1)(D)			
		(E) Taxes	9	c(1)(E)			
		(F) Charges for risks or other contingencies	9	c(1)(F)			
		(G) Other retention charges	g	c(1)(G)			
		(H) Total retention				9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These amount	s were paid in ca	ash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amour	nt held to provide be	nefits after	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not includ	e amount entered ir	n line <b>9c(2)</b>	.)	9e	
10	Nor	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carrier				10a	1122041
	b	If the carrier, service, or other organization incurred any s					
	C	retention of the contract or policy, other than reported in lecify nature of costs.	Part I, line 2 above,	report amo	ount	10b	
Pa	art l'	IV Provision of Information					
11	Did	d the insurance company fail to provide any information ne	cessary to complete	e Schedule	e Α?	Yes	No
		the answer to line 11 is "Yes," specify the information not p			<b>-</b>	<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

			, , ,			opeenen	
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan				<b>B</b> Thre	e-digit		
	RPORATION (	GROUP INSURANCE PLAN F	OR RETIRED		n number (PN)	591	
EMPLOYEES				, ,			
_							
C Plan sponsor's name a	is shown on line	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numl	ber (EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	-1893632		
		ning Insurance Contract. Individual contracts grouped					
1 Coverage Information:					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
1 Corolage III ciliano							
(a) Name of insurance ca	rrier						
KAISER FOUNDATION HI	EALTH PLAN C	OF GEORGIA					
	1	1					
(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	<b>(g)</b> To	
58-1592076	96237	4822	156		01/01/2021	12/31/2021	
2							
descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	tne agents, brokers, ar	nd other persons in	
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
		·					
3 Porsons receiving com	missions and fo	ees. (Complete as many entrie	e as pooded to report all	norconc)			
Fersons receiving com		nd address of the agent, broke			sions or foos wore noid		
	(a) Name a	illa address of the agent, broke	er, or other person to write	iii commiss	sions of fees were paid		
(In) Assessment of a class of		F	ees and other commission	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
commissions pa		(0) /		(a) : a.poo		(c) organization oddo	
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid		
			and other server's start	no noid			
(b) Amount of sales ar			ees and other commission	•		<del></del>	
commissions pa	ıd	(c) Amount		(d) Purpos	e	(e) Organization code	

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

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

P	art III Welfare Benefit Contract Informat	ion				
٠,	If more than one contract covers the same gro		e same empl	lover(s) or members of	the same en	nplovee organizations(s).
	the information may be combined for reporting					
	employees, the entire group of such individua	I contracts with each ca	arrier may be	e treated as a unit for pu	urposes of th	iis report.
8	Benefit and contract type (check all applicable boxes)					
		Dental	С	Vision		d Life insurance
		Long-term disabili	_	Supplemental unemp		<b>h</b> ☐ Prescription drug
					Dioyment	
		X HMO contract	κլ	PPO contract		I Indemnity contract
	m ☐ Other (specify) ▶					
	Experience-rated contracts:			1		_
	a Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid					
	(3) Increase (decrease) in unearned premium reser	ve	9a(3)		1	
	(4) Earned ((1) + (2) - (3))			······	9a(4)	0
	<b>b</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)	
	<b>c</b> 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					
	(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 a	mounts were paid ir	cash, or	credited.)	9c(2)	
	<b>d</b> 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	include amount entered	d in line 9c(2	<b>)</b> .)	9e	
10	Nonexperience-rated contracts:					
	a Total premiums or subscription charges paid to car	rier			10a	880566
	<b>b</b> If the carrier, service, or other organization incurred	I any specific costs in c	connection w	ith the acquisition or		
	retention of the contract or policy, other than report	ed in Part I, line 2 abov	e, report am	ount	10b	
	Specify nature of costs.					
Pa	art IV Provision of Information					
11	Did the insurance company fail to provide any informat	ion necessary to comp	lete Schedul	e A?	Yes	No No
	If the answer to line 11 is "Yes," specify the information				•	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and er	nding 12/31/2021	•
A Name of plan				<b>B</b> Thre	e-digit	
LOCKHEED MARTIN CO	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591
LIVII LOTELS						
C Plan sponsor's name a	as shown on lin	ne 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numb	per (EIN)
LOCKHEED MARTIN CO					·1893632	,
		rning Insurance Contract. Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca	arrier					
KAISER FOUNDATION H		OF HAWAII				
	1	T				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a			or contract year
(6) 2.111	code	identification number	policy or contract		(f) From	<b>(g)</b> To
94-1340523	60053	14934	6		01/01/2021	12/31/2021
		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, ar	nd other persons in
descending order of the	e amount paid. amount of com	missions paid		(b) T	otal amount of fees paid	٠
(a) Total	amount of com	missions paid		(6)	otal amount of fees paid	
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	nersons)		
T craons receiving com		and address of the agent, broke			sions or fees were paid	
	(*/		,		, , , , , , , , , , , , , , , , , , ,	
			ees and other commissio	ns naid		
(b) Amount of sales an commissions pa		(c) Amount	ees and strict commission	(d) Purpose		
				(1)		(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	
(h) Amount of color or	nd boos	F	ees and other commissio	ns paid		
(b) Amount of sales an commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code
		` '				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

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

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

Pa	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	rience-rated as a uni	t. Where co	ntracts cover indi	tions(s), vidual
8	Benefit and contract type (check all applicable boxes)	_		_			_	
	a Health (other than dental or vision)	Dental	(	C 🗌	Vision		<b>d</b> Life insurar	nce
	e ☐ Temporary disability (accident and sickness) <b>f</b>	Long-term disabili	ty 🧐	3 🗌	Supplemental unem	ployment	<b>h</b> Prescription	n drug
	i Stop loss (large deductible)	X HMO contract		kΠ	PPO contract		I Indemnity of	contract
	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>b</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)(U)		0
	(H) Total retention			_		9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These am	<b>—</b>		_		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 III 18 <b>9</b> 0	·(2).	)	9e		
	Total premiums or subscription charges paid to carri	er				10a		34347
						100		34347
	<b>b</b> If the carrier, service, or other organization incurred retention of the contract or policy, other than reporte					10b		
	Specify nature of costs.		-, · p - · · ·				<u></u>	
_	aut IV Dravision of Information							
Pa	art IV Provision of Information					., г	<del></del>	
11			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 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 er	nding 12/31/2021	•
A Name of plan				<b>B</b> Thre	e-digit	
LOCKHEED MARTIN CO	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591
EMPLOTEES						
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numb	per (EIN)
LOCKHEED MARTIN CO	RPORATION				1893632	,
		rning Insurance Contract. Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
KAISER FOUNDATION H		OF THE MID-ATLANTIC				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			or contract year
(6) 2.111	code	identification number	policy or contract		(f) From	<b>(g)</b> To
52-0954463	95639	3104-26; -31	1		01/01/2021	12/31/2021
		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, ar	nd other persons in
descending order of the			1	4) T		
(a) Lotal a	amount of com	missions paid		(b) 10	otal amount of fees paid	<u> </u>
2.5			1 14 4 11			
Persons receiving com		fees. (Complete as many entrice and address of the agent, broke			rions or foos wore paid	
	(a) Name a	and address of the agent, broke	er, or other person to who	III COIIIIII33	ions of fees were paid	
(b) Amount of sales a		(c) Amount	ees and other commissio	(e) Organization code		
commissions pa	ild	(C) Amount		(d) Purpos	С	(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	
	. ,	<b>3</b> ,	,		'	
(1) (1)		F	ees and other commissio	ns paid		
(b) Amount of sales au commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code
	-	\-\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		. , . , . ,		(-)

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

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

0

F	Part I	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	group of employees of the ng purposes if such cont	racts are e	xpe	rience-rated as a unit	. Where co	ontracts cove	
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	С	;∏	Vision		<b>d</b> Life in	nsurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	ıП	Supplemental unemp	olovment	h Preso	ription drug
	i [	Stop loss (large deductible)	j X HMO contract	າ s k		PPO contract	,	_ 📛	nnity contract
	. L	<u>-</u>	, M Thire contract	• • • • • • • • • • • • • • • • • • • •	, П	1 1 0 contract			mity contract
	m	Other (specify)							
9	Evno	prionog rated contracts:							
9		erience-rated contracts:		00/1)					
		Premiums: (1) Amount received		9a(1) 9a(2)	+			_	
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reso					02/4)		
	_	(4) Earned ((1) + (2) - (3))		9b(1)	·····		9a(4)		
	b	Benefit charges (1) Claims paid							
		(2) Increase (decrease) in claim reserves					0h/2\		0
		(3) Incurred claims (add (1) and (2))					9b(3) 9b(4)		
	_	(4) Claims charged					3D(4)		
	С	, , , ,	,	9c(1)(A)	<b>.</b>				
		(A) Commissions		9c(1)(A)				_	
		(B) Administrative service or other fees		9c(1)(C)				_	
		(D) Other expenses		9c(1)(D)	_				
		(E) Taxes		9c(1)(E)	_				
		(F) Charges for risks or other contingencies		9c(1)(F)	_				
		(G) Other retention charges			_				
		(H) Total retention					9c(1)(H)	1	0
		(2) Dividends or retroactive rate refunds. (These	_	_				<b>/</b>	
	А		<b>—</b> ·	<u> </u>			9c(2)		
	d	Status of policyholder reserves at end of year: (1)	·				9d(1)		
		(2) Claim reserves					9d(2)		
	е	(3) Other reserves					9d(3) 9e		
10	_	nexperience-rated contracts:	i include amount entered	ı III III 11 <b>90</b>	<b>(2)</b> .)		96		
		Total premiums or subscription charges paid to ca	arrior				10a		5635
							IVa		3030
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo	, .			•	10b		
		cify nature of costs.							
P	Part I	V Provision of Information							
11	Dic	the insurance company fail to provide any informa	ation necessary to compl	lete Schedi	ule /	A?	Yes	X No	
12	2 If th	ne answer to line 11 is "Yes," specify the information	on not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

2021

			, , , ,				
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan				<b>B</b> Thre	e-digit		
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED		number (PN)	591	
EMPLOYEES	EMPLOYEES				, ,		
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Num	nber (EIN)	
LOCKHEED MARTIN CO	DRPORATION			52-	1893632		
		ning Insurance Contra					
	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and I	ii can be re	ported on a single Scr	nedule A.	
1 Coverage Information:							
(a) Name of insurance ca	arrier						
` '		NE THE NORTHWEST					
KAISER FOUNDATION H	EALTH PLAN (	OF THE NORTHWEST					
	(a) NIAIC	(d) Contrast or	(e) Approximate no	umber of	Policy	or contract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f) From	<b>(g)</b> To	
	5545	identification rights	policy or contrac	t year	(1) 1 10111	(9) 10	
93-0798039	95540	8434-002	17		01/01/2021	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, a	and other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Parsons receiving com	missions and fe	ees. (Complete as many entrie	es as pooded to report all	norcone)			
J 1 elsons receiving con		nd address of the agent, broke			iona or food ware nois		
	(a) Name a	ind address of the agent, broke	ii, or other person to who	III COIIIIIISS	sions or lees were paid	<u>,                                      </u>	
			ees and other commissio	ne naid			
(b) Amount of sales a		(c) Amount	ees and other commissio	•			
commissions pa	liu	(c) Amount		(d) Purpos	С	(e) Organization code	
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	t c	
(b) Amount of sales a	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code	

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

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

0

Pa	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 i	
8	Benefi	it and contract type (check all applicable boxes)			<u> </u>	•	· · · · · · · · · · · · · · · · · · ·	
	_	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		d Life insu	rance
	느					nloven ont	블	
,	e	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental unem	ipioymeni	h Prescrip	_
	ᆝ빌	Stop loss (large deductible)	j X HMO contract	K _	PPO contract		I Indemnit	ty contract
	m 📙	Other (specify)						
							1	
		ence-rated contracts:						
•		emiums: (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
		Renefit charges (1) Claims paid						
	,	2) Increase (decrease) in claim reserves		· · · · · ·		9b(3)		0
		l) Claims charged				9b(4)		
	,	Remainder of premium: (1) Retention charges (c				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)		
	<b>d</b> S	Status of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
	(2	2) Claim reserves				9d(2)		
	`	3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2).	.)	9e		
10		experience-rated contracts:	orrior			100		05760
	_	otal premiums or subscription charges paid to c				10a		95760
		the carrier, service, or other organization incurietention of the contract or policy, other than rep				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						
11	Did t	he insurance company fail to provide any inform	ation necessary to compl	lete Schedule	A?	Yes	X No	
12	If the	answer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

2021

			, , ,	1		шереешен	
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>B</b> Thre	e-digit		
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591	
EMPLOYEES							
				_			
C Plan sponsor's name a		e 2a of Form 5500		-	oyer Identification Num	nber (EIN)	
LOCKHEED MARTIN CO	DRPORATION			52-	-1893632		
L			- 1 O	- 10-			
		rning Insurance Contract. Individual contracts grouped					
	ate Scriedule A	. Individual contracts grouped	as a uniil in Fans ii anu i	ii can be re	ported on a single Sci	ledule A.	
1 Coverage Information:							
(a) Name of insurance ca	rrier						
PACIFICARE OF ARIZON							
FACIFICANE OF ANIZON	A, INC.						
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy	or contract year	
<b>(b)</b> EIN	code	identification number	persons covered a		(f) From	<b>(g)</b> To	
			policy or contract	t year			
94-3267522	95617	H1401-1404&SUBS	44		01/01/2021	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, a	and other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
(a) rotal amount of commissions paid							
3 Persons receiving com	missions and fe	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 paid	<u> </u>	
		_					
(b) Amount of sales a			ees and other commission				
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code	
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	<u> </u>	
(b) Amount of sales a	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code	

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

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

0

Pa	art I	If more than one contract covers the same group the information may be combined for reporting p	p of employees of the ourposes if such conti	acts are ex	хре	rience-rated as a unit	. Where co	ontracts cove	anizations(s), r individual
0	D	employees, the entire group of such individual c	Unitacis with each ca	inei may t	Je ti	realed as a utilition pu	iiposes oi t	nis report.	
	_	nefit and contract type (check all applicable boxes)	7		_			a 🗆	
	a _	Health (other than dental or vision)			Ш	Vision			surance
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	у <b>д</b>	Ш	Supplemental unemp	oloyment	h Presci	ription drug
	i [	Stop loss (large deductible) j	HMO contract	k		PPO contract		I Indem	nity contract
	m	Other (specify)							
	L								
9 i	Ехре	perience-rated contracts:							
	a F	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		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)(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 amo	ounts were paid in	cash, or	CI	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Am	ount held to provide	benefits aft	ter r	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not inc	clude amount entered	in line 9c(	( <b>2)</b> .)		9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrie	r				10a		940021
	b	If the carrier, service, or other organization incurred a							
	O	retention of the contract or policy, other than reported ecify nature of costs.	in Part I, line 2 above	e, report ar	mou	unt	10b		
	<b>Opo</b> .								
_		N/ Duranisian of Information							
Pa	art l	IV Provision of Information							
11	Did	d the insurance company fail to provide any information	n necessary to compl	ete Schedu	ıle /	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information n	ot 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

		parouant to	=:	•		mspection	
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and er	nding 12/31/2021		
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO	OR RETIRED		e-digit number (PN)	591	
C Plan sponsor's name a	RPORATION			52-	oyer Identification Numbe 1893632		
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:					<u>,                                    </u>		
(a) Name of insurance ca							
41 EIN	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year	
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year		(f) From	<b>(g)</b> To	
94-3267522	95617	H1400	62		01/01/2021	12/31/2021	
descending order of the		ation. Enter the total fees and tot	tal commissions paid. Li		the agents, brokers, and	other persons in	
(a) rotari	amount or com	mosions paid		(6) 1	star amount or rees pard		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker,	, or other person to who	n commiss	sions or fees were paid		
(b) Amount of sales a	nd base		es and other commission	•			
commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code	
	(a) Name a	nd address of the agent, broker,	, or other person to who	n commiss	sions or fees were paid		
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code	

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

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

0

Pa	art I	III Welfare Benefit Contract Information If more than one contract covers the same growthe information may be combined for reporting	up of employees of the	e same em	ploy	yer(s) or members of	the same e	mployee org	ganizations(s), er individual
		employees, the entire group of such individual							
8	Bene	nefit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	Dental	С		Vision		d Life i	nsurance
	е	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	ty <b>g</b>	П	Supplemental unemp	oloyment	h Prese	cription drug
	i 🗂	Stop loss (large deductible)	X HMO contract	k	Ī	PPO contract		I Inder	nnity contract
	m [	Other (specify)	_					ш	-
	∟								
<b>9</b> 1	Expe	erience-rated contracts:							
	а <sup>.</sup> Р	Premiums: (1) Amount received		9a(1)					
	(	(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserv		9a(3)					
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	_	Benefit charges (1) Claims paid		9b(1)					
	(	(2) Increase (decrease) in claim reserves		9b(2)					
	(	(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on 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		9c(1)(F)					
		(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	CI	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide	benefits aft	ter r	retirement	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(	( <b>2)</b> .)	)	9e		
10	Nor	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carr	ier				10a		255638
	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 I'	IV Provision of Information						_	
<u>11</u>	Did	d the insurance company fail to provide any information	on necessary to compl	ete Schedu	ule /	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information	not provided.				·		

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2021

This Form is Open to Public

		pa.o.a	=:	•		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 EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO	R RETIRED		e-digit number (PN)	591	
C Plan sponsor's name a		e 2a of Form 5500		-	oyer Identification Numbe 1893632	r (EIN)	
		ning Insurance Contract  Individual contracts grouped a					
1 Coverage Information:		greek en			,		
(a) Name of insurance ca		ANCE COMPANY					
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year	
<b>(b)</b> EIN	code	identification number	persons covered at end of policy or contract year		(f) From	<b>(g)</b> To	
95-2931460	70785	142770; 144883	74		01/01/2021	12/31/2021	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. Li	st in line 3	the agents, brokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	omissions and fo	ees. (Complete as many entries	as needed to report all	nersons)			
T craona receiving con		nd address of the agent, broker,		· · · · · · · · · · · · · · · · · · ·	sions or fees were paid		
(b) Amount of sales a			es and other commission				
commissions pa	aid	(c) Amount	(d) Purpose		e	(e) Organization code	
	(a) Name a	nd address of the agent, broker,	, or other person to whor	n commiss	sions or fees were paid		
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code	

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

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

P	art III	Welfare Benefit Contract Informalif 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	expe	erience-rated as a ur	it. Where co	ontracts cover individu	
8	Donofit	1 7 . 0 1	ual contracts with each c	amei may	y be	irealed as a utilition p	ourposes or t	inis report.	
0	_	and contract type (check all applicable boxes)	<b>b</b> □ postal			1		<b>d</b> []	
	a ∐ ⊦	Health (other than dental or vision)	<b>b</b> Dental		c [	Vision		<b>d</b> Life insurance	
	е 📗	Temporary disability (accident and sickness)	f Long-term disabili	ty	g	Supplemental uner	nployment	<b>h</b> Prescription dr	ng
	i 🗌 🤋	Stop loss (large deductible)	j X HMO contract		k	PPO contract		I Indemnity conti	act
	m 🗌	Other (specify)							
9	Experie	ence-rated contracts:							
	<b>a</b> Pre	emiums: (1) Amount received		9a(1)	)				
	(2)	Increase (decrease) in amount due but unpaid	ł	9a(2)	)				
	(3)	Increase (decrease) in unearned premium res	erve	9a(3)	)				
	(4)	Earned ((1) + (2) - (3))			<u>.</u>		9a(4)		0
		enefit charges (1) Claims paid			_				
		Increase (decrease) in claim reserves							
	(3)	Incurred claims (add (1) and (2))					9b(3)		0
	` '	) Claims charged					9b(4)		
	C Re	emainder of premium: (1) Retention charges (o			1				
		(A) Commissions		9c(1)(/					
		(B) Administrative service or other fees		9c(1)(I					
		(C) Other specific acquisition costs		9c(1)(0					
		(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			•		00/1)/[	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0
	(0	(H) Total retention	_		_		9c(1)(H)	)	
		) Dividends or retroactive rate refunds. (These							
		tatus of policyholder reserves at end of year: (1					9d(1)		
	•	) Claim reserves					9d(2)		
	` '	Other reserves					` '		
10		ividends or retroactive rate refunds due. (Do n xperience-rated contracts:	ot include amount entere	a in line 9	C(2).	.)	9e		
10		otal premiums or subscription charges paid to c	arrior				10a		356750
	_						IUa		330730
		the carrier, service, or other organization incuri- tention of the contract or policy, other than rep-	, ,			•	10b		
		y nature of costs.	onted in Fait I, line 2 abov	е, героп	anio	Jui It	100		
	,	,							
D	art IV	Provision of Information							
							1 v	M No	
11		ne insurance company fail to provide any inform		lete Sche	dule	A?	Yes	X No	
12	If the	answer to line 11 is "Yes," specify the informat	on not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

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>B</b> Thre	e-digit	
	RPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591
EMPLOYEES						
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numb	per (EIN)
LOCKHEED MARTIN CO					1893632	(=)
		rning Insurance Contra A. Individual contracts grouped				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
PACIFICARE OF COLORA						
THOM TO TIKE OF GOLOTO	100 1110					
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		Policy	or contract year
(b) EIN	code	identification number	policy or contract		(f) From	<b>(g)</b> To
84-1011378	95434	CO-601-606&SUBS	2		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, ar	nd other persons in
descending order of the	amount paid.		·			
(a) Total amount of commissions paid (b) Total amount of fees paid					<u>!</u>	
3 Persons receiving com		ees. (Complete as many entrie				
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	
	1					
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		_
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code

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

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

Р	Part III Welfare Benefit Contract Informat	ion					
•	If more than one contract covers the same gro		e same emple	oyer(s) or members of	the same en	nployee organiza	itions(s),
	the information may be combined for reporting						vidual
	employees, the entire group of such individua	I contracts with each ca	arrier may be	treated as a unit for p	ourposes of th	is report.	
8	Benefit and contract type (check all applicable boxes)						
	a Health (other than dental or vision)	Dental	С	Vision		d Life insura	nce
		Long-term disabili	<u> </u>	Supplemental unem	nolovment	h Prescriptio	n drua
	. 📙	X HMO contract		PPO contract	ipioyiiioiik	I  Indemnity of	_
		HIVIO CONTIACT	ν_	FFO contract			Unitact
	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 reser	ve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		0
	<b>b</b> Benefit charges (1) Claims paid				-1 ( )		
	(2) Increase (decrease) in claim reserves						
	, ,				0h/3\		0
	(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
	(4) Claims charged				9b(4)		
	<b>c</b> Remainder of premium: (1) Retention charges (on	,					
	(A) Commissions		9c(1)(A)				
	(B) Administrative service or other fees		9c(1)(B)				
	(C) Other specific acquisition costs		9c(1)(C)				
	(D) Other expenses		9c(1)(D)				
	(E) Taxes		9c(1)(E)				
	(F) Charges for risks or other contingencies		9c(1)(F)				
	(G) Other retention charges		9c(1)(G)				
	(H) Total retention				9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These a	mounts were ☐ paid ir	cash, or	credited.)	9c(2)		
	<b>d</b> 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	include amount entered	d in line <b>9c(2)</b>	.)	9e		
10	Nonexperience-rated contracts:						
	a Total premiums or subscription charges paid to car	rier			10a		51666
	<b>b</b> If the carrier, service, or other organization incurred	d any specific costs in c	connection wit	th the acquisition or			
	retention of the contract or policy, other than report	ed in Part I, line 2 abov	e, report amo	ount	10b		
	Specify nature of costs.						
P	Part IV Provision of Information						
11	Did the insurance company fail to provide any informat	ion necessary to comp	lete Schedule	A?	Yes	X No	
	If the answer to line 11 is "Yes," specify the information				L	_	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021			and en	iding 12/31/2021		
A Name of plan					<b>B</b> Three	e-digit		
	RPORATION	GROUP INSURANCE PLAN F	FOR R	RETIRED	plan	number (PN)	591	
EMPLOYEES								
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500			<b>D</b> Emplo	yer Identification Numb	per (EIN)	
LOCKHEED MARTIN CO						1893632	,	
		rning Insurance Contra La Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
PACIFICARE OF COLORA		IVER CO SR HMO)						
(b) EIN	(c) NAIC	(d) Contract or		<ul><li>(e) Approximate nur persons covered at</li></ul>			or contract year	
(5) Env	code	identification number		policy or contract		(f) From	<b>(g)</b> To	
84-1011378	95434	29300		23		01/01/2021	12/31/2021	
		ation. Enter the total fees and t	total c	commissions paid. Lis	st in line 3	the agents, brokers, an	d other persons in	
descending order of the amount paid.  (a) Total amount of commissions paid  (b) Total amount of fees paid				<u> </u>				
(a) Total amount of commissions paid								
3 Persons receiving com	missions and f	ees. (Complete as many entrie	AS 2S	needed to report all n	ersons)			
T Cladia receiving com		and address of the agent, broke				ions or fees were paid		
	(*)	, , , , , , , , , , , , , , , , , , ,	, -					
(1) A		F	ees a	and other commission	s naid			
(b) Amount of sales ar commissions pa		(c) Amount	000 0		(d) Purpose (e) Organization code			
<b>.</b>		, ,		,			, ,	
	(a) Name a	and address of the agent, broke	er, or	other person to whom	commiss	ions or fees were paid		
(b) Amount of sales ar	nd base	F	ees a	and other commission	s paid			
commissions pa		(c) Amount			d) Purpos	e	(e) Organization code	
	I	I	Ī				ĺ	

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

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

Pź	art III Welfare Benefit Contract Informa	tion					
•	If more than one contract covers the same g		e same empl	oyer(s) or members of	the same en	nployee organizations	s(s),
	the information may be combined for reportir						aÌ 🦳
	employees, the entire group of such individu	al contracts with each ca	arrier may be	treated as a unit for p	urposes of th	is report.	
8	Benefit and contract type (check all applicable boxes)						
	a Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance	
		f ☐ Long-term disabili	_	⊒ │ Supplemental unem		h ☐ Prescription dru	ıa
					ployment	=	_
		j X HMO contract	ĸ	PPO contract		I Indemnity contra	3CI
	m ☐ Other (specify) ▶						
9	Experience-rated contracts:						
	a Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpaid		9a(2)				
	(3) Increase (decrease) in unearned premium rese	rve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)		0
	<b>b</b> Benefit charges (1) Claims paid		9b(1)				
	(2) Increase (decrease) in claim reserves		9b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)		0
	(4) Claims charged				9b(4)		
	c Remainder of premium: (1) Retention charges (on	an accrual basis)					
	(A) Commissions	•	9c(1)(A)				
	(B) Administrative service or other fees		9c(1)(B)				
	(C) Other specific acquisition costs		9c(1)(C)				
	(D) Other expenses		9c(1)(D)				
	(E) Taxes		0 (4)(5)				
	(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						
					9c(2)		
	<b>d</b> Status of policyholder reserves at end of year: (1)	·			9d(1)		
	(2) Claim reserves				9d(2)		
	(3) Other reserves				9d(3)		
	e Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line <b>9c(2</b>	<b>)</b> .)	9e		
10	Nonexperience-rated contracts:				<u> </u>		
	<b>a</b> Total premiums or subscription charges paid to ca	rrier			10a		125821
	<b>b</b> If the carrier, service, or other organization incurre						
	retention of the contract or policy, other than repor	ted in Part I, line 2 abov	e, report am	ount	10b		
	Specify nature of costs.						
Pa	art IV Provision of Information						
	Did the insurance company fail to provide any informa	tion necessary to comp	lete Schedul	е А?	Yes	X No	-
	If the answer to line 11 is "Yes," specify the information		ioto Gorioduli				
14	in the answer to line it is ites, specify the infolliation	ii not provid <del>e</del> d. 🔻					

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

			1 7 1	•		шересиен	
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>B</b> Thre	e-digit		
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591	
EMPLOYEES						·	
				_			
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500			oyer Identification Num	ber (EIN)	
LOCKHEED MARTIN CO	PROPRATION			52-	-1893632		
		ning Insurance Contra					
	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and I	ii can be re	ported on a single Sch	edule A.	
1 Coverage Information:							
(a) Name of insurance ca	rrior						
` '		THERM OF OR HIMO					
PACIFICARE OF COLORA	ADO INC (NOR	THERN CO SR HMO)					
	(a) NIAIC	(d) Contract or	(e) Approximate n	umber of	Policy	or contract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f) From	<b>(g)</b> To	
			policy or contract	ct year	(1) 110	(9)	
84-1011378	95434	29300	6		01/01/2021	12/31/2021	
_							
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, a	nd other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						d	
·		•			•		
2 Damana manising and		(Complete es manu entris		\		_	
3 Persons receiving com		ees. (Complete as many entrie					
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid		
			age and other commission	ne naid			
(b) Amount of sales a		(c) Amount	ees and other commission	ees and other commissions paid			
commissions pa	iu	(C) Amount		(d) Purpos	<u> </u>	(e) Organization code	
	L						
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid		
	1						
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code	

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

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

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	experience	e-rated as a uni	t. Where co	ntracts cover individual
8	Renefit	and contract type (check all applicable boxes)						
Ü		Health (other than dental or vision)	<b>b</b> Dental	_	Visio	n		d ☐ Life insurance
			<u> </u>					블
		emporary disability (accident and sickness)	f Long-term disabili			lemental unem	ployment	h Prescription drug
	i ∐ S	Stop loss (large deductible)	j X HMO contract	k	K PPO	contract		I Indemnity contract
	m 🗌 (	Other (specify)						
9	Experie	nce-rated contracts:		_				
	<b>a</b> Pre	miums: (1) Amount received		9a(1)				
	(2)	Increase (decrease) in amount due but unpaid	d	9a(2)				
	(3)	Increase (decrease) in unearned premium res	erve	9a(3)			1	
		Earned ((1) + (2) - (3))					9a(4)	
		nefit charges (1) Claims paid		(-)				_
	` '	Increase (decrease) in claim reserves					01 (0)	
		Incurred claims (add (1) and (2))					9b(3)	
	` ,	Claims charged					9b(4)	
	<b>C</b> Re	emainder of premium: (1) Retention charges (c		00/41//	<b>.</b>			
		(A) Commissions		9c(1)(A 9c(1)(B				
		(B) Administrative service or other fees		9c(1)(C				
		(C) Other specific acquisition costs(D) Other expenses		9c(1)(D				_
		(E) Taxes		9c(1)(E				_
		(F) Charges for risks or other contingencies .		9c(1)(F)				
		(G) Other retention charges						
		(H) Total retention					9c(1)(H)	
	(2)	Dividends or retroactive rate refunds. (These	_	_			9c(2)	
		atus of policyholder reserves at end of year: (1	_	-			9d(1)	
		Claim reserves	•				9d(2)	
	` '	Other reserves					9d(3)	
	` '	vidends or retroactive rate refunds due. (Do n					9e	
10	Nonex	perience-rated contracts:						
	<b>a</b> To	tal premiums or subscription charges paid to o	arrier				10a	2577
		he carrier, service, or other organization incur- ention of the contract or policy, other than rep					10b	
		nature of costs.	ortou iii i art i, iiilo 2 abov	c, report a	inount		100	
Б	art IV	Provision of Information						
							Vas	V Na
		e insurance company fail to provide any inform		lete Sched	ule A?		Yes	X No
12	If the a	answer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

2021

This Form is Open to Public

			, , , ,				оросион
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>B</b> Thre	e-digit		
	ORPORATION (	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	<b>▶</b>	591
EMPLOYEES							
				_			
C Plan sponsor's name a	as shown on line	e 2a of Form 5500		-	oyer Identification Nur	mber (EI	N)
LOCKHEED MARTIN CO	RPORATION			52-	-1893632		
		ning Insurance Contra					
	ate Schedule A	Individual contracts grouped	as a unit in Parts II and I	ii can be re	ported on a single So	neaule A	Α.
1 Coverage Information:							
(a) Name of insurance ca	rrior						
	iiiiGi						
PACIFICARE OF NV INC							
	(a) NIAIC	(d) Contract or	(e) Approximate no	umber of	Polic	y or conf	tract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f) From		<b>(g)</b> To
		10011111001110111001	policy or contrac	t year	(1)		(9)
86-0875231	95685	33502	6		01/01/2021		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 othe	er persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
							_
2 Porcono receiving com	missions and fe	ees. (Complete as many entrie	on an anadad to report all	norsons)		-	
Fersons receiving com					siona or food word noi		
	(a) Name a	and address of the agent, broke	er, or other person to who	III COIIIIIISS	sions or rees were par	u	
(1) A ( )		F	ees and other commissio	ns paid			
(b) Amount of sales an commissions pa		(c) Amount	(d) Purpose				(e) Organization code
commissions pa	ild	(c) / arround		(a) i dipoo	<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 pai	id	
	ı						
(b) Amount of sales a	nd base	F	ees and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code

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

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

Pa	art I	III Welfare Benefit Contract Informati If more than one contract covers the same ground the information may be combined for reporting employees, the entire group of such individua	oup of employees of the purposes if such conf	tracts are	expe	rience-rated as a un	it. Where co	ntracts cover i	
8	Rene	nefit and contract type (check all applicable boxes)		<u></u>		одгод до д д го. р	a.p0000 0		
	a 「		Dental		<b>-</b> П	Vision		d ☐ Life insu	ırance
	느		=		느				
	e L	Temporary disability (accident and sickness) <b>f</b>	Long-term disabili			Supplemental unem	ployment	h Prescrip	tion drug
	i L	Stop loss (large deductible)	X HMO contract		k 📗	PPO contract		I Indemni	y contract
	m	Other (specify)							
9	Expe	perience-rated contracts:							
		Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid			_				
		(3) Increase (decrease) in unearned premium reservable.							
	_	(4) Earned ((1) + (2) - (3))					. 9a(4)		0
		3 ( ) 1		(-)	_				
		(2) Increase (decrease) in claim reserves					01 (0)		
		(3) Incurred claims (add (1) and (2))					9b(3)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a		00/1)//				_	
		(A) Commissions		9c(1)(A 9c(1)(B				_	
		(B) Administrative service or other fees		9c(1)(C					
		(D) Other expenses		9c(1)(E				_	
		(E) Taxes		9c(1)(E	-				
		(F) Charges for risks or other contingencies		A (4) (=	_				
		(G) Other retention charges		0 (4)(4					
		(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)		
	е						9e		
10	No	onexperience-rated contracts:			. ,	,	· I		
	а	Total premiums or subscription charges paid to care	rier				10a		17875
	b	If the carrier, service, or other organization incurred	any specific costs in o	connection	with	n the acquisition or			
		retention of the contract or policy, other than reporte					10b		
	Spe	ecify nature of costs.							
Pa	art I	IV Provision of Information							
<u>1</u> 1	Did	id the insurance company fail to provide any informat	on necessary to comp	lete Sche	dule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the information							
-	,,,	, -, - ,							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

For calendar plan year 202	21 or fiscal plar	year beginning 01/01/2021		and en	iding 12/31/2021		
	RPORATION (	GROUP INSURANCE PLAN FO	OR RETIRED		B Three-digit plan number (PN) ▶ 591		
EMPLOYEES							
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		<b>D</b> Emplo	yer Identification Numb	per (EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		ning Insurance Contract  Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance car	rrier						
PACICIFARE SECURE HO		SR HMO					
(c) NAIC (d) Contract or (e) Approximate n				Policy	or contract year		
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To	
33-0115163	95174	18021	540		01/01/2021	12/31/2021	
2 Insurance fee and common descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, ar	nd other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid					<u>t</u>		
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees were paid		
(b) Amount of sales an	nd base	Fe	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code	
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	ions or fees were paid		
	(4) 1141110 4	na address or the agent, prone	., регост то тто		c. icco ire.e para		
(h) Amount of colors	(b) Amount of color and base Fees and other commissions paid						
(b) Amount of sales an commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code	

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

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

0

Part III	Welfare Benefit Contract Informa	ation				
I t	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 ex	perience-rated as a ι	ınit. Where co	ontracts cover individual
			anor may b	o troutou do a unit roi	parposos or a	iio roporti
	d contract type (check all applicable boxes)  Ith (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> ☐ Life insurance
	nporary disability (accident and sickness)	f  Long-term disabilit		Supplemental une	mployment	h Prescription drug
<u>=</u>		= =		PPO contract	inployment	
====	o loss (large deductible)	j 🛚 HMO contract	ĸ	PPO contract		I Indemnity contract
<b>m</b> Othe	er (specify)					
9 Experience	e-rated contracts:					
	Ims: (1) Amount received		9a(1)			-
	crease (decrease) in amount due but unpaid		9a(2)			
	crease (decrease) in unearned premium res		9a(3)			
	rned ((1) + (2) - (3))				9a(4)	0
	fit charges (1) Claims paid		9b(1)			
	crease (decrease) in claim reserves		9b(2)			
` '	curred claims (add (1) and (2))		( /		9b(3)	0
	aims charged					
` '	ainder of premium: (1) Retention charges (o					
	(a) Commissions		9c(1)(A)			_
`	B) Administrative service or other fees		9c(1)(B)			7
`	C) Other specific acquisition costs		9c(1)(C)			
`	O) Other expenses		9c(1)(D)			
(E	Taxes		9c(1)(E)			
(F	) Charges for risks or other contingencies.		9c(1)(F)			
(G	6) Other retention charges		9c(1)(G)			
	l) Total retention				9c(1)(H)	0
(2) Div	vidends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	s of policyholder reserves at end of year: (1					
	aim reserves				· · · ·	
( )	her reserves					
` '	ends or retroactive rate refunds due. (Do no					
	rience-rated contracts:		•	,	•	
	premiums or subscription charges paid to o	arrier			10a	2293029
<b>b</b> If the	carrier, service, or other organization incur	ed any specific costs in c	onnection w	vith the acquisition or		
retent	ion of the contract or policy, other than repo				10b	
Specify na	ture of costs.					
Part IV	Provision of Information					
11 Did the in	surance company fail to provide any inform	nation necessary to compl	ete Schedu	le A?	Yes	X No
	wer 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

OMB No. 1210-0110

2021

		•	ERISA section 103(a)(2)		iioii	Inis For	m is Open to Public Inspection
For calendar plan year 20	21 or fiscal pla	an year beginning 01/01/2021		and en	iding 12/3	1/2021	
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	LOCKHEED MARTIN CORPORATION GROUP INSURANCE PLAN F				e-digit number (PN	J) <b>•</b>	591
C Plan sponsor's name a				-	oyer Identifica 1893632	ation Number	(EIN)
on a separ		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		OF AMERICA					
	1	-1	(e) Approximate no	ımbor of		Policy or c	ontract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	(g) To
22-1211670	68241	23747-1	514		01/01/2021		12/31/2021
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, I	orokers, and o	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
246 0					0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE CAGO, IL 60674				
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	246	0	SUPPLEMENTAL COMM	MISSIONS			3
	(a) Name	and address of the agent, broke	er or other person to who	m commiss	ions or fees	were naid	
	(a) Name	and address of the agent, broke	or, or other person to who		10110 01 1000	were paid	
(b) Amount of sales ar	nd base	Ę	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

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

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

0

D	art I	Welfare Benefit Contract Informa	ntion				
	art II	If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	group of employees of the ng purposes if such cont	racts are ex	xperience-rated as a uni	t. Where co	ontracts cover individual
8	Rene	fit and contract type (check all applicable boxes)					
Ū	а	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		<b>d</b> X Life insurance
	<u> </u>						<u> </u>
	е	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	rience-rated contracts:					
	<b>a</b> P	remiums: (1) Amount received		9a(1)		130665	
	(	2) Increase (decrease) in amount due but unpaid		9a(2)		33635	
		3) Increase (decrease) in unearned premium res		9a(3)		1	
	-	(4) Earned ( <b>(1) + (2) - (3)</b> )				9a(4)	164300
		Benefit charges (1) Claims paid		9b(1)		162031	_
		2) Increase (decrease) in claim reserves				7423	400454
		(3) Incurred claims (add (1) and (2))				9b(3)	169454
		4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or		0-(4)(4)	. 1		
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			
		(C) Other specific acquisition costs(D) Other expenses		9c(1)(D)		-10595	_
		(E) Taxes		9c(1)(E)		4615	_
		(F) Charges for risks or other contingencies		9c(1)(F)		826	
		(G) Other retention charges		9c(1)(G)	)	020	
		(H) Total retention				9c(1)(H)	-5154
		(2) Dividends or retroactive rate refunds. (These		_	_	9c(2)	
		Status of policyholder reserves at end of year: (1)			-	9d(1)	
		(2) Claim reserves	•			9d(2)	32884
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do no				9e	
10		experience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo				10b	
		ify nature of costs.					
Р	art I	Provision of Information					
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedu	ule A?	Yes	X No
		e answer to line 11 is "Yes," specify the information					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2021

This Form is Open to Public

	pursuant to ERISA section 103(a)(2).			Inspection			
For calendar plan year 202	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/3	1/2021	
A Name of plan				<b>B</b> Three	e-digit		
LOCKHEED MARTIN CORPORATION		GROUP INSURANCE PLAN FO	OR RETIRED	plan number (PN) \$\int 591\$		591	
EMPLOYEES				·			
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)
LOCKHEED MARTIN CO	LOCKHEED MARTIN CORPORATION 52-1893632						
		rning Insurance Contract.  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		OF AMERICA					
	(a) NAIC	(d) Contract or	(e) Approximate no	umber of		Policy or co	entract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	ons covered at end of icy or contract year		From	<b>(g)</b> To
22-1211670	68241	23748-1	289		01/01/202	1	12/31/2021
2 Insurance fee and come 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 amount of commissions paid (b) Total amount of fees paid							
108 0							
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674				
(b) Amount of sales ar	nd hase	Fe	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	108	0	SUPPLEMENTAL COMM	MISSIONS			3
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
						·	
(la) A		Fe	ees and other commissio	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code

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

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

0

M. If D. C. O. A. A. C. C.			
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 complexes, the entire group of such individual contracts with each	ontracts are experience-rated	as a unit. Where contract	s cover individual
8 Benefit and contract type (check all applicable boxes)			
a ☐ Health (other than dental or vision) b ☐ Dental	<b>c</b> Vision	d⊠	Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disal	<b>=</b>	<u>=</u>	Prescription drug
	~ * <u>=                                  </u>	· · · · <u>-</u>	
i  Stop loss (large deductible) j  HMO contract	<b>k</b> PPO contrac	ct I	Indemnity contract
m ☐ Other (specify) ▶			
9 Experience-rated contracts:			
a Premiums: (1) Amount received	9a(1)	74156	
(2) Increase (decrease) in amount due but unpaid			
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ((1) + (2) - (3))		9a(4)	74156
<b>b</b> Benefit charges (1) Claims paid		75300	
(2) Increase (decrease) in claim reserves	. , ,	-1021	
(3) Incurred claims (add (1) and (2))		· · · · · · · · · · · · · · · · · · ·	74279
(4) Claims charged		9b(4)	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions			
(B) Administrative service or other fees			
(C) Other specific acquisition costs	0. (4)(D)		
(D) Other expenses	0 - (4)(5)	1758	
(E) Taxes		1853	
(F) Charges for risks or other contingencies	0 (4)(0)	848	
(G) Other retention charges	•	00(4)(U)	4450
(H) Total retention	_	````	4459
(2) Dividends or retroactive rate refunds. (These amounts were paid			7402
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide			
(2) Claim reserves			14860
(3) Other reserves		· · · · · ·	32961
e Dividends or retroactive rate refunds due. (Do not include amount ente	red in line 9c(2).)	9e	
10 Nonexperience-rated contracts:		- 10	
<b>a</b> Total premiums or subscription charges paid to carrier		10a	
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 at Specify nature of costs.			
Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to cor	nplete Schedule A?	Yes X No	)
12 If the answer to line 11 is "Yea" angelfy 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

					m is Open to Public Inspection		
For calendar plan year 20	21 or fiscal pla	an year beginning 01/01/2021		and en	ding 12/3	1/2021	•
A Name of plan LOCKHEED MARTIN CO	RPORATION	I GROUP INSURANCE PLAN F	OR RETIRED		e-digit number (PN	) •	591
EMPLOYEES				F 1-2-11	(	,	l
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		<b>D</b> Emplo	yer Identifica	ation Number (	EIN)
LOCKHEED MARTIN CO	RPORATION	I		52-	1893632		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca							
PRUDENTIAL INSURANC	E COMPANY	OF AMERICA					
a	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
22-1211670	68241	23749-1	48		01/01/2021		12/31/2021
2 Insurance fee and com descending order of the		nation. Enter the total fees and $\mathfrak{t}$	otal commissions paid. L	ist in line 3	the agents, b	orokers, and of	ther persons in
(a) Total a	amount of con	nmissions paid		<b>(b)</b> To	otal amount o	of fees paid	
23 0							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m 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) Purpose	е		(e) Organization code
	23	0	SUPPLEMENTAL COMM	MISSIONS			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 ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

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

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

0

Pa	rt I	Welfare Benefit Contract Informa	ition					
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ng purposes if such cont	racts are expe	erience-rated as a un	it. Where co	ontracts cover in	
8	Bene	efit and contract type (check all applicable boxes)			<u> </u>	•	<u> </u>	
	аГ	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> X Life insur	ance
	<u> </u>					nloven ont	<u> </u>	
,	e   .		f Long-term disabilit	- <u>-</u>	Supplemental unem	ipioymeni	h Prescript	_
	' <u> </u>	Stop loss (large deductible)	j HMO contract	K _	PPO contract		I Indemnit	y contract
	m _	Other (specify)						
		rience-rated contracts:		2 (1)				
•		Premiums: (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))	i	9b(1)		9a(4)		0
		Benefit charges (1) Claims paid		9b(1) 9b(2)				
		(2) Increase (decrease) in claim reserves(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (or				0.5(1)		
	-	(A) Commissions	,	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2).	)	9e		
10		nexperience-rated contracts:	i			100		15070
	_	Total premiums or subscription charges paid to co				10a		15270
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
;		cify nature of costs.	inted in Francis, into 2 abov	c, report amo	ditt	100	I	
Pa	rt I	V Provision of Information						
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No	
12	If th	ne answer to line 11 is "Yes," specify the information	on not provided.					· · · · · ·

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

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

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2021

		pursuant to				Inspection	
For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021						•	
A Name of plan				<b>B</b> Three	e-digit		
	RPORATION	I GROUP INSURANCE PLAN F	OR RETIRED	plan	number (Pl	N) <b>•</b>	591
EMPLOYEES							
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)
LOCKHEED MARTIN CORPORATION 52-1893632							
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca							
PRUDENTIAL INSURANC	E COMPANY	OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
22-1211670	68241	43406-2	700		01/01/202	1	12/31/2021
2 Insurance fee and coming 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							
92 0							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE CAGO, IL 60674				
(h) Amount of color on	d b	F	ees and other commissio	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
·	92		SUPPLEMENTAL COMM	• • • • • • • • • • • • • • • • • • • •			3
	(a) Name			:	:		
	(a) Name	and address of the agent, broke	er, or other person to who	III COMMISS	ions of tees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code

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

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

P	art I	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 employees, the entire group of such individual contracts with each of the contracts with each of the contracts.	contracts are	expe	erience-rated as a unit	. Where co	ontracts cover individual	
8	Bene	efit and contract type (check all applicable boxes)						
	аΓ	Health (other than dental or vision) <b>b</b> Dental		сΓ	Vision		<b>d</b> X Life insurance	
	_ _			_	1	-1	<b>=</b>	
	е	☐ Temporary disability (accident and sickness)    f ☐ Long-term dis	-	g		oloyment	h Prescription drug	
	i L	_ Stop loss (large deductible) j	t	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
	<u> </u>							
9	Expe	erience-rated contracts:						
		Premiums: (1) Amount received	9a(1	)				
		(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium reserve	- 1-	)				
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	_	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				9b(3)		0
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (on an accrual basis)				0.0(1)		
	•	(A) Commissions		Δ)				
		(B) Administrative service or other fees	2 (4) (					
		(C) Other specific acquisition costs	0-1411					
		(D) Other expenses	0.7477	_				
		(E) Taxes	0-/41/					
		(F) Charges for risks or other contingencies	0.7477	_				
		(G) Other retention charges	2 (4) (					
		(H) Total retention	L			9c(1)(H)	\	0
		` '		_			1	
		(2) Dividends or retroactive rate refunds. (These amounts were $\square$ pa		_		9c(2)		
		Status of policyholder reserves at end of year: (1) Amount held to pro-				9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do not include amount en	tered in line 9	c(2)	.)	9e		
10		onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a	5	3462
	b	If the carrier, service, or other organization incurred any specific costs retention of the contract or policy, other than reported in Part I, line 2 a				10b		
	Spec	ecify nature of costs.						
_		na Burnistan attac						
P	art I	IV Provision of Information						
11	Did	d the insurance company fail to provide any information necessary to co	omplete Sche	dule	A?	Yes	X No	
12	lf 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

This Form is Open to Public Inspection

		· · · · · · · · · · · · · · · · · · ·				
For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
	DRPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591
EMPLOYEES						
				_		
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500			oyer Identification Numb	per (EIN)
LOCKHEED MARTIN CO	DRPORATION			52-	-1893632	
		ning Insurance Contra				
on a separ	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and I	I can be re	ported on a single Scho	edule A.
1 Coverage Information:						
(-) Name of Commence of						
(a) Name of insurance ca	arrier					
SUMMACARE, INC.						
			(e) Approximate n	ımher of	Policy	or contract year
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	persons covered a			
. , ,	code	identification number	policy or contrac	t year	(f) From	<b>(g)</b> To
34-1726655	95202	HO 1011 MG	9		01/01/2021	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, ar	nd other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
2 Damana masai dan asan		(Camplete es manu catri				
3 Persons receiving com		ees. (Complete as many entrie				
	(a) Name a	and address of the agent, broke	er, or otner person to wno	m commiss	sions or fees were paid	
(b) Amount of sales a			ees and other commissio	•		<del></del>
commissions pa	ııd	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	
						_
(b) Amount of sales a	nd hase	F	ees and other commissio	ns paid		
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code
		` ,		. ,		, , , , , , , , , , , , , , , , , , , ,

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

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

Pa	Welfare Benefit Contract Information If more than one contract covers the same grout the information may be combined for reporting the employees, the entire group of such individual of the same provided in the same group of such individual of such individual of same gro	p of employees of the ourposes if such cont	racts are e	expe	erience-rated as a uni	t. Where co	ntracts cover indiv	tions(s), vidual
8	Benefit and contract type (check all applicable boxes)	<u></u>		_				
	<b>a</b> Health (other than dental or vision)	Dental	C	; □	Vision		<b>d</b> Life insuran	ce
	e ☐ Temporary disability (accident and sickness) f	Long-term disabili	ty C	<b>j</b> 🗌	Supplemental unem	ployment	<b>h</b> Prescription	n drug
	i Stop loss (large deductible)	X HMO contract	ŀ	ιΠ	PPO contract		I Indemnity c	ontract
	m ☐ Other (specify) ▶			ш				
	The Other (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 reserve		<del>``</del>					
	(4) Earned ((1) + (2) - (3))					. 9a(4)		0
	<b>b</b> Benefit charges (1) Claims paid							
	(2) Increase (decrease) in claim reserves		9b(2)					
	(3) Incurred claims (add (1) and (2))					9b(3)		0
	(4) Claims charged					9b(4)		
	<b>c</b> Remainder of premium: (1) Retention charges (on ar	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		0 (4)(0					
	(G) Other retention charges			-		00(4)(U)		0
	(H) Total retention	_	-			9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These am	<b>—</b>	-			9c(2)	-	
	d Status of policyholder reserves at end of year: (1) An	·				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:	ciude amount entered	ını iine <b>90</b>	(2).	)	9e		
	Total premiums or subscription charges paid to carrie	2r				10a		40950
						Toa		40000
	<b>b</b> If the carrier, service, or other organization incurred a retention of the contract or policy, other than reported					10b		
	Specify nature of costs.		-,,				-	
_	and Decree of the state of							
Pa	art IV Provision of Information					<b> -</b>		
11	Did the insurance company fail to provide any information	n necessary to compl	lete Sched	lule	A?	Yes	X No	
12	If the answer to line 11 is "Yes," specify the information r	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

		pa.oaa to 2	= : o :			mspection
For calendar plan year 20	21 or fiscal plar	n year beginning 01/01/2021		and en	ding 12/31/2021	
A Name of plan LOCKHEED MARTIN CO EMPLOYEES	ORPORATION	GROUP INSURANCE PLAN FO	R RETIRED		e-digit number (PN)	591
C Plan sponsor's name a	DRPORATION			52-	yer Identification Numbe	
		ning Insurance Contract  Individual contracts grouped a				
1 Coverage Information:					<u> </u>	
(a) Name of insurance ca		OF THE MID-ATLANTIC				
	(c) NAIC	(d) Contract or	(e) Approximate numb		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered at er policy or contract ye		(f) From	<b>(g)</b> To
52-0954463	95639	3104	28		01/01/2021	12/31/2021
descending order of the		ation. Enter the total fees and tot	al commissions paid. List i		the agents, brokers, and	other persons in
.,		·		• •	•	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all per	sons).		
	(a) Name a	nd address of the agent, broker,	or other person to whom o	ommiss	ions or fees were paid	
(b) Amount of sales a			es and other commissions p			
commissions paid		(c) Amount	(d)	Purpose	9	(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to whom c	ommiss	ions or fees were paid	
	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,			
(b) Amount of sales a	nd base	Fee	es and other commissions p	oaid		
commissions pa		(c) Amount	(d)	Purpose	e	(e) Organization code

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

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

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same of 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	xper	rience-rated as a unit	. Where co	ontracts cover i	izations(s), ndividual
8	Bene	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	<b>b</b> Dental	С	; □	Vision		d Life insu	rance
	еĪ	Temporary disability (accident and sickness)	f  Long-term disabili	ty <b>g</b>	ıП	Supplemental unemp	lovment	h Prescrip	tion drug
	i	Stop loss (large deductible)	j X HMO contract	, s k		PPO contract	,		ty contract
	. L		, A Time contract		- Ш	TT O COMMON		- Ldo	y contract
	m	Other (specify)							
9	Evno	rience-rated contracts:							
3		Premiums: (1) Amount received		9a(1)				_	
		(2) Increase (decrease) in amount due but unpaid		9a(1)				_	
		(3) Increase (decrease) in unearned premium rese		9a(3)				-	
		(4) Earned ((1) + (2) - (3))					9a(4)		
	_	Benefit charges (1) Claims paid		9b(1)	Π		Ja(+)		
		(2) Increase (decrease) in claim reserves						-	
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)		0
							9b(4)		
		(4) Claims charged					3D( <del>1</del> )		
	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)	<b>—</b> ·	L		•	9d(1)		
	u	(2) Claim reserves	•				9d(1)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no					9e		
10	_	nexperience-rated contracts:	t morado dimodrit oritorot	2 III III IO <b>30</b> (	( <b>-</b> /·/		- 30		
•		Total premiums or subscription charges paid to ca	arrier				10a		257878
	_	If the carrier, service, or other organization incurre							
		retention of the contract or policy, other than repo				•	10b		
		cify nature of costs.							
P	art I	V Provision of Information							
11	Did	the insurance company fail to provide any information	ation necessary to compl	ete Sched	ule /	Α?	Yes	X No	
12	2 If th	ne answer to line 11 is "Yes," specify the information	on not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# **Insurance Information**

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

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

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

2021

This Form is Open to Public

For calendar plan year 202	21 or fiscal plar	year beginning 01/01/2021		and er	nding 12/31/2021	
A Name of plan				<b>B</b> Thre	e-digit	
	RPORATION	GROUP INSURANCE PLAN F	OR RETIRED	plan	number (PN)	591
EMPLOYEES						·
C Plan sponsor's name a	is shown on line	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Numb	per (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632	
		ning Insurance Contra				
	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and II	I can be re	ported on a single Sche	edule A.
1 Coverage Information:						
(a) Name of incurance on	i					
(a) Name of insurance ca						
PACIFICARE OF COLORA	ADO INC (PUE	BLO SR HMO)				
			(e) Approximate nu	ımber of	Policy	or contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a			
	code	identification number	policy or contrac	t year	(f) From	<b>(g)</b> To
84-1011378	95434	29300	2		01/01/2021	12/31/2021
		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, ar	d other persons in
descending order of the	amount paid.		1			
(a) Total amount of commissions paid (b) Total amount of fees paid						
3 Persons receiving com	missions and fo	ees. (Complete as many entrie	es as needed to report all	nereone)		
O 1 Cladila receiving com		nd address of the agent, broke			sions or foos wors poid	
	(a) Name a	nd address of the agent, broke	ii, or other person to who	II COITIIII58	sions or lees were paid	
		F	ees and other commission	ne naid		
(b) Amount of sales ar		(c) Amount			^	(a) Organization and
commissions pa	ia	(C) Amount		(d) Purpos	<u>e</u>	(e) Organization code
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code
- Jr		, ,				,,,,,

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

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

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	roup of employees of the ng purposes if such cont	racts are e	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>b</b> Dental	С	; □	Vision		d ∏ Li	fe insurance
	e	Temporary disability (accident and sickness)	f  Long-term disabili	ty <b>g</b>	ıП	Supplemental unemp	olovment	h ∏ Pi	rescription drug
	i [	Stop loss (large deductible)	j X HMO contract	, s k		PPO contract	,		demnity contract
	. L		, A Time contract	-,	`Ш	110 contract		· П	dominity dominant
	m	Other (specify)							
9	Evno	riance rated centracte:							
9		rience-rated contracts:		00/1)					
		Premiums: (1) Amount received		9a(1) 9a(2)				-	
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium rese					02/4)		
	_	(4) Earned ((1) + (2) - (3))		9b(1)	····	•••••	9a(4)		
	b	Benefit charges (1) Claims paid							
		(2) Increase (decrease) in claim reserves					0b/2\		0
		(3) Incurred claims (add (1) and (2))					9b(3) 9b(4)		
	•	(4) Claims charged					30(4)		
	С	, , , , , , , , , , , , , , , , , , , ,	*	9c(1)(A	`				
		(A) Commissions		9c(1)(A)				-	
		(B) Administrative service or other fees		9c(1)(C)				-	
		(D) Other expenses		9c(1)(D)	_				
		(E) Taxes		9c(1)(E)					
		(F) Charges for risks or other contingencies		9c(1)(F)	_				
		(G) Other retention charges						_	
		(H) Total retention					9c(1)(H	\ <u> </u>	
		(2) Dividends or retroactive rate refunds. (These	_	_				<del>'</del>	
	لہ		<b>—</b> ·	L			9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•				9d(1)		
		(2) Claim reserves					9d(2)		
	_	(3) Other reserves					9d(3)		
10	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	i include amount entered	in line 9C	(2).	)	9e		
10		nexperience-rated contracts:	unio n				100		7265
		Total premiums or subscription charges paid to ca					10a		7365
	b Sne	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo- cify nature of costs.	, ,			•	10b		
Р	art I	V Provision of Information							
11	Dic	the insurance company fail to provide any informa	ation necessary to compl	ete Sched	ule	A?	Yes	X No	
12	lf th	ne answer to line 11 is "Yes," specify the information	n not provided.					<del></del>	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# **Insurance Information**

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

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

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

OMB No. 1210-0110

2021

This Form is Open to Public

		parouarit to				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 EMPLOYEES	ORPORATION (	GROUP INSURANCE PLAN FO			e-digit number (PN)	591
C Plan sponsor's name a	ORPORATION			52-	oyer Identification Number 1893632	
		ning Insurance Contract Individual contracts grouped a				
1 Coverage Information:	<u></u>	· ····a····audii oo:·····aoto g.oapoa o			portou on a onigio comos	
(a) Name of insurance ca		OF THE NORTHWEST				
	(c) NAIC	(d) Contract or	(e) Approximate num		Policy or	contract year
<b>(b)</b> EIN	code	identification number	persons covered at e policy or contract y		(f) From	<b>(g)</b> To
93-0798039	95540	21201	3		01/01/2021	12/31/2021
descending order of the		ation. Enter the total fees and tot	tal commissions paid. List		the agents, brokers, and	other persons in
(a) rotari	amount or com	mosions paid		(6) 10	otal amount of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all pe	ersons).		
	(a) Name a	nd address of the agent, broker,	, or other person to whom	commiss	sions or fees were paid	
(b) Amount of sales a	nd base		es and other commissions	•		
commissions pa	iid	(c) Amount	(d	(d) Purpose		(e) Organization code
	(a) Name a	nd address of the agent, broker,	, or other person to whom	commiss	sions or fees were paid	
(b) Amount of sales a	nd base	Fee	es and other commissions	paid		
commissions pa	iid	(c) Amount	(d	) Purpos	е	(e) Organization code

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

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

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same of 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>b</b> Dental	С	; <b></b>	Vision		<b>d</b> □ Li	fe insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	ıП	Supplemental unem	olovment	<b>h</b> ∏ Pi	rescription drug
	i [	Stop loss (large deductible)	j X HMO contract	, s k		PPO contract	,		demnity contract
	' L		) M Tiwo contract	N	`⊔	11 O contract		•□	definity contract
	m	Other (specify)							
0		winner unter discontinuents.							
9		rience-rated contracts:		0-(4)	-			_	
		Premiums: (1) Amount received		9a(1)				_	
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium rese		9a(3)			0-(4)		
	_	(4) Earned ((1) + (2) - (3))			····		9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)					
		(2) Increase (decrease) in claim reserves					01- (0)		0
		(3) Incurred claims (add (1) and (2))					9b(3)		0
	_	(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (or	,	0. (4)(4)				_	
		(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
		$\begin{tabular}{ll} \end{tabular} \begin{tabular}{ll} \end{tabular} \beg$	amounts were paid ir	cash, or	С	redited.)	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)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line <b>9c</b>	<b>(2)</b> .)	)	9e		
10	No	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to ca	arrier				10a		46560
	b	If the carrier, service, or other organization incurred retention of the contract or policy, other than repo					10b		
		cify nature of costs.							
Р	art I	V Provision of Information							
11	Dic	the insurance company fail to provide any informa	ation necessary to compl	ete Sched	ule	A?	Yes	X No	
12	lf th	ne answer to line 11 is "Yes," specify the information	on not provided.					<del></del>	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation **Service Provider Information** 

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2021

This Form is Open to Public 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 FOR RETIRED plan number (PN)  EMPLOYEES  B Three-digit plan number (PN)  591	
LOCKHEED MARTIN CORPORATION GROUP INSURANCE PLAN FOR RETIRED plan number (PN) 591	
EMPLOYEES	
C Plan sponsor's name as shown on line 2a of Form 5500  D Employer Identification Number (EIN)	
LOCKHEED MARTIN CORPORATION 52-1893632	
32-1093032	
Part I Service Provider Information (see instructions)	
Turt   Solving Fredrick Information (see metroscorie)	—
You must complete this Part, in accordance with the instructions, to report the information required for each person who received, directly or indirectly, \$5,000 control or each person who received directly or indirectly.	
or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received <b>only</b> eligible indirect compensation for which the plan received the required disclosures, you are required to	е
answer line 1 but are not required to include that person when completing the remainder of this Part.	
1 Information on Persons Receiving Only Eligible Indirect Compensation	
Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible	
indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)	
If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who	
received only eligible indirect compensation. Complete as many entries as needed (see instructions).	
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	_
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	

Schedule C (Form 5500) 2021	Page <b>2-</b>	. 1	
	-		
(b) Enter name and EIN or address of per	son who provided you disclosur	ures on eligible indirect compensation	
(b) Enter name and EIN or address of per	son who provided you disclosur	ures on eligible indirect compensation	
(b) Enter name and EIN or address of per	son who provided you disclosur	ures on eligible indirect compensation	
(b) Lines frame and Line of address of per	3011 Willo provided you disclosur	nes on engine maneer compensation	
(h) F			
(b) Enter name and EIN or address of per	son who provided you disclosur	ires on eligible indirect compensation	
(b) Enter name and EIN or address of per	son who provided you disclosur	res on eligible indirect compensation	
(b) Enter name and EIN or address of per	son who provided you disclosur	ures on eligible indirect compensation	
(b) Enter name and EIN or address of per	son who provided you disclosur	ures on eligible indirect compensation	
(b) Enter name and EIN or address of per	son who provided you disclosur	res on eligible indirect compensation	

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Schedule C (Form 5500) 2021				Page <b>3 -</b> 1		
answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
-			(a) Enter name and EIN o	r address (see instructions)		
AETNA H	IEALTH INC.					
23-244204	48					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
12	CLAIMS ADMINISTRATOR	3548599	Yes No X	Yes No		Yes No
	1		(a) Enter name and EIN or	address (see instructions)		
CICNATI	EALTHCARE	'	a) Littor hame and Litt of	address (see medacasne)		
06-03033	70					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
12	CLAIMS ADMINISTRATOR	660856	Yes No 🛚	Yes No		Yes No
	•	(	<b>a)</b> Enter name and EIN or	address (see instructions)		
HEALTHF	PARTNERS INC		. ,	· · · · · · · · · · · · · · · · · · ·		
41-169383	38					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount
12	CLAIMS ADMINISTRATOR	407134	Yes No X	Yes No		Yes No

Yes No X

Yes No

Yes No

Page 3	-	- 2
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Schedule C	(Form	5500)	2021
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CLAIMS ADMINISTRATOR 48336

Yes No X

Yes No

Yes No

12

				r Indirect Compensation		
		value) in connection	with services rendered to the	ne plan or their position with the		
			(a) Enter name and EIN o	r address (see instructions)		
AETNA L	IFE INSURANCE COM	MPANY				
06-60334	92					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you formula instead o an amount or estimated amount
12	CLAIMS ADMINISTRATOR	249334	Yes No X	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
59-10310	IEALTH & LIFE INSUR	ANCE CO.				
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you formula instead o an amount or estimated amount
12	CLAIMS ADMINISTRATOR	223165	Yes No 🛚	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
CIGNA IN 51-01116	NTERNATIONAL COR	PORATION				
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you formula instead o an amount or estimated amount

### Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensatio or provides contract administrator, consulting, custodial, investment advisory, investment manage questions for (a) each source from whom the service provider received \$1,000 or more in indirect provider gave you a formula used to determine the indirect compensation instead of an amount or many entries as needed to report the required information for each source.	ment, broker, or recordkeeping compensation and (b) each so	g services, answer the following urce for whom the service	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.	

Part II Service Providers Who Fail or Refuse to  4 Provide, to the extent possible, the following information for ea		mation er who failed or refused to provide the information necessary to complete
this Schedule.	acii service provide	a who falled of ferused to provide the illionnation necessary to complete
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Page 6	; <b>-</b>
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Pa	Termination Information on Accountants and Er (complete as many entries as needed)	nrolled Actuaries (see instructions)
а	Name:	<b>b</b> EIN:
C	Position:	
d	Address:	e Telephone:
Ex	planation:	
а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	<b>e</b> Telephone:
		·
Ex	planation:	
а	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:
-		
Ex	planation:	·
а	Name:	<b>b</b> EIN:
c	Position:	
d	Address:	e Telephone:
-	, adiooc.	• recognisine.
Ex	planation:	·
	'	
a	Name:	b EIN:
C	Position:	D LIIV.
d	Address:	e Telephone:
u	Audicoo.	с тетернопе.
	planation:	
ΕX	pianation.	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

# **DFE/Participating Plan Information**

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2021

This Form is Open to Public Inspection.

For calendar plan year 2021 or fiscal p	olan year beginning	01/01/2021 and	ending 12/31/2021
A Name of plan			<b>B</b> Three-digit
LOCKHEED MARTIN CORPORATIO	N GROUP INSURAN	CE PLAN FOR RETIRED EMPLOYEES	plan number (PN) 591
C Plan or DFE sponsor's name as sho	own on line 2a of Form	5500	D Employer Identification Number (EIN)
LOCKHEED MARTIN CORPORATIO	N		52-1893632
		Ts, PSAs, and 103-12 IEs (to be co	npleted by plans and DFEs)
(Complete as many	entries as needed	to report all interests in DFEs)	
a Name of MTIA, CCT, PSA, or 103-	12 IE: LOCKHEED	MARTIN CORP BENEFIT TRUST	
<b>b</b> Name of sponsor of entity listed in	(a): LOCKHEED	MARTIN CORPORATION	
• FINE DNE - 52 4640424 002	<b>d</b> Entity M	e Dollar value of interest in MTIA, CCT, P	SA, or 46369854
<b>C</b> EIN-PN 52-1610424-003	code	103-12 IE at end of year (see instructio	ns) 16268854
a Name of MTIA, CCT, PSA, or 103-	12 IE: LMC BENEF	IT TRUST FOR BARG EMP	
<b>b</b> Name of sponsor of entity listed in	(a).	MARTIN CORPORATION	
<b>c</b> EIN-PN 13-3507980-004	d Entity M code	e Dollar value of interest in MTIA, CCT, P 103-12 IE at end of year (see instruction	
a Name of MTIA, CCT, PSA, or 103-	12 IE:		
<b>b</b> Name of sponsor of entity listed in	(a):		
	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, P	SA or
C EIN-PN	code	103-12 IE at end of year (see instruction	
- 11 (1) (2) (2)			
a Name of MTIA, CCT, PSA, or 103-	12 IE:		
<b>b</b> Name of sponsor of entity listed in	(a):		
C EIN-PN	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, P	SA, or
C EIN-FIN	code	103-12 IE at end of year (see instruction	ns)
a Name of MTIA, CCT, PSA, or 103-	12 IE:		
· · · · · · · · · · · · · · · · · · ·			
<b>b</b> Name of sponsor of entity listed in	(a):		
C EIN-PN	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, P	SA, or
C LIIV-FIV	code	103-12 IE at end of year (see instruction	ns)
a Name of MTIA, CCT, PSA, or 103-	12 IE:		
<b>b</b> Name of sponsor of entity listed in	(a):		
	d Entity	Dollar value of interest in MTIA COT D	SA or
C EIN-PN	<b>d</b> Entity code	e Dollar value of interest in MTIA, CCT, P 103-12 IE at end of year (see instruction	
a Name of MTIA, CCT, PSA, or 103-	12 IE:		
<b>b</b> Name of sponsor of entity listed in	(a):		
C EIN-PN	<b>d</b> Entity	e Dollar value of interest in MTIA, CCT, P	SA, or
<u> </u>	code	103-12 IE at end of year (see instruction	ns)

Schedule D (Form 5500) 2	2021	Page <b>2 -</b> 1
a Name of MTIA, CCT, PSA, or 103	3-12 IE:	
<b>b</b> Name of sponsor of entity listed in	າ (a):	
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103	3-12 IE:	
<b>b</b> Name of sponsor of entity listed in	າ (a):	
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103	3-12 IE:	
<b>b</b> Name of sponsor of entity listed in	າ (a):	
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or     103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103	3-12 IE:	
<b>b</b> Name of sponsor of entity listed in	າ (a):	
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or     103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103	3-12 IE:	
<b>b</b> Name of sponsor of entity listed in	າ (a):	
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103	3-12 IE:	
<b>b</b> Name of sponsor of entity listed in	າ (a):	
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103	3-12 IE:	
<b>b</b> Name of sponsor of entity listed in	າ (a):	
C EIN-PN	<b>d</b> Entity code	Dollar value of interest in MTIA, CCT, PSA, or     103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103	3-12 IE:	
<b>b</b> Name of sponsor of entity listed in	າ (a):	

e Dollar value of interest in MTIA, CCT, PSA, or

103-12 IE at end of year (see instructions)

e Dollar value of interest in MTIA, CCT, PSA, or

103-12 IE at end of year (see instructions)

e Dollar value of interest in MTIA, CCT, PSA, or

103-12 IE at end of year (see instructions)

**d** Entity

**d** Entity

**d** Entity

code

code

code

C EIN-PN

C EIN-PN

C EIN-PN

a Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

a Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

F	Part II	Information on Participating Plans (to be completed by DFEs) (Complete as many entries as needed to report all participating plans)	
а	Plan na	me	
b	Name o		C EIN-PN
а	Plan na	me	
b	Name o		C EIN-PN
а	Plan na	me	
b	Name o		C EIN-PN
а	Plan na	me	
b	Name o		C EIN-PN
а	Plan na	me	
b	Name o		C EIN-PN
а	Plan na	me	
b	Name o		C EIN-PN
а	Plan na	me	
b 	Name o		C EIN-PN
а	Plan na	me	
b	Name o		C EIN-PN
а	Plan na	me	
b	Name o		C EIN-PN
	Plan na		
b	Name o		C EIN-PN
	Plan na		
b	Name o		C EIN-PN
	Plan na		
b	Name o		C EIN-PN

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Corporation

**Financial Information** 

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

and ending

12/31/2021

803027977

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

A Name of plan			B Three-digit		
LOCKHEED MARTIN CORPORATION GROUP INSURANCE PLAN FOR RETI	RED EMPLOYE	EES	plan number (PN)	) •	591
C Plan sponsor's name as shown on line 2a of Form 5500			D Employer Identifica	ation Number (E	EIN)
LOCKHEED MARTIN CORPORATION			52-1893632		
Part I Asset and Liability Statement		<u>'</u>			
1 Current value of plan assets and liabilities at the beginning and end of the plan the value of the plan's interest in a commingled fund containing the assets of lines 1c(9) through 1c(14). Do not enter the value of that portion of an insuran benefit at a future date. Round off amounts to the nearest dollar. MTIAs, (and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. Se	more than one pose contract which contract which contract which contract which contract which was an arm of the contract which was a contract with the contract was a contract with the contract was a contract with the contract was a contract with the contract was a contract with the contract was a contract with the contract was a contract with the contract was a contract with the contract which was a contract with the contract was a contract which was a contract which was a contract which was a contract which was a contract which was a contract which was a contract which was a contract which was a contract which was a contract which was a contract which was a contract with the contract	olan on a l ch guarant	ine-by-line basis unless ees, during this plan ye	the value is re ar, to pay a spe	portable on ecific dollar
Assets		<b>(a)</b> Be	eginning of Year	<b>(b)</b> End	of Year
a Total noninterest-bearing cash	1a				
<b>b</b> Receivables (less allowance for doubtful accounts):					
(1) Employer contributions	1b(1)				
(2) Participant contributions	1b(2)		97069		323635
(3) Other	1b(3)		200000		200000
<b>C</b> General investments:					
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)				
(2) U.S. Government securities	1c(2)				
(3) Corporate debt instruments (other than employer securities):					
(A) Preferred	1c(3)(A)				
(B) All other	1c(3)(B)				
(4) Corporate stocks (other than employer securities):					
(A) Preferred	1c(4)(A)				
(B) Common	1c(4)(B)				
(5) Partnership/joint venture interests	1c(5)				

1c(6)

1c(7)

1c(8)

1c(9)

1c(10)

1c(11)

1c(12)

1c(13)

1c(14)

1c(15)

funds) ..... (14) Value of funds held in insurance company general account (unallocated

(5) Partnership/joint venture interests .....

(6) Real estate (other than employer real property) ......

(7) Loans (other than to participants).....

(8) Participant loans .....

(9) Value of interest in common/collective trusts.....

(10) Value of interest in pooled separate accounts ......

(11) Value of interest in master trust investment accounts.....

(12) Value of interest in 103-12 investment entities ..... (13) Value of interest in registered investment companies (e.g., mutual

(15) Other.....

contracts).....

830638266

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	803325046	831161901
Liabilities			
g Benefit claims payable	1g	5846734	5801756
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k	5846734	5801756
Net Assets			
Net assets (subtract line 1k from line 1f)	11	797478312	825360145

## Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	7739190	
	(B) Participants	2a(1)(B)	12960253	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		20699443
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	<b>(F)</b> Other	2b(1)(F)		
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

			(a) Amount		(b) Total		
(6) Net investment gain (loss) from common/collective trusts	2b(6)						
(7) Net investment gain (loss) from pooled separate accounts	2b(7)						
(8) Net investment gain (loss) from master trust investment accounts	2b(8)				81017021		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)						
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)						
C Other income	2c						
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total	2d				101716464		
Expenses							
<b>e</b> Benefit payment and payments to provide benefits:							
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		583	318642	_		
(2) To insurance carriers for the provision of benefits	2e(2)		129	948413			
(3) Other	2e(3)						
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)				71267055		
f Corrective distributions (see instructions)	2f						
g Certain deemed distributions of participant loans (see instructions)	2g						
h Interest expense	2h						
i Administrative expenses: (1) Professional fees	2i(1)		23	345416			
(2) Contract administrator fees	2i(2)						
(3) Investment advisory and management fees	2i(3)		1	85588			
(4) Other	0:/4)			36572			
(5) Total administrative expenses. Add lines 2i(1) through (4)					2567576		
j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total					73834631		
Net Income and Reconciliation							
k Net income (loss). Subtract line 2j from line 2d	2k				27881833		
I Transfers of assets:					2.00.000		
(1) To this plan	2l(1)						
(2) From this plan	21(2)						
					<u>'</u>		
Part III Accountant's Opinion							
3 Complete lines 3a through 3c if the opinion of an independent qualified publ attached.	ic accountant	is attached	to this Form	5500. Co	mplete line 3d if an opinion is not		
$\boldsymbol{a}$ The attached opinion of an independent qualified public accountant for this $\mu$	olan is (see in	structions):					
(1) 🛚 Unmodified (2) 🗌 Qualified (3) 🗍 Disclaimer (4	4) Adverse	:					
<b>b</b> Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.							
(1) X DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (	3) neither D	OL Regula	tion 2520.10	3-8 nor D	OL Regulation 2520.103-12(d).		
<b>C</b> Enter the name and EIN of the accountant (or accounting firm) below:							
(1) Name: MITCHELL & TITUS, LLP		(2) EIN:	13-27816	41			
d The opinion of an independent qualified public accountant is <b>not attached</b> b							
(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be atta	ached to the n	ext Form 55	500 pursuan	t to 29 CF	R 2520.104-50.		
Part IV   Compliance Questions							
CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5.  103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.							
During the plan year:		1	Yes	No	Amount		
Was there a failure to transmit to the plan any participant contributions will period described in 29 CFR 2510.3-102? Continue to answer "Yes" for an fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction	y prior year fa		4a	X			
, total (555 monaths and 5525 volumery readily contour				I			

Page 4	- [
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Schedule H (Form 5500) 2021

Yes No Amount Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.) 4b Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) ..... Х 4c d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is X checked.) ..... 4d 100000000 Was this plan covered by a fidelity bond?.... 4e f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by 4f Χ fraud or dishonesty? ..... Did the plan hold any assets whose current value was neither readily determinable on an g established market nor set by an independent third party appraiser? ..... 4g Χ Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? ..... Х 4h Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)..... 4i X Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)..... 4j Χ Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? 4k Χ ı Has the plan failed to provide any benefit when due under the plan? ..... 41 Χ If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)..... 4m If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3..... X No 5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?...... If "Yes," enter the amount of any plan assets that reverted to the employer this year \_ If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.) 5b(1) Name of plan(s) 5b(2) EIN(s) 5b(3) PN(s) 5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year \_\_\_\_

# LOCKHEED MARTIN CORPORATION GROUP INSURANCE PLAN FOR RETIRED EMPLOYEES Financial Statements as of December 31, 2021 and 2020, and for the Year Ended December 31, 2021 with Independent Auditor's Report

# **Lockheed Martin Corporation Group Insurance Plan for Retired Employees**

### **Financial Statements**

# Year Ended December 31, 2021

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#### INDEPENDENT AUDITOR'S REPORT

To the Participants and Plan Administrator of the Lockheed Martin Corporation Group Insurance Plan for Retired Employees

#### Scope and Nature of the ERISA Section 103(a)(3)(C) Audit

We have performed an audit of the financial statements of the Lockheed Martin Corporation Group Insurance Plan for Retired Employees (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statement of net assets available for benefits as of December 31, 2021, the related statement of changes in net assets available for benefits for the year then ended, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audit of the Plan's financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audit need not extend to any statements or information related to assets held for investment of the Plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained a certification from a qualified institution as of and for the year ended December 31, 2021, stating that the certified investment information, as described in Note 4 to the financial statements, is complete and accurate.

#### **Opinion**

In our opinion, based on our audit and on the procedures performed as described in the Auditor's Responsibilities for the Audit of the Financial Statements section:

 The amounts and disclosures in the accompanying financial statements, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.



• The information in the accompanying financial statements related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

## **Basis for Opinion**

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our ERISA Section 103(a)(3)(C) audit opinion.

# Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for one year after the date that the financial statements are issued.

Management is also responsible for maintaining a current plan instrument, including all Plan amendments, administering the Plan, and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

## Auditor's Responsibilities for the Audit of the Financial Statements

Except as described in the Scope and Nature of the ERISA Section 103(a)(3)(C) Audit section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions,



misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether
  due to fraud or error, and design and perform audit procedures responsive to those risks.
   Such procedures include examining, on a test basis, evidence regarding the amounts and
  disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit
  procedures that are appropriate in the circumstances, but not for the purpose of expressing
  an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is
  expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

Our audit did not extend to the certified investment information, except for obtaining and reading the certification, comparing the certified investment information with the related information presented and disclosed in the financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of accounting principles generally accepted in the United States of America.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the financial statements as a whole are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

October 7, 2022

Mitchell: Titus, LLP



#### INDEPENDENT AUDITOR'S REPORT

To the Participants and Plan Administrator of the Lockheed Martin Corporation Group Insurance Plan for Retired Employees

We were engaged to audit the accompanying statement of net assets available for benefits of the Lockheed Martin Corporation Group Insurance Plan for Retired Employees (the Plan), as of December 31, 2020, and the related notes to the financial statement (2020 financial statement).

## Management's Responsibility for the Financial Statement

Management is responsible for the preparation and fair presentation of this financial statement in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of a financial statement that is free from material misstatement, whether due to fraud or error.

## **Auditor's Responsibility**

Our responsibility is to express an opinion on the 2020 financial statement based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the Basis for Disclaimer of Opinion paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

## **Basis for Disclaimer of Opinion**

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 4, which was certified by the Northern Trust Company, the trustee of the Plan, except for comparing such information with the related information included in the financial statement. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the trustee as of December 31, 2020 that the information provided to the plan administrator by the trustee is complete and accurate.



## **Disclaimer of Opinion**

Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the 2020 financial statement. Accordingly, we do not express an opinion on the 2020 financial statement.

# Report on Form and Content in Compliance With DOL Rules and Regulations for 2020 Financial Statement

The form and content of the information included in the 2020 financial statement, other than that derived from the information certified by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

October 7, 2022

Mitchell: Titas, LLP

# Lockheed Martin Corporation Group Insurance Plan for Retired Employees Statements of Net Assets Available for Benefits (in thousands)

# December 31,

	2021			2020
Assets				
Investments:				
Interest in Lockheed Martin Corporation Benefit Trust	\$	16,269	\$	23,309
Interest in Lockheed Martin Corporation Benefit Trust for Collectively Bargained Employees		814,369		779,719
Total investments		830,638		803,028
Net assets held in Lockheed Martin Corporation Salaried Employee Retirement Program 401(h) account		1,342,437		447,566
Net assets held in Lockheed Martin Corporation Salaried Savings Plan 401(h) account		17		12
Retiree contributions receivable		323		97
Income tax receivable		200		200
Transfer receivable				839,196
Total receivables		523		839,493
Total assets		2,173,615		2,090,099
Liabilities				
Payable to Lockheed Martin Corporation		5,801		5,846
Net assets available for benefits				
ivet assets available for beliefits	\$	2,167,814	\$	2,084,253

The accompanying notes are an integral part of these financial statements.

# Lockheed Martin Corporation Group Insurance Plan for Retired Employees Statement of Changes in Net Assets Available for Benefits (in thousands)

# Year Ended

	Dece	mber 31, 2021
Net assets available for benefits at beginning of year	\$	2,084,253
Additions to net assets:	· ·	, ,
Contributions:		
Employer		10,051
Retiree		67,537
Total contributions		77,588
Net increase in Lockheed Martin Corporation Salaried Savings Plan 401(h) account		1
Interest in net investment gains of the Trusts		228,029
Total additions		305,618
Deductions from net assets:		
Claims payments		183,718
Insurance premiums		33,012
Administrative expenses		5,327
Total deductions		222,057
Change in net assets		83,561
Net assets available for benefits at end of year	\$	2,167,814

The accompanying notes are an integral part of these financial statements.

# 1. Description of the Plan

The following description of the Lockheed Martin Corporation Group Insurance Plan for Retired Employees (the Plan) provides only general information about the Plan's provisions. Participants should refer to the Plan document and Summary Plan Descriptions for a more complete description of the Plan's provisions.

#### General

The Plan consists of (i) a defined benefit health and welfare plan covering certain retirees of Lockheed Martin Corporation (the Group Insurance Plan) and (ii) a qualified self-insured health reimbursement plan covering certain Medicare-eligible retirees of Lockheed Martin Corporation (the Retiree HRA), and has been amended from time to time. Lockheed Martin Corporation (the Corporation) is the Plan Sponsor and the Plan Administrator.

The assets of the Plan, excluding the "Retiree contributions receivable", "Income tax receivable", and "transfers receivable" are held and invested on a commingled basis in the Lockheed Martin Corporation Benefit Trust (the Trust) and the Lockheed Martin Corporation Benefit Trust for Collectively Bargained Employees (the Collectively Bargained Trust), as well as in the Lockheed Martin Corporation Salaried Employee Retirement Program (LMRP) 401(h) account and Lockheed Martin Corporation Salaried Savings Plan (SSP) 401(h) account. The assets of the Trust, the Collectively Bargained Trust, and the two 401(h) accounts are held by The Northern Trust Company (the Trustee).

#### 401(h) Account

Separate accounts have been established and maintained in LMRP and SSP for the net assets related to the medical benefit and the retiree HRA components of the Plan, in accordance with Section 401(h) of the IRC. In accordance with IRC Section 401(h), the Plan's investments in the 401(h) accounts may not be used for, or diverted to, any purpose other than providing health benefits for retirees and their beneficiaries. The related obligations for health benefits are not included in the LMRP or SSP obligations, but are reported as obligations in the accompanying financial statements of the Plan. In 2021, the health and welfare benefits of \$140,937,000 were paid from the LMRP 401(h) account.

The LMRP and the SSP each have an Internal Revenue Service (IRS) determination letter stating that the plans are designed in accordance with applicable sections of the Internal Revenue Code (IRC), and therefore, the related trusts are exempt from taxation. These plans have been amended since issuance of the determination letter. However, the Plan Administrator and the Corporation's counsel believe that the current design and operations of the LMRP and SSP are in compliance with the applicable provisions of the IRC and therefore, believe the LMRP and SSP, as amended, are qualified and the related trusts are tax exempt.

# **Funding Policy**

The Corporation's cash contributions are determined on an accrual basis in accordance with the requirements under Sections 105, 106, and 419 of the IRC and as defined in IRS Notice 2002-45, as applicable, and U.S. Government Cost Accounting Standards (CAS).

Although the Corporation expects to continue the Plan indefinitely, the Corporation may amend, suspend, or terminate the Plan for any reason at any time. If the Plan is terminated, any benefits with respect to claims or expenses incurred prior to the date of such Plan termination will be an obligation of the Plan.

Such benefits may be fully or partially provided for by the existing assets of the Plan, with any excess provided for by the Corporation.

#### **Contributions**

The Corporation makes actuarially determined contributions to the 401(h) accounts and Trusts that are used to fund the Corporation's portion of postretirement medical benefits incurred for covered retirees and spouses.

The cost of the postretirement benefit obligation is shared by the Corporation and retirees for the Group Insurance Plan. The Group Insurance Plan covers various groups of retirees with multiple cost-sharing provisions. Generally, for retirees age 65 and under, their contributions are based on years of service as well as amounts in excess of a monthly cap. For retirees over age 65, generally, their benefits are supplemental to Medicare and they generally contribute amounts in excess of a monthly cap. In some cases, represented retirees contribute a nominal amount.

The Retiree HRA provides Benefit Credits to participants each year based on a fixed dollar amount. Generally, a Benefit Credit for a full Plan year is \$900 for each participating retiree and participating spouse with higher amounts for some retiree groups. The Benefit Credit is prorated for the number of months remaining in the year if the participant becomes covered after January 1 in a Plan year. Benefit Credits that are not used by participants in each plan year are carried over and may be used in subsequent years throughout each participant's lifetime.

## **Payment of Claims and Premiums**

The Plan provides continuation of certain benefits upon retirement from the Corporation including medical, prescription drug, dental, and life insurance benefits. Benefits are either fully insured or self-insured. The claims for self-insured benefits are processed by the Plan's third-party administrators; however, the responsibility for payments to providers is retained by the Plan. The Retiree HRA reimburses participants for eligible medical expenses incurred up to their Benefit Credit amounts each year.

## 2. Summary of Significant Accounting Policies

## **Basis of Accounting**

The financial statements of the Plan are prepared on the accrual basis of accounting.

#### Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations and changes therein, and the disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

#### **Payment of Claims and Premiums**

Premiums paid by either the Corporation or the Trusts are recorded as insurance premiums in the accompanying Statement of Changes in Net Assets Available for Benefits.

Claims payments are recorded when paid by the Corporation. Amounts due to the Corporation for claims paid out but not yet reimbursed by the Plan are recorded as a payable to the Corporation in the Statements of Net Assets Available for Benefits.

## **Postretirement Benefit Obligations**

Postretirement benefit obligations represent the actuarial present value of those estimated future benefits that are attributed by the terms of the Plan to employees' service rendered to the valuation date. Postretirement benefits include future benefits expected to be paid to (i) currently retired employees and their beneficiaries and dependents and (ii) active employees and their beneficiaries and dependents, after retirement from service with the Corporation. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date. The benefit obligations information is presented in Note 3 to the financial statements.

#### **Risks and Uncertainties**

The Plan, through the Trusts and 401(h) accounts, invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, currency, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the Statements of Net Assets Available for Benefits.

Plan contributions are made and the actuarial present value of benefit obligations are reported based on certain assumptions pertaining to interest rates, health care inflation rates, and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimation and assumption processes, it is at least reasonably possible that changes in these estimates and assumptions in the near term could materially affect the amounts reported and disclosed in the financial statements.

#### **Investment Valuation and Income Recognition**

Investments in the Trusts and the net assets of the 401(h) accounts are reported at fair value. Fair value is the price that would have been received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 4 for discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. The Trusts' and LMRP 401(h)'s gains and losses on investments bought and sold as well as held during the year are included in interest in net investment gains or losses of the Trusts and LMRP 401(h) on the Statement of Changes in Net Assets Available for Benefits. The net assets of the SSP 401(h) account's gains or losses on investments bought and sold as well as held during the year are included in the net increase or decrease in the SSP 401(h) account.

## **Administrative Expenses**

Direct administrative expenses are paid by the Trusts and generally allocated to the Plan proportionally based on the Plan's interest in the Trusts' net assets or directly if specifically related to the Plan. Other indirect administrative expenses are paid by the Corporation. Certain indirect administrative expenses are paid by the Corporation and are excluded from the Plan's financial statements. Expenses paid by the Plan are shown on the Statement of Changes in Net Assets Available for Benefits.

## **Subsequent Events**

The Plan has evaluated subsequent events through October 7, 2022, the date the financial statements were available to be issued. Effective September 1, 2022, the Corporation transitioned the Trustee from The Northern Trust Company to The Bank of New York Mellon. Other than this change, no material subsequent events have occurred since December 31, 2021 that required recognition or disclosure in these financial statements.

## 3. Benefit Obligations

The actuarial present value of the estimated postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money and the probability of payment between the valuation date and the expected date of payment, and to reflect the portion of those costs expected to be borne by Medicare, the retired participants, and other providers.

The 2022 assumed health care cost trend rate for the December 31, 2021 postretirement benefit obligation is 7.50%, trending down to 4.50% by 2034, and the 2021 health care cost trend rate for the December 31, 2020 postretirement benefit obligation was 7.75%, trending down to 4.50% by 2034. The assumptions include the impact of Medicare cost-sharing provisions.

Other significant assumptions used in the valuations are as follows:

	Decem	ber 31,
	2021	2020
Weighted average discount rate	2.75%	2.375%
Average retirement age	62	62
Turnover	Based on termination experience of the Plan	Based on termination experience of the Plan
Mortality	Pri-2012 Collar Adjusted with Scale MP-2021	Pri-2012 Collar Adjusted with Scale MP-2020

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

The postretirement benefit obligation is as follows (in thousands):

	December 31,			
	 2021	2020		
Active employees, fully eligible for benefits	\$ 264,157 \$	350,109		
Active employees, not yet fully eligible for benefits	205,652	325,145		
Retirees	 1,400,965	1,633,185		
Postretirement benefit obligation	\$ 1,870,774 \$	2,308,439		

The change in the Plan's postretirement benefit obligations is as follows (in thousands):

	_	ear Ended mber 31, 2021
Balance at beginning of year	\$	2,308,439
Increase (decrease) in postretirement benefits attributable to:		
Increase for interest due to the decrease in the discount period		53,249
Benefits paid		(216,598)
Benefits earned and other changes		(46,454)
Changes in actuarial assumptions		(227,862)
Net decrease		(437,665)
Total postretirement benefit obligations at end of year	\$	1,870,774

The changes in actuarial assumptions in the table above reflect the increase in the discount rate, and updated mortality and participation assumptions, that impacted the postretirement benefit obligation by \$(71,099,000) and \$(156,763,000), respectively. A 1% increase in the assumed health care cost trend rates would increase the postretirement benefit obligation by approximately 2.6% as of December 31, 2021. The claims incurred but not reported (IBNR) by retirees at December 31, 2021 and 2020, were \$12,547,000 and \$13,112,000, respectively, and are included in the postretirement benefit obligation.

It is expected that the excess of postretirement benefit obligations over net assets available for benefits will be funded through future actuarially determined contributions to the Collectively Bargained Trust for certain hourly retirees, and through future actuarially determined contributions to the LMRP 401(h), the SSP 401(h), or the Trusts, for certain salaried retirees. Funding of benefits for all other postretirement benefit obligations will be made on a pay-as-you-go basis by the Corporation.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act) introduced a prescription drug benefit under Medicare as well as a federal subsidy to sponsors of retiree health care benefit plans that provide a benefit that is at least actuarially equivalent to Medicare Part D. Under the Act, the Medicare subsidy amount is received directly by the plan sponsor and not the related plan. Further, the plan sponsor is not required to use the subsidy amount to fund postretirement benefits and may use the subsidy for any valid business purpose.

The postretirement benefit obligation as of December 31, 2021 and 2020 and the changes in the postretirement benefit obligation for the year ended December 31, 2021 do not reflect any amount associated with the Medicare subsidy as the Plan is not directly entitled to the Medicare subsidy. The Plan's postretirement benefit obligation as of December 31, 2021 and 2020, differs from that disclosed by the Corporation because the Corporation's amounts are net of the Medicare subsidy. However, the Corporation has decided to contribute the subsidy into the Trusts.

#### 4. Benefit Trust

#### General

The Plan's investments are held by the Trusts and two 401(h) accounts, which were established for the investment of the Plan's assets and the assets of certain other defined benefit plans sponsored by the Corporation. The assets, realized and unrealized gains and losses, investment income, and plan expenses of the Trusts and LMRP 401(h) are included in the Trusts' and LMRP 401(h)'s net assets.

The Trusts owe direct reimbursements to the Corporation for certain claims paid by the Corporation.

Investment information disclosed in the fair value of assets tables including investments held as of December 31, 2021 and 2020, and net depreciation in fair value of investments, interest income, and dividend income for the year ended December 31, 2021, was obtained or derived from information provided to the Plan Administrator and certified as complete and accurate by The Northern Trust Company, the Trustee of the Trusts.

#### Fair Value of Assets

The accounting standard for fair value measurements defines fair value, establishes a market-based framework or hierarchy for measuring fair value, and requires disclosures regarding fair value measurements. The standard is applicable whenever assets and liabilities are measured and included in the financial statements at fair value.

The fair value hierarchy established in the standard prioritizes the inputs used in valuation techniques into three levels as follows:

- Level 1 Quoted prices in active markets for identical assets and liabilities;
- Level 2 Observable inputs, other than Level 1 prices, such as quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in inactive markets, and amounts derived from valuation models where all significant inputs are observable in active markets; and
- Level 3 Unobservable inputs where valuation models are supported by little or no market activity that one or more significant inputs are unobservable and require us to develop relevant assumptions.

Certain other investments are measured at fair value using their Net Asset Value (NAV) per share and do not have readily determined values and are thus not subject to leveling in the fair value hierarchy. The NAV is the total value of the fund divided by the number of shares outstanding.

The following table presents the fair value of the assets in the Trust by asset category and their level within the fair value hierarchy as of December 31, 2021 (in thousands):

December 31, 2021 Level 1 Level 2 Total Cash and cash equivalents and short-term investment fund \$ 2,035 \$ \$ 2,035 U.S. Government securities 5,255 5,255 Common collective trusts (a) 8,965 8,965 Total investment assets at fair value \$ 2,035 \$ 14,220 \$ 16,255 Receivables, net 14 \$ Total net assets 16,269

Interest income and dividend income earned by the Trust for the year ended December 31, 2021 was \$224,000 and \$65,000, respectively. The net appreciation for the year ended December 31, 2021 was \$781,000.

The following table presents the fair value of the assets in the Trust by asset category and their level within the fair value hierarchy as of December 31, 2020 (in thousands):

	December 31, 2020					
		Level 1		Level 2		Total
Cash and cash equivalents and short-term investment fund	\$	2,042	\$	_	\$	2,042
U.S. Government securities		_		4,015		4,015
Common collective trusts (a)		_		13,232		13,232
Other investments		_		3,995		3,995
Total investment assets at fair value	\$	2,042	\$	21,242	\$	23,284
Receivables, net						25
Total net assets					\$	23,309

The following table presents the fair value of the assets in the Collectively Bargained Trust by asset category and their level within the fair value hierarchy as of December 31, 2021 (in thousands):

#### December 31, 2021

		Level 1	Level 2	Total
Cash and cash equivalents and short-term investment fund	\$	6,689	\$ _	\$ 6,689
Common and preferred stock		221,274		221,274
Corporate debt securities		_	108,214	108,214
Common collective trusts (a)		_	54,972	54,972
Registered investment companies		77,472		77,472
U.S. Government securities			2,271	2,271
Other investments			341,878	341,878
Total investment assets at fair value	\$	305,435	\$ 507,335	\$ 812,770
Receivables, ne	t			1,599
Total net assets	3			\$ 814,369

Interest income and dividend income earned by the Collectively Bargained Trust for the year ended December 31, 2021 was \$7,117,000 and \$6,491,000, respectively. The net appreciation for the year ended December 31, 2021 was \$66,337,000.

The following table presents the fair value of the assets in the Collectively Bargained Trust by asset category and their level within the fair value hierarchy as of December 31, 2020 (in thousands):

## December 31, 2020

		Level 1	 Level 2	Total
Cash and cash equivalents and short-term investment fund	\$	3,639	\$ _	\$ 3,639
Common and preferred stock		228,482		228,482
Corporate debt securities		_	94,495	94,495
Common collective trusts (a)			55,885	55,885
Registered investment companies		88,785	<u> </u>	88,785
U.S. Government securities		_	3,206	3,206
Other investments			303,700	 303,700
Total investment assets at fair value	\$	320,906	\$ 457,286	\$ 778,192
Receivables, n	net			1,527
Total net asse	ets			\$ 779,719

<sup>(</sup>a) Certain Common collective trusts have been measured at fair value using the NAV per share (or its equivalent) but not as a practical expedient, which accordingly have been classified in the fair value hierarchy.

The fair value of the assets in the SSP 401(h) and in the LMRP 401(h) by asset category and their level within the fair value hierarchy as of December 31, 2021 and 2020, respectively, are presented in the SSP and LMRP financial statements.

## **Valuation Techniques**

Cash and cash equivalents and short-term investment fund investments are mostly comprised of cash and short-term money-market instruments and are valued at cost, which approximates fair value.

Common and preferred stock securities categorized as Level 1 are traded on active national and international exchanges and are valued at their closing prices on the last trading day of the year.

Common collective trusts are investment vehicles valued using the NAV provided by the fund managers. The NAV is the total value of the fund divided by the number of shares outstanding. Common collective trusts are categorized as Level 2 if the NAV is corroborated by observable market data (e.g., purchases or sales activity).

Registered investment company securities categorized as Level 1 are traded on active national and international exchanges and are generally valued at their closing prices on the last trading day of the year. In the cases where the valuation is based on NAV at the close of the year, these represent open-ended mutual funds valued by multiple pricing sources..

Corporate debt instruments and U.S. Government securities categorized as Level 2 are valued by the Trustee using pricing models that use verifiable observable market data (e.g., interest rates and yield curves observable at commonly quoted intervals and credit spreads), bids provided by brokers or dealers, or quoted prices of securities with similar characteristics.

Other investments consist of securities such as derivatives and fixed income securities not classified as corporate debt instruments or U.S. Government securities. Level 2 securities are mainly comprised of overthe-counter derivatives and fixed income investments valued by the Trustee using pricing models that use verifiable observable market data (e.g., interest rates and yield curves observable at commonly quoted intervals and credit spreads), bids provided by brokers or dealers, or quoted prices of securities with similar characteristics.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while management believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

In estimating the fair value of the investments not in a level of fair value hierarchy, management may use third-party pricing sources or appraisers. In substantiating the reasonableness of the pricing data provided by third parties, management evaluates a variety of factors including review of methods and assumptions used by external sources, recently executed transactions, existing contracts, economic conditions, industry and market developments, and overall credit ratings.

## 5. Parties-in-Interest Transactions

The Trusts invest in funds managed by The Northern Trust Company, the Trustee. Investments in these funds qualify as party-in-interest transactions for which a statutory exemption from the prohibited transaction regulation exists.

#### 6. Income Tax Status

The Trusts have received exemption letters from the IRS, dated October 15, 2012, stating that the Trusts are tax-exempt under the provisions of Section 501(c)(9) of the IRC as Voluntary Employee Beneficiary Association trusts. The Plan and Trusts are required to operate in conformity with the IRC to maintain the tax-exempt status of the Trusts. The Plan Administrator and the Plan's counsel believe the Plan is being operated in compliance with the applicable requirements of the IRC, and therefore, believes the related Plan and Trusts are tax-exempt.

Under Section 512 of the IRC, the investment earnings attributable to reserves for postretirement benefits are not exempt from income taxes.

Based on the available objective evidence, including the Plan Sponsor's decision to discontinue funding through the Trust, management believes it is more-likely-than-not that the net deferred tax assets will not be fully realizable. Accordingly, a full valuation allowance has been recorded against its deferred tax assets as of December 31, 2021.

Deferred income taxes consist of the following (in thousands):

	Dece	ember 31, 2021
Deferred tax assets:		
Capital loss carryforwards	\$	(1,079)
Unrealized gains/losses		239
Net operating loss carryforwards		(37)
Full valuation allowance on deferred tax assets		877
Total deferred tax assets	\$	

GAAP requires plan management to evaluate tax positions taken by the Plan to determine whether the Plan has taken any uncertain positions that more likely than not would not be sustained upon examination by the IRS. The Plan Administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2021, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or asset or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions, but no tax audits are in progress. The Plan Administrator considers the Plan is no longer subject to income tax examinations for years prior to 2018.

## 7. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 (in thousands):

	December 31,				
	2021			2020	
Net assets available for benefits per the financial statements	\$	2,167,814	\$	2,084,253	
Less: Net assets held in LMRP 401(h) account		1,342,437		447,566	
Less: Net assets held in SSP 401(h) account		17		12	
Less: Transfer receivable		_		839,196	
Net assets available for benefits per the Form 5500	\$	825,360	\$	797,479	

The following is a reconciliation of the change in net asset available for benefits per the financial statements to the Form 5500 (in thousands):

	Yes	ar Ended
	Decem	ber 31, 2021
Net increase per the financial statements	\$	83,561
Less: Net increase in LMRP and SSP 401(h) accounts		55,680
Net increase per Form 5500	\$	27,881

The net assets and related activity of the 401(h) account included in the financial statements are not included in the Form 5500 because the assets of the LMRP 401(h) account are held by the LMRP, and the assets of the SSP 401(h) account are held by the SSP.