LOCKHEED MARTIN

This document is a Lockheed Martin Summary Plan Description (SPD). Since SPDs change from time to time, it is important that you always review any updates before reading the document. The updates are located at the front of the SPD.

Finding what you want within this SPD is quick and easy. To navigate through the document, click on the *Bookmarks* tab at the left-hand side to display the document index. All applicable updates appear at the top of the index. After reviewing the updates, scroll down through the document or use the index and go directly to a section of specific interest.

If you have any questions about the benefits outlined in this SPD, please call the Lockheed Martin Employee Service Center:

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

LOCKHEED MARTIN

Feb. 8, 2017

Summary of Material Modifications

Important Information Regarding Changes Effective Jan. 1, 2017

This notice is being sent to you to update the benefit information in the Summary Plan Description (SPD) titled "Health Care and Dependent Care Spending Accounts, For certain non-represented and represented employees of Lockheed Martin Corporation" (ZZE – H10SPD183, effective Jan. 1, 2011). This notice is now part of the official plan document and is legally referred to as a Summary of Material Modifications (SMM) to the SPD.

Health Care Spending Account Limit Increase

Effective Jan. 1, 2017, the Health Care Spending Account (HCSA) limit will increase from $2,550 to $2,600. As a result, the following will replace the introduction to the "How the Health Care Spending Account (HCSA) Works" section of your SPD:

How the Health Care Spending Account (HCSA) Works

You may deposit between $100 and $2,600 in your HCSA each calendar year. The HCSA covers certain health care expenses that are not reimbursed by any health care plan and that the IRS allows to be reimbursed in accordance with Section 213(d) of the IRS Code.

Dependent Care Spending Account Advances

Effective Jan. 1, 2017, the Company will no longer advance amounts you have elected for Dependent Care Spending Account (DCSA) contributions. As a result, the following content, a portion of the "How to Be Reimbursed" subsection of the "How the Dependent Care Spending Account (DCSA) Works" section, in the SPD is deleted:

How the Dependent Care Spending Account (DCSA) Works: How to Be Reimbursed

To help you at the beginning of the calendar year, the Company will advance you an amount equal to four weeks of your elected DCSA contribution. Keep in mind, however, that you will never be reimbursed for more than the balance in your account (including the advance).

This same advance is available to new employees hired during the plan year.

When You Have Questions

If you have questions about this document or want to obtain a copy of the SPD, please access Lockheed Martin Employee Service Center Online (LMESC Online) at:

https://lmpeople.lmco.com – on the Lockheed Martin intranet
Click on *LM Employee Service Center* under *Pay and Benefits*, then *My Benefits>Health and Welfare*. From the *Health and Welfare* page, click the drop down menu in the *Resources* section and click *Find 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 *Pay and Benefits*, then *My Benefits>Health and Welfare*. From the *Health and Welfare* page, click the drop down menu in the *Resources* section and click *Find 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, choose *My Benefits>Health and Welfare*. From the *Health and Welfare* page, click the drop down menu in the *Resources* section and click *Find Summary Plan Descriptions*.

Or, you can call the Lockheed Martin Employee Service Center (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.

LOCKHEED MARTIN

June 24, 2016

Summary of Material Modifications

Important Information Regarding Changes Effective Jan. 1, 2015

Effective Jan. 1, 2015, you are eligible to participate in the benefits described in the Summary Plan Descriptions (SPDs) listed below if you are employed by Lockheed Martin MST Services and a member of the Davis-Monthan Flight Simulator Association (DMFSA). This notice, effective Jan. 1, 2015, is now part of the official plan documents and is legally referred to as a Summary of Material Modifications (SMM) to the below-listed SPDs:

- *LM Essentials* Plan, Health benefits for certain non-represented and certain represented employees of Lockheed Martin Corporation (ZBQ – 108SPDB12, effective Jan.1, 2012)
- *LM HealthWorks* Plan, Health benefits for certain non-represented and certain represented employees (ZAH – 207SPDB11, effective Jan. 1, 2011)
- Lockheed Martin Corporation Managed Care (HMO and PPO) Medical Plans, Medical Plans for non-represented and certain represented employees of Lockheed Martin Corporation (ZBJ – 112SPDB12, effective Jan. 1, 2012)
- Lockheed Martin Corporation Dental Plans, Comprehensive Dental, Comprehensive Plus Dental and Managed Dental for nonrepresented and certain represented employees of Lockheed Martin Corporation (ZBK – 113SPDB12, effective Jan. 1, 2012)
- Lockheed Martin Corporation Vision Plan, Vision Plan for non-represented and certain represented employees of Lockheed Martin Corporation (ZBL – 114SPDB12, effective Jan.1, 2012)
- Health Care and Dependent Care Spending Accounts, For certain non-represented and represented employees of Lockheed Martin Corporation (ZZE – H10SPD183, effective Jan. 1, 2011)
- Short-Term Disability (STD) Insurance, For non-represented and certain represented employees of Lockheed Martin Corporation (ZEM – 115SPDB15, effective Jan. 1, 2014)
- Long-Term Disability Insurance Benefits, Under the Lockheed Martin Group Benefits Plan and the Lockheed Martin Operations Support, Inc. Benefit Plan (ZBR – 107SPDB14, effective Jan. 1, 2014)
- Lockheed Martin Group Benefits Plan, Life and accident insurance for non-represented salaried and certain represented employees of Lockheed Martin Corporation (ZBC – 214SPDB11, effective Jan. 1, 2012)
- Lockheed Martin Business Travel Accident Plan, For certain non-represented and certain represented employees (ZZV – 213SPDB11, effective Jan. 1, 2011)
- Lockheed Martin Corporation International Indemnity Plan (IIP), Health benefits for certain employees of Lockheed Martin Corporation (ZCE – 107SPDB12, effective Jan. 1, 2012)
- *LM HealthWorks* Quit for Life™ Program, Tobacco cessation program for eligible employees of Lockheed Martin Corporation (ZN5 – G07SPD154, effective Sept. 25, 2006)
- *LM HealthWorks* Wellness Center (111SPDB13, effective Jan. 1, 2014)

When You Have Questions

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https://lmpeople.lmco.com – on the Lockheed Martin intranet
Click on *LM Employee Service Center* under *Pay and Benefits*, then *My Benefits>Health and Welfare*. From the *Health and Welfare* page, click the drop down menu in the *Resources* section and click *Find Summary Plan Descriptions*.
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(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.

LOCKHEED MARTIN

Jan. 16, 2015

Summary of Material Modifications

Important Information Regarding Changes Effective Jan. 1, 2015

This notice is a Summary of Material Modifications (SMM), a legal document that describes changes to the Summary Plan Description (SPD) entitled Health Care and Dependent Care Spending Accounts for certain non-represented and certain represented employees of Lockheed Martin Corporation (LMC-ZZE – H10SPD183, effective Jan. 1, 2011).

Health Care Spending Account Limit Increase

Effective Jan. 1, 2015, the Health Care Spending Account (HCSA) limit will increase to $2,550. As a result, the following will replace the introduction to the "How the Health Care Spending Account (HCSA) Works" section of your SPD:

How the Health Care Spending Account (HCSA) Works

You may deposit between $100 and $2,550 in your HCSA each calendar year. The HCSA covers certain health care expenses that are not reimbursed by any health care plan and that the IRS allows to be reimbursed in accordance with Section 213(d) of the IRS Code.

When You Have Questions

If you have questions about this document or want to obtain a copy of the SPD, please access Lockheed Martin Employee Service Center Online (LMESC Online) at:

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Or, you can call the Lockheed Martin Employee Service Center (LMESC) at:

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

Please keep this notice with your other important benefits information.

Summary Plan Description

Health Care and Dependent Care Spending Accounts

For certain non-represented and represented employees of
Lockheed Martin Corporation

Effective January 1, 2011

LMC-ZZE

About this Booklet

The Lockheed Martin Corporation Group Benefit Plan (the "LM Plan") provides benefits to certain employees of Lockheed Martin Corporation, and includes the Health Care Spending Account (HCSA) and Dependent Care Spending Account (DCSA) explained in this Summary Plan Description (SPD). The Lockheed Martin Operations Support, Inc. Benefit Plan (the LMOS Plan) provides benefits to certain employees of Lockheed Martin Operations Support, Inc. and its affiliates, and includes the HCSA and DCSA explained in this SPD. The HCSA and DCSA are also part of the Lockheed Martin Flexible Benefits Plan and the LMOS Flexible Benefit Plan, respectively, which are "cafeteria plans" for purposes of Section 125 of the Internal Revenue Code This SPD is based on the official legal documents. If there is any conflict between this SPD and the official plan documents, the official plan documents will govern. The Plan also provides other medical and non-medical benefits, which are described in other SPDs.

The Company (that is, Lockheed Martin Corporation or Lockheed Martin Operations Support, Inc., as applicable) 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. A collective bargaining agreement may restrict the Company's right to amend or terminate the benefit plans during the term of the agreement.

The Plans' terms 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.

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Who Is Eligible

You are eligible to participate in the Plan's HCSA and DCSA on your first day of work (or on the day you first become eligible) if you are:

- A regular full-time or part-time non-represented employee at a participating business unit (see Appendix A); or
- A regular full-time or part-time represented employee at a participating business unit (see Appendix A)*.

* If you are a represented new hire employee of Lockheed Martin Aeronautics Company – Fort Worth; Lockheed Martin Aeronautics Company – Marietta; Lockheed Martin Aeronautics Company – Palmdale; Lockheed Martin Space Systems Company, Missiles and Space Operations; or Lockheed Martin Technical Operations, you must first complete the 90-day waiting period. If you are recalled from lay-off, rehired, reinstated, transferring from non-represented to represented or changing from part-time without benefits to part-time with benefits, you do not have to meet the 90-day waiting period.

You are not eligible to participate unless you are scheduled to work at least 1,000 hours in a year. You are also not eligible to participate if you are:

- An intern/co-op student;
- A consultant;
- A leased employee;
- Paid by a third-party employer; or
- Otherwise not classified as an employee by the Company.

How the Health Care Spending Account (HCSA) Works

You may deposit between $100 and $5,000 ($2,500, effective January 1, 2013) in your HCSA each calendar year. The HCSA covers certain health care expenses that are not reimbursed by any health care plan and that the IRS allows to be reimbursed in accordance with Section 213(d) of the IRS Code.

Your Contributions Are Pre-Tax

The HCSA is a pre-tax benefit—that is, your contributions to the HCSA are automatically deducted from your paycheck before federal income taxes and, in most cases, state income taxes are taken out. Thus, you owe fewer taxes each pay period.

Eligible Expenses for Reimbursement

You may be reimbursed for your own expenses as well as those for your qualified dependents. A dependent means an individual who qualifies as a dependent under a Company-sponsored health plan. This generally includes your spouse, and your children up to age 26. For this purpose, "children" means your natural children, your stepchildren, your legally adopted children, and children placed with you for adoption.(Expenses for a domestic partner or children of a domestic partner are generally not eligible for reimbursement unless the person qualifies as your dependent for federal tax purposes). Your dependents do not need to be enrolled in a Company-sponsored health plan for you to receive reimbursement of their eligible health-related expenses. Only expenses incurred while you are participating in the HCSA are eligible for reimbursement.

Health-related expenses that qualify for reimbursement are defined by the IRS (details can be found in IRS Publication 502, which provides general guidance as to whether expenses qualify as medical care under Section 213). Keep in mind that eligible expenses may change if the tax laws are revised. The health care expenses below are examples of covered expenses when not reimbursed by another plan, insurance policy or Medicare.

- Health plan coinsurance, copayments or deductible expenses.
- Smoking cessation programs.
- Chiropractic care.
- Certain fertility procedures.
- Nursing care.
- Insulin and diabetic supplies.
- Certain durable medical supplies and equipment, such as wheelchairs.
- Medical services only from nursing homes, sanitariums and homes for the mentally retarded.
- Laser eye surgery.
- Eye exams, eyeglasses, or prescription sunglasses.
- Contact lenses including saline or enzyme solutions.
- Dental services such as restorations and some orthodontia.
- Over-the-counter drugs related to medical care, e.g., antacids, pain relievers, cough medicines, allergy medications, but only if prescribed in writing by a physician (prescription requirement effective January 1, 2011).
- Certain travel expenses related to the receipt of health care.

Some health care treatments or services, including those deemed cosmetic in nature, require written proof of medical necessity from your health care provider with your initial reimbursement request.

Expenses That Are Not Reimbursable

Under current IRS guidelines, the following expenses are not eligible for reimbursement:

- Expenses for which reimbursements are already available under any health care plan.
- Over-the-counter drugs related to medical care, e.g., antacids, pain relievers, cough medicines, allergy medications, except if prescribed in writing by a physician (prescription requirement effective January 1, 2011).
- Contributions/premiums (pre-tax or after-tax) paid for any coverage under any benefit plan or insurance policy, including the cost of Medicare insurance.
- Taxes withheld from your pay as part of Social Security or Medicare.
- Maternity clothes.
- Diaper service.
- Nursing care for a healthy baby.
- Illegal surgeries or drugs.
- Travel your doctor told you to take for rest.
- Funeral expenses.
- Cosmetic surgery (unless medically necessary).
- Marriage counseling.
- Health club dues.
- Electrolysis.
- Dietary supplements such as vitamins that are merely beneficial to general health.
- Toiletries, cosmetics, and sundry items.
- Any expenses incurred before your Plan participation begins or after your Plan participation ends.

Grace Period

If you are enrolled and have a remaining balance in the HCSA on December 31, a 2-½ month grace period applies. The grace period will run from January 1 through March 15 of the following plan year. During the grace period, eligible expenses incurred will be used to reduce the prior plan year's remaining balance. Contributions that remain unused after the 2-½ month grace period will be forfeited under the "use it or lose it" rule, described below.

For example, assume you have a balance of $250 remaining in your account on December 31 and have no outstanding eligible expenses to claim. Then, between January 1 and March 15 you incur $300 of eligible expenses that are not reimbursed by a health plan. When you submit the $300 claim to the HCSA claims administrator for reimbursement, the Plan will first use the prior year's remaining $250, then $50 from the current year's funds (if enrolled), to pay your claim.

NOTE
If you do not have a remaining balance from the current plan year and you elect to participate in a HCSA during the next plan year, eligible expenses you incur starting in January of the new plan year will be applied towards that year's account balance.

How to Be Reimbursed

- Certain Lockheed Martin health plan claims will be automatically submitted to the claims administrator for HCSA claims processing (see below).
- The HCSA claims administrator provides the option to submit claims through their online benefits Web site.
- You can also complete and fax (or mail) a HCSA reimbursement form to the HCSA claims administrator. You can obtain a claim form by contacting the HCSA claims administrator or by accessing the HCSA online benefits Web site. Health care expenses must be processed first by your primary health care plan and then by your secondary health care plan, if applicable.
- If the expense is partially covered under a health care plan, include the Explanation of Benefits (EOB) from your claims administrator with your signed reimbursement form. If the expense is not covered under another plan, include an itemized bill with your signed reimbursement form. The EOB or bill must contain the actual date of service, the name and address of the provider, a description of the services, the patient's name, and the amount charged.
- If you want to have your claim reimbursement automatically deposited to your checking or savings account, sign up directly by accessing the HCSA claims administrator's online benefits Web site or by completing a direct deposit form (available from the HCSA claims administrator).

The HCSA will pay up to the full amount of your annual election (reduced by prior claim payments) at any time during the plan year, regardless of the amount of money you have contributed to your account.

For Health Care Provided by Certain Claims Administrators of Lockheed Martin Sponsored Plans:

Some Lockheed Martin claims administrators will automatically submit claims on your behalf to the HCSA claims administrator. For confirmation on which claims administrators will provide the automatic claim submission to the HCSA claims administrator, please contact the Lockheed Martin Employee Service Center or the HCSA claims administrator. If you do not wish to have your health plan claims automatically submitted for HCSA claims processing, please contact the HCSA claims administrator.

The "Use It or Lose It" Rule for HCSA

You will have until April 30 of the next plan year to submit claims to the HCSA claims administrator for money you deposited in the prior plan year. Only eligible expenses incurred during the prior plan year while you were a participant or during the 2-½ month grace period, if applicable, are eligible for reimbursement.

Under the "use it or lose it" rule required by federal regulations, any remaining amounts not claimed for eligible expenses incurred during that year and its grace period are not returned to you. So be sure not to contribute more money than you think you will use during the year.

Please note: If you are an "eligible reservist" and called to active duty for 180 days or more, you may avoid forfeiting money in your HCSA by making a taxable withdrawal of the funds in your HCSA. You must make your withdrawal request before December 31 of the year you are called to active duty. For more information, call the Lockheed Martin Employee Service Center.

The IRS Has Other Important Rules

In exchange for the favorable tax treatment you receive, the IRS requires you to follow the rules listed below.

- If you have money left in your account at the end of the plan year, it may only be used for expenses you incurred during that plan year (or during the 2-½ month grace period after the end of the plan year) while you were a participant in the HCSA. Any money not used that plan year or during the grace period will be forfeited.
- You cannot change the dollar amount of your election during the plan year unless you have a qualified status change—see the "*Qualified Status Changes*" section.

When Your Participation Ends

Your participation in the HCSA will end when any of the following events occur:

- You leave employment at the Company;
- You are no longer an eligible employee;
- In the event of a strike, the day preceding the date you go out on strike;
- You retire;
- You die; or
- The plan is terminated, or is amended such that you do not meet the requirements for coverage under the plan.

If You Leave the Company

If you leave the Company during the year, any contributions you are making will stop. However, you may continue HCSA coverage for the remainder of the year under COBRA on an after-tax basis.

You have until April 30 of the following plan year to submit claims for reimbursement for any remaining balance. You will not be reimbursed for any eligible expenses incurred after your date of termination (or end of plan participation, if later, due to COBRA).

If you elect to continue your HCSA coverage, you may be able to continue to participate in the HCSA for the remainder of the calendar year by contributing to your account on an after-tax basis. See the "*Extending Your Participation After It Ends*" section for more information.

If You Are on Family and Medical Leave

If you are on an unpaid leave under the Family and Medical Leave Act (FMLA), you may either continue participating or stop participating in HCSA during the leave. In either case, contributions to the HCSA will start up again when you return from leave.

If you return in the same calendar year, your per pay period deductions will be increased to provide you with the same annual election in effect immediately before the date your leave began. Alternatively, you can reduce your annual election by the amount of contributions you missed while on leave. Contact the Lockheed Martin Employee Service Center to make any changes.

If you choose to stop participating in HCSA while on leave, you cannot be reimbursed for any eligible expenses you or your dependents incur while you are not participating.

If you return to work in a subsequent calendar year, contact the Lockheed Martin Employee Service Center for more information.

Extending Your Participation After It Ends

When your participation in the HCSA ends due to one of the qualifying events listed below, you may have limited rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA) until the end of the calendar year in which your participation ends.

- You leave the Company (for reasons other than gross misconduct);
- Your coverage stops because you no longer meet the eligibility requirements;
- You die;
- You fail to return to work at the end of your leave under FMLA.

Electing COBRA Coverage

If you have funds remaining in your HCSA account, the COBRA administrator will provide you with a COBRA election form for continued coverage. To elect COBRA continuation coverage, you must complete and return the form to the COBRA administrator within 60 days after your coverage ends or within 60 days after you receive the form (whichever is later). If you elect COBRA coverage, the effective date of the coverage is the date of the qualifying event. You will have an additional 45 days following your election of COBRA coverage to pay any outstanding premiums.

You can continue the coverage until the end of the calendar year, as long as:

- you continue to make contributions for coverage within 30 days of the due date, and
- the Company is still offering the Plan to its employees.

You will have to pay 100% of the monthly contribution plus a 2% administrative charge for coverage under COBRA. Your contributions will be made on an after-tax basis.

How the Dependent Care Spending Account (DCSA) Works

You may deposit between $100 and $5,000 in your DCSA on a calendar year basis with the following exceptions:

Your Tax Filing Status	Your Maximum Contribution
A working single parent	$5,000 per year
Married, filing a joint tax return and your spouse does not participate in a Dependent Care Spending Account	$5,000 per year
Married, filing a joint tax return and your spouse participates in a Dependent Care Spending Account	$5,000 per year, combined
Married, filing a joint tax return and your spouse is a student or physically or mentally incapable of self care	$250 per month (up to $2,500 per year) for one dependent or $500 per month (up to a limit of $5,000 a year) for two or more dependents
Married, and filing separate tax returns	$2,500 per year
Married, and you or your spouse earns less than $5,000 per year	Up to the lesser of your annual incomes

Your Contributions Are Pre-tax

The DCSA is a pre-tax benefit—that is, your contributions are automatically deducted from your paycheck before federal income taxes and, in most cases, state income taxes are taken out. Thus, you owe fewer taxes each pay period.

Eligible Dependents

Eligible expenses are reimbursable from your DCSA for care given to the following individuals, as long as they can be claimed as dependents on your federal income tax return.

- A child up to their 13th birthday who meets all of the following:
  - Is either your child (including a step, adopted, or foster child), grandchild, brother, sister, stepbrother, stepsister, or a descendant of any such relative;
  - Lives with you in the same principal place of abode for more than one-half of the taxable year; and
  - Does not provide over one-half of his or her own support for the taxable year.
- Any other qualifying relative over age 13 (such as a parent, stepparent, or grandparent) who meets all of the following:
  - Is physically or mentally incapable of self care;
  - Lives with you in the same principal place of abode for more than one-half of the taxable year;
  - Does not have gross income more than the exemption amount, which can be found in the Internal Revenue Code, Section 151(d); and
  - Receives at least one-half of his or her support from you.

You should check with your tax advisor if you have any questions about the eligibility of a dependent over age 13 that is incapable of self care.

The eligible expenses for care must be incurred and provided during the plan year while you are at work or actively seeking gainful employment. If you are married, your spouse must also be at work during the time the care is given, or your spouse must be disabled, a full-time student at least five months during the year or actively seeking gainful employment. If you are a single parent, you must work full-time or part-time. If you are divorced, you must have custody of the child for more than one-half of the year.

Care that is provided by your spouse, any person you claim as a tax exemption or your child, if under the age of 19, is not eligible for reimbursement under the DCSA.

Estimating Your Eligible Expenses

When you estimate your dependent care expenses, please keep the following in mind:

- Expenses applied to the federal tax credit may not be reimbursed through this program.
- Do not include expenses for times when you are not at work or actively seeking gainful employment or for periods when not covered by the Plan.
- The IRS requires you to forfeit any money left in your account at the end of the year, so it may be a good idea to contribute a more conservative amount to your DCSA.

Eligible Expenses for Reimbursement

In general, care must be provided by a licensed day care facility or by an individual not claimed as a dependent on your federal income tax return in order for expenses to be reimbursable. If provided in connection with dependent care, "household services" such as housekeeping or cleaning services may also be covered.

The following expenses for services provided during the plan year are reimbursable:

- Before- and after-school programs.
- Care in your own home or in someone else's home (as long as the caregiver is not your spouse or your dependent for tax purposes and is age 19 or older).
- Care in a licensed dependent care center or a licensed child care center (the center must comply with all applicable state and local regulations).
- Nursery school or preschool.
- Summer day camp (does not include overnight camp).
- Care provided by a housekeeper for an eligible dependent—you can include the housekeeper's entire salary, including any Social Security and other taxes you pay for that person.

Expenses That Are Not Reimbursable

The following expenses are not eligible for reimbursement under the DCSA.

- Care for a non-disabled child age 13 or older.
- Care given by a provider whom you claim as a dependent on your income tax return.
- An overnight camp.

- Food, clothing, or daycare transportation expenses.
- Care by a provider for whom you do not have a Social Security number or tax identification number.
- Any babysitting costs that are not considered "work-related expenses."
- Educational costs for kindergarten or a higher grade.
- Long-term care services.

Choose Between DCSA and the Federal Dependent Care Tax Credit

Please keep in mind that although the federal government offers a tax credit for dependent care expenses, you must choose between this credit and the DCSA. You cannot claim the same expenses for both the tax credit and the DCSA. In addition, every dollar you contribute to the DCSA reduces by one dollar the maximum amount you may claim for the federal income tax credit in that same year.

The federal tax credit for dependent care expenses and the income eligible for the federal tax credit may increase each year. These changes may affect your choice of using the federal tax credit or the DCSA.

Consult with your tax advisor if you need help deciding which method would give you the greatest tax savings.

How to Be Reimbursed

- The DCSA claims administrator provides the option to submit claims through their online benefits Web site.
- You can also complete and fax (or mail) a DCSA reimbursement form to the DCSA claims administrator. You can obtain a claim form by contacting the DCSA claims administrator or by accessing the online DCSA benefits Web site. You can submit either a DCSA reimbursement form signed by your provider or you can complete a DCSA reimbursement form and attach a receipt that contains your provider's signature, address, SSN or Tax Identification Number, the date of service, and the amount paid.
- If you want to have your claim reimbursement automatically deposited to your checking or savings account, complete a direct deposit form (available from the DCSA claims administrator).

The DCSA will pay up to the amount you have in your account at the time. If your claim is for more than the balance in your account, the rest of the claim will be paid as the money accumulates (you do not need to resubmit your claim).

To help you at the beginning of the calendar year, the Company will advance you an amount equal to four weeks of your elected DCSA contribution. Keep in mind, however, that you will never be reimbursed for more than the balance in your account (including the advance).

This same advance is available to new employees hired during the plan year.

The "Use It or Lose It" Rule for DCSA

You have until April 30 of the following year to submit claims to the DCSA claims administrator for expenses incurred during a prior year. Under the "use it or lose it" rule required by federal regulations, any remaining amounts not claimed for eligible expenses incurred during that year are not returned to you. So be sure not to contribute more money than you think you will use during the year.
Only eligible expenses that are incurred and provided after your Plan participation begins and while working or actively seeking work in that plan year are eligible for reimbursement.

The IRS Has Other Important Rules

In exchange for the favorable tax treatment you receive, the IRS requires you to follow the rules listed below.

- If you have money left in your account at the end of the plan year, it may only be used for expenses that are incurred and provided during that plan year. Any money you do not use that plan year will be forfeited.
- You cannot change the dollar amount of your election during the plan year unless you have a qualified status change or change in cost or scope of provider services—see the "*Qualified Status Changes*" section.
- If your spouse earns less than $5,000 a year, you can deposit up to the lower of your two incomes, provided you file a joint return. If you file separately, the maximum each of you may deposit is $2,500. Plus, if your spouse is physically or mentally incapable of self-care or is a full-time student in any given month, the IRS considers that person to have earned income for purposes of determining the DCSA maximum. See IRS Publication 503 for the current amounts.
- The services for which you are reimbursed must be incurred and provided during the plan year—that is, between January 1 and December 31—while you are working or actively seeking work.

When Your Participation Ends

Your participation ends when any of the following events occur:

- You leave employment at the Company;
- You are no longer an eligible employee;
- In the event of a strike, the day preceding the date you go out on strike;
- You retire;
- You die; or
- The Plan is terminated, or is amended such that you do not meet the requirements for coverage under the Plan.

If You Leave the Company

If you leave the Company during the year, any contributions you are making to your DCSA will stop.

You have until April 30 of the following plan year to submit eligible expenses provided during the plan year in which you terminated employment. These claims, however, must have been provided while working or actively seeking work.

If You Are on an Unpaid Leave of Absence

If you are on an unpaid leave, your DCSA contributions will stop. If you return to work during the same plan year, you may change your annual DCSA contribution amount when you return to work (or sooner, if a qualified status change occurs). However, you may not reduce your DCSA contribution below the amount you had contributed to the DCSA before the date your unpaid leave began.

If you do not change your DCSA contribution amount when you return to work, any DCSA contribution amounts in arrears will be taken prospectively from your paycheck. If you return to work in the next plan year, you can make a new DCSA election.

Enrolling in the Spending Accounts

Participation in the Spending Accounts is voluntary. The chart below describes the effective date of participation following proper enrollment.

Enrollment time frames	Your participation becomes effective, provided you are otherwise eligible…
If you are a new hire or newly eligible employee who enrolls within 30 days of your initial eligibility date and not subject to a waiting period	HCSA – On the first day of work or the date you meet the eligibility requirements DCSA – On the day you make the election
If you are a new hire, subject to a 90-day waiting period	On the 91st day following your date of hire or the date you meet the eligibility requirements
If you are rehired in the same plan year, your prior elections are reinstated	On the first day you return to work
If you are rehired in a different plan year and enroll within 30 days of your first day of work	HCSA – On the first day you return to work DCSA – On the day you make the election
If you enroll during an enrollment period	On the first day of the following plan year or as otherwise stated in your enrollment materials
If you enroll within 30 days of a qualified status change, except for the birth, adoption or placement for adoption of a child	On the date you make the election
If you enroll within 30 days of the birth, adoption, or placement for adoption of a child	HCSA – On the day of the qualifying event DCSA – On the day you make the election
If you are a benefit eligible part-time employee who moves to full time status or vice versa, and enroll or make a change within 30 days	HCSA – No changes permitted DCSA – On the date you make the election

You Must Re-enroll Every Plan Year

You must re-enroll in the Spending Accounts during each Annual Enrollment period to continue your participation. Your prior year contribution amount is not carried over into the new calendar year.

If you do not re-enroll during the Annual Enrollment period, your participation will end on December 31, and you cannot enroll again until the next Annual Enrollment period—unless a qualified status change occurs that will allow you to make a mid-year change. If you have a balance in your account on December 31, the grace period may apply. See the “*Grace Period*” section for more information.

If You Enroll During the Plan Year

For HCSA, if you enroll during the plan year because you are newly eligible or due to a qualified status change, only eligible expenses incurred on or after the date your Plan participation begins and before it ends may be reimbursed.

For DCSA, if you enroll during the plan year because you are newly eligible or due to a qualified status change, only expenses incurred and provided on or after the date your Plan participation begins and while working or actively seeking work during the plan year are eligible for reimbursement.

Changing Your Election During the Plan Year

You cannot change your election until an Annual Enrollment period unless a qualified status change occurs.

You must call or provide written notice to the Lockheed Martin Employee Service Center within 30 days after the date a qualified status change occurs. If you do not notify the Lockheed Martin Employee Service Center within the deadline, your right to make a qualified status change will be lost for that event.

Qualified Status Changes

Qualified status change	HCSA	DCSA
Marriage	Enroll, increase, decrease or stop contributions	Enroll, increase, decrease or stop contributions
Divorce, legal separation or annulment of a marriage	Enroll, increase, decrease or stop contributions	Enroll, increase, decrease or stop contributions
Birth, adoption or placement for adoption	Enroll or increase contributions	Enroll or increase contributions
Death of an eligible dependent	Decrease or stop contributions	Decrease or stop contributions
Loss of your dependent's eligibility	Decrease or stop contributions	Decrease or stop contributions
Changes in your employment status or your dependent's employment status that result in a *loss* of eligibility under a plan	Enroll or increase contributions	Enroll, increase, decrease or stop contributions
Changes in your employment status or your dependent's employment status that result in a *gain* of eligibility under a plan	Decrease or stop contributions	Enroll, increase, decrease or stop contributions
Significant changes in cost or scope of provider services*	No change	Increase or decrease contributions
Eligibility, or loss of eligibility, for Medicare or Medicare coverage	Enroll, increase, decrease or stop contributions	No change
Change in eligibility for benefits due to becoming eligible or ineligible for employee contribution subsidies from Medicaid or CHIP	Enroll, increase, decrease or stop contributions	No change
Certain family or medical leaves of absence	Decrease or stop contributions	No change

Qualified status change
* You may be able to change your existing DCSA contribution amount if there is an increase in cost imposed by a caregiver who is not your relative; if there is an increase or decrease in cost resulting from a change in caregivers; or if there is an increase or decrease in cost resulting from a change in the amount of time a caregiver is used.

If you have a qualified status change, you may change your election as long as the change is both on account of and is consistent with the qualified status change. For example, if you have a baby during the plan year, you may contribute more money to your Spending Account.

Any change must be made within the required enrollment time frames, or your right to make a change will be lost for that qualified status change.

If You Increase or Decrease Your Spending Account During the Plan Year Due to a Qualified Status Change

If you increase your Spending Account contribution due to a qualified status change, the increased contribution amount will only apply to eligible expenses incurred either on or after the day you increase your contribution or the date of the qualifying event, as applicable. Any expenses incurred before the effective date of the change will be reimbursed up to the previous amount you elected to contribute.

If you decrease your contribution due to a qualified status change, you may not reduce your contribution below the amount you have already contributed to the Plan.

You will need to contact the Lockheed Martin Employee Service Center within 30 days after the date a qualified status change occurs.

General Information

The following summarizes important administrative information about the Plan, Please Note: Each 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	For employees of Lockheed Martin Corporation, the HCSA and DCSA are part of the Lockheed Martin Group Benefit Plan, which is identified by the number 594. For employees of Lockheed Martin Operations Support, the HCSA and DCSA are part of the Lockheed Martin Operations Support, Inc. Benefit Plan, which is identified by the number 504. These are welfare benefit plans permitting pre-tax contributions. The HCSA and DCSA are also provided through the Lockheed Martin Corporation Flexible Benefit Plan and the Lockheed Martin Operations Support Flexible Benefit Plan.
Employer Identification Numbers	Lockheed Martin Corporation: 52-1893632 Lockheed Martin Operations Support, Inc.: 22-1937239
Plan Sponsors and Plan Administrators	Lockheed Martin Corporation 6801 Rockledge Drive Bethesda, MD 20817 **(301) 548-2301** Lockheed Martin Operations Support, Inc. 6801 Rockledge Drive Bethesda, MD 20817 **(301) 548-2301**
Plan Year	January 1 — December 31
Claims Administrator	Payflex Systems USA, Inc. PO Box 3039 Omaha, NE 68103 **(877) 312-2772** **Overnight mail** Payflex Systems USA, Inc. 10802 Farnam Drive Suite 100 Omaha, NE 68154

COBRA Administrator	CONEXIS PO Box 226985 Dallas, TX 75222-6985 **(800) 482-4105** **(877) 822-0032** (fax) For overnight mail: CONEXIS 6191 N. State Highway 61 Suite 400 Irving, TX 75038
Agent for Service of Legal Process	You can serve legal process on the Plan Administrator at the address listed under *"Plan Sponsor and Plan Administrator."*

Plan Document

This booklet describes the terms and conditions of the group plan as set forth in the Plan document. The statements in this booklet are subject to the provisions of the Plan document, which legally governs the operation of the Plan. If there is any conflict between this booklet and the Plan document, the Plan document will govern. This booklet does not give you any rights to benefits that are not expressly provided under the Plan document.

Plan Funding

The HCSA and DCSA plans provide an opportunity for you to be reimbursed for certain health care and dependent care expenses on a tax-free basis.

Future of the Plan

The Company expects to continue the plan as described in this booklet. However, the Company reserves to right to amend, suspend or terminate the Plans in whole or part at any time. The collective bargaining agreement(s) may restrict the Company's right to amend or terminate the benefit plans during the term(s) of the agreement(s). If a 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.

HIPAA Privacy Rights and Protected Health Information

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to protect the confidentiality of private health information. The Plan will not use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law. By law, the Plan requires all of its business associates to also observe HIPAA’s privacy rules.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the HIPAA Notice of Privacy Practices, please contact the Lockheed Martin Employee Service Center.

If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, you should contact the applicable claims administrator or the plan’s Privacy Officer.

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, or 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. 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, you should contact the Lockheed Martin Employee Service Center at:

Lockheed Martin Employee Service Center
P.O. Box 462
Little Falls, NJ 07424
(866) 562-2363 – Toll-free calls in the U.S.
(201) 242-4397 – International callers
(800) 833-8334 – Hearing impaired

Claims for Benefits

The Claims Administrator 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.

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, 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

For HCSA claims. 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 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.

For DCSA claims. The claims administrator has 90 days from the date your claim is received to determine whether or not benefits are payable to you. The claims administrator may require more time to review your claim, if necessary, due to circumstances beyond its control. If this should happen, the claims administrator must notify you in writing before the end of the original period that its review period has been extended for up to 90 days. If this extension is made because you must furnish additional information, this extension will begin when the additional information is received.

"Participation Matters." For determinations regarding Participation Matters, such as eligibility to participate or changes in coverage elections, the Plan Administrator or delegate will follow the same procedures and time frames as outlined above.

Claim denials. If your claim is denied, you will be notified in writing within the time periods outlined in the *"Claims for Benefits"* section. The notice will state the following, as applicable:

- The specific reasons for the denial.
- The Plan provisions that support the denial.
- A description of any additional information needed to review your claim 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 an adverse benefit determination on review of a HCSA claim.
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination on your appeal, either the specific rule, guideline, protocol or similar criterion, or a statement that one was relied on in making the adverse determination 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 the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The 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 limits set forth below. 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 or Plan Administrator.

You will be provided, upon written request and free of charge, reasonable access to and copies of all documents, records or other information relevant to your claim for benefits.

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.

Time Limits

You or your authorized representative have 180 calendar days from the date of the claims denial to make a written request for a review or appeal to the claims administrator (for benefit claims) or Plan Administrator (where the claim involves participation matters).

Generally, there may be two levels of appeal for appeals relating to HCSA claims. There is one level of appeal for DCSA claims.

Level One Appeal

The claims administrator will respond in writing with a decision within 30 calendar days after it receives an appeal for a claim determination. If more time or information is needed to make the determination, the claims administrator will notify you in writing of the need for an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level Two Appeal (for HCSA Claims)

If you are dissatisfied with the claims administrator's level one appeal decision, you may request a second review. The second level follows the same process as the first level of appeal.

The review committee will review the claim within 30 calendar days. If more time or information is needed to make the determination, the claims administrator will notify you in writing of the need for an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You will be notified in writing of the appeal decision within five working days after the committee meeting.

Participation Matters

For appeals regarding eligibility to participate, there is one level of appeal. The Plan Administrator or delegate will give you a written decision regarding the review of your claim within 60 calendar days of receipt of your request for review.

Decision on Appeal

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

If your claim is denied on review, in whole or in part, you will receive a written notice from the claims administrator or Plan Administrator within the review period outlined above for the applicable type of claim. The notice will include 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.

- If an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination on your appeal, either the specific rule, guideline, protocol or other similar criterion, or a statement that was relied on in making the adverse determination on review and that a copy will be provided free of charge upon request.
- 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 an adverse determination 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	Health Care Spending Account (HCSA) Claims	Dependent Care Spending Account (DCSA) Claims
How long does the Plan have to make an initial claim decision?	No later than 30 days after receipt of the claim	No later than 90 days after receipt of the claim (may be extended an additional 90 days)
How long does a participant have to appeal the decision?	180 days after receipt of the adverse 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	60 days after receipt of the appeal (may be extended an additional 60 days)

Your Rights Under ERISA

As a participant in this Plan, you are entitled to certain rights and protection 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, and copies of the latest annual report (Form 5500 Series), and an updated SPD. 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.

Continue Participation

You may be entitled to continue participation for you, your spouse and/or your dependent children if there is a loss of participation under the Plan as a result of a qualifying event. You may have to pay to continue your participation. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation rights.

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 terminate your employment 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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 **http://www.dol.gov/ebsa.**

Appendix A - Participating Business Units

All domestic businesses of Lockheed Martin Corporation as of January 1, 2011, are eligible except those listed below:

- LM Canada
- PAE
- Sandia National Laboratory
- Savi
- Employees permanently residing in Puerto Rico

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

When You Have Questions

For general enrollment and eligibility questions, please contact the Lockheed Martin Employee Service Center.

Visit the **Employee Service Center Online** at:
https://www.lmpeople.com – on the Internet
https://lmpeople.lmco.com – on the Lockheed Martin intranet
Click on "Health and Wellness" under "Pay and Benefits" then "Review or Change My Coverage."

Call the **Lockheed Martin Employee Service Center** 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.