Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan
This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089

This Form is Open to Public Inspection

Part I  Annual Report Identification Information
For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

A This return/report is for:
☐ a multiemployer plan;
☐ a single-employer plan;
☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions);
☐ a DFE (specify) __________.

B This return/report is:
☐ the first return/report;
☐ the final return/report;
☐ an amended return/report;
☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. ................................................................. ☑

D Check box if filing under:
☐ Form 5558;
☐ automatic extension;
☐ the DFVC program;
☐ special extension (enter description)

Part II  Basic Plan Information—enter all requested information

1a Name of plan
SANDIA CORPORATION VOLUNTARY TERM LIFE INSURANCE PLAN

1b Three-digit plan number (PN) ☐ 521

1c Effective date of plan
04/01/2011

2a Plan sponsor’s name (employer, if for a single-employer plan)
SANDIA CORPORATION

Mailing address (include room, apt., suite no. and street, or P.O. Box)
PO BOX 5800, MAIL STOP 1382
ALBUQUERQUE, NM 87185-1382

City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

2b Employer Identification Number (EIN)
85-0097942

2c Plan Sponsor’s telephone number
505-845-8350

2d Business code (see instructions)
541700

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE
Filed with authorized/valid electronic signature. 10/10/2016 TIMOTHY C KNEWITZ

Signature of plan administrator Date Enter name of individual signing as plan administrator

SIGN HERE
Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor

SIGN HERE
Signature of DFE Date Enter name of individual signing as DFE

Preparer’s name (including firm name, if applicable) and address (include room or suite number)
Preparer’s telephone number

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
### Form 5500 (2015) Page 2

#### 3a Plan administrator's name and address

Same as Plan Sponsor

**Employee Benefits Committee of Sandia Corporation**

PO BOX 5800, MS 1382
ALBUQUERQUE, NM 87185-1382

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#### 3b Administrator's EIN

85-0097942

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#### 3c Administrator's telephone number

505-845-8350

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#### 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

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#### 4b EIN

012345678

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#### 4c PN

123456789

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#### 5 Total number of participants at the beginning of the plan year

6728

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#### 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).

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#### 6a(1) Total number of active participants at the beginning of the plan year

5409

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#### 6a(2) Total number of active participants at the end of the plan year

5378

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#### 6b Retired or separated participants receiving benefits

1388

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#### 6c Other retired or separated participants entitled to future benefits

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#### 6d Subtotal. Add lines 6a(2), 6b, and 6c.

6766

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#### 6e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.

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#### 6f Total. Add lines 6d and 6e.

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#### 6g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

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#### 6h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

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#### 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)

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#### 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

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#### 8b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

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#### 9a Plan funding arrangement (check all that apply)

- Insurance
- Code section 412(e)(3) insurance contracts
- Trust
- General assets of the sponsor

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#### 9b Plan benefit arrangement (check all that apply)

- Insurance
- Code section 412(e)(3) insurance contracts
- Trust
- General assets of the sponsor

---

#### 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

#### a Pension Schedules

- R (Retirement Plan Information)
- MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

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#### b General Schedules

- H (Financial Information)
- I (Financial Information – Small Plan)
- A (Insurance Information)
- C (Service Provider Information)
- D (DFE/Participating Plan Information)
- G (Financial Transaction Schedules)
### Part III  Form M-1 Compliance Information (to be completed by welfare benefit plans)

**11a** If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)  
- [ ] Yes  
- [x] No  

If “Yes” is checked, complete lines 11b and 11c.

**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)  
- [x] Yes  
- [ ] No  

**11c** Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

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

- File as an attachment to Form 5500.
- Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

### Part I: Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

#### 1 Coverage Information:

- **(a)** Name of insurance carrier
  - METROPOLITAN LIFE INSURANCE COMPANY

<table>
<thead>
<tr>
<th>(b) EIN</th>
<th>(c) NAIC code</th>
<th>(d) Contract or identification number</th>
<th>(e) Approximate number of persons covered at end of policy or contract year</th>
<th>(f) From</th>
<th>(g) To</th>
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</thead>
<tbody>
<tr>
<td>13-5581829</td>
<td>65978</td>
<td>0146125</td>
<td>6766</td>
<td>01/01/2015</td>
<td>12/31/2015</td>
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</tbody>
</table>

#### 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

- **(a)** Total amount of commissions paid
- **(b)** Total amount of fees paid

<table>
<thead>
<tr>
<th>(c)</th>
<th>(d) Purpose</th>
<th>(e) Organization code</th>
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<tr>
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<tr>
<td>179</td>
<td>ADMIN FEES NON-MONETARY COMPENSATION</td>
<td>3</td>
</tr>
</tbody>
</table>

#### 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

- **(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid
  - MERCER HEALTH & BENEFITS LLC
    - 4565 PAYSHERE CIR
    - CHICAGO, IL 60674-0001

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<tr>
<th>(b) Amount of sales and base commissions paid</th>
<th>(c) Amount</th>
<th>(d) Purpose</th>
<th>(e) Organization code</th>
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</thead>
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<td><strong>(b)</strong> Amount of sales and base commissions paid</td>
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### Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<table>
<thead>
<tr>
<th>8 Benefit and contract type (check all applicable boxes)</th>
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<tbody>
<tr>
<td>a Health (other than dental or vision)</td>
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<td>e Temporary disability (accident and sickness)</td>
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<tr>
<td>i Stop loss (large deductible)</td>
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<td>m Other (specify)</td>
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### Part IV Provision of Information

<table>
<thead>
<tr>
<th>11 Did the insurance company fail to provide any information necessary to complete Schedule A?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>12 If the answer to line 11 is “Yes,” specify the information not provided.</td>
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