Summary Plan Description

Lockheed Martin Group Benefits Plan

Supplemental medical – 24-hour accident, critical illness and hospital indemnity insurance for non-represented and certain represented employees of Lockheed Martin Corporation

Effective January 1, 2021

Important

The Lockheed Martin Group Benefits Plan (Group Benefits Plan) includes the benefits explained in this Summary Plan Description (SPD). The benefit plans described in this SPD are based on the official legal documents. If there is any conflict between this SPD and the official plan document(s), the official plan document(s) will govern. For purposes of this SPD, the term "Plan," as the context requires, means the Group Benefits Plan and the benefits explained in this SPD.

Lockheed Martin Corporation (the Company) expects to continue the Plan indefinitely. However, the Company reserves the right to amend, suspend or terminate the Plan, in whole or in part, at any time. Collective bargaining agreements may restrict the Company's right to amend or terminate the benefit plans during the term of the agreements.

The terms of the Plan cannot be modified by written or oral statements to you from human resources (HR) representatives or other personnel. Where conflicts exist, the terms as set forth in the plan documents will govern.

The benefits described in this booklet are provided through contracts (or policies) of insurance. In the event there is a discrepancy between this booklet and the contract or policy of insurance, the contract or policy of insurance will govern, except with respect to eligibility (which shall be governed by this booklet).

About this Booklet

The benefits described in this booklet are available to certain employees of Lockheed Martin Corporation. As applicable, these coverages are part of the official Company Plan: the Lockheed Martin Group Benefits Plan. The Lockheed Martin Group Benefits Plan also covers other employees and benefits as described in other Summary Plan Descriptions.

This booklet includes:

- Information regarding eligibility for coverage, enrolling for coverage, when coverage begins and when evidence of insurability is required.
- Details about each of the Plans and information about filing a claim for benefits, when coverage ends, extending coverage after it ends and portability rights, if applicable.
- Important administrative information about the Plan and your rights under the Employee Retirement Income Security Act (ERISA).
- Definitions for certain terms used in this booklet.

The benefits described in this booklet are effective January 1, 2021 (unless a different effective date applies to specific provisions, as noted).

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Eligibility

Employee Eligibility

You may be eligible to participate in the coverages described in this booklet on your first day of work (or on the first day you become an eligible employee) if you are an employee of the Company at a participating business unit (see Appendix A) and you are:

- A regular full-time or part-time non-represented employee working at least 20 hours per week; or
- An employee represented by one of the bargaining units that have adopted the Plan as listed in Appendix B.

You are not eligible to participate if you are:

- An intern/co-op student;
- A local country national;
- A consultant;
- A leased employee;
- An independent contractor;
- A casual part-time employee;
- Paid by a third-party employer;
- Covered by a collective bargaining agreement that does not provide for participation in the Plan; or
- Otherwise not classified as an employee by the Company on its payroll records.

Dependent Eligibility

Eligible dependents that may be covered are:

- Your spouse*;
- Your same- or opposite-sex domestic partner, if you are not covering a spouse, neither you nor your domestic partner are married to someone else and your domestic partner meets the requirements outlined in the Company's *Domestic Partner Affidavit* and other materials that certify that he or she:
  - Shares financial resources and dependencies with you;
  - Is at least 18 years of age and not related to you by blood; and
  - Has lived with you continuously for at least six months or more in a sole-partner relationship that is intended to be permanent.
- Your children up to age 26 (regardless of student, marital or financial status), if they are:
  - Your natural children;
  - Your legally adopted children;
  - Children placed with you for legal adoption;
  - Your stepchildren (natural or legally adopted children of your legal spouse); or
  - Children (including, but not limited to, grandchildren) for whom you are a court-appointed legal guardian. Acceptable proof of court-appointed legal guardianship will be required before you can enroll such a child for the first time and from time to time on request.
- Your disabled children age 26 or older who are incapable of self-sustaining employment because of an intellectual disability, serious mental illness, physical sickness or injury. Coverage may continue to age 65 as long as your child remains incapacitated and is otherwise eligible for coverage. To extend

this coverage, you must show proof of your child's incapacity within 30 days after regular coverage ends or within 30 days of your child's initial eligibility date, if later. Extended coverage ends when:

- Your child age 26 or older marries;
- Your child age 26 or older becomes capable of self-support;
- Your child fails to report for a scheduled physical exam;
- Proof of incapacity is requested and not presented; or
- Coverage terminates for reasons other than reaching the limiting age.

➢ Your qualified domestic partner's child(ren) are eligible for coverage under the same option you choose, if they are:

- The natural or legally adopted child(ren) of your domestic partner whom you have not legally adopted; and
- Under the age of 26.

NOTE: You may elect to cover the eligible child(ren) for your qualified domestic partner, even if you do not elect coverage for your partner. If you elect to cover eligible child(ren) of your qualified domestic partner, you will need to complete a *Domestic Partner Affidavit*. Coverage for your domestic partner's child(ren) who have been legally adopted by you is accomplished through the standard enrollment process and no Affidavit is required.

* *For purposes of the Plan, the term "spouse" means the person to whom the participant is legally married under applicable state law, regardless of the sex of the person. This means, for example, that if a participant and his/her same-sex partner have a valid state-issued marriage certificate, then the participant's partner qualifies as his or her spouse. For this purpose, "state" includes the District of Columbia, a U.S. territory or a foreign country having the legal authority to sanction marriages.*

Note that the term marriage does not include registered domestic partnerships, civil unions or similar formal relationships recognized under state law that are not denominated as marriage. Persons in these types of unions do not qualify as spouses for purposes of the Plan.

In certain very limited circumstances, the term spouse may include a common law spouse (where common law marriage is recognized by your state of residence and you have met all requirements of a common law marriage). If requested, you must demonstrate to the satisfaction of the Plan Administrator that you meet the requirements of a common law marriage.

Dependent Exclusions

Dependents do not include any individual who is also covered as an employee, former employee or retiree under any other Company-sponsored medical plan or a medical plan where the Company is a participating employer. For example, if you are an LMC employee married to, or in a domestic partnership with, another LMC employee or retiree, you and your spouse or domestic partner cannot be covered as both an employee or retiree and a dependent. One of you may elect to waive coverage and be enrolled under your spouse's or domestic partner's coverage, or you may both elect single coverage. In addition, any dependents can only be covered by one of you.

Proof of Dependent Eligibility

You must provide reasonable proof of dependent status upon request. Failure to provide proof upon request will result in the cancellation of that dependent's coverage. Once coverage has been cancelled, coverage can only be reinstated (if at all) on a prospective basis from the date the required information is received by the Lockheed Martin Employee Service Center (LMESC), and only if reinstatement is

permitted under the terms of the Plan (for example, during Annual Enrollment or where there has been a qualifying event).

You are responsible for maintaining accurate and up-to-date information on the eligibility status of your enrolled dependents. You must notify the LMESC within 30 days of a change in a dependent's status. Intentionally falsifying information is also a violation of Company policy.

Enrolling for Coverage

The enrollment materials you will receive from the Lockheed Martin Employee Service Center (LMESC) include detailed instructions on how to enroll in the Plans and the resources available to you in the event you have questions.

Cost of Coverage

You pay the cost for the coverages available to you under the Plan on a post-tax basis. These costs are subject to annual review and change. See your enrollment materials.

When Coverage Begins

You are eligible for the coverage described in this SPD on your first day of service (or on the first day you meet the eligibility requirements) provided you are actively at work. If you are not actively employed on that date due to temporary layoff, leave of absence or Family and Medical Leave of Absence (or disability, injury or sickness for critical illness coverage), coverage begins on the date you return to active employment. This applies to initial coverage, as well as any increase in coverage that occurs after your initial coverage is effective.

For any change in coverage that is subject to evidence of insurability, the change in coverage is effective on the date the Insurer approves the change. For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date the Insurer receives the request for change.

With respect to critical illness, 24-hour accident and hospital indemnity coverage, any decrease in coverage will take effect on the first day of the calendar month that next follows the date you apply for the decrease, but will not affect a payable claim that occurs prior to the effective date of the decrease.

Subject to all Plan provisions and proper enrollment, the chart below explains when coverage becomes effective.

When You Enroll	Your and Your Dependent's Coverage Becomes Effective*
Within 30 days of your initial eligibility date	The day you enroll
Within 30 days of a qualified status change	The day you enroll
During an Annual Enrollment period	The first day of the following plan year

* *If you do not enroll within 30 days of your eligibility date, you will not be covered and, except as described below, cannot enroll in coverage until the next Annual Enrollment period unless a qualified status change occurs.*

Changing Your Elections during the Plan Year

Birth

A child born to you or your spouse while you have individual and children or family coverage will be eligible for coverage. This coverage begins at the moment of birth of the child and benefits will be the same as provided for any other child insured under this Plan. No additional premium will be required for newborns added if you already have individual and children or family coverage in force at the time the newborn is added.

If you have individual or individual and spouse coverage, newborn children are automatically covered from the moment of birth for a period of 30 days. If you desire uninterrupted coverage for a newborn child, you must notify the LMESC within 30 days of that child's birth. Upon timely and proper notice, your coverage will be changed to include the additional child and you will be notified of the additional premium due. If you do not notify the LMESC within 30 days of the birth of the child, the temporary automatic coverage ends.

Marriage

If you have individual or individual and children coverage, then marry and desire coverage for your spouse, you must notify the LMESC of the marriage within 30 days of the marriage. Upon timely and proper notice, your coverage will be changed to include your spouse and you will be notified of the additional premium due.

Adoption

An adopted child or child pending adoption will be covered as follows, as long as individual and children or family coverage is in force:

- Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 30 days after the date of birth.
- If adoption proceedings have been instituted by you within 30 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
- With respect to critical illness coverage, for children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within one year from the institution of the proceedings, coverage will begin upon temporary custody for one year, unless extended by the order of the court by reasons of the special needs of the child.
- With respect to 24-hour accident and hospital indemnity coverage, coverage will begin from the moment of placement.

Coverage will be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

If you do not already have individual and children or family coverage in force, or do not have coverage in force that covers more than one child, adopted children or children pending adoption are automatically covered as described above for a period of 30 days. If you desire uninterrupted coverage for an adopted child or child pending adoption, you must notify the LMESC within 30 days of the moment of placement. Upon timely and proper notice, your coverage will be changed to include the additional adopted child or child pending adoption and you will be notified of the additional premium due.

No additional premium will be required for an adopted child or foster child added if you already have individual and children or family coverage in force at the time the adopted child or foster child is added.

Critical Illness, Hospital Indemnity and 24-Hour Accident Coverage

You may apply for critical illness, hospital indemnity and 24-hour accident coverage during the annual or initial enrollment period or at any other time, subject to any evidence of insurability requirements. You may increase critical illness, hospital indemnity and 24-hour accident coverage at any time, subject to any evidence of insurability requirements. You may decrease critical Illness, hospital indemnity and 24-hour accident coverage at any time. You may discontinue critical illness, hospital indemnity and 24-hour accident coverage at any time.r

If you wish to make a change during the plan year, you may do so by visiting the Lockheed Martin Employee Service Center Online (LMESC Online) or by calling the LMESC.

Supplemental Medical – 24-Hour Accident Insurance

The following benefits are paid for a loss if, while the coverage is in force, a covered person sustains an injury as a result of an accident. The injury must be diagnosed by a physician and the services described below must be provided or received within 180 days of the covered accident, or unless otherwise stated. Any loss not stated in the "*Summary of Benefits*" table below is not covered. The services must be received in the United States or its territories, except in the case of an emergency.

The "*Summary of Benefits*" table below outlines what the Plan covers.

Summary of Benefits

	Plan Option 1	Plan Option 2
Initial Hospital Confinement Paid for the first time a covered person is confined in a hospital after that person's effective date of coverage. This benefit is payable only once per covered person, per calendar year.	$2,000	$4,000
Daily Hospital Confinement Paid for each day a covered person is confined in a hospital, up to a maximum of 365 days for any one accident, starting with the first full day of confinement. This maximum number of days may be used over a 2-year period following the date of the accident.	$400	$800
Intensive Care Paid for each day a covered person is confined in a hospital intensive care unit, up to 180 days for each period of continuous confinement, starting with the first full day of confinement.	$800	$1,600
Dislocation/Fracture Rider (Closed) **Dislocation/Fracture Rider (Open)** Paid for the amount shown multiplied by the applicable factor in the Schedule of Benefit Factors set forth below. If more than one dislocation or fracture is sustained in any one injury, the total amount that will be paid for the multiple dislocations or fractures will not exceed the scheduled maximum benefit amount. No benefit will be paid for any dislocation or fracture that is not listed in the Schedule of Benefit Factors set forth below.	$6,000 $18,000	$12,000 $36,000
Accident Treatment & Urgent Care Rider		
Ground Ambulance Paid if a covered person requires ground ambulance service for the transfer to or from a hospital. This benefit is payable only once per covered person, per accident.	$400	$800

	Plan Option 1	Plan Option 2
Air Ambulance Paid if a covered person requires air ambulance service for the transfer to or from a hospital. This benefit is payable only once per covered person, per accident.	$1.200	$2,400
Accident Physicians Treatment Paid if a covered person receives treatment by a physician. This benefit is payable only once per covered person, per accident.	$200	$400
X-ray Paid if a covered person receives x-rays. This benefit is payable only once per covered person, per accident.	$400	$800
Urgent Care Paid if a covered person receives services at an urgent care facility. This benefit is payable only once per covered person, per accident.	$200	$400
Emergency Room Services Rider		
Emergency Room Services Paid if a covered person, as a result of an injury, receives emergency room services. This benefit is payable only once per covered person, per accident.	$200	$400
Benefit Enhancement Rider		
Accident Follow-Up Treatment Paid for each day a covered person receives follow-up treatment. The Insurer pays for one follow-up treatment per day for up to a maximum of two treatments per covered person, per accident. Treatments must be administered by a physician in a physician's office or in a hospital on an outpatient basis and must be for injuries sustained in an accident. This benefit is not payable for the same visit for which the Physical, Occupational or Speech Therapy benefit is paid.	$150	$300
Lacerations Paid if a covered person receives treatment for one or more lacerations (cuts). This benefit is payable only once per covered person, per accident.	$150	$300
Burns ➢ < 15% of body ➢ ≥ 15% of body Paid if a covered person receives treatment for one or more burns, other than sun burns. This benefit is payable only once per covered person per accident.	 $300 $1,500	 $600 $3,000

	Plan Option 1	Plan Option 2
Skin Graft (% of Burns Benefit) Paid if a covered person receives a skin graft for a burn for which a benefit is paid under the Burns benefit. This benefit is payable only once per covered person per accident.	50% of burn benefit	50% of burn benefit
Brain Injury Diagnosis Paid upon the first diagnosis of one of the following traumatic brain injuries by a covered person: concussion, cerebral laceration, cerebral contusion or intracranial hemorrhage. The covered traumatic brain injury must be diagnosed by computed tomography (CT) scan, magnetic resonance imaging (MRI), electroencephalogram (EEG), positron emission tomography (PET) scan or x-ray. This benefit is payable only once per covered person, per accident.	$900	$1,800
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) Benefit Paid if a covered person receives a CT scan or MRI. The covered person must be first treated by a physician within 30 days after the accident. This benefit is payable only once per covered person per accident and is limited to once per calendar year.	$300	$600
Paralysis Benefit ➢ Paraplegia ➢ Quadriplegia Paid if a covered person receives a spinal cord injury resulting in the complete and permanent loss of use of two or more limbs as a result of an injury. Paralysis must be confirmed by the attending physician after the accident and have a duration of at least 90 consecutive days. This benefit is payable only once per covered person.	 $22,500 $45,000	 $45,000 $90,000
Coma with Respiratory Assistance Paid if a covered person is in a coma. This benefit is payable only once per covered person, per accident.	$30,000	$60,000
Open Abdominal or Thoracic Surgery Paid if a covered person undergoes open abdominal or thoracic surgery for internal injuries. The surgical procedure must be performed by a physician. This benefit is paid even if no surgical repair is required. This benefit is payable only once per covered person, per accident. If two or more surgical procedures are performed through the same incision or entry point, they are considered one operation.	$3,000	$6,000

	Plan Option 1	Plan Option 2
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery Benefit ➢ With Repair ➢ Without Repair The first amount is paid if a covered person undergoes a surgical procedure to repair an injury to a tendon, ligament, rotator cuff or knee cartilage. The injured site must be torn, ruptured or severed and the surgical procedure must be performed by a physician. This benefit is payable only once per covered person, per accident. If exploratory surgery using arthroscopy is performed and no surgical repair is required, then the second amount will be paid. If two or more surgical procedures are performed through the same incision or entry point, they are considered one operation, and the amount for the procedure with the largest dollar amount benefit will be paid.	 $1,500 $450	 $3,000 $900
Ruptured Disc Surgery Paid if a covered person undergoes a surgical procedure to repair a ruptured disc of the spine. The ruptured disc must be diagnosed and the surgical procedure must be performed by a physician. This benefit is payable only once per covered person, per accident. If two or more surgical procedures are performed through the same incision or entry point, they are considered one operation.	$1,500	$3,000
Eye Surgery Paid for surgery or removal of a foreign object from the eye of a covered person. The procedure must be performed by a physician. An examination with or without anesthesia is not considered surgery. This benefit is payable only once per covered person, per accident.	$300	$600
General Anesthesia Paid if a covered person received general anesthesia administered by a nurse anesthetist or physician for surgery required to treat an injury provided a benefit is paid for the surgery under one of the Surgery benefits in this Plan. This benefit is payable only once per covered person, per accident.	$300	$600
Blood and Plasma Paid if a covered person receives a blood or plasma transfusion. This benefit is payable only once per covered person, per accident.	$900	$1,800

	Plan Option 1	Plan Option 2
Appliance Paid if a covered person receives one of the following medical appliances prescribed by a physician as an aid in personal locomotion or mobility: wheelchair, crutches or walker. This benefit is payable only once per covered person per accident.	$375	$750
Medical Supplies Paid for over-the-counter medical supplies purchased for a covered person. This benefit is payable only once per covered person per accident.	$15	$30
Medicine Paid for prescription or over-the-counter medicine purchased for a covered person This benefit is payable only once per covered person per accident.	$15	$30
Prosthesis ➢ 1 Device ➢ 2+ Devices Paid for a prosthetic arm, leg, hand, foot or eye prescribed by a physician to replace an arm, leg, hand, foot or eye that a covered person loses as a direct result of an accident. This benefit is payable only once per covered person, per accident.	 $1,500 $3,000	 $3,000 $6,000
Physical, Occupational or Speech Therapy Paid per day for physical, occupational or speech therapy treatment received by a covered person when prescribed by a physician for an injury. This includes chiropractic treatment. The Insurer will pay for one physical, occupational or speech therapy treatment per day for up to a maximum of six treatments per covered person, per accident. Physical, occupational or speech therapy must be for injuries sustained in an accident. This benefit is not payable for the same visit for which the Accident Follow-Up Treatment benefit is paid.	$90	$180
Rehabilitation Unit Paid per day if a covered person is confined to a rehabilitation unit as a result of an injury, provided that the covered person has been hospital confined immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days on which the Daily Hospital Confinement benefit in the policy is paid.	$300	$600

	Plan Option 1	Plan Option 2
Non-Local Transportation Paid per trip for non-local treatment of a covered person by a physician when the same or similar treatment cannot be obtained locally. ***Non-local*** means a one-way trip of 50 miles or more from the covered person's home to the nearest treatment facility. This benefit is payable up to three times per covered person, per accident. Transportation by ground or air ambulance is not covered under this benefit.	$750	$1,500
Family Member Lodging Paid per day for the lodging of one adult family member of the covered person's family to be with the covered person when a covered person is confined in a hospital. This benefit is payable for up to 30 days for each accident. This benefit is not payable if the family member lives within 50 miles one-way of the hospital.	$300	$600
Post-Accident Transportation Paid if a covered person is hospital confined for at least three consecutive days due to an injury resulting from an accident which occurs more than 250 miles from his or her place of residence and the covered person is brought home by a common carrier. Travel to the place of residence must take place within 48 hours following discharge from the hospital. This benefit is payable for the injured covered person only, and only if the Daily Hospital Confinement benefit in the policy is paid. This benefit is payable only once per covered person, per calendar year.	$600	$1,200
Broken Tooth Paid if a covered person sustains a broken tooth that is repaired by a dental crown or filling or is extracted. This benefit is payable for one crown, one filling or one extraction per covered person, per accident, regardless of the number of teeth involved. This benefit is only payable for injury to a sound, natural tooth. This benefit is not payable for injury caused by biting or chewing.	$300	$600
Residence/Vehicle Modification Paid if a covered person requires a permanent structural modification to the covered person's primary residence or vehicle. The modification must be certified by a physician as necessary to help enable the covered person to live in his or her primary residence or travel in his or her primary vehicle, due to the injury. The modification must occur within 365 days after the accident. This benefit is payable only once per covered person, per accident.	$1,500	$3,000

	Plan Option 1	Plan Option 2
Pain Management (Epidural Injection) Paid if a covered person receives an epidural injection in the spine to manage pain. This benefit is payable only once per covered person, per accident. An epidural injection must be for injuries sustained in an accident.	$150	$300
Miscellaneous Outpatient Surgery Paid if a covered person undergoes surgery on an outpatient basis. The surgical procedure must be performed by a physician. This benefit is payable only once per covered person, per accident. This benefit is not payable if the Open Abdominal or Thoracic Surgery, Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery, Ruptured Disc Surgery or Eye Surgery benefit is paid.	$300	$600

Dislocation/Fracture Rider Schedule of Benefit Factors

For the Complete Dislocation of:	Factor	For Complete, Simple or Closed Fracture of Bone or Bones of:	Factor
Hip Joint	1.00	Skull (except bones of face or nose)	0.95
Knee Joint (except Patella)	0.40	Hip, Thigh (Femur)	1.00
Bone or Bones of the Foot, other than Toes	0.40	Pelvis (except Coccyx)	1.00
Ankle Joint	0.40	Arm, between Shoulder and Elbow (shaft)	0.55
Wrist Joint	0.35	Shoulder Blade (Scapula)	0.55
Elbow Joint	0.30	Leg (Tibia or Fibula)	0.55
Shoulder Joint	0.20	Ankle	0.40
Bone or Bones of the Hand, other than Fingers	0.15	Knee Cap (Patella)	0.40
Collar Bone	0.15	Collar Bone (Clavicle)	0.40
Two or more Fingers	0.07	Forearm (Radius or Ulna)	0.40
Two or more Toes	0.07	Foot (except Toes)	0.35
One Finger or One Toe	0.03	Hand or Wrist (except Fingers)	0.35
		Lower Jaw (except Alveolar Process)	0.20
		Two or More Ribs, Fingers or Toes	0.15
		Bones of Face or Nose	0.15
		One Rib, Finger or Toe	0.07
		Coccyx	0.07

What is Not Covered

Benefits will not be paid for any loss that is caused by, contributed to by or results from:

- Injury incurred prior to the covered person's effective date of coverage subject to the "*Incontestability*" provision;
- Any act of war whether or not declared, participation in a riot, insurrection or rebellion;
- Suicide, or any attempt at suicide, whether sane or insane;
- Intentionally self-inflicted injury or action;
- Any bacterial infection (except pyogenic food poisoning and infections which shall occur with and through an accidental cut or wound);
- Participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
- Engaging in an illegal occupation or committing or attempting to commit a felony;
- Driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
- Hernia, including complications due to hernia; or
- Any injury sustained or contracted in consequence of the covered person's being intoxicated or under the influence of any narcotic, unless administered and taken as prescribed by a physician.

Any injury incurred while a covered person is an active member of the Military, Naval or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, the Insurer will return the pro-rata portion of the premium paid for any period of such service.

Supplemental Medical – Critical Illness

Subject to the conditions, limitations and exclusions of this coverage, a benefit will be paid when a covered person is diagnosed with a critical illness described in this coverage if the:

- Date of diagnosis for the critical illness is while the covered person is insured under the Plan; and
- Critical illness is not excluded by name or specific description.

A covered person can receive a benefit for each critical illness only once, unless the Second Event Critical Illness Benefit for that critical illness is included in the coverage. A covered person can receive benefits for different critical illnesses described in the Plan if the dates of diagnosis for each critical illness are separated by at least 90 days.

Coverage for a covered person terminates when the covered person is not eligible for any further benefits.

Each critical illness must be diagnosed by a physician in the United States. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

The "*Summary of Benefits*" table below outlines what the Plan covers. Benefits are not paid for any condition or loss not described below. The benefit amounts listed in the table are the amounts payable for covered employees. Covered dependents are eligible for 50% of the employee benefit amount.

Summary of Benefits

Covered Illnesses	Plan Option 1	Plan Option 2
Initial Critical Illness Benefits		
Heart Attack The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be based on both: new electrocardiographic changes; and elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack. Heart attack does not include an established (old) myocardial infarction. The date of diagnosis for Heart Attack is the date of death (infarction) of a portion of the heart muscle. A cardiac arrest is not a heart attack and is not covered by this benefit.	$15,000	$30,000
Sudden Cardiac Arrest Sudden cardiac arrest means the sudden and unexpected loss of normal heart function due to a malfunction in the electrical system of the heart, resulting in serious irregularity (cardiac arrhythmia) and/or cessation (asystole) of a normal heart rhythm.	$3,750	$7,500

Covered Illnesses	Plan Option 1	Plan Option 2
Pulmonary Embolism A blockage in one of the pulmonary arteries in your lungs. In most cases, pulmonary embolism is caused by blood clots that travel to the lungs from deep veins in the legs or, rarely, from veins in other parts of the body (deep vein thrombosis).	$3,750	$7,500
Pulmonary Fibrosis A lung disease that occurs when lung tissue becomes damaged and scarred. This thickened, stiff tissue makes it more difficult for your lungs to work properly. As pulmonary fibrosis worsens, you become progressively shorter of breath.	$3,750	$7,500
Stroke The death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit. Stroke does not include: transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits. The date of diagnosis for Stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.	$15,000	$30,000
Coronary Artery Bypass Surgery The surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required. Coronary artery bypass surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures. The date of diagnosis for Coronary Artery Bypass Surgery is the date the actual coronary artery bypass surgery occurs.	$3,750	$7,500
Major Organ Transplant The surgical transplantation of a heart, lung, liver, pancreas or kidney. The transplanted organ must come from a human donor. The date of diagnosis for Major Organ Transplant is the date the actual surgery occurs for the covered transplant.	$15,000	$30,000

Covered Illnesses	Plan Option 1	Plan Option 2
End Stage Renal Failure The irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis. End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas. The date of diagnosis for End Stage Renal Failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.	$15,000	$30,000

	Plan Option 1	Plan Option 2
Cancer Critical Illness Benefits		
Invasive Cancer A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Invasive Cancer includes Leukemia and Lymphoma. Invasive cancer does not include: carcinoma in situ; or tumors in the presence of any human immuno-deficiency virus; or skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or early prostate (stages A, I or II) cancer.	$15,000	$30,000
Carcinoma in Situ A cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in situ includes: early prostate cancer diagnosed as stages A, I or II or equivalent staging; and melanoma not invading the dermis. Carcinoma in situ does not include: other skin malignancies; or pre-malignant lesions (such as intraepithelial neoplasia); or benign tumors or polyps.	$3,750	$7,500
Skin Cancer - Skin cancer includes basal cell carcinoma and squamous cell carcinoma of the skin. • Positive diagnosis of skin cancer means a diagnosis by a licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on microscopic examination of skin biopsy samples. • The date of diagnosis for skin cancer is the earliest date tissue specimen, culture and/or titer(s) are taken upon which the positive diagnosis of Skin Cancer is based. • Skin cancer does not include: malignant melanoma. It also does not include any conditions which may be considered pre-cancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; non-malignant melanoma; moles; or similar diseases or lesions.	$250 per calendar year	$250 per calendar year

	Plan Option 1	Plan Option 2
Supplemental Critical Illness Benefits		
Benign Brain Tumor A non-cancerous brain tumor: confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption. Benign brain tumor does not include: tumors of the skull; or pituitary adenomas; or germinomas. The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.	$15,000	$30,000
Coma A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness prolonged nature requiring significant medical intervention and life support measures. Coma does not include a medically induced coma. The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.	$15,000	$30,000
Complete Blindness A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with: sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or visual field restriction to 20 degrees or less in both eyes. The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.	$15,000	$30,000
Complete Loss of Hearing The total and irreversible loss of hearing in both ears. Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device. The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.	$15,000	$30,000
Loss of Speech - Complete loss of speech means the total and irreversible loss of the ability to speak or communicate verbally without the assistance of a medical device. The diagnosis of Complete Loss of Speech must be made by a physician. • The date of diagnosis for Complete Loss of Speech is the date a physician makes accurate certification of total and permanent loss of speech.	$15,000	$30,000

	Plan Option 1	Plan Option 2
Paralysis The total and permanent loss of voluntary movement or motor function of two or more limbs. The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.	$15,000	$30,000
Advanced Alzheimer's Disease A progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease that causes the covered person to be incapacitated as defined in the policy and unable to perform at least three of the activities of daily living: bathing, dressing, toileting, bladder and bowel continence, transferring or eating. The date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease. We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.	$15,000	$30,000
Advanced Parkinson's Disease A brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease that causes the covered person to be incapacitated as defined in the policy and unable to perform at least three of the activities of daily living: bathing, dressing, toileting, bladder and bowel continence, transferring or eating. The date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.	$15,000	$30,000
Additional Benefits		
Second Event Initial Critical Illness Benefit This benefit will be paid if the covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the Initial Critical Illness Benefit provision if the second date of diagnosis is: ➢ More than 6 months after the first date of diagnosis for the initial critical illness; and ➢ While the covered person is insured under the policy. A covered person can receive a Second Event Initial Critical Illness Benefit only once for each initial critical illness.	Yes	Yes

	Plan Option 1	Plan Option 2
Second Event Cancer Critical Illness Benefit This benefit will be paid if the covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the Cancer Critical Illness Benefit provision if: ➢ The second date of diagnosis is more than 6 months after the first date of diagnosis for the cancer critical illness; and ➢ The covered person did not receive treatment during that 6 month period; and ➢ The second date of diagnosis is while the covered person is insured under the policy. For the purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up visits to verify if the cancer critical illness has returned. A covered person can receive a Second Event Cancer Critical Illness Benefit only once for each cancer critical illness.	Yes	Yes
Remove Pre-existing Condition Limitation Cancer critical illness benefits are payable for a diagnosis of a new or a recurrence of cancer, as long as the insured is diagnosed after the effective date of coverage, and has been free of any symptoms and treatment of cancer for 12 consecutive months immediately preceding the effective date of coverage, or any 12 consecutive months thereafter. The date of diagnosis for each illness must be separated by 90 days.	Yes	Yes

What Is Not Covered

Benefits will not be paid for a critical illness that is, or is caused by, contributed to by or results from:

- War, declared or undeclared, during military service.
- Participation in a riot, insurrection or rebellion.
- Intentionally self-inflicted injury or action.
- Illegal activities or committing or attempting to commit a felony.
- Suicide while sane, or self-destruction while insane, or any attempt at either.
- Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.

When Evidence of Insurability Is Required

Evidence of insurability is required if:

- You:
  - Voluntarily canceled coverage and are reapplying;
  - Are applying for an amount of coverage over the guaranteed issue limit; or

- Are applying for the coverage, or an increase in the amount of coverage, at any time after your initial enrollment period; or

- An eligible dependent did not enroll within 30 days of eligibility.

Waiver of Premium Benefit

Your premiums for this coverage will be waived if, while covered under the Plan, you:

- Become disabled due to a critical illness for which a benefit is paid; and
- Remain disabled for at least 90 consecutive days.

After the 90th day, the premiums due will be waived for the first 90 days and each consecutive day thereafter you are disabled, until the earliest of:

- The date you are no longer disabled;
- Two years from the first day of disability; or
- The date coverage ends according to the "*Termination of Coverage*" provision.

Disabled means you are:

- Unable to work;
- Not working at any job for pay or benefits; and
- Under the care of a physician for the treatment of a covered critical illness.

Unable to work means:

- During the first 365 days of disability, you are unable to work at the occupation you were performing when your disability began; and
- During the second 365 days of disability, you are unable to work at any gainful occupation for which you are suited by education, training or experience.

This benefit is payable only for the disability of the insured employee. It does not apply to any other covered person. You must provide sufficient proof of disability at least once every six months.

Supplemental Medical – Hospital Indemnity

The following benefit(s) are paid for service and treatment administered to or received by a covered person. Such service or treatment must be:

- Incurred by a covered person while coverage is in force on that person; and
- Provided for the care and treatment of sickness or injury of a covered person.

Any loss not stated in the "*Summary of Benefits*" table is not covered under this Plan. Treatment must be received in the United States or its territories, except in the case of an emergency.

The "*Summary of Benefits*" table below outlines what the Plan covers.

Summary of Benefits

	Plan Option 1	Plan Option 2
First Day Hospital Confinement Benefit The Insurer pays the benefit amount shown for the first day a covered person is confined in a hospital. This benefit is payable only once per continuous confinement in a hospital per covered person. The benefit is not paid for a newborn child's initial confinement in a hospital. The covered person must provide proof for each day that a hospital room and board charge is incurred.	$500	$1,000
Limit to Number of Occurrences	No limit	No limit
Daily Hospital Confinement Benefit The Insurer pays the benefit amount shown per day when a covered person is confined in a hospital. If the First Day Hospital Confinement benefit is payable, this benefit pays for each day after the first day of a continuous confinement in a hospital for one day less than the maximum stated number of days. If the First Day Hospital Confinement benefit is not payable, this benefit pays for each day of a continuous confinement in a hospital for the maximum stated number of days. This benefit is not payable for: ➢ Any day for which the First Day Hospital Confinement benefit is payable; or ➢ A newborn child's routine nursing or routine well baby care during the initial confinement in a hospital. The covered person must provide proof for each day that a hospital room and board charge is incurred.	$250	$350
Maximum Number of Days*	30 days max	30 days max

	Plan Option 1	Plan Option 2
Hospital Intensive Care Benefit The Insurer pays the benefit amount shown for each day a covered person is confined in a hospital intensive care unit, up to the maximum stated number of days. This benefit is paid in addition to the First Day Hospital Confinement benefit and Daily Hospital Confinement benefit. The covered person must provide proof for each day that a hospital room and board charge is incurred.	$200	$300
Maximum Number of Days**	30 days max	30 days max
Mental and Nervous Disorders Covered	No	No
Drug Addiction and Alcoholism Covered	No	No
Pregnancy Waiting Period	None	None
Pregnancy (Normal and Complications) Covered	Yes	Yes
Removal of Pre-Existing Conditions Limitation	Yes	Yes

* *Payable for each day, up to the max per continuous confinement in a hospital; not paid for any day the First Day Hospital Confinement Benefit is paid.*

** *Payable for each day, up to the max per continuous confinement in a hospital intensive care unit; pays in addition to the First Day Hospital Confinement Benefit and Daily Hospital Confinement Benefit.*

What Is Not Covered

No benefits will be paid for any loss caused by or resulting from (directly or indirectly):

- Any act of war whether or not declared, during military service;
- Participation in a riot, insurrection or rebellion;
- Suicide, or any attempt at suicide, whether sane or insane;
- Injury incurred while committing or attempting to commit a felony;
- Dental or plastic surgery for cosmetic purposes except when such surgery is required to:
  - Treat an injury;
  - Correct a disorder of normal bodily function; or
  - Congenital defects;
- Intentionally self-inflicted injuries;
- Confinement that begins before the covered person's effective date of coverage;
- The reversal of a tubal ligation or vasectomy;
- Artificial insemination, in vitro fertilization and test tube fertilization, including any related testing, medications or physician services, unless required by law;
- Participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
- A newborn child's routine nursing or routine well baby care during the initial confinement in a hospital;
- Mental or nervous disorders; or
- Alcoholism, drug addiction or dependence upon any controlled substance.

When Coverage Ends

Generally, when your employment terminates for any reason, including voluntary termination, involuntary termination, retirement, layoff, or death, coverage ends on the last day of the pay week in which your employment ends. Otherwise, your coverage ends when any of the following occur:

- You are no longer eligible for coverage;
- You stop making required contributions;
- You decline coverage (following an election at annual enrollment or upon a qualifying life event or special enrollment right);
- The plan is terminated or is amended such that you do not meet the requirements for coverage under the plan.
- With respect to critical illness coverage, the date you have received the maximum total percentage of the basic benefit amount for each critical illness; or
- A discovery of fraud or material misrepresentation in the presentation of a claim under this Plan.

Your coverage may also be terminated if you fail to comply with a reasonable plan rule, if you intentionally provide false information, or for other plan-related misconduct.

Coverage for your dependents will end when any of the following occur:

- Your coverage ends;
- Your spouse, domestic partner or other dependent(s) no longer meet the dependent eligibility requirements under the plan (If your dependent child reaches the age limitation requirement for a dependent child, coverage will end at the end of the month in which he or she turns 26);
- You decline coverage for your dependents (following an election at annual enrollment or upon a qualifying life event or special enrollment right);
- You stop making the required contributions for you or your dependents;
- You die; or
- The plan is terminated or is amended such that you or your dependents do not meet the requirements for coverage under the plan.

If a premium is accepted for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate, and claims will not be paid. There may be no refund due if you have coverage in force that covers more than one child and there are other eligible dependents still insured under the Plan.

Coverage may be eligible for continuation as outlined in the "*Continuation of Insurance*" and "*Portability Privilege*" sections below.

Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence

If you cease active employment because of a temporary layoff or leave of absence while coverage is in force, coverage will be continued in accordance with the personnel practices of the Company, if premium payments continue (whether through payroll deduction or direct payment to the Insurer) and the Company approved the leave in writing. Coverage will be continued for three months following the date you ceased active employment.

If your coverage ends while on a Family and Medical Leave of Absence, the coverage will be reinstated when you return to active status.

The Insurer will not require evidence of insurability.

Continuation of Critical Illness and 24-Hour Accident Insurance Coverage

This section provides for automatic continuation of insurance coverage (Continuation Coverage). It applies if a covered person suffers the loss of critical illness or 24-hour accident insurance coverage under the Plan due to one of the following events:

- Termination of your employment; or your eligibility due to reduction in your hours; or the date you are no longer in an eligible class; or the date your class is no longer eligible. Insurance may be continued for any covered person.
- Your death. Insurance may be continued for any covered person.
- Divorce or legal separation. Insurance may be continued for any covered person whose insurance would otherwise end.
- Your becoming eligible for Medicare. Insurance may be continued for any covered person who is not entitled to Medicare.
- A child ceasing to be an eligible dependent as defined in the Plan. Insurance may continue for that child.
- The Company filing a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within one year before or after the filing of the bankruptcy.
- Termination of the Plan. (Benefits will be determined as if the Plan had remained in full force and effect)
- Strike, layoff, leave of absence for personal reasons (not Family or Medical Leave Act (FMLA)). Insurance may be continued for any covered person.
- Military Service. Your leave of absence due to military service. Insurance may be continued for any covered person, except for the person who is in active military service.

Continuation Coverage is not available for any person if coverage under the Plan terminated due to your failure to make required premium payments. Continuation Coverage is not available to any person who is on FMLA. Continuation Coverage is also not available if a person fails to pay premium while on FMLA.

To be eligible for Continuation Coverage, a person must be insured under the Plan on the day before the event that caused loss of coverage. In the case of bankruptcy, the person must also be:

- An employee who retired on or before the date insurance ends or is substantially reduced; or
- A dependent of the retiree on the day before the bankruptcy.

A person will not be denied Continuation Coverage solely because he or she is covered under another group health plan like this one, or eligible for Medicare on the date of the event that caused loss of coverage.

The Continuation Coverage may include any eligible dependents who were covered under the Plan. The coverage being continued is subject to all terms and provisions of the Plan that do not conflict with this section. The coverage will be the same as that provided under the Plan for other persons in the same insurance class in which such person would have been if the loss of coverage had not occurred. The coverage will be subject to any changes to the Plan affecting the benefits of such class. The coverage will be effective on the day after the insurance under the Plan terminates.

Notification and Payment Requirements

You or other qualifying dependents have the responsibility to inform the Insurer of divorce, legal separation or a child losing eligibility under the Plan. This notice must be made within 60 days of these events. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The Company has the responsibility of notifying the Insurer of an insured's death, termination of employment or reduction in hours or the Company's bankruptcy. This notice must be made within 30 days of the event.

The Insurer will notify the qualifying person of the right to continue within 14 days of the notice described above. The qualifying person will be required to pay a premium for the Continuation Coverage to the Insurer.

Premiums

Premiums are due and payable in advance to the Insurer. Premium due dates are the first day of each calendar month. The premium rate for the first 36 months of Continuation Coverage will not exceed 102% of the rate in effect under the Plan covering similarly situated class of employees who have not elected Continuation Coverage. After the first 36 months, the premium rate may change for the class of persons covered under Continuation Coverage. Written notice will be given at least 60 days before any change is to take effect

Termination of Insurance

Insurance under Continuation Coverage will automatically end on the earliest of the following dates:

- The date the person again becomes eligible for insurance under the Plan.
- The last day for which premiums have been paid, if the insured fails to pay premiums when due, subject to the grace period.
- With respect to insurance for dependents:
  - The date your insurance terminates; or
  - The date the dependent ceases to be an eligible dependent under the Plan.
- With respect to critical illness coverage, the later of:
  - The date you reach age 70; or
  - 36 months after the date Continuation Coverage became effective.

A dependent child whose Continuation Coverage terminates when he or she reaches the age limit may apply for Continuation Coverage in his or her own name, if he or she is otherwise eligible.

Continuation Coverage for critical illness coverage will remain in effect for no longer than 36 months, or until you reach age 70, whichever occurs later.

Portability Privilege for Hospital Indemnity Insurance Coverage

Portability coverage will be provided for hospital indemnity insurance coverage under the Plan, subject to these provisions.

Such coverage will not be available to you, unless:

- Coverage under the Plan terminates under the "*Termination of Coverage*;"
- The Insurer receives a written request and payment of the first premium for the portability coverage no later than 30 days after such termination; and
- the request is made for that purpose.

No portability coverage will be provided for any person, if his or her insurance under the Plan terminated due to his or her failure to make required premium payments.

Portability Coverage

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Plan when your coverage terminated. Portability coverage may include any eligible dependents who were covered under the Plan. Any change made to the Plan after a person is insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after your coverage under the Plan terminates.

Portability Premiums

Premiums for portability coverage are due and payable in advance to the Insurer. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for active employees and may change on any premium due date. Written notice will be given at least 60 days before a change is to take effect.

Termination of Insurance

Coverage under this portability privilege ends on the earliest of:

- The date the person again becomes eligible for coverage under the Plan.
- The last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period.
- With respect to coverage for dependents:
  - The date your coverage terminates; or
  - The date the dependent ceases to be an eligible dependent, as defined.
- 36 months after the date portability coverage became effective.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

Portability coverage will remain in effect for no longer than 36 months.

Termination of the Plan

If the Plan terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the Plan. Portability coverage may continue beyond the termination date of the Plan, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the Plan had remained in full force and effect.

Claims and Appeals Procedures

This section includes the general claims and appeals procedures for plans sponsored by the Company.

You or your authorized representative may file a claim for eligibility and/or a claim for benefits. An authorized representative is any person (such as a spouse, parent, medical provider, executor of your estate or attorney) whom you authorize in writing to act on your behalf. The Plan will also recognize representatives authorized through a court order giving a person authority to submit claims on your behalf.

Claims for Eligibility

The Plan Administrator is generally responsible for determining whether someone is eligible for the Plan and for deciding appeals of denied **claims involving questions of eligibility** to participate in the Plan or changes in coverage elections, such as the addition or deletion of dependents (these will be referred to as Eligibility Claims). In carrying out these functions, the Plan Administrator has full discretionary authority to interpret and construe the terms of the Plan, to decide questions regarding eligibility for the Plan and to make any related findings of fact. The Plan Administrator can act through its delegate. The decision of the Plan Administrator shall be final and binding to the full extent permitted by law.

Where the claim involves eligibility to participate or addition or deletion of dependents, you should contact the Lockheed Martin Employee Service Center (LMESC) at:

Lockheed Martin Employee Service Center (LMESC)
P.O. Box 18020
Norfolk, VA 23501-1848
866-562-2363 – Toll-free calls in the U.S.
201-242-4397 – International callers
800-833-8334 – Hearing impaired

Eligibility Claim Denials

If your Eligibility Claim is denied in whole or in part, you will be notified in writing within 90 days of the receipt of your claim. The notice will state the following:

- Specific reasons for the denial.
- Plan provisions that support the denial.
- A description of any additional information needed to review your Eligibility Claims request.
- Instructions for requesting a review of your claim denial and the applicable time limits, including information regarding your right to bring a civil lawsuit under Section 502(a) of ERISA following a benefit claim denial on review.

Internal Appeals Process

If your Eligibility Claim is denied in whole or in part, you or your authorized representative can request an internal review of (or appeal) the denied Eligibility. The review will take into account all comments, documents, records and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If you wish, you or

your authorized representative may review the appropriate Plan documents and submit written information supporting your claim to the Plan Administrator.

You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records or other information relevant to your Eligibility Claim. You will be able to review your file and present information as part of the review.

Additional rules apply if the appeal relates to an Eligibility Claim that either has a direct adverse effect on a specific benefit claim or involves a retroactive termination of coverage (other than for failure to pay premiums).

Your internal appeal will be reviewed and decided independently to the original claim process. The appeal decision will not be made by someone who was involved in the original decision or by someone who reports to the initial decision maker. The Plan Administrator, as applicable, will ensure that all eligibility claims and appeals are handled impartially. The person involved in making the decision will not receive compensation, promotion, continued employment or other similar items based upon the likelihood he or she will support a denial of the Eligibility Claim.

Time Limits

With respect to Eligibility Claims, you or your authorized representative have 180 calendar days from the date of the claim denial to make a written request for an internal review or appeal to the Plan Administrator. For appeals regarding eligibility to participate or changes in coverage elections such as the addition or deletion of dependents, there is one level of internal appeal.

The Plan Administrator or delegate will give you a written decision regarding the review of your claim within 45 calendar days of receipt of your request for review. If more time is needed to make the determination, the Plan Administrator will notify you in writing of the need for an extension of up to 45 calendar days.

If, after exhausting your rights under these claim and appeal procedures, you want to initiate a lawsuit to challenge a denied claim, you must do so within 12 months of the claim denial. You must file any lawsuit in connection with the Plan in the United States District Court for the District of Maryland.

Decision on Internal Appeal

If your Eligibility Claim is denied on internal appeal, in whole or in part, you will receive a written notice from the Plan Administrator within the review period outlined above. The notice will provide the following:

- The specific reasons for the decision.
- A reference to the specific Plan provisions upon which the decision is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain these procedures.

Where required, a statement that there may be other voluntary alternative dispute resolution options. The written denial on appeal will include a statement regarding your right to bring a timely civil lawsuit under Section 502(a) of ERISA following a benefit claim denial on appeal.

Claims for Benefits

The applicable claims administrator for the particular benefit (see the "*Claims Administrators*" section) is responsible for determining whether benefits are payable under the Plan, determining the amount of benefits payable, if any, and deciding appeals of denied claims for benefits (these will be referred to as Benefit Claims).

In carrying out these functions, including conducting a full and fair review of denied claims, the claims administrator has the full discretionary authority to interpret and construe the terms of the Plan and to decide questions related to the payment of benefits. The decision of the claims administrator shall be final and binding to the full extent permitted by law.

You or your authorized representative should file a written claim for benefits with the claims administrator. To ensure timely processing of your claim, you should contact the claims administrator to confirm the claim filing address.

Time Frame for Claim Reviews

You will normally be notified of the decision within 30 calendar days after receipt of the claim.

This time period may be extended up to an additional 15 calendar days due to circumstances outside the Plan's control. If an extension is required, you will be notified of the need for the extension before the end of the initial 30-day period. The notice will set forth the circumstances requiring the extension of time and the date by which the claims administrator expects to make a decision. For example, the 30-day time period may be extended because you have not submitted sufficient information, in which case, you will be notified of the specific information necessary and given an additional period of at least 45 calendar days after receiving the notice to furnish that information.

Benefit Claim Denials

If your claim is denied in whole or in part, you will be notified in writing within the time period outlined above. The notice will state the following:

- Specific reasons for the denial.
- Plan provisions that support the denial.
- A description of any additional information needed to review your claim request.
- If an internal rule, guideline, protocol or similar criterion was relied on in making the benefit claim denial, either the specific rule, guideline, protocol or similar criterion that was relied on, or a statement that one was relied on and that a copy will be provided free of charge upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Instructions for requesting a review of your claim denial and the applicable time limits, including information regarding your right to bring a civil lawsuit under Section 502(a) of ERISA following a benefit claim denial on review.

Appeals Process

If your claim is denied in whole or in part, you or your authorized representative can request a review of (or appeal) the denied claim within the time limit set forth in this section. The review will take into account all comments, documents, records and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If you wish, you or your authorized representative may review the appropriate Plan documents and submit written information supporting your claim to the claims administrator (if related to a Benefit Claim) or Plan Administrator (if related to an Eligibility Claim).

If the Plan fails to meet the requirements of the internal claims and appeals process for your claim, you are deemed to have exhausted the internal process.

You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records or other information relevant to your claim for benefits. You will be able to review your file and present information as part of the review.

Your appeal will be reviewed and decided independently to the original claim process. The appeal decision will not be made by someone who was involved in the original decision or by someone who reports to the initial decision maker. The claims administrator or Plan Administrator, as applicable, will ensure that all claims and appeals are handled impartially. The person involved in making the decision will not receive compensation, promotion, continued employment or other similar items based upon the likelihood he or she will support a denial of Plan benefits.

In deciding an appeal of a claim that was denied based on a medical judgment, a provider with appropriate training and experience in the field of medicine involved will be consulted (such provider will not be someone who was consulted in connection with the original claim denial nor someone who reports to the original consultant). You may request the identity of any medical or vocational experts consulted in making a determination of your appeal.

Time Limits for Appeals

You or your authorized representative have 180 calendar days from the date of the claims denial to make a written request for an internal review or appeal to the claims administrator (for Benefit Claims) or Plan Administrator (where the claim involves an Eligibility Claim).

The claims administrator will respond in writing with a decision within 60 calendar days (45 days for any disability claims) after it receives an appeal for a claim determination.

If, after exhausting your rights under these claim and appeal procedures, you want to initiate a lawsuit to challenge a denied claim, you must do so within 12 months of the claim denial. You must file any lawsuit in connection with the Plan in the United States District Court for the District of Maryland.

Decision on Appeal

If your claim is approved, you will receive the appropriate benefit from the Plan.

If your claim is denied on appeal, in whole or in part, you will receive a written notice from the claims administrator (if related to a Benefit Claim) or Plan Administrator (if related to an Eligibility Claim) within the review period outlined above. The notice will provide the following:

- The specific reasons for the decision.

- A reference to the specific Plan provisions upon which the decision is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.
- If an internal rule, guideline, protocol or similar criterion was relied on in making the benefit claim denial, either the specific rule, guideline, protocol or similar criterion that was relied on, or a statement that one was relied on and that a copy will be provided free of charge upon request.
- If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge.
- Where required, a statement that there may be other voluntary alternative dispute resolution options. The written denial on appeal will include a statement regarding your right to bring a timely civil lawsuit under Section 502(a) of ERISA following a benefit claim denial on appeal.

Claims and Appeals Time Limits – At a Glance

The time limits applicable to claims and appeals are summarized in the chart below.

Event	
How long does the Plan have to make an initial claim decision?	No later than 30 days after receipt of the claim
How long does a participant have to appeal the decision?	180 days after receipt of the adverse decision
How long does the Plan have to determine the appeal?	60 days after receipt of the appeal (45 days for any disability claims)

Physical Examination and Autopsy

The Insurer has the right, at its own expense, to have you examined by a physician of its choosing, as often as may be reasonably required while a claim is pending. The Insurer may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

Payment of Claims

After receiving written proof of claim, the Insurer will pay all benefits then due under this Plan and will make payment to you. Any amounts unpaid at your death may, at the Insurer's option, be paid either to the named beneficiary or to your estate. If benefits are payable to your estate or a beneficiary who cannot execute a valid release, up to $1,000 can be paid to someone related to you or your beneficiary by blood or marriage whom the Insurer considers to be entitled to the benefits. The Insurer will be discharged to the extent of any such payment made in good faith. There may be cases where a law requires any benefits be paid to an agency of government. The Insurer will abide by any such law that may apply. The Insurer will not be liable to you or anyone else for such law that may apply. The Insurer will not be liable to you or anyone else for such benefits to the extent it is required by law to pay them to such agency.

Overpaid Claim

The Insurer has the right to recover any overpayments due to:

- Fraud; or

- Any error it makes in processing a claim.

You must reimburse the Insurer in full. The Insurer will work with you to develop a reasonable method of repayment if you are financially unable to repay it in a lump sum. The Insurer will not recover more money than the amount it overpaid you.

Unpaid Premium

Upon the payment of a claim under Plan, any unpaid premium may be deducted.

Legal Action

No legal action may be brought to obtain benefits under the Plan:

- For at least 60 days after proof of loss has been furnished; or
- After the expiration of three years from the time written proof of loss is required to have been furnished

Incontestability

After two years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim. With respect to 24-hour accident and hospital indemnity coverage, after two years, the validity of the coverage may not be contested except for nonpayment of premiums.

Clerical Error

Clerical error on the part of the Company or the Insurer will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the Insurer or the Company documenting any clerical errors.

Plan Administration

This section provides you with important information about the Plan as required by the Employee Retirement Income Security Act of 1974, as amended (ERISA). While ERISA does not require the Company to provide you with benefits, it does mandate that the Company clearly communicate to you how the plans subject to the provisions of ERISA operate and what rights you have under the law regarding Plan benefits.

General Information

The following summarizes important administrative information about the Plan. NOTE: The Plan can be identified by a specific plan number, which is on file with the U.S. Department of Labor.

Plan Information Overview

Plan Names and Numbers	Lockheed Martin Group Benefits Plan, which is identified by the number 594. Plan 594 is a welfare benefit plan within the meaning of the Employee Retirement Income and Security Act (ERISA), and provides health and welfare benefits to covered employees. The Company assigns the plan numbers. Please use this number whenever you correspond with anyone about the Plan.
Employer Identification Number	Lockheed Martin Corporation: 52-1893632
Plan Sponsor and Plan Administrator	Lockheed Martin Corporation 6801 Rockledge Drive Bethesda, MD 20817 **301-548-2320**
Plan Year	January 1 - December 31
Claims Administrator	The contact information for the claims administrator for each benefit plan can be found in the "*Claims Administrators*" section.
Agent for Service of Legal Process	The Company's agent for service of legal process is: Corporation Service Company 7. St. Paul Street Suite 820 Baltimore, MD 21202 Alternatively, you can serve legal process on the Plan Administrator at the address listed under Plan Sponsor and Plan Administrator.

Claims Administrators

This section provides specific contact information for the Plans described in this SPD.

For Issues on:	Contact:	At:
General Information		
General Plan administration and eligibility to participate in the Plan	Lockheed Martin Employee Service Center (LMESC)	Lockheed Martin Employee Service Center (LMESC) P.O. Box 18020 Norfolk, VA 23501-1848 **866-562-2363** – Toll-free calls in the U.S. **201-242-4397** – International callers **800-833-8334** – Hearing impaired
Supplemental Medical		
Filing an initial claim, benefit provisions, payment of benefits, denial of benefits	American Heritage Life Insurance Company	American Heritage Life Insurance Company 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687 **866-828-8501** Or visit **www.allstatebenefits.com/mybenefits** to register and file a claim online

Plan Funding

The benefits described in this booklet are guaranteed under a contract or policy issued by the Insurer. In the event there is a discrepancy between this booklet and the contract or policy of insurance, the contract or policy of insurance will govern.

Future of the Plan

The Company reserves the right to amend, suspend or terminate the Plan in whole or part at any time. The collective bargaining agreement(s), if any, may restrict the Company's right to amend or terminate the benefit plans during the term(s) of the agreement(s). If the Plan is terminated, coverage under the Plan for you and your covered dependents will end, and payments under the Plan will generally be limited to covered expenses incurred before the termination.

No Right to Continued Employment

Participation in the Plan is not a contract of employment and does not constitute a contract for, nor guarantee of, continued or future employment with the Company. The Plan provisions also do not prohibit changes in the terms of your employment.

Collective Bargaining Agreements

The Plan may be maintained pursuant to collective bargaining agreements. Copies of the agreements are available to employees covered by the particular agreement and may be requested from your Human Resources office. If you wish to obtain your own copy, submit a written request to your Human Resources office.

Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the provisions stated below.

Receive Information about Your Plan and Benefits

- You are entitled to examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements.
- You can obtain a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, which is available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you make a written request for a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your local telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. To obtain the addresses and telephone numbers of the District offices, you may access the Department of Labor Employee Benefits Security Administration Web site at **www.dol.gov/ebsa**.

Definitions

This section is a general list of common definitions. Therefore, certain terms listed here may not be used in this SPD.

Accident means a sudden, unforeseen and unexpected event which occurs without the covered person's intent which results in an injury to the covered person independent of disease, infirmity or any other cause.

Active employment or **actively employed** means that the covered person is working for the Company for earnings that are paid regularly and that the covered person is performing the material and substantial duties of his/her regular occupation. When used in connection with:

- You must be working at least 30 hours per week; and
- You will be deemed to be in active employment on a day which is not one of the Company's scheduled work days only if you were actively employed on the preceding scheduled work day.

The covered person's work site must be:

- The Company's usual place of business;
- An alternative work site at the direction of the Company; or
- A location to which the covered person's job requires travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Ambulatory surgical center means a licensed surgical center consisting of an operating room, facilities for the administration of general anesthesia and a post-surgery recovery room in which the patient is admitted to, and discharged from, within a period of less than 24 hours.

Calendar year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Coma means a continuous state of profound unconsciousness which lasts seven or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.

Common carrier means only the following: commercial airlines, passenger trains or inter-city bus lines. It does not include: taxis, intra-city bus lines or private charter planes.

Complications of pregnancy mean any of the following:

- A condition whose diagnosis is distinct from pregnancy but that is adversely affected by or caused by pregnancy, such as acute nephritis or nephrosis, cardiac decompensation, missed abortion or similar medical and surgical conditions of comparable severity;
- A non-elective caesarean section;

- Termination of ectopic pregnancy; and
- Spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of pregnancy do not include: false labor, occasional spotting, morning sickness, body aches, body pains, prescribed rest, hyperemesis gravidarum, pre-eclampsia, premature births, multiple births (twins, triplets, etc.) or any condition caused by the pregnancy that places the covered person or the pregnancy at risk.

Confined or **confinement** means admitted to and confined as an inpatient in an institution for which a room and board charge is made by the institution. It does not include confinement for an observation room.

Continuous confinement means with respect to:

- 24-hour accident coverage, one continuous confinement or two or more confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements; and
- Hospital indemnity coverage, one continuous confinement or two or more confinements not separated by more than 24 hours. If there are more than 24 hours between confinements, they are considered separate confinements.

Cosmetic means surgery or other treatment to improve a person's appearance which is not required for treatment of a sickness or injury.

Covered person means any of the following:

- Any eligible family member (including you) named on the enrollment or evidence of insurability and acceptable for coverage by the Insurer;
- Any eligible family member added by endorsement after the effective date; or
- A newborn or adopted child.

Critical illness means one of the critical illnesses described in the "*Supplemental Medical – Critical Illness*" provision for which a benefit may be paid.

Day means a 24-hour period.

Emergency room means a hospital area equipped and staffed for the reception and prompt treatment of acute illness, trauma, other medical emergencies and major life threatening emergencies. An emergency room has immediate access to operating rooms and critical care units and provides 24-hour care, 7 days per week. An emergency room also includes a satellite emergency center of a hospital.

Evidence of insurability means a statement of your or your dependent's medical history which will be used to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.

Family coverage means coverage that includes you, your spouse and eligible children.

General anesthesia means a process that produces loss of consciousness, in addition to pain relief and paralysis of skeletal muscle over the entire body, by the administration of anesthetic drugs and is used during major and other invasive surgical procedures.

Grace period means a period of 31 days following the premium due date during which premium payment may be made.

Hospital means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery and 24-hour nursing service. Hospital does not include any institution that is mainly:

- A rest home, nursing home, convalescent home or home for the aged; or
- For the care and treatment of alcoholics or drug addicts or mental or nervous disorders.

Hospital intensive care unit means a hospital area of special care, including cardiac and coronary care units, surgical intensive care units or cardiovascular intensive care units, which at the time of admission are separate and apart from the surgical recovery room or other rooms, beds or wards normally used for patient confinement. In addition, such a unit must provide the following:

- 24-hour continuous nursing care and attendance by nurses assigned to the unit on a full-time basis;
- Direction and/or supervision by a full-time physician director or a standing "intensive care" committee of the medical staff; and
- Special medical apparatus used to treat the critically ill.

The following do not qualify as hospital intensive care units: progressive care units, sub-acute intensive care units, intermediate care units, private rooms with monitoring, step-down units or any other lesser care treatment units.

Individual coverage means coverage that includes only you.

Individual and children coverage means coverage that includes only you and your eligible children.

Individual and spouse coverage means coverage that includes only you and your eligible spouse.

Initial enrollment period means one of the following periods during which you may first apply, in writing, for coverage under the Plan:

- A period before the Plan effective date as set by the Insurer and the Company if you are eligible for coverage on the Plan effective date; or
- The period ending 30 days after the date you are first eligible to apply for coverage if you become eligible for coverage after the Plan effective date.

Injury means with respect to:

- Critical illness coverage, accidental bodily injury;
- Hospital indemnity coverage, accidental bodily injury to a covered person, as the result of an accident while coverage under the Plan is in force, and the injury is the direct cause of the loss independent of disease, bodily infirmity or any other cause. All injuries sustained in any one accident and all complications and recurrences of complications are considered to be a single "injury;" and
- 24-hour accident coverage, accidental bodily injury to a covered person as the result of an accident while coverage under the Plan is in force and the injury is the direct cause of the loss independent of disease, bodily infirmity or any other cause which results in medical treatment received within 180

days after the injury is sustained. All injuries sustained in any one accident and all complications and recurrences of complications are considered to be a single "injury."

Inpatient means a covered person who is a resident patient using the room and board facilities of an institution.

Insured employee means the employee accepted for coverage by the Insurer who has completed and signed the enrollment form and whose name appears on the certificate specifications page.

Insurer means American Heritage Life Insurance Company.

Issue day means the same day of the month as the effective date of coverage.

Material and substantial duties means duties that:

- Are normally required for the performance of the covered person's regular occupation; and
- Cannot be reasonably omitted or modified, except that if the covered person is required to work on average in excess of 40 hours per week, the covered person will be considered able to perform that requirement if he/she is working or has the capacity to work 40 hours per week.

Mental or nervous disorder means a psychiatric or psychological condition regardless of cause, such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, post-traumatic stress disorder, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods.

Nurse means any one of the following who is not a member of the covered person's immediate family or, with respect to 24-hour accident and critical illness coverage, employed by the hospital where the covered person is confined:

- Licensed practical nurse (L.P.N.);
- Licensed vocational nurse (L.V.N.); or
- Graduate registered nurse (R.N.).

Payable claim means a claim for which the Insurer is liable under the terms of the Plan.

Physician means a person:

- Performing tasks that are within the limits of his or her medical license; and
- Who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- Who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

You or your spouse, children, parents or siblings will not be recognized as a physician for a claim.

Policy means the policy of insurance issued by the Insurer to the Company in connection with the Plan.

Policy date means the effective date of the policy.

Primary residence means the dwelling where a covered person lives for the majority of the time, regardless of whether the covered person owns or rents the dwelling.

Re-enrollment period means a period of time as set by the Company and the Insurer during which you may apply, in writing, for coverage under the Plan, or change coverage under the Plan if you are currently enrolled.

Sickness means an illness or disease, including, with respect to the hospital indemnity coverage, complications of pregnancy that must begin while the covered person is insured.

Surgery means manual procedures involving cutting of body tissue, debridement or permanent joining of body tissue for repair of wounds, treatment of fractured bones or dislocated joints, endoscopic procedures and other manual procedures, when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Symptoms mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

Temporary layoff, leave of absence or **family and medical leave of absence** means you are absent from active employment for a period of time that has been agreed to in advance in writing by the Company.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Under the influence means a condition as determined by the laws of the state in which the loss occurred.

Appendix A: Participating Business Units*

All domestic businesses of Lockheed Martin Corporation are eligible effective January 1, 2021, except those listed below:

- Zeta Associates
- Astrotech Space Operations, Inc.
- Any other business to the extent that it does not participate in the Lockheed Martin Group Benefits Plan

If you have any questions concerning your eligibility, please contact the Lockheed Martin Employee Service Center.

*This list is current as of the time of publication; participating businesses are subject to change.

Appendix B: Participating Bargaining Units

The benefits described in this booklet are available to eligible employees of Lockheed Martin Corporation who are represented by one of the following unions:

- Association of Scientists and Professional Engineering Personnel (ASPEP) (AASP01, AASP02)
- Association of Scientists and Professional Engineering Personnel (ASPEP) Services Engineering Unit Grandfathered (AASP04);
- Association of Scientists and Professional Engineering Personnel (ASPEP) Services Engineering Unit (AASP03)
- Harrisburg Association of Flight Simulator Instructors, Harrisburg/Middletown, PA (AHAF01)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local 776-F (formerly Federated Independent Texas Unions (FITU) Aircraft Local 900) Fort Worth, TX (AFIT01)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local Lodge 1027, Clarksburg, WV (AIAM01)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local Lodge 2386, Meridian, MS (AIAM02)
- International Association of Machinists and Aerospace Workers, AFL-CIO District W2 Local Lodge 463 (AIAM2A)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local Lodge 709, Marietta, GA (AIAM03)
- International Association of Machinists and Aerospace Workers Local Lodge 2228, Santa Clara County, CA (AIAM12)
- International Association of Machinists and Aerospace Workers Local Lodge 2228 (Santa Cruz County, CA) or Local Lodge 2786 (Santa Maria and Vandenberg, CA) (AIAM16)
- International Association of Machinists and Aerospace Workers (IAM), District 112 and Local Lodge 2772, St. Mary's, GA (AIAM18)
- International Association of Machinists and Aerospace Workers (IAM), District 160 and Local Lodge 282, Silverdale, WA (AIAM19)
- International Association of Machinists and Aerospace Workers (IAM) Local Lodge 610, Brevard County, FL (AIAM20)
- International Association of Machinists and Aerospace Workers and its Local Lodge 2171, District 98, Johnstown, PA (AIAM21)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local 1998, Ewa Beach, HI (AIAM37, AIAM43)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local 2916, Corpus Christi, TX (AIAM42)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local 20, Fort Walton Beach, FL (AIAM48)
- International Union, Security, Police, and Fire Professionals of America (SPFPA) and its Amalgamated Local No. 265 (ASPF05)
- International Association of Machinists and Aerospace Workers District Lodge 725, Palmdale, CA (AIAW01)
- International Brotherhood of Electrical Workers, Local No. 2995, Palmdale, CA (AIBE03)
- International Brotherhood of Electrical Workers, AFL-CIO Local Union 1245 (Sunnyvale - Palo Alto Plants and Santa Cruz Facility), Sunnyvale, CA (AIBE04)
- International Union of Operating Engineers, AFL-CIO Local Union 501 (Weldors), Palmdale, CA (AIUO02)
- International Union of Operating Engineers, AFL-CIO (Stationary Engineers), Local 39, Sunnyvale, CA (AIUO03)

- International Union of Operating Engineers, AFL-CIO Local Union 501 (Stationary Engineers), Palmdale, CA (AIUO04)
- The International Federation of Professional and Technical Engineers (IFPTE) AFL-CIO, Local 241 (AIFP02)
- The International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers – IUE – CWA (AFL-CIO) Local 106 (AIUE01)
- The International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers – IUE – CWA (AFL-CIO) Local 320 (AIUE03)
- International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers, AFL – CIO and Engineer Union Local 444, Mitchel Field, NY (AIUE07)
- International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers, AFL – CIO and Engineer Union Local 444A, Mitchel Field, NY (AIUE04)
- Little Rock Association of Instructors, Technicians and Support Personnel, JMATS, Little Rock, AR (AJMT01)
- Office and Professional Employees International Union, Local No. 277, AFL-CIO (AOPE01)
- Syracuse Draftsmen's Association (SDA) (ASDA01)
- International Brotherhood of Electrical Workers (IBEW) Local and its Local No. 220, Dallas, TX (AIBE01)
- International Union, United Automobile, Aerospace and Agricultural Implement Workers (UAW) of America and its Local 766 (AUAW01)
- International Union, United Automobile, Aerospace and Agricultural Implement Workers (UAW) of America and its Local 848 (AUAW03)
- International Union, United Automobile, Aerospace and Agricultural Implement Workers (UAW) of America and its Local 738 (AUAW04)
- International Union, United Automobile, Aerospace and Agricultural Implement Workers (UAW) of America and its Local 788 (AUAW05)
- International Union, United Automobile, Aerospace and Agricultural Implement Workers (UAW) of America and its Local 1821 (AUAW06)
- Lowcountry Contract Instructor Pilot Association (LCIPA) F35, MCAS, Beaufort, SC (ALCP01)
- International Association of Machinists and Aerospace Workers, AFL-CIO, District Lodge 110 Morrisville, NC (AATM01)
- International Association of Machinists and Aerospace Workers, AFL-CIO, District Lodge 725 Fort Irwin, CA (AATM02)
- International Association of Machinists and Aerospace Workers, AFL-CIO, District Lodge 711, Local 1501 Tullahoma, TN (AATM03)
- International Association of Machinists and Aerospace Workers, AFL-CIO, District Lodge 623 Camp Ripley, Little Falls, MN (AATM04)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local 47 Fort Carson, CO (AATM05)
- International Association of Machinists and Aerospace Workers, AFL-CIO, District Lodge 73 Meridian, MS (AATM06)
- International Association of Machinists and Aerospace Workers, AFL-CIO, Local Lodge 519 Luke Air Force Base, AZ (AATM07)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, Local Lodge 519, Luke Air Force Base, AZ - F-16 SMEs/Weapons Director (AATM08)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, Local Lodge 519, Luke Air Force Base, AZ - F-16 Electronic Technicians (AATM09)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, Local Lodge 568, Hill Air Force Base, UT – Instructors (AATM10)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, Local Lodge 568, Hill Air Force Base, UT - Sim Techs (AATM11)

- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, District Lodge 725, Local Lodge 2947, Lemoore, CA – Instructors (AATM12)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, Local Lodge SC711, Nellis Air Force Base, NV (AATM13)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, District Lodge 725, Local Lodge 2947, Lemoore, CA - Sim Techs (AATM14)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, District Lodge 725, Local Lodge 2947, Lemoore, CA - Sim Techs (AATM15)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, Local Lodge SC310 at Yuma Marine Corp Air Station, AZ (effective January 4, 2021) (AATM16)
- International Association of Machinists and Aerospace Workers (IAM), AFL-CIO, Local Lodge 519, Luke Air Force Base, AZ - Field Engineers / Sim Techs (effective February 1, 2021) (AATM17)
- International Association of Firefighters, Sikorsky Aircraft Firefighters Local I-68 (AIAF01)
- Sikorsky Aircraft Security Officers Association (ASOA02)

If you have any questions concerning your eligibility, please contact the Lockheed Martin Employee Service Center (LMESC).

*This list is current as of the time of publication; participating unions may change from time to time.

When You Have Questions

If you have questions about this document or want to obtain a copy of the SPD, please access LMESC Online at:

https://lmpeople.lmco.com – on the Lockheed Martin intranet
Click on *LM Employee Service Center* under *Benefits*. From the LMESC Online, click *Library* and then *Summary Plan Descriptions*.

https://www.lmpeople.com – on the Internet
You will need your User ID (NT ID) and Password to access the website from the Internet. Click on *LM Employee Service Center* under *Benefits*. From the LMESC Online, click *Library* and then *Summary Plan Descriptions*.

lmc.lifeatworkportal.com – on the Internet
You will need your Login ID (not your NT ID) and Password to access the website from the Internet. Refer to *Login Help* on the login screen for guidance. Once logged in, click *Library* and then *Summary Plan Descriptions*.

Or, you can call the LMESC at:

866-562-2363 – Toll-free calls in the U.S.
201-242-4397 – International callers
800-833-8334 – Hearing impaired

For specific questions regarding benefits and claim information, please contact the claims administrator.

Please keep this notice with your other important benefits information.