Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor

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

OMB Nos. 1210-0110 1210-0089

2017

Employee Benefits Security Administration		the instructions to the Form 5500.					
Pensio	on Benefit Guaranty Corporation	_		This Form is Open Inspection			ublic
Part I		lentification Information					
For cale	ndar plan year 2017 or fisc	cal plan year beginning 01/01/2017		and ending 12/31/20	17		
A This	return/report is for:	a multiemployer plan	participating er	loyer plan (Filers checking the mployer information in accordance)			ns.)
		a single-employer plan	a DFE (specify	·)			
B This	return/report is:	the first return/report	the final return/	report/report			
		an amended return/report	a short plan ye	ar return/report (less than 12	2 months))	
C If the	plan is a collectively-barga	ained plan, check here				×	
D Chec	k box if filing under:	X Form 5558	automatic exten	sion	the	e DFVC program	
		special extension (enter description)	1				
Part II	Basic Plan Inform	nation—enter all requested informatio	n				
1a Nam	ne of plan	SURANCE PLAN FOR RETIRED EMPL			1b	Three-digit plan number (PN) ▶	591
					1c	Effective date of pl 01/01/1993	an
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)						2b Employer Identification Number (EIN) 52-1893632	
LOCKHE	ED MARTIN CORPORAT	ION			2c Plan Sponsor's telephone number 863-647-0370		
	CKLEDGE DRIVE, CCT-1 DA, MD 20817	15			2d Business code (see instructions)		е
Caution	: A penalty for the late or	r incomplete filing of this return/repor	t will be assessed ւ	unless reasonable cause is	s establis	shed.	
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.							
SIGN HERE	Filed with authorized/valid	d electronic signature.	10/15/2018	ROBERT MUENINGHOFF			
IILIKE.	Signature of plan admi	nistrator	Date	Enter name of individual si	gning as	plan administrator	
SIGN							
HERE	Signature of employer/	plan sponsor	Date	Enter name of individual si	anina as	employer or plan sn	onsor
SIGN	- Simulation of Simple year	F			<u> </u>		
LEDE			l				

Date

Signature of DFE Da Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2017) v. 170203

Enter name of individual signing as DFE

	Form 5500 (2017)	Page 2		
3a	Plan administrator's name and address X Same as Plan Sponsor		3b Administrate	r's EIN
			3c Administrato number	r's telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the enter the plan sponsor's name, EIN, the plan name and the plan number from the later the plan sponsor.		4b EIN	
a c	Sponsor's name Plan Name		4d PN	
5	Total number of participants at the beginning of the plan year		5	15199
6	Number of participants as of the end of the plan year unless otherwise stated (welfar 6a(2), 6b, 6c, and 6d).	re plans complete only lines 6a(1),		
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)	0
b	Retired or separated participants receiving benefits		6b	14003
С	Other retired or separated participants entitled to future benefits		6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.		6d	14003
е	Deceased participants whose beneficiaries are receiving or are entitled to receive be	enefits	6e	
f	Total. Add lines 6d and 6e .		6f	
g	Number of participants with account balances as of the end of the plan year (only decomplete this item)		. 6g	
h	Number of participants who terminated employment during the plan year with accrue less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiem	nployer plans complete this item)	. 7	
	If the plan provides pension benefits, enter the applicable pension feature codes from If the plan provides welfare benefits, enter the applicable welfare feature codes from 4A 4B 4D 4E 4Q			
10	(1)		insurance contrac	
d		General Schedules (1)	mation)	

(2)

(3)

(4)

(5)

(6)

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)

50 A (Insurance Information)

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.)					
11b Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
Recei	the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the pt 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 pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				
Rece	ipt Confirmation Code				

Form 5500 (2017)

Page 3

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

2017

		pursuant to	E(10A, 3001011, 103(a)(2)	•		Inspection	
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017		and en	iding 12/31/2017		
A Name of plan LOCKHEED MARTIN GR	OUP INSURAI	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN)	591	
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 Informat	t ion Concer ate Schedule A	rning Insurance Contrac . Individual contracts grouped a	i t Coverage, Fees, as a unit in Parts II and II	and Con I can be re	nmissions Provide ir ported on a single Sche	nformation for each contract	
1 Coverage Information:					,		
(a) Name of insurance ca AETNA INC AZ SR HMC							
/L\	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy o	r contract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To	
06-1345436	95003	172310;172312	3	3	01/01/2017	12/31/2017	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and	d other persons in	
(a) Total a	amount of comi	missions paid		(b) To	otal amount of fees paid		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees were paid		
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	e	(e) Organization code	
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees were paid		
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
			FF00				

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	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 e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

F	Part III Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individual	oup of employees of the g purposes if such contra	acts are exp	perience-rated as a un	it. Where co	ontracts cover individual
8	Benefit and contract type (check all applicable boxes)					
	a Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	e Temporary disability (accident and sickness)	f Long-term disability	, g	Supplemental unem	ployment	h Prescription drug
		i X HMO contract	k [=	' '	I Indemnity contract
		, M Third contract	., L	11000111111111		
	m ☐ Other (specify) ▶					
0						
J	Experience-rated contracts:	Г	00/1)			
	a Premiums: (1) Amount received	<u> </u>	9a(1) 9a(2)			
	(2) Increase (decrease) in amount due but unpaid		9a(2)			
	(3) Increase (decrease) in unearned premium reservity. (4) Earned ((1) + (2) - (3))	_			9a(4)	
	b Benefit charges (1) Claims paid		9b(1)		Ja(4)	
	(2) Increase (decrease) in claim reserves		9b(1) 9b(2)			
	(3) Incurred claims (add (1) and (2))	<u> </u>			9b(3)	
	(4) Claims charged				9b(4)	
	C Remainder of premium: (1) Retention charges (on				55(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	F	9c(1)(F)			
	(G) Other retention charges	F	9c(1)(G)			
	(H) Total retention	_			9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These a	mounts were paid in	cash, or	credited.)		
	d Status of policyholder reserves at end of year: (1)	<u> </u>				
	(2) Claim reserves	·			9d(2)	
	(3) Other reserves				9d(3)	
	e Dividends or retroactive rate refunds due. (Do not					
10	Nonexperience-rated contracts:			,		
	a Total premiums or subscription charges paid to car	rrier			. 10a	3742
	b If the carrier, service, or other organization incurred					
	retention of the contract or policy, other than report	, ,		•	10b	
	Specify nature of costs.	·	•			•
P	Part IV Provision of Information					_
11	1 Did the insurance company fail to provide any information	tion necessary to comple	te Schedul	e A?	Yes	X No
12	2 If the answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

				,		inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURAI	NCE PLAN FOR RETIRED EM	PLOYEES	B Thre	e-digit number (PN)	591
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 Informat	ion Concer ate Schedule A	ning Insurance Contra . Individual contracts grouped	ct Coverage, Fees,	and Con	nmissions Provide in	formation for each contract
Coverage Information:		9.00			,	
(a) Name of insurance car AETNA INC FL	rrier					
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy o	r contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To
59-2411584	95088	0701220HNO		8	01/01/2017	12/31/2017
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. I	ist in line 3	the agents, brokers, and	d other persons in
(a) Total a	amount of comi	missions paid		(b) To	otal amount of fees paid	
3 Persons receiving com		ees. (Complete as many entrie			iono or food ware noid	
			ees and other commissic		ions of rees were paid	
(b) Amount of sales ar		(c) Amount	· · · · · · · · · · · · · · · · · · ·		Δ	(e) Organization code
commissions paid		(c) Amount	(d) Purpose		(c) organization code	
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpose		

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	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 e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	III 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 conti	racts are exp	perience-rated as a	unit. Where co	intracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)		-			·
	а	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	L			L	=		
	e	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental un	employment	h Prescription drug
	İ	Stop loss (large deductible)	j 🔀 HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	erience-rated contracts:	ı				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))					(
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				_
		(A) Commissions	ľ	9c(1)(A)			_
		(B) Administrative service or other fees	İ	9c(1)(B)			_
		(C) Other specific acquisition costs	ľ	9c(1)(C)			_
		(D) Other expenses	l	9c(1)(D)			_
		(E) Taxes					_
		(F) Charges for risks or other contingencies					_
		(G) Other retention charges	-			0o/1\/U\	
		(H) Total retention					
		(2) Dividends or retroactive rate refunds. (These		_			
	d	Status of policyholder reserves at end of year: (1)	·				
		(2) Claim reserves					
	_	(3) Other reserves				• • •	+
10	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	it include amount entered	i in line 9c(2	() .)	9e	
10	_	onexperience-rated contracts: Total premiums or subscription charges paid to ca	orrior			10a	456770
	a						156778
	b	If the carrier, service, or other organization incurred retention of the contract or policy, other than repo			•		
	Spe	ecify nature of costs.	ited iii i ait i, iiile 2 abov	e, report am	Ourit		_
	- 1	•					
Р	art	IV Provision of Information					
11		d the insurance company fail to provide any inform	ation necessary to compl	ata Schadul	ο Δ2	Yes	X No
				ete ocheaul	C M!	100	<u> </u>
14	. IT T	the 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

2017

		parsaant to	ETTIOA 30011011 103(a)(2)	•			Inspection
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017		and en	nding 12/31/201	7	
A Name of plan LOCKHEED MARTIN GR	OUP INSURAI	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN)	•	591
C Plan sponsor's name a		e 2a of Form 5500			yer Identification I	Number (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca AETNA INC GA SR HMC							
	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	ı	(g) To
58-1649568	95094	172310;172312	366	6	01/01/2017		12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, broke	rs, and o	ther persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
3 Persons receiving com		ees. (Complete as many entries					
	(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 ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(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 ar	nd base	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individua	roup of employees of the ng purposes if such contr	acts are expe	erience-rated as a ur	nit. Where co	ontracts cover individual
8	Ber	enefit and contract type (check all applicable boxes)		· ·		· ·	·
•	a		b Dental	с	Vision		d Life insurance
		\(\begin{array}{cccccccccccccccccccccccccccccccccccc	<u>=</u>	<u>_</u>	1		=
	е		f Long-term disability	y g _	Supplemental uner	nployment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)			
		(4) Earned ((1) + (2) - (3))	<u>.</u>			9a(4)	C
	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)	C
		(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	<u> </u>	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	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е		include amount entered	in line 9c(2).	.)	9e	
10	No	Ionexperience-rated contracts:				_	
	а	Total premiums or subscription charges paid to ca	rrier			10a	1761860
	b	retention of the contract or policy, other than repor				10b	
	Spe					<u>10b</u>	
Р	art	IV Provision of Information					
		Did the insurance company fail to provide any informa	tion necessary to comple	ata Schadula	Δ2	Yes	X No
				sie Scriedule	Λ:		
14	. 111	the answer to line 11 is "Yes," specify the information	n not provided. 🕨				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		p		-		inspection			
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	iding 12/31/2017				
A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EN			PLOYEES		e-digit number (PN)	591			
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Num	ber (EIN)			
LOCKHEED MARTIN CO				-	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 AETNA INC VA SR HMC									
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy	or contract year			
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To			
52-1353802	95590	19528	5	5	01/01/2017	12/31/2017			
2 Insurance fee and complete descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	ist in line 3	the agents, brokers, a	nd other persons in			
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons receiving com	missions and fo	ees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid					
commissions pai	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	ions or fees were paid				
(b) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid								
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code			

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	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 contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j X HMO contract	k			I Indemnity contract
	m	Other (specify)	, Marine sommas				
	•••						
9	Exp	erience-rated contracts:					
_		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)			
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 7	
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or	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)) (
		(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 I	penefits after	er retirement		
		(2) Claim reserves	·			, , ,	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2	2) .)		
10) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	23469
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	rith the acquisition	or	
		retention of the contract or policy, other than repo					
		cify nature of costs.					
F	art	IV Provision of Information					
1	Di	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

		F 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		7.		mspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and er	nding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES	B Thre	e-digit number (PN)	591
C Plan sponsor's name a LOCKHEED MARTIN CO	RPORATION	e 2a of Form 5500	ct Coverage Fees	52-	oyer Identification Number 1893632	
Part I Information a separa	ate Schedule A	Individual contracts grouped	as a unit in Parts II and	III can be re	ported on a single Sched	dule A.
1 Coverage Information:						
(a) Name of insurance ca						
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or	contract year
(b) EIN	code	identification number	persons covered a policy or contra		(f) From	(g) To
52-1353802	95590	19528		4	01/01/2017	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. I	ist in line 3	the agents, brokers, and	other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	I nersons)		
• 1 crooms receiving com		and address of the agent, broke			sions or fees were paid	
(b) Amount of sales ar	nd base _	F	ees and other commission	ons paid		
commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	om commiss	sions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ons paid		
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [j X HMO contract	, S k		1 1, 1, 1	I Indemnity contract
	m	Other (specify)	, <u></u>				
	••••						
9	Fxp	erience-rated contracts:					
Ī		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)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 ()	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	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	1	9c(1)(G)			
		(H) Total retention	-			9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)		
	d	Status of policyholder reserves at end of year: (1)	—				
	<u> </u>	(2) Claim reserves	•			· · · · · ·	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do not					
1(pnexperience-rated contracts:	inologo amount ontolog		- / ·/·································		
- 1	а	Total premiums or subscription charges paid to ca	rrier			10a	22747
	b	If the carrier, service, or other organization incurre					ZZIII
		retention of the contract or policy, other than report					
		ecify nature of costs.					
F	art	IV Provision of Information					_
1	l Die	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		F	=::::::::::::::::::::::::::::::::::::::	-		inspection			
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017				
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	591			
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Num	ber (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 AETNA INC NORTHERN									
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy	or contract year			
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To			
52-1270921	95287	019528	6	5	01/01/2017	12/31/2017			
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, a	nd other persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid						d			
3 Persons receiving com	missions and fo	ees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid				
(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 a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions paid (c) Amount				(d) Purpos	е	(e) Organization code			
(e)									

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		,				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

Р	art						
		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 conti	racts are exp	erience-rated as a uni	t. Where co	ntracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	nlovment	h Prescription drug
	:			·	<u>-</u>	ploymont	
	• [Stop loss (large deductible)	j X HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
_	_						
9	•	erience-rated contracts:	ļ	0-(4)			_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid		9a(2)			-
		(3) Increase (decrease) in unearned premium reso				02/4)	0
	b	(4) Earned ((1) + (2) - (3))				. 9a(4)	
	D	(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					
		(A) Commissions	, i	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(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					
	d	Status of policyholder reserves at end of year: (1)					
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
40	е.	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2)	.)	9e	
10	_	onexperience-rated contracts:	i			100	40575
	a	Total premiums or subscription charges paid to ca				. <u>10a</u>	48575
	b	If the carrier, service, or other organization incurred retention of the contract or policy, other than repo			•	. 10b	
	Spe	ecify nature of costs.	Tited III I ait I, IIIIc 2 abov	c, report arric	June		
	·	•					
							_
Р	art	IV Provision of Information					
11	Di	d the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No
12	l If t	the 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

2017

		parsaant to	ETTIOA SCOTIOTI TOS(a)(Z)	·			Inspection	
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/31/201	7		
A Name of plan LOCKHEED MARTIN GR	OUP INSURAI	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN)	•	591	
C Plan sponsor's name a		e 2a of Form 5500			yer Identification I	Number ((EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	1893632			
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:		<u> </u>			<u> </u>			
(a) Name of insurance ca AETNA INC SOUTHERN								
41 N = 1 N 1	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	1	(g) To	
52-1270921	95287	019528	33		01/01/2017		12/31/2017	
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	st in line 3	the agents, broke	rs, and o	ther persons in	
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fee	s paid		
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 whor	n commiss	ions or fees were	paid		
(b) Amount of sales ar	nd base	Fe	es and other commissior	ns paid				
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code	
	(a) Name a	nd address of the agent, broker	, or other person to whor	n commiss	ions or fees were	paid		
(b) Amount of sales ar	nd base	Fe	es and other commissior	ns paid				
commissions pai		(c) Amount	((d) Purpose	е		(e) Organization code	

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		,				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	roup of employees of the ng purposes if such contr	acts are expe	erience-rated as a u	nit. Where co	ontracts cover individual
8	Ber	nefit and contract type (check all applicable boxes)					
•	а		b Dental	с	Vision		d Life insurance
			브	<u> </u>	1		
	е		f Long-term disability	y g [Supplemental une	mployment	h Prescription drug
	İ	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	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)	C
		(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	F	9c(1)(B)			
		(C) Other specific acquisition costs	F	9c(1)(C)			_
		(D) Other expenses		9c(1)(D)			_
		(E) Taxes	l -	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges					
		(H) Total retention		_)
		(2) Dividends or retroactive rate refunds. (These a	_				
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide by	penefits after	retirement		
		(2) Claim reserves					
		(3) Other reserves				` '	
	е		include amount entered	in line 9c(2) .	.)	9e	
10	No	Ionexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			<u>10a</u>	297582
	b	retention of the contract or policy, other than repor				10b	
	Spe	ecify nature of costs.	ted in Part I, line 2 above	e, report amo	unt.	105	
Р	art	IV Provision of Information	_				
		oid the insurance company fail to provide any informa	ation necessary to comple	ete Schedule	A?	Yes	X No
		the answer to line 11 is "Yes," specify the information					
		2 2					

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

2017

		F 4 5 4.6		,·		inspection		
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017			
A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EM			IPLOYEES	B Thre	591			
C Plan sponsor's name a LOCKHEED MARTIN CO	RPORATION			D Employer Identification Number (EIN) 52-1893632				
Part I Information a separa	t ion Concei ate Schedule <i>A</i>	rning Insurance Contra . Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and I	and Con Il can be re	nmissions Provide in ported on a single Sched	formation for each contract dule A.		
1 Coverage Information:					,			
(a) Name of insurance ca AETNA INC NY POS GR								
(1.) EIN	(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	(g) To		
22-2663623	95234	0701220HNO	38	5	01/01/2017	12/31/2017		
descending order of the	amount paid.	ation. Enter the total fees and t	otal commissions paid. L			other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).				
Ŭ		and address of the agent, broke			sions or fees were paid			
(b) Amount of sales ar	nd base _	F	ees and other commissio	ns paid				
commissions paid		(c) Amount	(d) Purpose		(e) Organization code			
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid			
(b) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code		
(4) - 41,000								

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	(0	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	Г			1	
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization	
commissions paid	(0)	,		code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:				
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			ion gaaramoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•				
		,				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)				
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	Part III Welfare Benefit Contract Information						
		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 conti	acts are exp	perience-rated as a	unit. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)		-			
	а	X Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	I.			<u> </u>		amala, mant	
	e	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental un	employment	h Prescription drug
	İ	Stop loss (large deductible)	j HMO contract	k [PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	erience-rated contracts:	ı		1		
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))	ſ		 I	9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))					(
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	, , , , , , , , , , , , , , , , , , ,	- (1)(1)	1		_
		(A) Commissions	l	9c(1)(A)			_
		(B) Administrative service or other fees	ŀ	9c(1)(B)			
		(C) Other specific acquisition costs	ľ	9c(1)(C)			_
		(D) Other expenses	l	9c(1)(D)			_
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies (G) Other retention charges					_
		(H) Total retention	-			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	٦						
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves	·				
		• •					
	е	(3) Other reserves					
10	_	pnexperience-rated contracts:	n include amount entered	111111111111111111111111111111111111111	<i>J</i> .)	30	
	a	Total premiums or subscription charges paid to ca	arrior			10a	760616
	_						700010
	b	If the carrier, service, or other organization incurrent retention of the contract or policy, other than repo					
	Spe	ecify nature of costs.	ated in Fait i, inio 2 above	o, roport am	Odi (
		•					
Р	art	IV Provision of Information					
11		d the insurance company fail to provide any inform	ation necessary to compl	ete Schedul	е А?	Yes	X No
		the answer to line 11 is "Yes," specify the information		oto Gorieduli	O / \:		<u> </u>
1 4	. II T	the answer to line it is tres, 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

2017

		F 4		-		mspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EMP			IPLOYEES		e-digit number (PN)	591
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Numb	per (EIN)
LOCKHEED MARTIN CO				-	1893632	,
Part I Informat on a separa	i on Conce l ate Schedule <i>A</i>	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con I can be re	nmissions Provide i ported on a single Sche	nformation for each contract edule A.
1 Coverage Information:						
(a) Name of insurance ca AETNA INC SOUTHEAS						
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy of	or contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To
23-2348574	96792	019528	33	3	01/01/2017	12/31/2017
2 Insurance fee and come descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, an	d other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	1
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 ar	nd base	F	ees and other commission	ns paid		
commissions pai		(c) Amount	(d) Purpose		e	(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						
commissions pai		(c) Amount	(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4						
		rent value of plan's interest under this contract in the general account at year rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		,				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	III Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individu	group of employees of the ing purposes if such conti	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j X HMO contract	k	H	1 1	I Indemnity contract
	m	Other (specify)	, 🗠				
9	Expe	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid	ŀ	9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 7	
		(2) Increase (decrease) in claim reserves	l	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged				: :	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions	i	9c(1)(A)			
		(B) Administrative service or other fees	ľ	9c(1)(B)			_
		(C) Other specific acquisition costs	ŀ	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)	(
		(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	penefits afte	er retirement		
		(2) Claim reserves	•			· · · · ·	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	2).)		
10) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	24967
	b	If the carrier, service, or other organization incurr	ed any specific costs in co	onnection w	vith the acquisition	or or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
P	art	IV Provision of Information					
11		I the insurance company fail to provide any inform	ation necessary to compl	ete Schedu	le A?	Yes	X No
				ore ocueda	ιο Λ:		<u>n</u>
14	i it t	he 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

2017

		- Parsuant to	ENTOA SCCIOTI TOS(a)(z)	·			Inspection	
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/31/201	7		
A Name of plan LOCKHEED MARTIN GR	OUP INSURAI	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN)	•	591	
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	yer Identification	Number ((EIN)	
LOCKHEED MARTIN CO	RPORATION			52-	1893632			
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
Coverage Information:	ate correduce / t	marviadai ooniradio groupea c		r dan be re	ported on a single	Concadi	ο <i>τ</i> ι.	
(a) Name of insurance ca AETNA INC TX SR	rrier							
	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	1	(g) To	
75-1996860	95490	172310;172312	277	,	01/01/2017		12/31/2017	
2 Insurance fee and complete descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, broke	rs, and o	ther persons in	
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).				
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees were	paid		
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid				
commissions pai	id	(c) Amount		(d) Purpos	е		(e) Organization code	
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees were	paid		
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code	

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4						
		rent value of plan's interest under this contract in the general account at year rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	roup of employees of the ng purposes if such contr	acts are expe	erience-rated as a u	nit. Where co	ontracts cover individual
8	Ber	nefit and contract type (check all applicable boxes)		· ·		· · ·	·
•	a		b Dental	с	Vision		d Life insurance
			브	<u>_</u>	1		
	е		f Long-term disability	y g	Supplemental une	mployment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)			
		(4) Earned ((1) + (2) - (3))	r			9a(4)	C
	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)	C
		(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	The state of the s	9c(1)(D)			
		(E) Taxes	F	9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges				0-(4)/[1]	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		(H) Total retention)
		(2) Dividends or retroactive rate refunds. (These a	<u> </u>				
	d		·				
		(2) Claim reserves					
	_	(3) Other reserves				` '	
40	е .		include amount entered	in line 9c(2).	.)	9e	
10	_	lonexperience-rated contracts:				100	000000
	a	1 0 1				<u>10a</u>	989890
	b	retention of the contract or policy, other than repor				10b	
	Spe	pecify nature of costs.	,				
Р	art	IV Provision of Information					
		Did the insurance company fail to provide any informa	tion necessary to comple	ete Schedule	Α?	Yes	X No
		the answer to line 11 is "Yes," specify the information		J.C Ocheuule	/ X :		<u>[1]</u> - 19
12	. IT	the answer to line 11 is it es, 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).

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

OMB No. 1210-0110

2017

		parsaant to	ENION SCOROTT TOS(a)(2)	•			Inspection			
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/31	1/2017				
A Name of plan LOCKHEED MARTIN GR	ROUP INSURAI	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN) •	591			
C Plan sponsor's name a		e 2a of Form 5500			yer Identifica	ation Number	r (EIN)			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
1 Coverage Information:										
(a) Name of insurance ca										
41 \ FIN	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or	contract year			
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To			
35-2145715	62825	173039	23	3	01/01/2017		12/31/2017			
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, b	orokers, and	other persons in			
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid									
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	m commiss	ions or fees	were paid				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid						
commissions pa	id	(c) Amount		(d) Purpose	e		(e) Organization code			
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid						
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code			

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4						
		rent value of plan's interest under this contract in the general account at year rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

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Benefit and contract type (check all applicable boxes) a	Р	art	Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individua	roup of employees of the ig purposes if such contr	acts are expe	erience-rated as a	unit. Where co	ontracts cover individual
a Health (other than dental or vision) b Dental C Temporary disability (accident and sickness) f Long-term disability g Supplemental unemployment h Dental Signature (accident and sickness) f Long-term disability g Supplemental unemployment h Dental Signature (accident and sickness) f Long-term disability g Supplemental unemployment h Dental Signature (accident and sickness) f Long-term disability g Supplemental unemployment h Dental Signature (accident and s	8	Ben	nefit and contract type (check all applicable boxes)					
e Temporary disability (accident and sickness) i Stop loss (large deductible) j HMO contract Stop loss (large deductible) J HMO contract	•	F		h □ Dental	сГ	Vision		d ☐ Life insurance
i				<u>=</u>	<u> </u>	<u>.</u>		
## Common		e		<u>=</u>	y 9 _	1 -	employment	
9 Experience-rated contracts: a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unwarred premium reserve. 9a(3) (4) Earned ((1) + (2) - (3)) 9a(4) (5) Increase (decrease) in claim reserves. 9b(1) (7) Increase (decrease) in claim reserves. 9b(2) (8) Increase (decrease) in claim reserves. 9b(2) (9) Increase (decrease) in claim reserves. 9b(2) (9) Increase (decrease) in claim reserves. 9b(2) (9) Increase (decrease) in claim reserves. 9b(2) (9) Increase (decrease) in claim reserves. 9b(2) (9) Increase (decrease) in claim reserves. 9b(2) (9) Increase (decrease) in claim reserves. 9b(2) (1) Increase (decrease) in claim reserves. 9b(3) (4) Claims charged. (5) Increase (decrease) in claim reserves. 9b(1) (6) Other specific acquisition costs. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(A) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim reserves. 9c(1)(B) (9) Increase (decrease) in claim rese		İ	Stop loss (large deductible)	MO contract	k _	PPO contract		I Indemnity contract
a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unearned premium reserve. (4) Earned ((1) + (2) - (3)) (5) Benefit charges (1) Claims paid. (7) Increase (decrease) in claim reserves. (8) Incurred claims (add (1) and (2)). (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (8) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in claim reserves. (1) On the repension of the control of the co		m	Other (specify)					
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(3) Increase (decrease) in unearned premium reserve. (4) Earned ((1) + (2) - (3))		а	Premiums: (1) Amount received		9a(1)			
(4) Earned ((1) + (2) - (3))			(2) Increase (decrease) in amount due but unpaid.		9a(2)			
b Benefit charges (1) Claims paid			(3) Increase (decrease) in unearned premium rese	rve	9a(3)		1	
(2) Increase (decrease) in claim reserves. (3) Incurred claims (add (1) and (2)). (4) Claims charged. (A) Commissions. (B) Administrative service or other fees. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other expenses. (F) Charges for risks or other contingencies. (S) Other retention charges. (S) Other retention charges. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited). (B) Other reserves. (C) Other specific acquisition costs. (D) Other retending charges. (E) Taxes. (F) Charges for risks or other contingencies. (B) Other retending charges. (C) Other retending charges. (C) Other retending charges (not contingencies). (E) Taxes. (B) Other retending charges (not contingencies). (C) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited). (C) Dividends or retroactive rate refunds that the contingencies are retirement. (C) Claim reserves. (D) Other re			(4) Earned ((1) + (2) - (3))	r			9a(4)	C
(3) Incurred claims (add (1) and (2))		b	Benefit charges (1) Claims paid					
(4) Claims charged. Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other expenses. (E) Taxes. (G) Other retention charges. (G) Other retention charges. (G) Other retention charges. (G) Other retention charges. (G) Other retroactive rate refunds. (These amounts were paid in cash, or credited.) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or detected.) (2) Claim reserves. (3) Other reserves. (3) Other reserves. (4) Total premiums or subscription charges paid to carrier. (B) Taxes. (C) Other specific acquisition of the contracts: (C) Dividends or retroactive rate refunds due. (Do not include amount entered in line sc(2)). (D) Total premiums or subscription charges paid to carrier. (D) Total premiums or su			(2) Increase (decrease) in claim reserves		9b(2)			
C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges (H) Total retention (2) Dividends or retroactive rate refunds. (These amounts were (C) Point reserves (C) Other reserves at end of year: (1) Amount held to provide benefits after retirement (C) Claim reserves (C) Other retroactive rate refunds due. (Do not include amount entered in line 9c(2)) (B) Nonexperience-rated contracts: (C) Total premiums or subscription charges paid to carrier (D) Nonexperience-rated contracts: (C) Total premiums or subscription charges paid to carrier (D) Nonexperience-rated contracts: (D) Nonexperience-rated contracts: (D) Nonexperience-rated contract or policy, other than reported in Part I, line 2 above, report amount (D) Nonexperience								С
(A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (C) Other specific acquisition costs. (D) Other expenses. (E) Taxes. (F) Charges for risks or other contingencies. (G) Other retention charges. (H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) (3) Other reserves. (3) Other reserves. (3) Other reserves. (4) Experience-rated contracts: (5) Experience-rated contracts: (6) Nonexperience-rated contracts: (7) Amount held to provide benefits after retirement. (8) Experience-rated contracts: (9) Experience-rated contracts: (1) Nonexperience-rated contracts: (2) Total premiums or subscription charges paid to carrier. (3) Other reserves, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. (2) Provision of Information Part IV Provision of Information 10 Did the insurance company fail to provide any information necessary to complete Schedule A?							9b(4)	
(B) Administrative service or other fees 9c(1)(B) 9c(1)(C) 9c(C) Other specific acquisition costs 9c(1)(D) (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(E) (H) Total retention charges 9c(1)(E) (H) Total retention charges 9c(1)(E) (H) Total retention charges 9c(1)(E) (H) Total retention charges 9c(1)(E) (H) Total retention charges 9c(1)(E) (H) Total retention (H) To		С	Remainder of premium: (1) Retention charges (on	an accrual basis)				
(C) Other specific acquisition costs			(A) Commissions					
(D) Other expenses			` '	F				
(E) Taxes				F				
(F) Charges for risks or other contingencies			(D) Other expenses					
(G) Other retention charges (H) Total retention (P) Total retentio				l -				
(H) Total retention								
(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) e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier. 10a 18204: b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b Specify nature of costs.							- (1) (1)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves. (9d(2) 8 Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9 Total premiums or subscription charges paid to carrier. 10 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?			. ,)
(2) Claim reserves				<u> </u>				
(3) Other reserves		d	Status of policyholder reserves at end of year: (1)	Amount held to provide h	benefits after	retirement		
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)			(2) Claim reserves					
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier			· /					
a Total premiums or subscription charges paid to carrier			·	include amount entered	in line 9c(2) .	.)	9e	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. Part IV Provision of Information 10b Provision of Information Yes X No	10	No						
retention of the contract or policy, other than reported in Part I, line 2 above, report amount		а	Total premiums or subscription charges paid to ca	rrier			<u>10a</u>	182043
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?			retention of the contract or policy, other than repor					
11 Did the insurance company fail to provide any information necessary to complete Schedule A?		Spe	ecify nature of costs.	ted in Part I, line 2 above	e, report amo	unt.	105	
The bit the insurance company fair to provide any information necessary to complete deficulties.	Р	art	IV Provision of Information					
	11	Die	bid the insurance company fail to provide any informa	tion necessary to comple	ete Schedule	A?	Yes	X 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

2017

For calendar plan year 20°	17 or fiscal plar	n year beginning 01/01/2017	() ()	and en	ding 12/31/2017	mspection				
A Name of plan	NCE PLAN FOR RETIRED EM	PLOYEES	B Thre	e-digit number (PN)	591					
C Plan sponsor's name a LOCKHEED MARTIN CO		e 2a of Form 5500		•	oyer Identification Numb 1893632	per (EIN)				
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.										
1 Coverage Information:										
(a) Name of insurance ca										
/L) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy o	or contract year				
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To				
35-2145715	62825	173039	15		01/01/2017	12/31/2017				
2 Insurance fee and coming descending order of the	mission informa amount paid.	ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, brokers, an	d other persons in				
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	l				
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).						
		and address of the agent, broke			ions or fees were paid					
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid						
commissions pai	d	(c) Amount	-	(d) Purpose	e	(e) Organization code				
	(a) Name a	and address of the agent, broke	r, or other person to whor	n commiss	ions or fees were paid					
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid						
commissions pai		(c) Amount		(e) Organization code						
commissions paid (c) Amount (d) Purpose (e) Organization										

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

F	art	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 contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f \(\sum_{\text{Long-term disabilit}} \)	v a	Supplemental	unemplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j X HMO contract	k	=		I Indemnity contract
	m	Other (specify)	,				
9	Expe	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid	•	9a(2)			
		(3) Increase (decrease) in unearned premium rese		9a(3)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 ()	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))	•			9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or					
		(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	1	9c(1)(G)			
		(H) Total retention	-			9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)		
	d	Status of policyholder reserves at end of year: (1)	_	<u> </u>			
	-	(2) Claim reserves	·			` ` `	
		(3) Other reserves				- 1/25	
	е	Dividends or retroactive rate refunds due. (Do no					
10	No	nexperience-rated contracts:			, ,		
	а	Total premiums or subscription charges paid to ca	arrier			10a	316053
	b	If the carrier, service, or other organization incurre					
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
Р	art	IV Provision of Information					
11		d the insurance company fail to provide any inform	ation necessary to comple	ete Schedu	le A?	Yes	X No
		the answer to line 11 is "Yes," specify the information		oto Coricuu			<u> </u>
1 4	- 11 (ie answer to line i i is i es, specity 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

2017

		F *** * * * * * * * * * * * * * * * * *		/ ·		inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	591
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Number	er (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632	
1						
Part I Information a separa	t ion Concer ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and I	and Con	nmissions Provide in ported on a single Sched	formation for each contract dule A.
1 Coverage Information:						
(a) Name of insurance ca BLUE CROSS BLUE SHIE		A				
	(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	(g) To
58-1638390	96962	174524	1:	3	01/01/2017	12/31/2017
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	other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	
3 Persons receiving com	missions and fo	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 ar	nd hase	F	ees and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	е	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i		j X HMO contract	k	=	1 1, 1, 1	I Indemnity contract
	m	Other (specify)	, A rime communi				
9	Exp	erience-rated contracts:					
•		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)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 ()	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged					
	С	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)	
		(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 I	benefits afte	er retirement		
		(2) Claim reserves	•			· · · · · ·	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2	2) .)		
10) No	onexperience-rated contracts:		•	•	•	
	а	Total premiums or subscription charges paid to ca	rrier			10a	402398
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	vith the acquisition	or	
		retention of the contract or policy, other than repo					
		ecify nature of costs.					
_	10 == 1	W Dravisian of Information					
	art					Пу	V No
11		d the insurance company fail to provide any informa		ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

		parsaant to	ETTIOA SCCIIOTI 105(a)(z)	•			Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/3	1/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURAN	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN	1) •	591
C Plan sponsor's name a LOCKHEED MARTIN CO		e 2a of Form 5500			yer Identifica 1893632	ation Number	r (EIN)
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:		 		'			
(a) Name of insurance ca							
(L) FINI	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or o	contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
86-0334392	95125	4225	32		01/01/2017	7	12/31/2017
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, I	brokers, and	other persons in
(a) Total a	amount of comr	nissions paid		(b) To	otal amount o	of fees paid	
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	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	е		(e) Organization code
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
(2), a.a.a.a.a.a.a.a.a.a.a.a.a.a.a.							
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid	-	<u> </u>	
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	t III Welfare Benefit Contract Information If more than one contract covers the same ground the information may be combined for reporting employees, the entire group of such individual of the contract of th	up of employees of the purposes if such contra	acts are expe	erience-rated as a u	ınit. Where co	ontracts cover individual
8	Ben	enefit and contract type (check all applicable boxes)		· ·		· · ·	·
•	a [Dental	с	Vision		d Life insurance
		<u>'</u>					
	е	Temporary disability (accident and sickness) f	<u> </u>	⁄ g∐	Supplemental une	employment	h Prescription drug
	i	Stop loss (large deductible)	X HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserve	ə	9a(3)			
		(4) Earned ((1) + (2) - (3))	<u>.</u>			9a(4)	C
	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)	C
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on ar	n accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	<u></u>	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	_	-) (
		(2) Dividends or retroactive rate refunds. (These am	ounts were paid in	cash, or	credited.)	···· 9c(2)	
	d	Status of policyholder reserves at end of year: (1) Ar	nount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е		clude amount entered	in line 9c(2) .	.)	9e	
10	No	Nonexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carri	er			<u>10a</u>	128191
	b	retention of the contract or policy, other than reported				10b	
	Spe	retention of the contract or policy, other than reported becify nature of costs.	a in Part I, line 2 above	, герогt ато	unt.		
Р	art	t IV Provision of Information					
		Did the insurance company fail to provide any information	n necessary to comple	te Schedule	A?	Yes	X No
		f the answer to line 11 is "Yes," specify the information i				<u>- </u>	
	•	2					

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

2017

		F				inspection			
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	iding 12/31/2017				
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	591			
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500		D Emplo	yer Identification Nu	ımber (EIN)			
LOCKHEED MARTIN CO				-	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 EYEMED VISION CARE	rrier								
	(c) NAIC	(d) Contract or	(e) Approximate no		Polic	cy or contract year			
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To			
43-0949844	71870	9660556 & SUBS	338	5	01/01/2017	12/31/2017			
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers,	and other persons in			
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees p	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	ions or fees were pa	ıid			
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid					
commissions pai	id	(c) Amount		(d) Purpos	e	(e) Organization code			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were pa	aid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid									
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid					
commissions pai		(c) Amount		(d) Purpose					

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	Part III Welfare Benefit Contract Information						
		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 contr	acts are exp	érience-rated as a un	it. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance
	L			<u> </u>	<u></u>		
	e	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental unem	ipioyment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
	_						
9	Expe	perience-rated contracts:	i				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	· · · · · · · · · · · · · · · · · · ·	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		1	
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		1	
		(3) Incurred claims (add (1) and (2))				9b(3)	С
		(4) Claims charged				9b(4)	
	С	Remainder 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)			\dashv
		(E) Taxes	l-	9c(1)(E)			_
		(F) Charges for risks or other contingencies (G) Other retention charges					_
			•			0o(1)(H)	<u> </u>
		(H) Total retention	_	_			1
		(2) Dividends or retroactive rate refunds. (These	—				
	d		•				
		(2) Claim reserves				9d(2)	
	_	(3) Other reserves				9d(3)	
10	<u>e</u>	,	it include amount entered	i in iine 9c(2)	.)	9e	
10	_	onexperience-rated contracts: Total premiums or subscription charges paid to c	orrior			10a	2456
	a					<u>10a</u>	31567
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	
	Spe	ecify nature of costs.	itted iii i ait i, iiile 2 above	e, report ame	Juni	100	
	•	,					
P	art	IV Provision of Information					
			ation nonconstrute as	oto Cobodul-	. A2	Yes	X No
11		id the insurance company fail to provide any inform		ete Schedule	9 A (169	NO INO
12	2 If t	the 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

2017

This Form is Open to Public Inspection

v. 170203

For calendar plan year 20	17 or fiscal plan	year beginning 01/01/2017		and en	iding 12/31/2017	·
A Name of plan				B Three-digit		
LOCKHEED MARTIN GR	OUP INSURAN	NCE PLAN FOR RETIRED EMP			591	
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	yer Identification Number	r (EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632	
David Lufermet	ion Concer	ning Ingurance Contract	· Cavaraga Fasa	and Can	uminaiana D i . i .	
		ning Insurance Contract . Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance car	rrior					
GROUP HEALTH COOPE						
	T	T				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a		·	contract year
	code	identification number	policy or contract		(f) From	(g) To
91-0511770	95672	973000	3	3	01/01/2017	12/31/2017
2 Insurance fee and com	mission informa	ation. Enter the total fees and tot	al commissions paid I	ist in line 3	the agents brokers and	other persons in
descending order of the	amount paid.	ation. Enter the total root and tot	ar commiscione para. E		and agonto, pronoro, and	
(a) Total a	amount of comm	missions paid		(b) To	otal amount of fees paid	
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	m commiss	ions or fees were paid	
(b) Amount of sales ar			es and other commissio			
commissions pai	id	(c) Amount		(d) Purpos	<u>e</u>	(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees were paid	
	(0)	······································	F			
(b) Amount of sales and base Fees and other commissions paid						
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code
For Paperwork Reductio	n Act Notice, s	see the Instructions for Form 5	5500.		Sch	edule A (Form 5500) 2017

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e		5		
		tracts With Allocated Funds:				
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u					
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)				
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract of	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a uni	t. Where c	ontracts cover ind	
8	Ben	efit a	nd contract type (check all applicable boxes)			_			
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d Life insura	nce
	е	Te	mporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h Prescription	n drug
	ιİ	Sto	op loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity	contract
	m	=	her (specify)	<i>.</i> .	_	I		<u></u>	
9	Ехр	eriend	ce-rated contracts:						
	а	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid	d	9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	serve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		C
	b	Ben	efit charges (1) Claims paid		9b(1)				
		` '	ncrease (decrease) in claim reserves				T		
		(3) Ir	ncurred claims (add (1) and (2))				. 9b(3)		C
		(4) C	laims charged				. 9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	on an accrual basis)					
		((A) Commissions						
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs						
			(D) Other expenses						
			(E) Taxes						
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges				0-/4\/11	X	
			(H) Total retention				9c(1)(H)	
			Dividends or retroactive rate refunds. (These						
	d		us of policyholder reserves at end of year: (1						
		` '	Claim reserves				9d(2)		
		` '	Other reserves				9d(3)		
40			dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2).	.)	. 9e		
10	_		erience-rated contracts:				40-		
	а		Il premiums or subscription charges paid to d				. 10a		50790
	b	rete	ntion of the contract or policy, other than rep				10b		
	Spe	rete ecify r	eature of costs.				10b		
Р	art	IV	Provision of Information						
11	Die	d the	insurance company fail to provide any inforn	nation necessary to compl	ete Schedule	A?	Yes	X No	
12	lf t	he ar	swer 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

2017

		F 4 9 40 41 11		-		inspection			
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017				
A Name of plan LOCKHEED MARTIN GR	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	591				
C Plan sponsor's name a	C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification 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 GROUP HEALTH COOPE		CARE HMO							
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy	Policy or contract year			
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To			
91-0511770	95672	1069000/4069000	15	i	01/01/2017	12/31/2017			
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, brokers,	and other persons in			
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees pa	aid			
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 whor	m commiss	ions or fees were pai	d			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pa	id	(c) Amount		(d) Purpose					
	(a) Name a	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees were pai	d			
(b) Amount of sales and base Fees and other commissions paid									
commissions pa		(c) Amount		(e) Organization code					

Schedule A (Form 5500)	2017	Page 2 – [1				
(a) No.			aminaiana ar fana wara naid				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid				
Fees and other commissions paid							
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose				Organization code			
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid				
(-)		,					
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization			
commissions paid	(c) Amount	(0	d) Purpose	code			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
	Г			1			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization			
commissions paid	(c) Amount	((d) Purpose	code			
(a) Na	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
		Fees and other commissions p	naid	(e)			
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization			
commissions paid	(0)	,		code			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
		Fees and other commissions	paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code			

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ be treated	d as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e		5		
		tracts With Allocated Funds:				
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u					
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•				
		,				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)				
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [j X HMO contract	, S k			I Indemnity contract
	m	Other (specify)	, <u></u>				
	••••						
9	Fxp	erience-rated contracts:					
Ī		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid.	⊢	9a(2)			
		(3) Increase (decrease) in unearned premium rese	T T	9a(3)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid	T T	9b(1)		1 7	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (on					
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees	T T	9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	T T	9c(1)(D)			_
		(E) Taxes	•	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges	F	9c(1)(G)			
		(H) Total retention	-		1	9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in	cash. or	credited.)		
	d	Status of policyholder reserves at end of year: (1)					
	<u>~</u>	(2) Claim reserves(1)	•			` .	
		(3) Other reserves				2 1/2	
	е	Dividends or retroactive rate refunds due. (Do not					
10		onexperience-rated contracts:	mode amount ontolog		- / ·/·································		
	а	Total premiums or subscription charges paid to ca	rrier			10a	97789
	b	If the carrier, service, or other organization incurre					01100
		retention of the contract or policy, other than reporecify nature of costs.					
	art						
11		d the insurance company fail to provide any informa		ete Schedu	le A?	Yes	X No
12	2 If t	the answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

For calendar plan year 20°	17 or fiscal plar	year beginning 01/01/2017	() ()	and en	nding 12/31/2017	mspection		
A Name of plan	NCE PLAN FOR RETIRED EM	PLOYEES	B Thre	e-digit	591			
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 car HAWAII MEDICAL SERVICE								
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy o	r contract year		
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To		
99-0040115	49948	41635	10)	01/01/2017	12/31/2017		
2 Insurance fee and communication descending order of the	mission informa amount paid.	ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, an	d other persons in		
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fees paid			
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	sions or fees were paid			
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid				
commissions pai	d	(c) Amount		(d) Purpose		(e) Organization code		
	(a) Name a	nd address of the agent, broke	r, or other person to who	m commiss	sions or fees were paid			
(b) Amount of sales and base Fees and other commissions paid								
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code		

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [j X HMO contract	, S k		1 1, 1, 1	I Indemnity contract
	m	Other (specify)	, <u></u>				
	••••						
9	Fxp	erience-rated contracts:					
Ī		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)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged					
	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)	(
		(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 I	benefits afte	er retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	t include amount entered	in line 9c(2	2) .)	9e	
10) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			10a	109639
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	ith the acquisition	n or	
	_	retention of the contract or policy, other than repore ecify nature of costs.	rted in Part I, line 2 above	e, report am	nount	10b	
F	art	IV Provision of Information					
11	l Di	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

For calendar plan year 2017 or fiscal plan year beginning 01912017 and ending 12912017 A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EMPLOYEES B Three-dight plan number (PN)			F		,·		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 1 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 HEALTHNET - NORTHERN CAS R HMO (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year persons 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 paid (c) Amount of sales and base Fees and other commissions paid (b) Amount of sales and base	For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
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 HEALTHNET - NORTHERN CA SR HMO (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year policy or contract year (l) From (g) To policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year (l) From (g) To 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 (l) From (g) To policy or contract year policy or contract year policy or contract year policy or contract year policy or contract year (l) From (g) To 12:31/2017 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 (c) Amount (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	•	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES	-		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 HEALTHNET - NORTHERN CA SR HMO (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 (f) From (g) To 12/31/2017 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: (a) Name of insurance carrier HEALTHNET - NORTHERN CA SR HMO (b) EIN (c) NAIC code identification number policy or contract year policy or contract	Part I Informat	:I ON CONCEI ate Schedule A	rning Insurance Contra	ct Coverage, Fees, as a unit in Parts II and I	and Con	nmissions Provide in ported on a single Sched	formation for each contract
(a) Name of insurance carrier HEALTHNET - NORTHERN CA SR HMO (b) EIN (c) NAIC code identification number persons covered at end of persons covered at end of policy or contract year (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year (c) From (g) To 35-4402957 95800 57534 99 01/01/2017 12/31/2017 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>	g.oupou			portou on a omgre conte	
(b) EIN (c) NAIC code identification number persons covered at end of policy or contract year policy o	(a) Name of insurance ca)				
Code identification number persons covered at end of policy or contract year of policy or contract year of policy or contract year of policy or contract year of policy or contract year of year	(1) FIN	(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					(f) From	(g) 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	95-4402957	95800	57534	99	9	01/01/2017	12/31/2017
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 or fees were paid	descending order of the	amount paid.		otal commissions paid. L			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 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	(4) 101411	amount of com	micolone paid		(2) 1	star amount or root 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 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	3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).		
(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	<u> </u>					sions or fees were 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							
(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	(b) Amount of sales ar	nd base	F				
(b) Amount of sales and base Fees and other commissions paid	commissions pai					(e) Organization code	
(b) Amount of sales and base		(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 and base							
commissions paid (c) Amount (d) Purpose (e) Organization code	(b) Amount of sales and base Fees and other commissions paid						
	commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individu	group of employees of the ing purposes if such conti	acts are ex	perience-rated as	a unit. Where co	ntracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j X HMO contract	k		1 1	I Indemnity contract
	m	Other (specify)	,				
	L	_ carer (epocary) /					
9	Fxpe	erience-rated contracts:					
Ī		Premiums: (1) Amount received		9a(1)			_
	_	(2) Increase (decrease) in amount due but unpaid	ŀ	9a(2)			_
		(3) Increase (decrease) in unearned premium res		9a(3)			_
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid	ſ	9b(1)		1 ()	
		(2) Increase (decrease) in claim reserves	ľ	9b(2)			7
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or					
		(A) Commissions	·	9c(1)(A)			7
		(B) Administrative service or other fees	ľ	9c(1)(B)			
		(C) Other specific acquisition costs	ŀ	9c(1)(C)			7
		(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)	(
		(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 afte	er retirement		
		(2) Claim reserves	•			· · · · ·	
		(3) Other reserves				2 1(2)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	2) .)		
10) No	nexperience-rated contracts:		•	•		
	а	Total premiums or subscription charges paid to c	arrier			10a	612602
	b	If the carrier, service, or other organization incurr	ed any specific costs in co	onnection w	vith the acquisition	n or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
P	art	V Provision of Information					
11			ation necessary to some	ata Sahadii	Jο Δ2	Yes	X No
		the insurance company fail to provide any inform		ete ochedu	ile A ?	i es	<u> </u>
14	ı it t	he 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

2017

		F 4 9 40 41 11	=			inspection				
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017					
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	591				
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Nur	mber (EIN)				
LOCKHEED MARTIN CO					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 HEALTHNET - SOUTHER										
<i>a</i> > -	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy	y or contract year				
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To				
95-4402957	95800	5030 & SUBS	11		01/01/2017	12/31/2017				
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, brokers,	and other persons in				
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).						
	(a) Name a	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees were pai	id				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid						
commissions pa	id	(c) Amount		(d) Purpose	e	(e) Organization code				
	(a) Name a	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees were pai	id				
(b) Amount of sales and base Fees and other commissions paid										
commissions pa		(c) Amount		(d) Purpose	e	(e) Organization code				
						•				

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individuals.	group of employees of the ing purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k	=	1 1, 1, 1	I Indemnity contract
	m	Other (specify)	,				
9	Exp	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid	⊢	9a(2)			
		(3) Increase (decrease) in unearned premium res	The state of the s	9a(3)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid	T T	9b(1)		1 ()	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (o					
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs	ļ ·	9c(1)(C)			
		(D) Other expenses	The state of the s	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)	
		(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 afte	er retirement		
		(2) Claim reserves				· · · · · ·	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in line 9c(2	2) .)		
10) No	nexperience-rated contracts:		-			
	а	Total premiums or subscription charges paid to c	arrier			10a	174408
	b	If the carrier, service, or other organization incurr	ed any specific costs in co	onnection w	vith the acquisition	or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
-	lor4	W Provision of Information					
	art					П	
11		the insurance company fail to provide any inform		ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

		F 4		-		inspection			
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	iding 12/31/2017				
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	591			
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Nur	mber (EIN)			
LOCKHEED MARTIN CO				-	1893632	` '			
Part I Informat on a separa	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 HEALTHNET - SOUTHER)							
	(c) NAIC	(d) Contract or	(e) Approximate no		Policy	y or contract year			
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To			
95-4402957	95800	57534	202	2	01/01/2017	12/31/2017			
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers,	and other persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were pai	d			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pai	id	(c) Amount		(d) Purpose	e	(e) Organization code			
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were pai	d			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpose	e	(e) Organization code			

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

F	art	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 contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k		1 1, 1	I Indemnity contract
	m	Other (specify)	,				
	[
9	Fxpe	erience-rated contracts:					
Ī		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)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		, , ,	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))	•			9b(3)	(
		(4) Claims charged				: :	
	С	Remainder of premium: (1) Retention charges (or					
		(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	1	9c(1)(G)			
		(H) Total retention	-			9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)		
	d	Status of policyholder reserves at end of year: (1)	_		1		
	-	(2) Claim reserves	·			` '	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no					
10) No	nexperience-rated contracts:		,	,,	•	
	а	Total premiums or subscription charges paid to ca	arrier			10a	535208
	b	If the carrier, service, or other organization incurre					
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
P	art	IV Provision of Information					
						Пус	V No.
11		the insurance company fail to provide any information		ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

	pursuant to ERISA section 103(a)(2). Inspection							
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017							1/2017	
A Name of place LOCKHEED N		OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN	N) •	591
C Plan spons	or's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)
LOCKHEED N	MARTIN CO	RPORATION			52-	1893632		
Part I			rning Insurance Contra A. Individual contracts grouped					
1 Coverage Ir	nformation:							
(a) Name of ir								
		(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
(b) E	IN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
41-1693838		95766	2181	22	2	01/01/2017	7	12/31/2017
		mission inform amount paid.	ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
	(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons red	ceiving comi		ees. (Complete as many entrie					
		(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amoun	t of sales an	d base	F	ees and other commission	ns paid			
	missions pai		(c) Amount		(d) Purpose	9		(e) Organization code
		(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
		(6)		., s. s. s				
(h) Amorro	t of sales an	d base	F	ees and other commission	ns paid			
` '	missions pai		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual contract in the co	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a unit	. Where c	ontracts cover indi	
8	Ben	efit a	nd contract type (check all applicable boxes)	_		_		_	
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d Life insura	nce
	е	Te	mporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h Prescriptio	n drug
	ιİ	Sto	op loss (large deductible)	j X HMO contract	k 🗌	PPO contract		I Indemnity	contract
	m	_	her (specify)	<i>.</i> .		I			
9	Ехр	erien	ce-rated contracts:						
	а	Prem	iums: (1) Amount received		9a(1)				
		(2) lı	ncrease (decrease) in amount due but unpai	d	9a(2)				
		(S) I	ncrease (decrease) in unearned premium res	serve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		C
	b		efit charges (1) Claims paid		• • •				
			ncrease (decrease) in claim reserves						
		(S) I	ncurred claims (add (1) and (2))				9b(3)		C
		(4) C	Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	on an accrual basis)					
			(A) Commissions						
			(B) Administrative service or other fees		0 (4)(0)				
			(C) Other specific acquisition costs						
			(D) Other expenses						
			(E) Taxes						
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges				00/41/14	\ \ \	
			(H) Total retention	_	_		9c(1)(H)	
			Dividends or retroactive rate refunds. (These						
	d		us of policyholder reserves at end of year: (1				_ ` _		
		` '	Claim reserves				9d(2)		
	_	` '	Other reserves				9d(3)		
10			dends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2).	.)	. 9e		
10	_		erience-rated contracts:				100		444004
	a		al premiums or subscription charges paid to o				10a		111091
	b	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep				10b		
	Spe	rete	ntion of the contract or policy, other than rep lature of costs.				. 10b		
	art		Provision of Information			\Box	V	□ N.	
			insurance company fail to provide any inforn		ete Schedule	A?	Yes	X No	
12	lf t	he ar	nswer 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

2017

		F		-		mspection			
For calendar plan year 20	17 or fiscal pla	in year beginning 01/01/2017		and en	ding 12/31/2017				
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	591			
C Plan sponsor's name a	s shown on lir	ne 2a of Form 5500		D Emplo	yer Identification Nur	ımber (EIN)			
LOCKHEED MARTIN CO				-	1893632	, ,			
Part I Informat on a separa	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 KAISER - NORTHERN CA									
	(c) NAIC	(d) Contract or	(e) Approximate nu		Polic	cy or contract year			
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To			
94-1340523	60053	582-100;101	409)	01/01/2017	12/31/2017			
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 other persons in			
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees pa	paid			
3 Persons receiving com	missions and t	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 pai	uid			
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pa		(c) Amount		(d) Purpose	e	(e) Organization code			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were pai	aid			
(b) Amount of sales and base Fees and other commissions paid									
commissions pa		(c) Amount	(d) Purpose			(e) Organization code			

Schedule A (Form 5500)	2017	Page 2 – [1					
(a) No.			aminaiana ar fana wara naid					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid					
4.1.		Fees and other commissions	paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code				
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid					
(-)		,						
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization				
commissions paid	(c) Amount	((d) Purpose	code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
	<u> </u>							
(b) Amount of sales and base		Fees and other commissions p		(e) Organization				
commissions paid	(c) Amount	(1	d) Purpose	code				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid					
		Fees and other commissions p	naid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code				
commissions paid		,	<u>, </u>	code				
(1)								
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid					
All American Control		Fees and other commissions	paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code				

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	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	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k	=		I Indemnity contract
	m	Other (specify)	,				
	[
9	Exp	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid	ŀ	9a(2)			
		(3) Increase (decrease) in unearned premium rese		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 7	
		(2) Increase (decrease) in claim reserves	l	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions	·	9c(1)(A)			
		(B) Administrative service or other fees	ľ	9c(1)(B)			
		(C) Other specific acquisition costs	ŀ	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)	
		(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 aft	er retirement		
		(2) Claim reserves	·			` .	
		(3) Other reserves				2 1/2	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2) .)		
10) No	nexperience-rated contracts:		•	•	•	
	а	Total premiums or subscription charges paid to ca	arrier			10a	5569674
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection v	vith the acquisition	or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
_)ar4	IV Provision of Information					
	art					П ,	
11		the insurance company fail to provide any information		ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

For calendar plan year 2017 or fiscal plan year teginning 0101(2017) A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EMPLOYEES B Three-Gight plan number (PN)			F 4 5 4.6		-/·		inspection
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 - NORTHERN CA SR HMO (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of 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 commissions paid (c) Amount (d) Purpose (e) Organization code	For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
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 - NORTHERN CA SR HMO (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year of persons covered at end of policy or contract year of policy or contract year of policy or contract year of policy or contract year of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid (b) Amount of sales and base Fees and other commissions or fees were paid (b) Amount of sales and base Fees and other commissions or fees were paid (b) Amount of sales and base Fees and other commissions paid (c) 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 or fees were paid	•	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES			591
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1 Coverage Information: (a) Name of insurance carrier KAISER - NORTHERN CA SR HMO (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 persons overed at end of policy or contract year policy or contract year policy or contract year policy or contract year persons overed at end of policy or contract year policy or contract year policy or contract year (f) From (g) To policy or contract year policy or contract year policy or contract year policy or contract year (f) From (g) To policy or contract year policy or contract year policy or contract year policy or contract year (f) From (g) To policy or contract year policy or contrac	Part I Informat	t ion Concei ate Schedule A	rning Insurance Contra	ct Coverage, Fees as a unit in Parts II and	s , and Con Ill can be re	nmissions Provide in ported on a single Sched	formation for each contract
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(b) EIN (c) NAIC code identification number persons covered at end of policy or contract year policy or contract year solution of policy or contract year solution or policy or contract year solution of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order of the agents, brokers, and other persons in descending order o	(a) Name of insurance ca						
Second Identification number Persons covered at end of policy or contract year (f) From (g) To	# N = 10 1	(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			'		(f) From	(g) To
(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	60053	582-165;4697	53	32	01/01/2017	12/31/2017
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	descending order of the	amount paid.		otal commissions paid.			I 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 (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) Lotal a	amount of com	missions paid		(b) 10	otal 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 (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	3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report a	Il persons).		
(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	<u> </u>					sions or fees were 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							
(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	(b) Amount of sales ar	nd base	F	ees and other commissi			
(b) Amount of sales and base Fees and other commissions paid	commissions pa					(e) Organization code	
(b) Amount of sales and base		(a) Name a	and address of the agent, broke	er, or other person to wh	om commiss	sions or fees were paid	
(b) Amount of sales and base							
commissions paid (c) Amount (d) Purpose (e) Organization code	(b) Amount of sales ar	nd base		ees and other commissi			
	commissions pa	id	(c) Amount		(d) Purpos	е	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1					
(a) No.			omicciono ar foco ware noid					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid					
4.1.		Fees and other commissions	paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code				
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid					
(-)		,						
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization				
commissions paid	(c) Amount	((d) Purpose	code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
	<u> </u>							
(b) Amount of sales and base		Fees and other commissions p		(e) Organization				
commissions paid	(c) Amount	(1	d) Purpose	code				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid					
		Fees and other commissions p	naid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code				
commissions paid		,	<u>, </u>	code				
(1)								
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid					
All American Control		Fees and other commissions	paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code				

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

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Р	art	t III Welfare Benefit Contract Informati If more than one contract covers the same gro the information may be combined for reporting employees, the entire group of such individual	oup of employees of the group purposes if such contra	acts are expe	erience-rated as a ur	nit. Where co	ontracts cover individual
8	Ber	enefit and contract type (check all applicable boxes)					
•	а		Dental	с	Vision		d Life insurance
		<u>'</u>	<u>=</u>	<u> </u>			
	е		Long-term disability	′ g <u> </u>	Supplemental uner	npioyment	h Prescription drug
	İ	Stop loss (large deductible)	X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserv	/e	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	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)	C
		(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	<u> </u>	9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes	<u> </u>	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges				0 (4)(1)	
		(H) Total retention					
		(2) Dividends or retroactive rate refunds. (These ar	<u> </u>				
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide b	enefits after	retirement		
		(2) Claim reserves					
		(3) Other reserves				` '	
4.0	е		nclude amount entered	in line 9c(2) .	.)	9e	
10	No	lonexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carr	ier	•••••		<u>10a</u>	1091597
	b	retention of the contract or policy, other than reporte				10b	
	Spe	reterition of the contract of policy, other than reported pecify nature of costs.	gu III Falt I, IIIIe 2 above	, тероп ато	uit		
Р	art	t IV Provision of Information					
		Did the insurance company fail to provide any informati	on necessary to comple	ita Schadula	Δ2	Yes	X No
				ie Scriedule	Λ:		
14	. 111	f 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

2017

For calendar plan year 20°	17 or fiscal plar	n year beginning 01/01/2017		and en	nding 12/31/2017	шѕресноп			
A Name of plan		NCE PLAN FOR RETIRED EM	PLOYEES	B Thre	e-digit number (PN)	591			
C Plan sponsor's name a LOCKHEED MARTIN CO		e 2a of Form 5500		-	oyer Identification Numb 1893632	per (EIN)			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance car KAISER - SOUTHERN CA									
(I.) FINI	(c) NAIC	(d) Contract or	(e) Approximate no		Policy of	or contract year			
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To			
94-1340523	95708	101200;114302	210)	01/01/2017	12/31/2017			
2 Insurance fee and communication descending order of the	mission informa amount paid.	ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, an	d other persons in			
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	1			
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).					
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees were paid				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid					
commissions pai	d	(c) Amount		(d) Purpos	e	(e) Organization code			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees were paid				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code			

Schedule A (Form 5500)	2017	Page 2 – [1					
(a) No.			omicciono ar foco ware noid					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid					
4.1.		Fees and other commissions	paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code				
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid					
(-)		,						
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization				
commissions paid	(c) Amount	((d) Purpose	code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
	<u> </u>							
(b) Amount of sales and base		Fees and other commissions p		(e) Organization				
commissions paid	(c) Amount	(1	d) Purpose	code				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid					
		Fees and other commissions p	naid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code				
commissions paid		,	<u>, </u>	code				
(1)								
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid					
All American Control		Fees and other commissions	paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code				

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ 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 e			5	
		tracts With Allocated Funds:				
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u					
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)				
		•				
		(5) Total deductions			. 7e(5)	0

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F	If more than one the information	nefit Contract Informate contract covers the same may be combined for report entire group of such individuals.	group of employees of the ing purposes if such conti	acts are exp	perience-rated as a un	it. Where co	ontracts cover individual
8	Benefit and contract type	(check all applicable boxes)					
	a Health (other than o	dental or vision)	b Dental	С	Vision		d Life insurance
	e Temporary disabilit	y (accident and sickness)	f Long-term disabilit	у д	Supplemental unem	ployment	h Prescription drug
	i Stop loss (large ded		j X HMO contract	, J_ k[. ,	I Indemnity contract
		adottolo)	, Mariano dominant	., _	11 0 contract		I I machinity contract
	m ☐ Other (specify)						
^	For a decrease and a decrease of						
J	Experience-rated contracts		Ī	00(1)			
	` '	t received	ŀ	9a(1) 9a(2)			
		e) in amount due but unpaid		9a(2)			
		e) in unearned premium res · (3))				9a(4)	
		Claims paid		9b(1)		Ja(+)	
	• , ,	e) in claim reserves	l				
	` '	dd (1) and (2))				9b(3)	
						9b(4)	
	()	ım: (1) Retention charges (c					
		g (-)		9c(1)(A)			
	` '	e service or other fees	ľ	9c(1)(B)			
	` '	acquisition costs	ŀ	9c(1)(C)			
	. , .	ses		9c(1)(D)			
	(E) Taxes			9c(1)(E)			
	(F) Charges for ri	sks or other contingencies.		9c(1)(F)			
	(G) Other retention	on charges		9c(1)(G)			
	(H) Total retention	n				9c(1)(H))
	(2) Dividends or retro	pactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d Status of policyholde	r reserves at end of year: (1) Amount held to provide	benefits after	r retirement	9d(1)	
	(2) Claim reserves					9d(2)	
	(3) Other reserves					9d(3)	
	e Dividends or retroact	ive rate refunds due. (Do n	ot include amount entered	l in line 9c(2)) .)	9e	
10	Nonexperience-rated cor	ntracts:					
	a Total premiums or su	bscription charges paid to d	arrier			10a	301984
	b If the carrier, service,	, or other organization incur	ed any specific costs in co	onnection wi	th the acquisition or		
	retention of the contra	act or policy, other than rep	orted in Part I, line 2 above	e, report amo	ount	10b	
	Specify nature of costs.						
F	Part IV Provision of	of Information					
	_	any fail to provide any inform	nation necessary to comple	ete Schedule	e A?	Yes	X No
	2 If the answer to line 11 is			22.0001			
		, , , ,	•				

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

2017

For calendar plan year 20°	17 or fiscal plar	year beginning 01/01/2017	() ()	and en	iding 12/31/2017	inspection			
A Name of plan	NCE PLAN FOR RETIRED EM	PLOYEES	B Thre	e-digit number (PN)	591				
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION D Employer Identification Number (EIII 52-1893632						er (EIN)			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance car KAISER - SOUTHERN CA									
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate n		Policy o	r contract year			
(b) EIN	code	identification number		persons covered at end of policy or contract year (f) From		(g) To			
94-1340523	95708	114302-65	638	5	01/01/2017	12/31/2017			
descending order of the	mission informa amount paid.	ntion. Enter the total fees and to	otal commissions paid. L		the agents, brokers, an	·			
(u) rotare	amount or com	moorono para		(6) 10	nai amount of feed paid				
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).					
		nd address of the agent, broke			ions or fees were paid				
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid					
commissions pai	id	(c) Amount		(d) Purpos	е	(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				
(b) Amount of sales and base Fees and other commissions paid									
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code			

Schedule A (Form 5500)	2017	Page 2 – [1							
(a) No.	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid									
(a) Nai	ne and address of the agent, broker	, or other person to whom con	nimissions or lees were paid							
4.1.		Fees and other commissions	paid	(e)						
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code						
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid							
(-)		,								
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization						
commissions paid	(c) Amount	(0	d) Purpose	code						
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid							
	Г			1						
(b) Amount of sales and base		Fees and other commissions p		(e) Organization						
commissions paid	(c) Amount	((d) Purpose	code						
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid							
		Fees and other commissions p	naid	(e)						
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization						
commissions paid	(0)	,		code						
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid							
		Fees and other commissions	paid	(e)						
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code						

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ 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 e			5	
		tracts With Allocated Funds:				
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u					
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)				
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	Part	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	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i İ	Stop loss (large deductible)	j X HMO contract	, S k			I Indemnity contract
	m	Other (specify)	,	1			
9	Fxne	erience-rated contracts:					
•		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)			
		(4) Earned ((1) + (2) - (3))				9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)		1 7	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))	•			9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or	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)	
		(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 I	enefits afte	er retirement		
		(2) Claim reserves	·			· · · · · ·	
		(3) Other reserves					
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2	2) .)		
10) No	onexperience-rated contracts:		•	•		
	а	Total premiums or subscription charges paid to ca	arrier			10a	1740435
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	nnection w	ith the acquisition	or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
F	art	IV Provision of Information					
11	l Did	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

				,		mspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	NCE PLAN FOR RETIRED EM	PLOYEES	B Thre	e-digit number (PN)	591	
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 Informat	ion Conce ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees	s, and Con	nmissions Provide ir	nformation for each contract
1 Coverage Information:					,	
(a) Name of insurance ca	rrier					
	(c) NAIC	(d) Contract or	(e) Approximate	number of	Policy o	r contract year
(b) EIN	code	identification number	persons covered policy or contra		(f) From	(g) To
84-0591617	95669	2001-006;-008	2	53	01/01/2017	12/31/2017
descending order of the	amount paid.	ation. Enter the total fees and to	otal commissions paid.	List in line 3	the agents, brokers, and	d other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	
3 Persons receiving com		ees. (Complete as many entrie			. ,	
(b) Amount of sales ar	nd base		ees and other commiss	ions paid		(a) Organization code
commissions pai	(c) Amount		(d) Purpos	e	(e) Organization code	
	(a) Name a	and address of the agent, broke	er, or other person to wh	om commiss	sions or fees were paid	
(b) Amount of sales ar	nd base	F	ees and other commiss	ions paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	Welfare Benefit Contract Information If more than one contract covers the same group of emplo the information may be combined for reporting purposes if employees, the entire group of such individual contracts w	uch contracts are experience-rated a	s a unit. Where contr	acts cover individual
8	Ben	nefit and contract type (check all applicable boxes)	. cao caca, zo aca.ca ac a a		
Ū		Health (other than dental or vision)	c Vision	d	Life insurance
	a				
	е		n disability $g \coprod$ Supplementa		Prescription drug
	i	Stop loss (large deductible) j 🗶 HMO co	tract k PPO contract	: I	Indemnity contract
	m	Other (specify)			
9	Ехре	perience-rated contracts:			
	a I	Premiums: (1) Amount received	9a(1)		
		(2) Increase (decrease) in amount due but unpaid	9a(2)		
		(3) Increase (decrease) in unearned premium reserve	9a(3)		
		(4) Earned ((1) + (2) - (3))		9a(4)	(
	b	Benefit charges (1) Claims paid			
		(2) Increase (decrease) in claim reserves	9b(2)		
		(3) Incurred claims (add (1) and (2))		9b(3)	(
		(4) Claims charged		9b(4)	
	С	Remainder of premium: (1) Retention charges (on an accrual ba			
		(A) Commissions	· · · · · · · · · · · · · · · · · · ·		
		(B) Administrative service or other fees	0. (4)(0)		
		(C) Other specific acquisition costs	a (4)(m)		
		(D) Other expenses			
		(E) Taxes	2 (1)(=)		
		(F) Charges for risks or other contingencies	. (1)()		
		(G) Other retention charges		00/41/11/	
		(H) Total retention	_	```	
		(2) Dividends or retroactive rate refunds. (These amounts were	-		
	a		·	· · · · ·	
		(2) Claim reserves			
	_	(3) Other reserves		- · · ·	
10	<u>e</u>	(it entered in line 9c(2).)	9e	
10	_	Ionexperience-rated contracts:		10a	2040000
	a	1 0 1			3019068
	b	If the carrier, service, or other organization incurred any specific retention of the contract or policy, other than reported in Part I, I			
	Spe	ecify nature of costs.	e z above, report amount	100	
Р	art l	IV Provision of Information			
11	Dic	id the insurance company fail to provide any information necessar	to complete Schedule A?	Yes	No
12		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

2017

		F *** ********************************	=::::::::::::::::::::::::::::::::::::::	-		inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	PLOYEES		e-digit number (PN)	591
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Numb	per (EIN)
LOCKHEED MARTIN CO				-	1893632	,
Part I Informat on a separa	tion Concer ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con I can be re	nmissions Provide i	information for each contract edule A.
1 Coverage Information:						
(a) Name of insurance ca KAISER - CO SR HMO	rrier					
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy of	or contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To
84-0591617	95669	2001-006	35	5	01/01/2017	12/31/2017
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	ist in line 3	the agents, brokers, ar	nd other persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid					
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 whor	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid		
commissions pa	id	(c) Amount		(d) Purpose	e	(e) Organization code
	(a) Name a	and address of the agent, broke	r, or other person to whor	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code
		· ·				

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art l	III Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such conti	acts are exp	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Bene	nefit and contract type (check all applicable boxes)			<u> </u>	-		
	аΓ		b Dental	сГ	Vision		d Life insurance	
	_ 			<u> </u>	<u>-</u>			
	e	, (, , (, ,,,,	f Long-term disabilit	·	Supplemental unem	pioyment	h ☐ Prescription drug	
	i L	Stop loss (large deductible)	j X HMO contract	k_	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Ехрє	erience-rated contracts:	,					
	a i	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)				
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				. 9b(3)		С
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (or	· ·					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies (G) Other retention charges		9c(1)(G)				
		(H) Total retention	•			9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These					<i>)</i>	
	٨		_	_				
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves	·			` '		
		(3) Other reserves				. 9d(2) . 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no						
10		pnexperience-rated contracts:	i include amount entered	1 111 11110 30(2)	.)	., 36		
		Total premiums or subscription charges paid to ca	arrier			. 10a	140	9081
	_	If the carrier, service, or other organization incurre					140	7001
	D	retention of the contract or policy, other than repo			•	. 10b		
	Spe	ecify nature of costs.	, =	-,				
Pa	art l	IV Provision of Information						
11	Dic	d the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the information		2.5 20/104410				
. 2	n u	The answer to line it is ites, specify the infolliation	an 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

2017

For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017			
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	•	591	
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 car KAISER - GEORGIA	rrier							
/L) [IN]	(c) NAIC	(d) Contract or	(e) Approximate nu		Poli	icy or co	ntract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From		(g) To	
58-1592076	96237	4822	12	2	01/01/2017		12/31/2017	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers	s, and ot	her persons in	
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees	paid		
3 Persons receiving com		ees. (Complete as many entricand address of the agent, broke			iono or food ware n	o i d		
	(4)	aaa. 555 57 11.5 a.g. 11.7 a.g. 11.7	.,					
(b) Amount of sales ar			ees and other commission					
commissions pai	id	(c) Amount	(c) Amount (d) Purpose			(e) Organization code		
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were p	aid		
(b) Amount of sales ar	nd base		ees and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code	

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

P	art	t III Welfare Benefit Contract Informatic If more than one contract covers the same gro the information may be combined for reporting employees, the entire group of such individual	up of employees of the purposes if such contra	acts are expe	erience-rated as a u	nit. Where co	ontracts cover individual
8	Ber	enefit and contract type (check all applicable boxes)					
-	а		Dental	с	Vision		d Life insurance
		<u>'</u>					
	е.		Long-term disability		Supplemental une	mpioyment	h Prescription drug
	I	Stop loss (large deductible)	X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	perience-rated contracts:	-				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserv	e	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))					С
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on a		1			
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs	F	9c(1)(C)			
		(D) Other expenses	<u> </u>	9c(1)(D)			
		(E) Taxes	F	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges				- (1)(1)	
		(H) Total retention	_)
		(2) Dividends or retroactive rate refunds. (These an					
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide b	enefits after	retirement		
		(2) Claim reserves					
		(3) Other reserves					
	е		nclude amount entered	in line 9c(2) .	.)	9e	
10	No	Ionexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carri	er			<u>10a</u>	196154
	b	retention of the contract or policy, other than reporte				10b	
	Spe	pecify nature of costs.	α in Paπ I, line 2 above	, герогt ато	unt		
Р	art	t IV Provision of Information					
11	Di	Did the insurance company fail to provide any information	on necessary to comple	te Schedule	A?	Yes	X No
		f 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

2017

For calendar plan year 20°	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/201	7		
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	1PLOYEES	B Thre	e-digit number (PN)	•	591	
C Plan sponsor's name a LOCKHEED MARTIN CO		e 2a of Form 5500		_	oyer Identification 1893632	Number (EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca KAISER - GEORGIA SR H								
/b) FINI	(c) NAIC	(d) Contract or	(e) Approximate no		Po	olicy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	1	(g) To	
58-1592076	96237	4822	189)	01/01/2017		12/31/2017	
2 Insurance fee and coming descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, broke	ers, and of	ther persons in	
(a) Total a	amount of com	missions paid		(b) To	otal amount of fee	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	ions or fees were	paid		
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid				
commissions pai	id	(c) Amount		(d) Purpos	е		(e) Organization code	
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were	paid		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
(b) Amount of sales and base Fees and other commissions paid								
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code	
				commissions paid (c) Amount (d) Purpose				

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	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 ing purposes if such conti	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k	H	,	I Indemnity contract
	m	Other (specify)	, 🗠				
9	Exp	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid	ŀ	9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		, , ,	
		(2) Increase (decrease) in claim reserves	ľ	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or					
		(A) Commissions	·	9c(1)(A)			
		(B) Administrative service or other fees	ľ	9c(1)(B)			
		(C) Other specific acquisition costs	ŀ	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)	
		(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	penefits afte	er retirement		
		(2) Claim reserves	•			` '	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	2).)		
10) No	nexperience-rated contracts:		•	•	•	
	а	Total premiums or subscription charges paid to ca	arrier			10a	1067039
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	vith the acquisition	or or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
_		Dunyinian of Information					
P	art						
11		the insurance company fail to provide any inform		ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

		parsaant to	ETTIOA 30011011 103(a)(2)	•			Inspection		
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017		and en	ding 12/31/201	7			
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN)	•	591		
C Plan sponsor's name a		e 2a of Form 5500			yer Identification	Number ((EIN)		
LOCKHEED MARTIN CO	RPORATION			52-	1893632				
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca KAISER - HI SR HMO	rrier								
	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year		
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	1	(g) To		
94-1340523	60053	30980; 31934	9)	01/01/2017		12/31/2017		
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, broke	rs, and o	ther persons in		
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).					
	(a) Name a	and address of the agent, broker	, or other person to whor	m commiss	ions or fees were	paid			
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid					
commissions pai	id	(c) Amount		(d) Purpos	е		(e) Organization code		
	(a) Name a	and address of the agent, broker	, or other person to whor	m commiss	ions or fees were	paid			
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code		

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	Welfare Benefit Contract Informat If more than one contract covers the same gu the information may be combined for reportir employees, the entire group of such individual	roup of employees of the ng purposes if such contr	acts are expe	erience-rated as a u	ınit. Where co	ontracts cover individual
8	Ber	nefit and contract type (check all applicable boxes)					
-	а		b Dental	с	Vision		d Life insurance
			브	<u>_</u>	1		
	е		f Long-term disability	y g [Supplemental une	employment	h Prescription drug
	İ	Stop loss (large deductible)	j 🔀 HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.	<u></u>	9a(2)			
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		r	
		(3) Incurred claims (add (1) and (2))				9b(3)	C
		(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	T T	9c(1)(C)			_
		(D) Other expenses	·····-	9c(1)(D)			
		(E) Taxes	F	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges				0 (1)(1)	
		(H) Total retention		_)
		(2) Dividends or retroactive rate refunds. (These a					
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide to	penefits after	retirement		
		(2) Claim reserves					
		(3) Other reserves					
	е		include amount entered	in line 9c(2).	.)	9e	
10	No	Ionexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			<u>10a</u>	40342
	b	retention of the contract or policy, other than repor				10b	
		pecify nature of costs.	ted in Part I, line 2 above	e, report amo	unt.	100	
Р	art	IV Provision of Information					
11	Di	oid the insurance company fail to provide any informa	tion necessary to comple	ete Schedule	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

2017

		F		-		inspection		
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	iding 12/31/2017			
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	PLOYEES		e-digit number (PN)	591		
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Numl	per (EIN)		
LOCKHEED MARTIN CO				-	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 KAISER - MID-ATLANTIC								
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy	or contract year		
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To		
52-0954463	95639	3104-26; -31	2	2	01/01/2017	12/31/2017		
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, ar	nd other persons in		
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	d		
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			
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid				
commissions pa	id	(c) Amount	(d) Purpose			(e) Organization code		
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees were paid			
(b) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code		

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	III	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract of the c	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a unit	. Where c	ontracts cover individu	
8	Ben	efit a	nd contract type (check all applicable boxes)	<u>_</u>		_		_	
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	Te	emporary disability (accident and sickness)	f Long-term disability	ty g	Supplemental unem	ployment	h Prescription di	rug
	ιİ	Sto	op loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity con	tract
	m	_	ther (specify)	, .		I			
9	Ехр	eriend	ce-rated contracts:						
	а	Prem	iums: (1) Amount received		9a(1)				
		(2) lı	ncrease (decrease) in amount due but unpai	d	9a(2)				
		(S) I	ncrease (decrease) in unearned premium res	serve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		(
	b		efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves						
		(S) I	ncurred claims (add (1) and (2))				9b(3)		(
		(4) C	Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	on an accrual basis)					
			(A) Commissions						
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs		- 4.114-1				
			(D) Other expenses						
			(E) Taxes						
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges				0-/4\/11	1)	
			(H) Total retention				9c(1)(H)	
			Dividends or retroactive rate refunds. (These	_					
	d		us of policyholder reserves at end of year: (1	'			_ ` _		
		` '	Claim reserves				9d(2)		
		` '	Other reserves				9d(3)		
40			dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2) .	.)	9e		
10	_		erience-rated contracts:				40		
	а		al premiums or subscription charges paid to o				10a		835
	b Sne	rete	ntion of the contract or policy, other than rep				. 10b		
n	b Spe	If the rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.	red any specific costs in c	onnection with	h the acquisition or			
	art		Provision of Information						
			insurance company fail to provide any inform		ete Schedule	A?	Yes	X No	
12	If t	he ar	nswer 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

2017

		1		,		inspection
For calendar plan year 20°	17 or fiscal plar	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURAI	NCE PLAN FOR RETIRED EM	IPLOYEES	B Thre	e-digit number (PN)	591
C Plan sponsor's name a LOCKHEED MARTIN CO	RPORATION		ot Coverage Food	52-	oyer Identification Number 1893632	
Part I Informat on a separa	ate Schedule A	rning Insurance Contra Individual contracts grouped	as a unit in Parts II and I	and Con	nmissions Provide in ported on a single Sched	formation for each contract dule A.
1 Coverage Information:		<u> </u>			, g	
(a) Name of insurance car KAISER - OR SR HMO	rrier					
# N = W .	(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	(g) To
93-0798039	95204	8434-002	25	5	01/01/2017	12/31/2017
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, brokers, and	other persons in
(a) Total a	amount of comi	missions paid		(b) To	otal amount of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	es as needed to report all	persons).		
g		and address of the agent, broke			sions or fees were paid	
(b) Amount of sales an	nd base	F	ees and other commissio	ns paid		
commissions paid (c) Amount (d) Purpose			е	(e) Organization code		
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	sions or fees were paid	
(b) Amount of sales an			ees and other commissio			
commissions pai	d	(c) Amount		(d) Purpos	е	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	roup of employees of the ng purposes if such contr	acts are expe	erience-rated as a u	nit. Where co	ontracts cover individual
8	Ber	nefit and contract type (check all applicable boxes)		· ·		· · · · · · · · · · · · · · · · · · ·	·
•	a		b Dental	с	Vision		d Life insurance
			브	<u> </u>	<u>.</u>		
	е		f Long-term disability	⁄ g <u></u>	Supplemental une	mployment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		1	
		(3) Incurred claims (add (1) and (2))				9b(3)	C
		(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	The state of the s	9c(1)(D)			
		(E) Taxes	F	9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges				0-(4)(11)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		(H) Total retention)
		(2) Dividends or retroactive rate refunds. (These a	<u> </u>				
	d		·				
		(2) Claim reserves					
	_	(3) Other reserves				` '	
40	<u>e</u>		include amount entered	in line 9c(2).	.)	9e	
10	_	lonexperience-rated contracts:				100	40070
	а	1 0 1				<u>10a</u>	123704
	b Sn/	retention of the contract or policy, other than repor				10b	
	Spe	pecify nature of costs.	ted in Fait I, line 2 above	s, report amo	WIII.		
Р	art	IV Provision of Information					
		oid the insurance company fail to provide any informa	ation necessary to comple	ete Schedule	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

2017

For calendar plan year 201	7 or fiscal plan	vear beginning 01/01/2017		and en	ding 40/04/0047	
		. , ca. 20gg 01/01/2017		and en	iding 12/31/2017	
A Name of plan LOCKHEED MARTIN GRO	OUP INSURAN	NCE PLAN FOR RETIRED EM	PLOYEES	B Thre	e-digit number (PN)	591
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 Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information Concerning Insurance Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Fees, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, Contract Coverage, C						
Part I Information on a separa	te Schedule A	. Individual contracts grouped	as a unit in Parts II and III	can be re	ported on a single Sched	ule A.
1 Coverage Information:						
(a) Name of insurance car PACIFICARE - AZ	rier					
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	(g) To
94-3267522	95617	H1401 & SUBS	66		01/01/2017	12/31/2017
2 Insurance fee and comm descending order of the		ation. Enter the total fees and to	otal commissions paid. Lis	st in line 3	the agents, brokers, and	other persons in
(a) Total a	mount of comr	nissions paid		(b) To	otal amount of fees paid	
3 Persons receiving comm	nissions and fe	ees. (Complete as many entrie	s as needed to report all p	ersons).		
<u> </u>		nd address of the agent, broke			ions or fees were paid	
(b) Amount of sales and	d base	Fe	ees and other commission	s paid		
			d) Purpos	e	(e) Organization code	
	(a) Name a	nd address of the agent, broke	r, or other person to whom	n commiss	ions or fees were paid	
(b) Amount of sales and base Fees and other commissions paid						
commissions paid	d	(c) Amount	(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ 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 e		5		
		tracts With Allocated Funds:				
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			ion gaaramoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(./			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art l	III Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same g the information may be combined for reporting employees, the entire group of such individu	ng purposes if such conti	acts are expe	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Bene	nefit and contract type (check all applicable boxes)			<u> </u>	-		
	аΓ		b Dental	с	Vision		d Life insurance	
	느		봄	<u> </u>	<u>-</u>			
	e	, (, , (, ,,,	f Long-term disabilit	·	Supplemental unem	pioyment	h ☐ Prescription drug	
	i L	Stop loss (large deductible)	j X HMO contract	k _	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	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 rese		9a(3)				
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves				1		
		(3) Incurred claims (add (1) and (2))				. 9b(3)		С
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (or						
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)			_	
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies (G) Other retention charges		9c(1)(G)				
		(H) Total retention	•			9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These					<i>)</i>	
	٦							
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves	·			` '		
		(3) Other reserves				. 9d(2) . 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no						
10		pnexperience-rated contracts:	i ilicidae alliodili eliterec	1 111 11110 30(2)	.)	., 36		
		Total premiums or subscription charges paid to ca	rrier			. 10a	156	9754
		If the carrier, service, or other organization incurre					100	510
	D	retention of the contract or policy, other than repo				. 10b		
	Spe	ecify nature of costs.	, =	-,			.	
Pa	art I	IV Provision of Information						
11	Dic	d the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	A?	Yes	X No	
		the answer to line 11 is "Yes," specify the information						
. 2	n u	The answer to line it is ites, specify the infolliation	ar 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

2017

		p 3.10 3.01.11	=::::::::::::::::::::::::::::::::::::::	,·		inspection	
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017		and en	nding 12/31/2017		
A Name of plan LOCKHEED MARTIN GR	NCE PLAN FOR RETIRED EM	PLOYEES		B Three-digit plan number (PN) 591			
C Plan sponsor's name a LOCKHEED MARTIN CO	RPORATION		ot Coverage Fee	52-	oyer Identification Number 1893632		
Part I Informat	ate Schedule A	rning Insurance Contract. Individual contracts grouped	as a unit in Parts II and I	Il can be re	ported on a single Sche	formation for each contract dule A.	
1 Coverage Information:		-			-		
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To	
94-3267522	95617	H1400	8.	1	01/01/2017	12/31/2017	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brokers, and	other persons in	
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid		
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).		_	
· creens recentling com		and address of the agent, broke			sions or fees were paid		
(b) Amount of sales ar	nd base	F ₁	ees and other commissio	ns paid			
commissions paid (c) Amount			(d) Purpose (e) Organization cod				
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees were paid		
()	(b) Amount of sales and base Fees and other commissions paid						
commissions pai	id	(c) Amount		(d) Purpos	e	(e) Organization code	

Schedule A (Form 5500)	2017	Page 2 – [1			
(a) No.			aminaiana ar fana wara naid			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid			
4.1.		Fees and other commissions	paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid			
(-)		,				
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization		
commissions paid	(c) Amount	(0	d) Purpose	code		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
	Г			1		
(b) Amount of sales and base		Fees and other commissions p		(e) Organization		
commissions paid	(c) Amount	((d) Purpose	code		
(a) Na	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
		Fees and other commissions p	naid	(e)		
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization		
commissions paid	(0)	,		code		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid			
Fees and other commissions paid						
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code		

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	/ 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 e		5		
		tracts With Allocated Funds:				
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) dother (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			ion gaaramoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•				
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(./			
		•				
		(5) Total deductions			. 7e(5)	0

0

ı	Page	4

F	art	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individu	group of employees of the ing purposes if such conti	acts are ex	perience-rated as	s a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k			I Indemnity contract
	m	Other (specify)	,				
	[
9	Fxpe	erience-rated contracts:					
Ī		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid	ŀ	9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)			_
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		, , ,	
		(2) Increase (decrease) in claim reserves	l	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (o					
		(A) Commissions	i	9c(1)(A)			
		(B) Administrative service or other fees	ľ	9c(1)(B)			_
		(C) Other specific acquisition costs	ŀ	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)	(
		(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 afte	er retirement		
		(2) Claim reserves	•			` ` `	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	2) .)		
10) No	nexperience-rated contracts:		-			
	а	Total premiums or subscription charges paid to c	arrier			10a	352616
	b	If the carrier, service, or other organization incurr	ed any specific costs in co	onnection w	vith the acquisition	n or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
D	art	IV Provision of Information					
						Пу	V No
11		the insurance company fail to provide any inform		ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

		F 4		-		inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017	
A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EMP			IPLOYEES		e-digit number (PN)	591
C Plan sponsor's name a	ıs shown on lin	e 2a of Form 5500		D Emplo	yer Identification Nur	mber (EIN)
LOCKHEED MARTIN CO					1893632	· ,
Part I Informat on a separa	tion Conce ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con	nmissions Provide ported on a single Sc	e information for each contract hedule A.
1 Coverage Information:						
(a) Name of insurance ca PACIFICARE - SOUTHER)				
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy	or contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To
95-2931460	70785	142770; 144883	121		01/01/2017	12/31/2017
2 Insurance fee and come descending order of the		ation. Enter the total fees and t	otal commissions paid. Li	st in line 3	the agents, brokers,	and other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees pa	aid
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 whor	m commiss	ions or fees were pai	d
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pa	id	(c) Amount		(d) Purpose (e) Organization		
	(a) Name a	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees were pai	d
(b) Amount of sales and base Fees and other commissions paid						
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,		code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	Welfare Benefit Contract Information If more than one contract covers the same ground the information may be combined for reporting employees, the entire group of such individual of the contract of the contract covers the same ground in the contract of t	up of employees of the purposes if such contra	acts are expe	erience-rated as a u	nit. Where co	ontracts cover individual
8	Ben	enefit and contract type (check all applicable boxes)		· ·		· · ·	·
•	a [Health (other than dental or vision)	Dental	с	Vision		d Life insurance
	е	Temporary disability (accident and sickness) f	<u> </u>	′ g <u>⊔</u>	Supplemental une	mployment	h Prescription drug
	i	Stop loss (large deductible)	X HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserve	e	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	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)	C
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on ar	·				
		(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	<u></u>	9c(1)(D)			
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			_
		(G) Other retention charges				0-(4)/[1]	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		(H) Total retention	_	-)
		(2) Dividends or retroactive rate refunds. (These am					
	d	()	•				
		(2) Claim reserves					
		(3) Other reserves				` '	
40	e		clude amount entered	in line 9c(2) .	.)	9e	
10	_	lonexperience-rated contracts:				100	454005
	а	1 9 1				<u>10a</u>	451927
	b	retention of the contract or policy, other than reported				10b	
	Spe	pecify nature of costs.	Jili Fait I, iilie Z above	, төрөт ато	un.		
Р	art	t IV Provision of Information					
		Did the insurance company fail to provide any informatio	n necessary to comple	te Schedule	A?	Yes	X No
		the answer to line 11 is "Yes," specify the information r					<u></u>
	•	2 2 3-, -p,					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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OMB No. 1210-0110

2017

(b) EIN (c) NAIC code (d) Contract or persons covered at end of policy or contract year (e) Approximate number of persons covered at end of policy or contract year (f) From (g) To			F 4		7-		inspection
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 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 PACIFICARE - CO (b) EIN (c) NAIC (d) Contract or identification number (g) Approximate number of persons covered at end of policy or contract year (g) To persons covered at end of policy or contract year (g) To 12/31/2017 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 paid (c) Amount of sales and base Fees and other commissions paid	For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	iding 12/31/2017	
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 PACIFICARE - CO (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year (t) From (g) To 12/31/2017 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	•	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES			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 PACIFICARE - CO (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 95434 CO-601-606&SUBS 5 01/01/2017 12/31/2017 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	LOCKHEED MARTIN CO	` '					
1 Coverage Information: (a) Name of insurance carrier PACIFICARE - CO (b) EIN (c) NAIC code (identification number pacification number of persons covered at end of policy or contract year policy o	on a separa	ate Schedule A	rning insurance Contra A. Individual contracts grouped	as a unit in Parts II and	lll can be re	ntmissions Provide in ported on a single Sched	formation for each contract dule A.
(b) EIN (c) NAIC code 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 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 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 of commissions 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			<u>. </u>			Ţ	
(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 12/31/2017 12/31/2017 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	rrier					
Code identification number persons covered at end of policy or contract year of policy or contract year of policy or contract year of policy or contract year of policy or contract year of policy or contract year of policy or contract year of year of the amount policy. 12/31/2017 1	# N = 10 1	(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 of commissions 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	` '		'		(f) From	(g) 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	84-1011378	95434	CO-601-606&SUBS		5	01/01/2017	12/31/2017
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			ation. Enter the total fees and t	otal commissions paid. I	ist in line 3	the agents, brokers, and	I 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 (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) Total a	amount of com	missions paid		(b) To	otal 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 (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	3 Persons receiving com	missions and f	ees (Complete as many entrie	es as needed to report al	I nersons)		
(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	T craons receiving com					ions or fees were 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			-				
(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	(b) Amount of sales ar	nd base	F	ees and other commission	ons paid		
(b) Amount of sales and base Fees and other commissions paid	commissions pa					(e) Organization code	
(b) Allount of sales and base		(a) Name a	and address of the agent, broke	er, or other person to who	om commiss	ions or fees were paid	
(b) Allount of sales and base							
commissions paid (c) Amount (d) Purpose (e) Organization code	()						
	commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	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 contr	acts are expe	erience-rated as a ι	unit. Where co	ontracts cover individual
8	Ber	enefit and contract type (check all applicable boxes)					·
Ŭ			Dental	с Г] Vicion		d ☐ Life insurance
	a		브	c [Vision		
	е	Temporary disability (accident and sickness) f	Long-term disability	y g <u> </u>	Supplemental une	employment	h Prescription drug
	i	Stop loss (large deductible) j	X HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Ехр	perience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserv	/e	9a(3)			
		(4) Earned ((1) + (2) - (3))	<u>.</u>			9a(4)	C
	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)	C
		(4) Claims charged				9b(4)	
	C	Remainder of premium: (1) Retention charges (on a	n accrual basis)				
		(A) Commissions	<u> </u>	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs	<u> </u>	9c(1)(C)			
		(D) Other expenses	<u>.</u>	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	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide b	enefits after	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	in line 9c(2).	.)	9е	
10	No	Ionexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carr	ier			10a	139180
	b	retention of the contract or policy, other than reporte					
Р	art	IV Provision of Information					
		Did the insurance company fail to provide any information	on necessary to comple	ete Schedule	A?	Yes	X No
		the answer to line 11 is "Yes," specify the information		2.5 00.100010		<u> </u>	.——
		and and the state of appears are another desired	p. 0				

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

2017

For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017	(/ (/	and en	nding 12/31/2017	mspection				
A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EMPLOYEES			PLOYEES	B Thre	e-digit	591				
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION D Employer Identification Number 52-1893632					er (EIN)					
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.										
1 Coverage Information:										
(a) Name of insurance car PACIFICARE - DENVER C										
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy o	r contract year				
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To				
84-1011378	95434	29300	26	i	01/01/2017	12/31/2017				
2 Insurance fee and communication descending order of the	mission informa amount paid.	ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, brokers, and	d other persons in				
(a) Total a	amount of comi	missions paid		(b) To	otal amount of fees paid	_				
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).						
		and address of the agent, broke			sions or fees were paid					
(b) Amount of sales ar	nd base		ees and other commission	ns paid						
commissions paid (c) Amount (d) Purpose				(e) Organization code						
	(a) Name a	and address of the agent, broke	r, or other person to whor	m commiss	sions or fees were paid					
(b) Amount of sales and base Fees and other commissions paid										
commissions pai		(c) Amount		(d) Purpos	e	(e) Organization code				

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individuals.	group of employees of the ing purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i	Stop loss (large deductible)	j X HMO contract	k		1 1, 1	I Indemnity contract
	m	Other (specify)	,				
9	Exp	erience-rated contracts:					
Ī		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)			
		(4) Earned ((1) + (2) - (3))	-			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		, , ,	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (o					
		(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)	
		(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	_		3		
		(2) Claim reserves	•			` '	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	2) .)		
10) No	nexperience-rated contracts:		-		·	
	а	Total premiums or subscription charges paid to c	arrier			10a	143018
	b	If the carrier, service, or other organization incurr	ed any specific costs in co	onnection w	vith the acquisition	n or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
P	art	V Provision of Information					
11	Dic	I the insurance company fail to provide any inform	ation necessary to comple	ete Schedu	ıle A?	Yes	X No
		he answer to line 11 is "Yes," specify the informati					<u> </u>
•	(12 miles to mile 11 to 100, opening 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

2017

		pursuant to	E(10A, 3001011, 103(a)(2)	•		Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	iding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURAI	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN)	591
LOCKHEED MARTIN CO	C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION				oyer Identification Numb 1893632	
Part I Informat	tion Concer	ning Insurance Contract. Individual contracts grouped a	t Coverage, Fees,	and Con	nmissions Provide ir	nformation for each contract
Coverage Information:	ate concade /	. marriada contracto groupea c		r dan be re	ported on a single cone	adio 7 t.
(a) Name of insurance ca PACIFICARE SECURE HO		RTHERN CO SR HMO				
/L) FIN	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy o	r contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To
84-1011378	95434	29300	5	;	01/01/2017	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and	d other persons in
(a) Total a	amount of comi	nissions paid		(b) To	otal amount of fees paid	
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	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		
commissions pa	id	(c) Amount		(d) Purpos	<u>e</u>	(e) Organization code
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid		
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code
						

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [j X HMO contract	, S k			I Indemnity contract
	m	Other (specify)	, <u></u>				
	••••						
9	Exp	erience-rated contracts:					
•		Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid	⊢	9a(2)			_
		(3) Increase (decrease) in unearned premium rese	T T	9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid	T T	9b(1)		1 7	
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged					
	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)	(
		(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 afte	er retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2	2) .)	9e	
10) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			10a	20342
	b	If the carrier, service, or other organization incurre	d any specific costs in co	onnection w	ith the acquisition	or	
		retention of the contract or policy, other than report	ted in Part I, line 2 above	e, report am	nount	10b	
		ecify nature of costs.					
P	art	IV Provision of Information					
11	Die	d the insurance company fail to provide any informa	tion necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	the answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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OMB No. 1210-0110

2017

		p 3.10 3.0 1.1 1.0		-		inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	PLOYEES		e-digit number (PN)	591
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Num	ber (EIN)
LOCKHEED MARTIN CO				-	1893632	, ,
Part I Informat on a separa	tion Concer ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con I can be re	nmissions Provide ported on a single Sch	information for each contract edule A.
1 Coverage Information:						
(a) Name of insurance ca PACIFICARE - NV SR HM						
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy	or contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To
86-0875231	95685	33502	13	3	01/01/2017	12/31/2017
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, a	nd other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	d
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).		
	(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid		
commissions pai	id	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	v a	Supplemental	unemplovment	h Prescription drug
	i İ		j X HMO contract	, S k		, , ,	I Indemnity contract
	m	Other (specify)	,				
	••••						
9	Exp	erience-rated contracts:					
-		Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid	F	9a(2)			_
		(3) Increase (decrease) in unearned premium rese		9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))	_			9b(3)	(
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)				
		(A) Commissions	T .	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)	(
		(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 I	benefits afte	er retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	t include amount entered	l in line 9c(2	2) .)	9e	
10) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	ırrier			10a	36147
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	ith the acquisition	n or	
	_	retention of the contract or policy, other than report	rted in Part I, line 2 above	e, report am	nount	10b	
		ecify nature of costs.					
F	art	IV Provision of Information					
11	Die	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

				,		mspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES	B Thre	e-digit number (PN)	591
C Plan sponsor's name a LOCKHEED MARTIN CO	RPORATION	e 2a of Form 5500	ct Coverage Fees	52-	oyer Identification Number 1893632	
Part I Informat on a separa	ate Schedule A	. Individual contracts grouped	as a unit in Parts II and	III can be re	ported on a single Sched	dule A.
1 Coverage Information:						
(a) Name of insurance car PACIFICARE - TX	rrier					
	(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	(g) To
33-0115163	95174	6000-00 & SUBS		1	01/01/2017	12/31/2017
2 Insurance fee and coming descending order of the		ation. Enter the total fees and t	otal commissions paid. I	ist in line 3	the agents, brokers, and	other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	nersons)		
• 1 crooms receiving com		and address of the agent, broke			sions or fees were paid	
		_				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pai	id	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name a	and address of the agent, broke	er, or other person to who	om commiss	sions or fees were paid	
(b) Amount of sales ar			ees and other commission	•		
commissions pai	d	(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [j X HMO contract	k	=	1 1, 1, 1	I Indemnity contract
	m	Other (specify)	,				
	!						
9	Fxp	erience-rated contracts:					
Ī		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)			_
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid	The state of the s	9b(1)		1 ()	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	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	1	9c(1)(G)			
		(H) Total retention	-			9c(1)(H)	(
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)		
	d	Status of policyholder reserves at end of year: (1)			1		
	<u>.</u>	(2) Claim reserves	·			· · · · · ·	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no					
10		pnexperience-rated contracts:	t morado amodrit ontoroa				
	а	Total premiums or subscription charges paid to ca	arrier			10a	23455
	b	If the carrier, service, or other organization incurre					20100
		retention of the contract or policy, other than repo					
	Spe	ecify nature of costs.					
F	art	IV Provision of Information					
11	Die	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

		F		-		mspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	PLOYEES		e-digit number (PN)	591
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Numb	er (EIN)
LOCKHEED MARTIN CO				-	1893632	,
Part I Information a separa	tion Concer ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con	nmissions Provide in ported on a single Sche	nformation for each contract dule A.
1 Coverage Information:						
(a) Name of insurance ca PACICIFARE SECURE HO		SR HMO				
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy o	r contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To
33-0115163	95174	18021	769)	01/01/2017	12/31/2017
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, an	d other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid	
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	sions or fees were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid		
commissions pa	id	(c) Amount		(d) Purpose	e	(e) Organization code
	(a) Name a	and address of the agent, broke	r, 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		(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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Р	art	If more than one contract covers the same growthe information may be combined for reporting employees, the entire group of such individual	oup of employees of the g purposes if such contra	acts are expe	erience-rated as a ur	nit. Where co	ontracts cover individual
8	Ber	enefit and contract type (check all applicable boxes)		· ·			·
•	a		Dental	с	Vision		d Life insurance
			<u>=</u>	<u> </u>			
	е		Long-term disability	⁄ g <u></u>	Supplemental uner	mployment	h Prescription drug
	i	Stop loss (large deductible)	X HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Ехр	perience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reser	ve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	C
	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)	C
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on a					
		(A) Commissions	Telephone	9c(1)(A)			
		(B) Administrative service or other fees	-	9c(1)(B)			
		(C) Other specific acquisition costs	<u> </u>	9c(1)(C)			
		(D) Other expenses	<u> </u>	9c(1)(D)			
		(E) Taxes	<u> </u>	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges				0.41/11	<u> </u>
		(H) Total retention					
		(2) Dividends or retroactive rate refunds. (These a	<u>—</u>				
	d	()	·				
		(2) Claim reserves					
		(3) Other reserves				` '	
40	е.		include amount entered	in line 9c(2) .	.)	9e	
10	_	lonexperience-rated contracts:				40	
	а	1 0 1				10a	3406587
	b	retention of the contract or policy, other than report				10b	
	Spe	retention of the contract or policy, other than report pecify nature of costs.	ed in Part I, line 2 above	a, report amo	unt	105	
Р	art	IV Provision of Information					
		Did the insurance company fail to provide any informat	ion necessary to comple	ete Schedule	А? Г	Yes	X No
				no ochedule	Λ:		
12	. IT	the answer to line 11 is "Yes," specify the information	i noi provided. 🔻				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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OMB No. 1210-0110

2017

		F 4 9 40 41 11		-		inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	NCE PLAN FOR RETIRED EM	IPLOYEES		e-digit number (PN)	591
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identification Nur	mber (EIN)
LOCKHEED MARTIN CO					1893632	` ,
Part I Informat on a separa	tion Conce ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Con	nmissions Provide	e information for each contract chedule A.
1 Coverage Information:						
(a) Name of insurance ca UNITED HEALTHCARE - I						
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy	y or contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To
63-1036817	95716	65089	2		01/01/2017	12/31/2017
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, brokers,	and other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees pa	aid
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 whor	n commiss	ions or fees were pai	id
(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 a	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees were pai	id
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpos	е	(e) Organization code
						•

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.								
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 e		5					
		tracts With Allocated Funds:							
·	a	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 corretention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) definition of the other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma							
-	а	Type of contract: (1) deposit administration (2) immedia							
	u			ion gaaramoo					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			. 7b	0			
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(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)						
		•							
		(6)Total additions			. 7c(6)	0			
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0			
	е	Deductions:							
		(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)						
		\(\frac{1}{2} \)							
		•							
		(5) Total deductions			. 7e(5)	0			

0

ı	Page	4

F	art	Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporting employees, the entire group of such individu	roup of employees of the	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [j X HMO contract	k	=		I Indemnity contract
	m	Other (specify)	,				
	••••						
9	Fxp	erience-rated contracts:					
Ī		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)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	(
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	(
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or	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)	(
		(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 I	penefits after	er 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	in line 9c(2	2) .)	9e	
10) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	32980
	b	If the carrier, service, or other organization incurre	ed any specific costs in co	onnection w	vith the acquisition	n or	
	_	retention of the contract or policy, other than repo- ecify nature of costs.	rted in Part I, line 2 above	e, report an	nount	10b	
F	art	IV Provision of Information					_
11	Die	d the insurance company fail to provide any informa	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he 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

2017

(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			F 4 5 4.6		7-		inspection				
C Plan sponsor's name as shown on line 2a of Form 5500 CC Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) 52-18936322 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 AETNA LIFE INSURANCE CO (b) EIN (c) NAIC (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year policy or contract year 1389 01/01/2017 12/31/2017 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 of the person of the commissions or fees were paid	For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and er	nding 12/31/2017					
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 ARETNA LIFE INSURANCE CO (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of 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 Fees and other commissions paid (e) Organization or fees were paid (b) Amount of sales and base Fees and other commissions or fees were paid	•	·				501					
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 AETNA LIFE INSURANCE CO (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 1 1389 01/01/2017 12/31/2017 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 of the agent, broker, or other person to whom commissions or fees were paid	LOCKHEED MARTIN CC	RPORATION		et Coverage Foos	* *						
(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 of sales and base (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year (g) From (g) To (g) To (g) To (h) From (g) To (g) To (g) To (h) From (g) To (g) Organization of (g	on a separ	on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
(e) Approximate number of persons covered at end of policy or contract year or identification number of persons covered at end of policy or contract year opolicy of the person to whom commissions or fees were paid opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy or contract year opolicy	1 Coverage Information:										
(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 1389 01/01/2017 12/31/2017 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 or fees were paid	` '										
Code identification number persons covered at each of From (g) To	# N = N .	(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 or fees were paid (b) Amount of sales and base and address of the agent, broker, or other person to whom commissions or fees were paid	(b) EIN	` '		· ·		(f) From	(g) To				
(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 or fees were paid (b) Amount of sales and address of the agent, broker, or other person to whom commissions or fees were paid (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	06-6033492	60054	375891	138	9	01/01/2017	12/31/2017				
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 commissions or fees were paid (b) Amount of sales and address of the agent, broker, or other person to whom commissions or fees were paid	descending order of the	amount paid.		otal commissions paid. I			I 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 or fees were 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) Total	amount of com	missions paid		(b) To	otal 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 or fees were 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	3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).						
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization or (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base	J					sions or fees were paid					
(c) Amount (d) Purpose (e) Organization of (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base											
(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	(b) Amount of sales a	nd base	F	ees and other commission							
(b) Amount of sales and base Fees and other commissions paid	commissions pa	id	(c) Amount		(d) Purpose		(e) Organization code				
(b) Amount of sales and base	(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 co	(b) Amount of sales and base Fees and other commissio			ons paid							
	commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code				

Schedule A (Form 5500)	2017	Page 2 – [1				
(a) No.			aminaiana ar fana wara naid				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid				
Fees and other commissions paid							
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose				Organization code			
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid				
(-)		,					
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization			
commissions paid	(c) Amount	(0	d) Purpose	code			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
	Г			1			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization			
commissions paid	(c) Amount	((d) Purpose	code			
(a) Na	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
		Fees and other commissions p	naid	(e)			
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization			
commissions paid	(0)	,		code			
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid				
Fees and other commissions paid							
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	(e) Organization code			

F	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.								
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 e		5					
		tracts With Allocated Funds:							
·	a	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 corretention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) dother (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, o	check here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma							
-	а	Type of contract: (1) deposit administration (2) immedia							
	u			ion gaaramoo					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			. 7b	0			
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(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)						
		•							
		(6)Total additions			. 7c(6)	0			
	d	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>		. 7d	0			
	е	Deductions:							
		(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)						
		\(\frac{1}{2} \)							
		•							
		(5) Total deductions			. 7e(5)	0			

0

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P	Part III Welfare Benefit Contract Information							
		If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such conti	acts are expe	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Bene	nefit and contract type (check all applicable boxes)			<u> </u>		i	
	аΓ		b Dental	с	Vision		d X Life insurance	
	_ 			<u> </u>	<u>-</u>	nlaumant		
	e [, (, , (, ,,,,	f Long-term disabilit	·	Supplemental unem	pioyment	h Prescription drug	
	i L	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Ехрє	erience-rated contracts:	,					
	a i	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)		1		
	_	(4) Earned ((1) + (2) - (3))				9a(4)		<u>C</u>
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves				1		
		(3) Incurred claims (add (1) and (2))				. 9b(3)		С
		(4) Claims charged				. 9b(4)		
	С	Remainder of premium: (1) Retention charges (or	· ·					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies (G) Other retention charges		9c(1)(G)				
		(H) Total retention	•			. 9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These					<i>)</i>	_
	٨		_					
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves	·			•		
		(3) Other reserves				9d(2) 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no						
10		pnexperience-rated contracts:	i include amount entered	1 111 11110 30(2)	.)	., 36		
		Total premiums or subscription charges paid to ca	arrier			. 10a	1352	<u></u>
		If the carrier, service, or other organization incurre					1002	50 1
	D	retention of the contract or policy, other than repo				. 10b		
	Spe	ecify nature of costs.	, =	-,			 	_
Pa	art I	IV Provision of Information						
11	Dic	d the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	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

OMB No. 1210-0110

2017

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					111101011	Inspection			
For calendar plan year 20	17 or fiscal plar	n year beginning 01/01/2017		and en	ding 12/3	31/2017			
A Name of plan LOCKHEED MARTIN GR	NCE PLAN FOR RETIRED EMPL	PLOYEES B Three-digit plan number (PN)		N) •	591				
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION D Employer Identification Number (E 52-1893632							EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca		ANY OF AMERICA							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at e			Policy or co	contract year		
(b) LIN	code	identification number	policy or contract y		(f)	From	(g) To		
22-1211670	68241	23747-1	149		01/01/201	7	12/31/2017		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List	in line 3 t	the agents,	brokers, and of	ther persons in		
(a) Total a	amount of comi	missions paid		(b) To	tal amount	of fees paid			
		102					0		
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all pe	ersons).					
	(a) Name a	and address of the agent, broker, o	r other person to whom	commissi	ons or fees	were paid			
MERCER HEALTH & BEN	EFITS LLC		YSPHERE CIRCLE O, IL 60674						
(b) Amount of sales ar	nd base	Fees	and other commissions	paid					
commissions pa		(c) Amount		(d) Purpose					
	0 SU	SUPPLEMENTAL COMMISSIONS 3				3			
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
	(5)								
(b) Amount of sales ar	nd base	Fees	and other commissions	paid					
commissions pa		(c) Amount	(d) Purpose				(e) Organization code		

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4				
		rent value of plan's interest under this contract in separate accounts at year e			5				
		tracts With Allocated Funds:			1 - 1				
·	a	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 corretention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) dother (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma							
-	а	Type of contract: (1) deposit administration (2) immedia							
	u			on gaarantoo					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			. 7b	0			
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(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)						
		•	(-)						
		(6)Total additions			. 7c(6)	0			
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0			
	е	Deductions:							
		(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)						
		\(\frac{1}{2} \)	(- /						
		•							
		(5) Total deductions			. 7e(5)	0			

0

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P	Part III Welfare Benefit Contract Information						
		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 conti	racts are exp	érience-rated as a unit	. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)		-	· · · · · · · · · · · · · · · · · · ·		
	а	Health (other than dental or vision)	b Dental	сГ	Vision		d X Life insurance
			=	<u> </u>	4		
	e	Temporary disability (accident and sickness)	f Long-term disabilit	` <u> </u>	3	oloyment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	erience-rated contracts:	i				
	a I	Premiums: (1) Amount received		9a(1)		62717	<u>r </u>
		(2) Increase (decrease) in amount due but unpaid		9a(2)		6267	,
		(3) Increase (decrease) in unearned premium res	erve	9a(3)		1	
		(4) Earned ((1) + (2) - (3))				9a(4)	68984
	b	Benefit charges (1) Claims paid		9b(1)		55699)
		(2) Increase (decrease) in claim reserves				1656	
		(3) Incurred claims (add (1) and (2))				9b(3)	57355
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	, , , , , , , , , , , , , , , , , , ,				_
		(A) Commissions	ŀ	9c(1)(A)			_
		(B) Administrative service or other fees	ŀ	9c(1)(B)			_
		(C) Other specific acquisition costs	ľ	9c(1)(C)			
		(D) Other expenses	l	9c(1)(D)		3137	
		(E) Taxes				1760	
		(F) Charges for risks or other contingencies (G) Other retention charges				356	<u>)</u>
			•			9c(1)(H)	5253
		(H) Total retention	_				6375
	اء	(2) Dividends or retroactive rate refunds. (These					0370
	d	Status of policyholder reserves at end of year: (1)	•			9d(1)	9200
		(2) Claim reserves				9d(2) 9d(3)	8292
	е	(3) Other reserves				90(3) 9e	
10		onexperience-rated contracts:	nicidae amount entered	1 111 1111e 3C(2)	·)·····	36	
	a	Total premiums or subscription charges paid to ca	arrior			10a	
		, , , , , , , , , , , , , , , , , , , ,				100	
	b	If the carrier, service, or other organization incurre- retention of the contract or policy, other than repo			•	10b	
	Spe	ecify nature of costs.	attod iii i dit i, iiio 2 doov	o, roport arric			
Р	art	IV Provision of Information					
11	Dic	d the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No
		the answer to line 11 is "Yes," specify the information			·· L		<u> </u>
	0						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

•			ERISA section 103(a)(2)		lion	This For	m is Open to Public Inspection
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017						2017	
A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EM			PLOYEES		e-digit n number (PN)	•	591
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION D Employer Identification Number (EIN) 52-1893632							
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		PANY OF AMERICA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			•	ontract year I
(6) LIN	code	identification number	policy or contrac		(f) Fr	om	(g) To
22-1211670	68241	23748-1	103		01/01/2017		12/31/2017
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. L	st in line 3	the agents, bro	kers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
, ,		34		, ,		•	0
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	sions or fees we	ere paid	
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose				(e) Organization code
	34	0	SUPPLEMENTAL COMN	IISSIONS			3
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	sions or fees we	ere paid	
(b) Amount of sales ar	nd hase	Fe Fe	ees and other commission	ns paid			
` ,		(c) Amount		(d) Purpos	е	-	(e) Organization code
	commissions paid (c) Amount (d) Purpose						

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4				
		rent value of plan's interest under this contract in separate accounts at year e			5				
		tracts With Allocated Funds:			1 - 1				
·	a	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 corretention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) definition of the other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma							
-	а	Type of contract: (1) deposit administration (2) immedia							
	u			on gaarantoo					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			. 7b	0			
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(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)						
		•	(-)						
		(6)Total additions			. 7c(6)	0			
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0			
	е	Deductions:							
		(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)						
		\(\frac{1}{2} \)	(- /						
		•							
		(5) Total deductions			. 7e(5)	0			

0

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Р	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual						
		employees, the entire group of such individua					
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
	e	Temporary disability (accident and sickness) f	Long-term disability	, g ¯	Supplemental une	mployment	h Prescription drug
	iΓ	Stop loss (large deductible)	i ☐ HMO contract	k [I Indemnity contract
	m	Other (specify)		<u>L</u>	₫		☐ ,
	L	_ Carlot (specify)					
9	Expe	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)		25040	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			1
		(3) Increase (decrease) in unearned premium reser		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	25040
	b	Benefit charges (1) Claims paid		9b(1)		23800	
		(2) Increase (decrease) in claim reserves		9b(2)		575	
		(3) Incurred claims (add (1) and (2))				9b(3)	24375
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on					_
		(A) Commissions	Telephone	9c(1)(A)			4
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs	<u> </u>	9c(1)(C)			_
		(D) Other expenses	_	9c(1)(D)		494	_
		(E) Taxes	<u> </u>	9c(1)(E) 9c(1)(F)		621	-
		(F) Charges for risks or other contingencies (G) Other retention charges	-	9c(1)(G)		286	-
		(H) Total retention(H)	_			9c(1)(H)	1401
		(2) Dividends or retroactive rate refunds. (These a	_				2598
	٨		<u> </u>				2000
	d	Status of policyholder reserves at end of year: (1) A (2) Claim reserves	·			, , ,	3524
		(3) Other reserves					14361
	е	Dividends or retroactive rate refunds due. (Do not					1100
10		pnexperience-rated contracts:	molado amodrit oritoroa	00(2)	,,,		
		Total premiums or subscription charges paid to car	rier			10a	
	_	If the carrier, service, or other organization incurred					
		retention of the contract or policy, other than report				10b	
	Spe	ecify nature of costs.		•			
P	art I	IV Provision of Information					
11	Did	d the insurance company fail to provide any informat	ion necessary to comple	ete Schedule	e 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

OMB No. 1210-0110

nursuant to EDICA section 102(a)(2)					m is Open to Public Inspection				
For calendar plan year 20	17 or fiscal pla	an year beginning 01/01/2017		and en	ding 12/3	1/2017	•		
A Name of plan LOCKHEED MARTIN GR	OUP INSURA	ANCE PLAN FOR RETIRED EM	PLOYEES		e-digit number (PN	N) •	591		
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION D Employer Identification Number (EIN) 52-1893632							(EIN)		
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
1 Coverage Information:									
(a) Name of insurance ca PRUDENTIAL LIFE INSUR		PANY OF AMERICA							
/L\ FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year		
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To		
22-1211670	68241	23749-1	14		01/01/2017	7	12/31/2017		
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in		
(a) Total a	amount of con	nmissions paid		(b) To	otal amount	of fees paid			
	5 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 whor	n commiss	ions or fees	were paid			
MERCER HEALTH & BEN	EFITS LLC		PAYSPHERE CIRCLE AGO, IL 60674						
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code		
	5	0	SUPPLEMENTAL COMM	ISSIONS			3		
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	ions or fees	were paid			
	(4)	a a.a.a	,, s. s. s. posser to me.						
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid					
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code		

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4				
		rent value of plan's interest under this contract in separate accounts at year e			5				
		tracts With Allocated Funds:			1 - 1				
·	a	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 corretention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) definition of the other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma							
-	а	Type of contract: (1) deposit administration (2) immedia							
	u			on gaarantoo					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			. 7b	0			
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(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)						
		•	(-)						
		(6)Total additions			. 7c(6)	0			
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0			
	е	Deductions:							
		(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)						
		\(\frac{1}{2} \)	(- /						
		•							
		(5) Total deductions			. 7e(5)	0			

0

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P	art	If more t	re Benefit Contract Inform than one contract covers the same mation may be combined for repor- ees, the entire group of such indivice	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a unit	. Where co	ontracts cover individual
8	Ben		ct type (check all applicable boxes			·		·
	а	Health (other	er than dental or vision)	b Dental	с	Vision		d X Life insurance
	е		disability (accident and sickness)	f Long-term disabili	ty g \square	Supplemental unem	olovment	h Prescription drug
	: [_			• • =		pioyment	
	' [arge deductible)	j HMO contract	k _	PPO contract		I Indemnity contract
	m	Other (spec	eify) •					
_								
9	•	rience-rated c			0-(4)			
	a i	` '	Amount received		9a(1)			
			decrease) in amount due but unpai					
			decrease) in unearned premium re				9a(4)	0
	b		es (1) Claims paid				3a(4)	
		_	decrease) in claim reserves		• • •			
			laims (add (1) and (2))				9b(3)	0
			arged				9b(4)	
	С	` '	f premium: (1) Retention charges (
			nissions		9c(1)(A)			
		` '	nistrative service or other fees		- 4.11.			
		(C) Other	specific acquisition costs		9c(1)(C)			
		(D) Other	expenses					
			i					
		(F) Charg	es for risks or other contingencies		9c(1)(F)			
		(G) Other	retention charges		9c(1)(G)			_
		` '	retention		_		9c(1)(H)	0
		(2) Dividends	or retroactive rate refunds. (These	e amounts were paid ir	cash, or	credited.)	9c(2)	
	d	•	cyholder reserves at end of year: (<i>'</i>				
		` '	erves				9d(2)	
		` '	erves				9d(3)	
4.0			retroactive rate refunds due. (Do r	not include amount entered	d in line 9c(2).	.)	9e	
10	_		ated contracts:				100	4220
	a		ns or subscription charges paid to				10a	4339
	b Spe	retention of th	service, or other organization incur ne contract or policy, other than rep costs				. 10b	
P	Spe	V Provi	sion of Information					
						🗆	V	V Na
11			e company fail to provide any inforr		ete Schedule	A?	Yes	X No
12	2 If th	ne answer to li	ne 11 is "Yes," specify the informa	tion 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

nursuant to FDICA coetion 400(a)(0)					Inspection		
For calendar plan year 20	17 or fiscal plan	year beginning 01/01/2017		and en	ding 12/3	1/2017	
A Name of plan LOCKHEED MARTIN GR	OUP INSURAN	NCE PLAN FOR RETIRED EMPL	OYEES		e-digit number (PN	N) •	591
•	C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION D Employer Identification Number (EIN) 52-1893632						EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca PRUDENTIAL LIFE INSUR		ANY OF AMERICA					
/LA FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
22-1211670	68241	43406-2	199)	01/01/2017	7	12/31/2017
2 Insurance fee and come descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr			(b) To	otal amount	of fees paid	
		30					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
		nd address of the agent, broker, o		m commiss	ions or fees	were paid	
MERCER HEALTH & BEN	EFITS LLC		AYSPHERE CIRCLE GO, IL 60674				
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	30	0 SU	IPPLEMENTAL COMN	IISSIONS			3
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code
Fan Damamuanlı Danlıyatla	A a 4 Nla 4 i a a	see the Instructions for Form F	F00			Calaaa	I.I. A (Farm FEOO) 2017

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	art	III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual	group of employees of the ting purposes if such cont	racts are expe	erience-rated as a unit	. Where c	ontracts cover ind	
8	Ben	efit a	nd contract type (check all applicable boxes)	<u> </u>		_		_	
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d Life insura	nce
	е	Te	mporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	ployment	h Prescription	n drug
	i İ	Sto	op loss (large deductible)	j HMO contract	k 🗆	PPO contract		I Indemnity	contract
	m		her (specify) AD&D	<i>,</i> .		I		<u> </u>	
9	Ехр	eriend	ce-rated contracts:						
	а		iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpai	d					
		(3) Ir	ncrease (decrease) in unearned premium res	serve	9a(3)				
		` '	arned ((1) + (2) - (3))				9a(4)		
	b	Ben	efit charges (1) Claims paid		` '				
		` '	ncrease (decrease) in claim reserves						
			ncurred claims (add (1) and (2))				9b(3)		
		` '	Claims charged				9b(4)		
	С		nainder of premium: (1) Retention charges (•	0 (4)(4)				
			(A) Commissions		. , , , ,				
			(B) Administrative service or other fees		0 (4)(0)				
			(C) Other specific acquisition costs						
			(D) Other expenses		0.(4)(5)				
			(E) Taxes(F) Charges for risks or other contingencies.						
			(G) Other retention charges						
			(H) Total retention				9c(1)(H	\	(
			Dividends or retroactive rate refunds. (These	_	_			,	
	٨								
	d		us of policyholder reserves at end of year: (1 Claim reserves	,			9d(1) 9d(2)		
		` '	Other reserves				9d(2)		
	е	` '	dends or retroactive rate refunds due. (Do n						
10			erience-rated contracts:	ot include amount entered	2 111 11110 3C(2).	.)	1 36		
. •	a		al premiums or subscription charges paid to	carrier			10a		15503
	b		e carrier, service, or other organization incur				100		10000
	_	rete	ntion of the contract or policy, other than rep				10b		
		rete ecify r	ntion of the contract or policy, other than rep nature of costs.				. 10b		
	art		Provision of Information						
11	Die	d the	insurance company fail to provide any inforn	nation necessary to compl	ete Schedule	A?	Yes	X No	
12	If t	he ar	nswer 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

2017

This Form is Open to Public Inspection

		parodant to	LINIOA 30011011 103(a)(2)	•			Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/31/201	7	
A Name of plan LOCKHEED MARTIN GR	OUP INSURAN	NCE PLAN FOR RETIRED EMP	PLOYEES		e-digit number (PN)	•	591
C Plan sponsor's name a		e 2a of Form 5500			yer Identification	Number ((EIN)
LOCKHEED MARTIN CO	RPORATION			52-	1893632		
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca SUMMACARE - OH SR HM							
	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	ı	(g) To
34-1726655	95202	HO 1011 MG	10)	01/01/2017		12/31/2017
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, broke	rs, and o	ther persons in
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fee	s paid	
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 whor	m commiss	ions or fees were	paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpos	е		(e) Organization code
	(a) Name a	nd address of the agent, broker	, or other person to whor	m commiss	ions or fees were	paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	9		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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F	art	III Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the ng purposes if such contr	acts are ex	perience-rated as	a unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental	unemplovment	h Prescription drug
	i [j X HMO contract	, S k		,	I Indemnity contract
	m	Other (specify)	, <u></u>				
	!						
9	Fxp	erience-rated contracts:					
Ī		Premiums: (1) Amount received		9a(1)			
	_	(2) Increase (decrease) in amount due but unpaid.	⊢	9a(2)			
		(3) Increase (decrease) in unearned premium rese	T T T T T T T T T T T T T T T T T T T	9a(3)			
		(4) Earned ((1) + (2) - (3))	_			9a(4)	
	b	Benefit charges (1) Claims paid	T T	9b(1)		, , ,	
		(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (on					
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees	T T	9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	T T T T T T T T T T T T T T T T T T T	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)	
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits afte	er retirement		
		(2) Claim reserves	•			` '	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2	2) .)		
10) No	onexperience-rated contracts:		•		•	
	а	Total premiums or subscription charges paid to ca	rrier			10a	4368
	b	If the carrier, service, or other organization incurre	d any specific costs in co	onnection w	vith the acquisition	or or	
		retention of the contract or policy, other than report					
		ecify nature of costs.					
F	art	IV Provision of Information					_
11	Die	d the insurance company fail to provide any informa	tion necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		parodantio	E1110/4 3cction 103(a)(2)	•			Inspection	
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/31/201	7		
A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EMPLOYEES				e-digit number (PN)	•	591		
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION				•	oyer Identification 1893632	Number ((EIN)	
Dort I Informat	ion Concor	ning Insurance Contrac	t Coverage Foos	and Con	amissions Dro	vida infar	mation for each contract	
		. Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca MONUMENTAL LIFE INSU		PANY						
	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	1	(g) To	
52-0419790	46866	C3802-B	46	;	01/01/2017		12/31/2017	
2 Insurance fee and come descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	st in line 3	the agents, broke	rs, and o	ther persons in	
(a) Total a	amount of com	missions paid		(b) To	otal amount of fee	s paid		
3 Persons receiving com		ees. (Complete as many entries						
	(a) Name a	nd address of the agent, broker	, or other person to whor	m commiss	ions or fees were	paid		
(b) Amount of sales ar	nd base	Fe	es and other commissior	ns paid				
commissions pai		(c) Amount	((d) Purpose			(e) Organization code	
	(a) Name a	nd address of the agent, broker	, or other person to whor	n commiss	ions or fees were	paid		
(b) Amount of sales ar	nd base	Fe	es and other commissior	ns paid				
commissions pai		(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid			Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end		4	
		rent value of plan's interest under this contract in separate accounts at year e			5	
		tracts With Allocated Funds:			1 - 1	
·	a	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) definition of the other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	Type of contract: (1) deposit administration (2) immedia				
	u			on gaarantoo		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			. 7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(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)			
		•	(-)			
		(6)Total additions			. 7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		. 7d	0
	е	Deductions:				
		(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)			
		\(\frac{1}{2} \)	(- /			
		•				
		(5) Total deductions			. 7e(5)	0

0

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P	Part III Welfare Benefit Contract Information						
		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 conti	racts are exp	perience-rated as a	unit. Where co	intracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-			· · · · · · · · · · · · · · · · · · ·
	а	X Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	I.	Temporary disability (accident and sickness)	f Long-term disabilit	L	Supplemental ur	amplayment	h Prescription drug
	e					iempioyment	
	ן י	Stop loss (large deductible)	j HMO contract	ΚL	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
9		erience-rated contracts:	ľ				_
	а	Premiums: (1) Amount received	İ	9a(1)			_
		(2) Increase (decrease) in amount due but unpaid		9a(2)			_
		(3) Increase (decrease) in unearned premium res		9a(3)		0-(4)	
	h	(4) Earned ((1) + (2) - (3))	ľ			9a(4)	
	b	Benefit charges (1) Claims paid	ľ	9b(1) 9b(2)			-
		(2) Increase (decrease) in claim reserves				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or		•••••		<u>35(4)</u>	
	Ů	(A) Commissions	, i	9c(1)(A)			7
		(B) Administrative service or other fees	ľ	9c(1)(B)			
		(C) Other specific acquisition costs	ŀ	9c(1)(C)			=
		(D) Other expenses	ľ	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)	(
		(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 afte	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in line 9c(2) .)	9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	6554
	b	If the carrier, service, or other organization incurr					
	Sno	retention of the contract or policy, other than repo	rted in Part I, line 2 above	e, report am	ount	<u>10b</u>	
	Spe	ecify nature of costs.					
P	art	IV Provision of Information					
11		d the insurance company fail to provide any inform	ation necessary to compl	ete Schedul	е А?	Yes	X No
		the answer to line 11 is "Yes," specify the informati		cie odneduli	о л:		<u>~</u>
1 4		ne answer to line in is nes, specify the informati	on not provided. 🔻				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

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.

Service Provider Information

OMB No. 1210-0110

2017

This Form is Open to Public Inspection.

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017	and ending 12/31/2017	
A Name of plan	B Three-digit	
LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EMPLOYEES	plan number (PN)	591
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
LOCKHEED MARTIN CORPORATION	52-1893632	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information re or more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received only eligible indirect compensation for which answer line 1 but are not required to include that person when completing the remainder of t	with services rendered to the plan or t the plan received the required disclosi	he person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compensati	on	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of the	is Part because they received only elig	ible
indirect compensation for which the plan received the required disclosures (see instructions	for definitions and conditions)	Yes X No
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see inst		e providers who
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensat	ion
(b) Enter name and EIN or address of person who provided you dis		ian
(b) Enter name and Env or address or person who provided you dis	closures on engible indirect compensat	.1011
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensat	ion
(1.) -		
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensat	ion

Schedule C (Form 5500) 2017	Page 2- 1
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the control of th	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person where	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the control of th	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the control of th	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2017		Page 3 - 1		
2. Inform	nation on Other S	Service Providers e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
	, , , ,	<u> </u>		address (see instructions)		
AETNA HE	EALTH PLANS		` '	· · · · · · · · · · · · · · · · · · ·		
23-244204	8					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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	5089832	Yes No 🗵	Yes No		Yes No
	•	(a) Enter name and EIN or	address (see instructions)		
CIGNA HE	ALTHCARE					
(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	452958	Yes No 🗵	Yes No		Yes No
		((a) Enter name and EIN or	address (see instructions)		
HEALTHW 41-169383		<u> </u>		<u> </u>		
(b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service

include eligible indirect

compensation, for which the plan received the required

disclosures?

Yes No

compensation received by

service provider excluding

eligible indirect

answered "Yes" to element (f). If none, enter -0-.

compensation for which you estimated amount?

provider give you a

formula instead of

an amount or

Yes No

Code(s)

12

employer, employee

organization, or

person known to be

a party-in-interest

CLAIMS ADMINISTRATOR compensation paid

by the plan. If none,

enter -0-.

433891

receive indirect

compensation? (sources

other than plan or plan

sponsor)

Yes No X

age 3 -	2	
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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).						
		(a) Enter name and EIN or	address (see instructions)		
	CIGNA INTERNATIONAL 51 0111677					
51-011167	7					
(b) Service Code(s)	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?
2	CLAIMS ADMINISTRATOR	48426	Yes No 🛚	Yes 🗌 No 🗍		Yes No
	·	(3	a) Enter name and EIN or	address (see instructions)		·
(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?
			Yes No No	Yes No		Yes No
		(3	a) Enter name and EIN or	address (see instructions)		
(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?
			Yes No	Yes 📗 No 🗍		Yes No

Page	4	-	I
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Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment ma questions for (a) each source from whom the service provider received \$1,000 or more in ind provider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	nagement, broker, or recordkeepinç lirect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	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 the 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 the indirect compensation.

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D(II O 1 D	wt II Coming Dravidore Who Fail at Defuge to Dravido Information							
this Schedule.	vide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete Schedule.							
(a) Enter name and E	IN 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 E	IN 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 E	IN 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 E	IN 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 E	IN 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 E	IN 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					

Schedule C (Form 5500) 2017

Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)						
	(complete as many entries as needed)	L =					
a	Name:	b EIN:					
C	Position:						
d	Address:	e Telephone:					
Fx	planation:						
	prantation.						
а	Name:	b EIN:					
c	Position:	EIII.					
d	Address:	e Telephone:					
-							
Ex	planation:						
а	Name:	b EIN:					
С	Position:						
d	Address:	e Telephone:					
	planation:						
LX	pianation.						
а	Name:	b EIN:					
C	Position:	D LIIV.					
d	Address:	e Telephone:					
Ex	planation:						
a	Name:	b EIN:					
C	Position:						
d	Address:	e Telephone:					
	planation						
ĽΧ	planation:						

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

2017

This Form is Open to Public Inspection.

	1			
For calendar plan year 2017 or fiscal p	olan year beginning	01/01/2017	and ending 12	/31/2017
A Name of plan			B Three-dig	it
LOCKHEED MARTIN GROUP INSUR	ANCE PLAN FOR RE	TIRED EMPLOYEES	plan nun	nber (PN) 591
				·
			_	
C Plan or DFE sponsor's name as sho		n 5500		Identification Number (EIN)
LOCKHEED MARTIN CORPORATION	١		52-1893	632
		Ts, PSAs, and 103-12 IEs (to I		plans and DFEs)
		to report all interests in DFEs	<u> </u>	
a Name of MTIA, CCT, PSA, or 103-				
b Name of sponsor of entity listed in	(a): LOCKHEED I	MARTIN CORPORATION		
C EIN-PN 52-1610424-003	d Entity M	e Dollar value of interest in MTIA, 0	CCT, PSA, or	33835019
5 EINTIN 32-1010424-003	code	103-12 IE at end of year (see ins	tructions)	33033019
a Name of MTIA, CCT, PSA, or 103-	12 IE: LMC BENEFI	T TRUST FOR BARG EMP		
		MARTIN CORPORATION		
b Name of sponsor of entity listed in	(a):	WARTIN CORFORATION		
	d Entity M	e Dollar value of interest in MTIA, 0	CCT, PSA, or	745507400
C EIN-PN 13-3507980-004	code	103-12 IE at end of year (see ins		715537182
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
C EIN-PN	d Entity	e Dollar value of interest in MTIA, 0	CCT, PSA, or	
C EIN-FIN	code	103-12 IE at end of year (see ins	tructions)	
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
	d Entity	e Dollar value of interest in MTIA, 0	CCT PSA or	
C EIN-PN	code	103-12 IE at end of year (see ins		
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
a Name of With, CCT, 1 SA, of 103-	12 1L.			
b Name of sponsor of entity listed in	(a):			
	d Carr	• Della unite of interest in MTIA	NOT DOA	
C EIN-PN	d Entity code	e Dollar value of interest in MTIA, 0 103-12 IE at end of year (see ins		
		1 100 12 12 at 6.14 or year (600 min		
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
C EINI DNI	d Entity	e Dollar value of interest in MTIA, 0	CCT, PSA, or	
C EIN-PN	code	103-12 IE at end of year (see ins	· ·	
a Name of MTIA, CCT, PSA, or 103-	12 IE:			
b Name of sponsor of entity listed in	(a):			
	d Entity	e Dollar value of interest in MTIA, 0	CCT, PSA, or	
C EIN-PN	code	103-12 IE at end of year (see ins	· ·	

Page	2	-
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Schedule D (Form 5500) 2017

a Name of MTIA, CCT, PSA, or 103-12 IE:						
b Name of sponsor of entity listed in (a):						
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d 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-	12 IE:					
b Name of sponsor of entity listed in	(a):					
C EIN-PN	d Entity code	Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)				

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		
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
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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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.

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017	and e	ending 12/31/2017			
A Name of plan LOCKHEED MARTIN GROUP INSURANCE PLAN FOR RETIRED EMPLOYEES		B Three-digit plan number (PN) >	591	
			_		
C Plan sponsor's name as shown on line 2a of Form 5500 LOCKHEED MARTIN CORPORATION			D Employer Identifica 52-1893632	ation Number (E	EIN)
Part I Asset and Liability Statement					
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 n lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance benefit at a future date. Round off amounts to the nearest dollar. MTIAs, C and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. Se	nore than one se contract wh CTs, PSAs, a	plan on a nich guaran nd 103-12	line-by-line basis unless tees, during this plan ye	the value is repart, to pay a spe	oortable on ecific dollar
Assets		(a) B	eginning of Year	(b) End	of Year
a Total noninterest-bearing cash	1a				
b Receivables (less allowance for doubtful accounts):					
(1) Employer contributions	1b(1)				
(2) Participant contributions	1b(2)		94582		105663
(3) Other	1b(3)		1467250		968087
c 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)				
(6) Real estate (other than employer real property)	1c(6)				
(7) Loans (other than to participants)	1c(7)				
(8) Participant loans	1c(8)				

1c(9)

1c(10)

1c(11)

1c(12)

1c(13)

1c(14)

1c(15)

(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

(15) Other.....

contracts).....

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

749372201

0

726873848

1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	729578259	750445951
	Liabilities			
g	Benefit claims payable	1g	5299239	4763529
	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k	5299239	4763529
	Net Assets			
ı	Net assets (subtract line 1k from line 1f)	11	724279020	745682422

Part II Income and Expense Statement

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)	6753378	
	(B) Participants	2a(1)(B)	14564475	
	(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)		21317853
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)		
	(F) 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) Amo	ount			(b) To	otal
	(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)							86941238
	(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)	2h/10\							
С	Other income	2c							
d	Total income. Add all income amounts in column (b) and enter total	2d							108259091
	Expenses								
е	Benefit payment and payments to provide benefits:								
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)			6715	1329			
	(2) To insurance carriers for the provision of benefits	2e(2)			1483	0957			
	(3) Other	0 (0)							
	(4) Total benefit payments. Add lines 2e(1) through (3)	2 (4)							81982286
f	Corrective distributions (see instructions)								01002200
g									
	Interest expense	-							
ï	Administrative expenses: (1) Professional fees								
•	(2) Contract administrator fees	-1/2			206	3888	_		
		0:(0)			200	3000	_		
	(3) Investment advisory and management fees	2:/4\			000	0545			
	(4) Other	0:(5)			200	9515			1070 100
	(5) Total administrative expenses. Add lines 2i(1) through (4)	-							4873403
J	Total expenses. Add all expense amounts in column (b) and enter total Net Income and Reconciliation	2j							86855689
l,		2k							04.400.400
K	Net income (loss). Subtract line 2j from line 2d	21							21403402
•	Transfers of assets:	21(1)							
	(1) To this plan								
	(2) From this plan								
Pa	art III Accountant's Opinion								
	Complete lines 3a through 3c if the opinion of an independent qualified public attached.	c accountant	is attached to	o this F	Form 5	500. Co	mplete line	3d if ar	opinion is not
а	The attached opinion of an independent qualified public accountant for this p	lan is (see in:	structions):						
	(1) Unqualified (2) Qualified (3) Disclaimer (4	Adverse							
b	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.1	03-8 and/or 1	03-12(d)?				X Yes	3	No
	Enter the name and EIN of the accountant (or accounting firm) below:						<u> </u>		
	(1) Name:MITCHELL & TITUS, LLP		(2) EIN	: 13-27	781641				
d	The opinion of an independent qualified public accountant is not attached be (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached	ecause: ached to the	next Form 55	500 pu	rsuant	to 29 C	FR 2520.10	4-50.	
Da				-					
<u>Ра</u> 4	art IV Compliance Questions CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do	not complet	a lines 4a 44	α Λf Λ	a 4h	1k 1m	An or 5		
•	103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not comple		e III 165 4a, 46	e, 41, 4 <u>.</u>			411, 01 5.		
During the plan year: Yes No Amount							unt		
Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until									
	fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction	•		4a		X			
b	Were any loans by the plan or fixed income obligations due the plan in defa	ault as of the							
	close of the plan year or classified during the year as uncollectible? Disreg secured by participant's account balance. (Attach Schedule G (Form 5500	gard participa							
	checked.)			4b		X			

Page 4-	Page	4-
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Schedule H (Form 5500) 2017

			Yes	No		Amou	unt	
С	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.)	4c		X				_
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							
	checked.)	4d		Х				
е	Was this plan covered by a fidelity bond?	40	Х				00000000	
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by	4e	^				0000000	
•	fraud or dishonesty?	4f		Х				
g	Did the plan hold any assets whose current value was neither readily determinable on an							
3	established market nor set by an independent third party appraiser?	4g		X				
h	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?	4h		Х				
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and	411						
•	see instructions for format requirements.)	4i		Х				
j	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		X				
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another							
_	plan, or brought under the control of the PBGC?	4k		X				
ı	Has the plan failed to provide any benefit when due under the plan?	41		X	_			
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR							
_	2520.101-3.)	4m						
n	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.	4n						
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?	·	No					
-	If "Yes," enter the amount of any plan assets that reverted to the employer this year							
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide transferred. (See instructions.)	ntify tl	he plan	(s) to v	vhich	assets or liabil	ities were	
	5b(1) Name of plan(s)				5b	(2) EIN(s)	5b(3) PN(s	s)
	f the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section		21.)?	🗍 `	⁄es	No N	lot determine	d
ı	f "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan y	/ear_				(See	e instructions	.)

Lockheed Martin Corporation Group Insurance Plan for Retired Employees

Financial Statements as of December 31, 2017 and 2016, and for the Year Ended December 31, 2017, with Independent Auditor's Report

Lockheed Martin Corporation Group Insurance Plan for Retired Employees

Financial Statements

Year Ended December 31, 2017

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INDEPENDENT AUDITOR'S REPORT

Plan Administrator Lockheed Martin Corporation Group Insurance Plan for Retired Employees

Report on the Financial Statement

We were engaged to audit the accompanying financial statements of Lockheed Martin Corporation Group Insurance Plan for Retired Employees, which comprise the statements of net assets available for benefits as of December 31, 2017 and 2016, and the related statement of changes in net assets available for benefits for the year ended December 31, 2017, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements 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 financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements 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 statements. 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, 2017 and 2016 and for the year ended December 31, 2017, that the information provided to the plan administrator by the trustee is complete and accurate.

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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. Accordingly, we do not express an opinion on these financial statements.

Report on Form and Content in Compliance with DOL Rules and Regulations

Mitchell: Titus, LLP

The form and content of the information included in the financial statements, other than that derived from the information certified by the trustee (or custodian), 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 Employee Retirement Income Security Act of 1974.

October 9, 2018

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

	Decembe	er 31,
	2017	2016
Assets Investments:		
Interest in Lockheed Martin Corporation Benefit Trust Interest in Lockheed Martin Corporation Benefit Trust for Collectively	\$ 33,835	\$ 40,372
Bargained Employees	715,537	686,502
Total investments	749,372	726,874
Program 401(h) account	437,077	418,331
Net assets held in Lockheed Martin Corporation Salaried Savings Plan 401(h) account	24	5,349
Retiree contributions receivable	106	94
Income tax receivable	968	1,467
Total receivables	1,074	1,561
Deferred tax assets	<u> </u>	1,143
Total assets	1,187,547	1,153,258
Liabilities		
Payable to Lockheed Martin Corporation	4,763	5,299
Net assets available for benefits	\$ 1,182,784	\$ 1,147,959

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 December 31, 2017
Net assets available for benefits at beginning of year	\$ 1,147,959
Additions to net assets: Contributions:	
Employer	6,753
Retiree	14,565
Total contributions	21,318
Net increase in Lockheed Martin Corporation Salaried Employee Retirement Program 401(h)	
account	18,747
Interest in net investment gain of the Trusts	86,941
Total additions	127,006
Deductions from net assets:	
Net decrease in Lockheed Martin Corporation Salaried Savings Plan 401(h) account	5,325
Claims payments	67,151
Insurance premiums	17,695
Administrative expenses	867
Tax expenses	1,143
Total deductions	92,181
Change in net assets	34,825
Net assets available for benefits at end of year	\$ 1,182,784

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 is a defined benefit health and welfare plan covering certain retirees of Lockheed Martin Corporation (the Corporation), and has been amended from time to time. The Corporation is the Plan Sponsor and the Plan Administrator.

The assets of the Plan, excluding the "Retiree contributions receivable," "Income tax receivable," and "Deferred tax assets," 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 two 401(h) accounts. The assets of the Trust, the Collectively Bargained Trust, and the 401(h) accounts are held by The Northern Trust Company (the Trustee).

Funding Policy

The Corporation's cash contributions are determined on an accrual basis in accordance with the requirements under Section 419 of the Internal Revenue Code (IRC) and also satisfy the funding requirements for U.S. Government Cost Accounting Standards (CAS) reimbursements. The cost of the postretirement benefit obligation is shared by the Corporation and retirees. The 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 supplemented by Medicare and they generally contribute amounts in excess of a monthly cap. In some cases, represented retirees contribute a nominal amount.

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.

401(h) account

Separate accounts have been established and maintained in the Lockheed Martin Corporation Salaried Employee Retirement Plan (LMRP) and the Lockheed Martin Corporation Salaried Savings Plan (SSP) for the net assets related to the medical benefit component 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.

The LMRP and the SSP each have an IRS determination letter stating that the plan is designed in accordance with applicable sections of the Internal Revenue Code (IRC) and, therefore, the related trust is 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 plans are in compliance with the applicable provisions of the IRC and, therefore, believe the plans, as amended, are qualified and the related trusts are tax exempt.

Contributions

The Corporation makes actuarially determined contributions to the 401(h) accounts that are used to fund the Corporation's portion of postretirement medical benefits incurred for certain salaried retirees. The Corporation makes contributions to the Trust and the Collectively Bargained Trust (the Trusts) for any contributions in excess of amounts allowed to the 401(h) accounts.

Payment of Claims and Premiums

The Plan provides medical (including prescription drug), dental, and life insurance benefits. The Plan provides continuation of certain benefits upon retirement from the Corporation.

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 and participants is retained by the Plan.

2. Summary of Significant Accounting Policies

Basis of Accounting

The financial statements of the Plan are prepared on the accrual basis of accounting. Certain amounts in the prior year have been reclassified to conform to the current year presentation.

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.

Postretirement Benefit Obligations

Postretirement benefit obligations represent the actuarial present value of those estimated future benefits credits to be paid out 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.

Payment of Claims and Premiums

Premiums paid by either the Corporation or the Trusts are recorded as premium payments 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 Statement of Net Assets Available for Benefits.

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 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' gains and losses on investments bought and sold as well as held during the year are included in interest in net investment gain of the Trusts on the Statement of Changes in Net Assets Available for Benefits. The net assets of the 401(h) accounts' gains and losses on investments bought and sold as well as held during the year are included in the net increase or decrease in the 401(h) accounts.

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.

Recent Accounting Pronouncements

In February 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) 2017-06, which clarifies the presentation and disclosure requirements for an employee benefit plan's interest in a master trust. The new standard requires a plan's interests in master trust balances and activities to be presented on the face of the Plan's financial statements as a single line item for each interest in a master trust. The new standard also requires the disclosure of the master trust's investments by general type and the dollar amount of the plan's interest in each type; and the disclosure of the master trust's other assets and liabilities on a gross basis and the dollar amount of the plan's interest in each balance. An adoption of the new standard will eliminate the requirement to disclose the Plan's overall percentage interest in the trust and the health and welfare plans' requirement to disclose 401(h) investment account information, in which such information will be disclosed in the defined benefit plan. The standard is effective for the Plan beginning on January 1, 2019, with early adoption permitted. The Plan's management is currently evaluating the impact of the standard on the financial statements and related disclosures.

In August 2018, the FASB issued ASU 2018-13, Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement, which amends ASC 820, Fair Value Measurement. This ASU modifies the disclosure requirements for fair value measurements by removing, modifying, or adding certain disclosures. The effective date is January 1, 2020, with early adoption permitted for the removed and modified disclosures and delayed adoption until the effective date for the new disclosures. The removed and modified disclosures will be adopted on a retrospective basis and the new disclosures will be adopted on a prospective basis. The adoption will not have a material effect on the Plan's financial statements.

Subsequent Events

The Plan has evaluated subsequent events through October 9, 2018, the date the financial statements were available to be issued. No material subsequent events have occurred since December 31, 2017 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 2017 assumed health care cost trend rate for the December 31, 2017 postretirement benefit obligation is 8.50%, trending down to 5.00% by 2032, and the 2017 health care cost trend rate for the December 31, 2016 postretirement benefit obligation was 8.75%, trending down to 5.00% by 2032. The assumptions include the impact of Medicare cost-sharing provisions.

Other significant assumptions used in the valuations are as follows:

	Decem	ber 31,
	2017	2016
Weighted average discount rate	3.625%	4.00%
Average retirement age	63	63
Turnover	Based on termination experience of	Based on termination experience of
	the Plan	the Plan
Mortality	RP-2014 Total Dataset Adjusted to 2006 with Scale MP-2017	RP-2014 Total Dataset Adjusted to 2006 with Scale MP-2016

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,			
	 2017		2016	
Active employees, fully eligible for benefits	\$ 218,338	\$	245,844	
Active employees, not yet fully eligible for benefits	153,109		137,990	
Retirees	 1,268,748		1,340,894	
Postretirement benefit obligation	\$ 1,640,195	\$	1,724,728	

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

	Year Ended December 31, 2017
Balance at beginning of year	\$ 1,724,728
Increase (decrease) in postretirement benefits attributable to:	
Increase for interest due to the decrease in the discount period	66,325
Benefits paid	(189,292)
Plan amendment	49
Benefits earned and other changes	(7,550)
Changes in actuarial assumptions	45,935
Net decrease	(84,533)
Total postretirement benefit obligations at end of year	\$ 1,640,195

The changes in actuarial assumptions in the table above reflect the decrease in the discount rate and updated mortality table that impacted the postretirement benefit obligation by \$62,353,000 and (\$16,418,000), respectively. A 1% increase in the assumed health care cost trend rates would increase the postretirement benefit obligation by approximately 5.0% and 5.5% at December 31, 2017 and 2016, respectively. The claims incurred but not reported (IBNR) by retirees at December 31, 2017 and 2016, were \$14,427,000 and \$14,029,000, 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 Trust, 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, 2017 and 2016 and the changes in the postretirement benefit obligation for the year ended December 31, 2017 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, 2017 and 2016, 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 Trusts and 401(h) accounts

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, and investment income of the Trusts are allocated among the participating plans included therein proportionally based on each plan's interest in the Trusts' net assets. The Plan's interest in the Trust's net assets as of December 31, 2017 and 2016 was 99.99% and 99.94%, respectively. The Plan's interest in the Collectively Bargained Trust's net assets as of December 31, 2017 and 2016 was 100% and 99.97%, respectively.

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, 2017 and 2016, and net appreciation in fair value of investments, interest income, and dividend income for the year ended December 31, 2017, 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 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, 2017 (in thousands):

<u>_</u>	Level 1	Level 2	<u>Total</u>
Cash and cash equivalents and short term investment fund	\$ 10,440 —	\$ — 11,859 11,409	\$ 10,440 11,859 11,409
Total investment assets at fair value	\$ 10,440	\$ 23,268	\$ 33,708
Receivables, net			131
Total net assets			\$ 33,839

Interest income and dividend income earned by the Trust for the year ended December 31, 2017 was \$650,000 and \$1,000, respectively. The net appreciation for the year ended December 31, 2017 was \$1,664,000.

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, 2016 (in thousands):

_	Level 1	Level 2	Total
Cash and cash equivalents and short term investment fund	\$ 17,28 	9 \$ — - 11,933 - 11,046	\$ 17,289 11,933 11,046
Total investment assets at fair value	\$ 17,28	9 \$ 22,979	\$ 40,268
Receivables, net			129
Total net assets			\$ 40,397

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, 2017 (in thousands):

_	Level 1	Level 2	Total
Cash and cash equivalents and short term investment fund	\$ 18,133	\$ —	\$ 18,133
Common and preferred stock	68,246	_	68,246
Corporate debt securities		83,805	83,805
Common collective trusts (a)		38,391	38,391
Registered investment companies	237,542	_	237,542
US Government securities		541	541
Other investments		267,510	267,510
Total investment assets at fair value	\$ 323,921	\$ 390,247	\$ 714,168
Receivables, net			1,370
Total net assets			\$ 715,538

Interest and dividend income earned by the Collectively Bargained Trust for the year ended December 31, 2017 was \$7,886,000 and \$7,015,000, respectively. Other income was \$535,000 for the year ended December 31, 2017. The net appreciation for the year ended December 31, 2017 was \$69,202,000.

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, 2016 (in thousands):

	Level 1	Level 2	Total
Cash and cash equivalents and short term investment fund	\$ 188,665	\$ —	\$ 188,665
Common and preferred stock	212,332		212,332
Corporate debt securities		58,748	58,748
Common collective trusts (a)		37,169	37,169
Registered investment companies (b)	80,451	_	80,451
Other investments		108,085	108,085
Total investment assets at fair value	\$ 481,448	\$ 204,002	\$ 685,450
Receivables, net			1,285
Total net assets			\$ 686,735

SSP 401(h) account

The following table presents the fair value of the assets in the SSP 401(h) account by asset category and their level within the fair value hierarchy as of December 31, 2017 (in thousands):

	L	evel 1	Total	
Cash and cash equivalents and short term investment fund	\$	19 4	\$	19 4
Total investment assets at fair value	\$	23	\$	23
Receivables, net				11
Total net assets		-	\$	34

Interest and dividend income earned by the SSP 401(h) account for the year ended December 31, 2017 was \$6,000. The net appreciation for the year ended December 31, 2017 was \$128,000. Other income for the year ended December 31, 2017 was \$7,000. Health and Welfare benefits payments to retirees and administrative expenses for the year ended December 31, 2017 were \$7,590,000 and \$20,000, respectively.

The following table presents the fair value of the assets in the 401(h) account by asset category and their level within the fair value hierarchy as of December 31, 2016 (in thousands):

<u>-</u>	Level 1	Level 2	Total
Cash and cash equivalents and short term investment fund	\$ 1,236 4 4,313	\$ <u>—</u> 1,884 <u>—</u>	\$ 1,236 4 1,884 4,313
Total investment assets at fair value	\$ 5,553	\$ 1,884	\$ 7,437
Receivables, net			66
Total net assets			\$ 7,503

LMRP 401(h) account

The following table presents the fair value of the assets in the LMRP 401(h) account by asset category and their level within the fair value hierarchy as of December 31, 2017 (in thousands):

_	Level 1	Level 2	Level 3	Total
Cash and cash equivalents and short term investment fund	\$ 47,541	\$ —	\$ —	\$ 47,541
Common and preferred stocks	337,507 42,436	837	88 —	338,432 42,436
Common collective trusts	_	100,783		100,783
Corporate debt securities U.S. Government securities (c)	_	166,466	163	166,629
Other investments (d)	432	152,521 58,742	171	152,521 59,345
Commodities	43	30		73
Total investment assets at fair value	\$ 427,959	\$ 479,379	\$ 422	\$ 907,760
Investments measured at NAV (e):				
Common collective trusts				1,840
Registered investment companies				1,867
Other investments ^(d)				2,275
Private equity funds Real estate funds				143,341
Hedge funds				51,821 23,797
Total investment assets at NAV			_	\$ 224,941
Receivables, net			_	2,081
Total net assets			=	\$ 1,134,782

Interest and dividend income earned by the LMRP 401(h) account for the year ended December 31, 2017 was \$8,986,000 and \$9,930,000, respectively. The net appreciation for the year ended December 31, 2017 was \$108,400,000. Other income for the year ended December 31, 2017 was \$12,214,000.

The following table presents the fair value of the assets in the LMRP 401(h) account by asset category and their level within the fair value hierarchy as of December 31, 2016 (in thousands):

	Level 1	Level 2	Level 3	ŗ	<u> Fotal</u>
Cash and cash equivalents and short term	\$ 71,828	\$ —	\$ —	\$	71 020
investment fund Common and preferred stocks	253,579	₃ — 1,796	ه — 159	Ф	71,828 255,534
Registered investment companies (f)	22,432	1,/90	139		233,334
•	22,432	17 656			
Common collective trusts	_	47,656	406		47,656
Corporate debt securities	_	150,674	496		151,170
U.S. Government securities (c)	_	250,346			250,346
Other investments (d)	914	53,973	121		55,008
Hedge funds	_	3,575	_		3,575
Commodities	17,074	(68)			17,006
Total investment assets at fair value	\$ 365,827	\$ 507,952	\$ 776	\$	874,555
Investments measured at NAV (e):					
Common collective trusts					1,485
Registered investment companies					15,353
Private equity funds					117,850
Real estate funds					45,564
Hedge funds					815
Total investment assets at NAV				\$	181,067
Receivables, net					1,874
Total net assets			<u>-</u>	\$	1,057,496

The following table presents the changes in the fair value of the LMRP 401(h) account Level 3 assets for the year ended December 31, 2017 (in thousands):

	Bala begin	ning	Reali gai (loss	ns/	Unrealiz gains/ (losses	/	Purcha	ises	Sa	les	Settle	nents	Transfe into Level		Transfer out of Level		Balance, end of year
Common and preferred stocks	\$	159	\$	6	\$	22	\$	17	\$	(108)	\$	(8)	\$	_	\$	_	\$ 88
securities Other investments		496		(17)		(6)		_		(84)		(241)		15		_	163
(d)		121		(19)		23		169		(126)		3		_		_	171
Total	\$	776	\$	(30)	\$	39	\$	186	\$	(318)	\$	(246)	\$	15	\$	<u> </u>	\$ 422

⁽a) Common collective trusts, have been measured at fair value using the net asset value per share (or its equivalent) and not as a practical expedient which accordingly is classified in the fair value hierarchy.

- (b) The Corporation reclassified \$108,136,000 of registered investment companies to other investments for 2016 based on the valuation techniques used to value the assets. This 2016 reclassification was due to management's re-evaluation of the nature of the investments and does not impact the 2016 financial statements or the total plan assets previously reported rather just the presentation of the components of total Collectively Bargained Trust assets.
- (c) Includes U.S. Government-sponsored enterprise securities.
- (d) Includes collateralized mortgage obligations, municipals, asset-backed securities, inflation index linked bonds, foreign government securities, swaps, warrants, group annuity contracts, repurchase agreements, depository receipts, and venture capital.
- (e) Certain investments that are valued using the net asset value per share (or its equivalent) as a practical expedient have not been classified in the fair value hierarchy and are included in the table to permit reconciliation of the fair value hierarchy to the aggregate postretirement benefit plan assets.
- The Corporation reclassified \$11,541,000 of registered investment companies to other investments for 2016 based on the valuation techniques used to value the assets. This 2016 reclassification was due to management's re-evaluation of the nature of the investments and does not impact the 2016 financial statements or the total plan assets previously reported rather just the presentation of the components of total LMRP 401(h) account assets in the table above.

The Trusts and the 401(h) accounts recognize transfers between levels of the fair value hierarchy as of the date of the change in circumstances that causes the transfer.

Valuation Techniques

Cash and cash equivalents and short term investment fund (STIF) 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. For common and preferred stock securities not traded on an active exchange, or if the closing price is not available, the Trustee obtains indicative quotes from a pricing vendor, broker, or investment manager. These securities are generally categorized as Level 2 if the custodian obtains corroborated quotes from a pricing vendor or generally categorized as Level 3 if the custodian obtains uncorroborated quotes from a broker or investment manager.

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), or not categorized in a level of fair value hierarchy (excluded from the fair value table) where certain liquidity provisions apply and the NAV is deemed a practical expedient with regards to valuation. Funds may be redeemed daily, monthly, or annually, depending upon notification requirements, liquidity, and other matters. Certain funds may require notification of management's intent to redeem at least one to 90 days in advance of exercising management's redemption right.

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. For those securities not categorized in within a level of fair value hierarchy, the Corporation cannot fully redeem the investment in the near-term and NAV as a practical expedient is deemed to apply to those assets.

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. Corporate debt instruments are categorized at Level 3 when valuations using observable inputs are unavailable. The Trustee obtains pricing based on indicative quotes or bid evaluations from vendors, brokers, or the investment manager.

Other investments consists of securities such as derivatives and fixed income securities not classified as corporate debt instruments or U.S. Government securities. Level 1 securities are comprised of derivative securities traded on national and international exchanges. Level 2 securities are mainly comprised of over-the-counter (OTC) 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. Other investments are categorized at Level 3 when valuations using observable inputs are unavailable. The Trustee obtains pricing based on bid evaluations from vendors or the investment manager. For those securities not categorized within a level of fair value hierarchy, the Corporation cannot fully redeem the investment in the near-term and NAV as a practical expedient is deemed to apply to those assets.

Commodities categorized as Level 1 are traded on an active commodity exchange and are valued at their closing prices on the last trading day of the year. Commodities categorized as Level 2 represent over the counter derivative instruments using observable inputs other than quoted prices in active markets.

Private equity funds, real estate funds, and hedge funds are valued using the NAV based on the valuation models of underlying securities which generally include significant unobservable inputs that cannot be corroborated using verifiable observable market data. Valuations for private equity funds and real estate funds are determined by the general partners. Depending on the nature of the assets, the general partners may use various valuation methodologies, including the income and market approaches in their models. The market approach consists of analyzing market transactions for comparable assets while the income approach uses earnings or the net present value of estimated future cash flows adjusted for liquidity and other risk factors. Hedge funds are valued by independent administrators using various pricing sources and models based on the nature of the securities. Private equity funds, real estate funds, and hedge funds are generally not categorized in a level of fair value hierarchy as the Corporation cannot fully redeem the investment in the near-term and NAV as a practical expedient is deemed to apply to those assets. Hedge funds categorized as Level 2 contain liquidity provisions which allow proceeds from redemptions / liquidations in the near term.

Private equity funds consist of investments held primarily by limited partnerships in various strategies, including venture capital, corporate finance, opportunistic, and distressed. The term of each private equity fund is generally 10 years, and the private equity fund's investors do not have the right to redeem their investment at its NAV. Instead, the investors receive distributions as the underlying assets of the fund are liquidated. Real estate funds consist of investments in U.S. and international commercial real estate held primarily by limited partnerships. The term of each real estate fund is generally 10 years, and the real estate fund's investors do not have the right to redeem their investment at its NAV. Instead, the investors receive distributions as the underlying assets of the fund are liquidated. Unfunded capital commitments related to the LMRP's 401(h) account's investment in private equity and real estate funds as of December 31, 2017 and 2016 totaled \$118,061,000 and \$103,523,000, respectively. Hedge fund investments are made through commingled fund vehicles and depending on the hedge fund, redemptions can be monthly or annually. The redemption notice period, depending on the hedge fund, is typically 45 to 180 days in advance.

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 Taxes

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 at December 31, 2017.

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

	December 31,			
		2017	2	2016
Deferred tax assets:				
Capital loss carryforwards	\$	1,083	\$	1,083
Unrealized gains/losses		50		60
Net operating loss carryforwards		25		19
Full valuation allowance on deferred tax assets		(1,158)		(19)
Total deferred tax assets	\$	_	\$	1,143

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, 2017, 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 believes the Plan is no longer subject to income tax examinations for years prior to 2014.

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,				
		2017		2016		
Net assets available for benefits per the						
financial statements	\$	1,182,784	\$	1,147,959		
Less: Net assets held in LMRP 401(h) account		437,077		418,331		
Less: Net assets held in SSP 401(h) account		24		5,349		
Net assets available for benefits per the Form 5500	\$	745,683	\$	724,279		

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

	Year Ended
	December 31, 2017
Net increase per the financial statements	\$ 34,825
Less: Net increase in LMRP and SSP 401(h) accounts	13,422
Net increase per Form 5500	\$ 21,403

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 Lockheed Martin Corporation Salaried Employee Retirement Program and the assets of the SSP 401(h) account are held by the Lockheed Martin Corporation Salaried Savings Plan.