GENERAL

1. What are my default benefits as a new employee and what levels of coverage are they?

   *The default benefits coverage for a new **hourly** employee are as listed:*

- *Basic Life Insurance $15,000*
- *Medical - Blue Cross Blue Shield PPO (National) - Employee only*
- *Dental - MetLife Preventive Dental - Employee only*
- *Business Travel Accident - basic coverage*

   *The default benefits coverage for a new **salaried** employee are as listed:*

- *Basic Life Insurance 1.5 x salary*
- *Medical - Blue Cross Blue Shield PPO (National) - Employee only*
- *Dental - MetLife Preventive Dental - Employee only*
- *Business Travel and Accident - basic coverage*
- *Long Term Disability - 50% coverage*

2. When will my elected benefits become effective?

   Elected benefits will become effective the first of the month following 30 days of employment if elected within 30 days of date of hire. Premium payments will begin with the first payroll after the first of the month following 30 days of employment.

3. What if I fail to make my elections within the 30 day time limit, what coverages will I have?

   The default benefits coverage for an hourly employee are as listed:

- *Basic Life Insurance $15,000*
- *Medical – Blue Cross Blue Shield PPO (National) – Employee only*
- *Smoker Surcharge - Yes*
- *Dental – MetLife Preventive Dental – Employee only*
- *Business Travel Accident – basic coverage*

The default benefits coverage for a salaried employee are as listed:

- *Basic Life Insurance 1.5 x salary*
- *Medical – Blue Cross Blue Shield PPO (National) – Employee only*
- *Smoker Surcharge - Yes*
- *Dental – MetLife Preventive Dental – Employee only*
- *Business Travel and Accident -basic coverage*
- *Long Term Disability – 50% coverage*

4. When can I make changes to my current coverage?
   Changes to coverage can be made once a year during open enrollment unless there is a qualifying event during the plan year (according to IRS guidelines). If a qualifying event occurs, changes must be made within 30 days of the event. Examples of qualifying events are:

- *Marriage*
- *Divorce*
- *Birth of a child/Adoption of a child*
- *A change in your or your spouse's employment status effecting benefits*
- *A dependent child's change of age, marital status or student status*
- *Death of a dependent*

5. Why is Martin Marietta implementing the "Smoker Surcharge?"
   The purpose of the smoker surcharge is to promote good health habits among employees and their family members. The surcharge will also help offset the higher medical costs associated with regular tobacco users.

6. What services does Martin Marietta provide to help me quit?
   Martin Marietta offers several programs to help in your efforts to quit using tobacco. We will provide a one-time reimbursement of your expenses at 80% up to $250.00 for participating in a smoking cessation program.

7. How does the "Smoker Surcharge" work?
   The Smoker surcharge is an additional pre-tax contribution you make because you and/or your covered spouse have used tobacco products daily or frequently at any time during the last 12 months. Below are some important points about the surcharge:

- *The surcharge is $45.00 per month or $480.00 per year for 2008, and $50.00 per month or $600.00 per year for*

2009. The surcharge applies in addition to the standard medical contribution for your tier of coverage. Daily or frequent use of tobacco products is defined as use of any tobacco product (cigarettes, clove cigarettes, cigars, pipe tobacco, smokeless tobacco, etc.) at least once a day on average.

- *The surcharge applies only if you and/or your covered spouse use tobacco products. It does not apply to children covered under the medical plan, nor to your spouse if you do not cover your spouse.*
- *If you and/or your covered spouse use tobacco regularly, as defined above, the surcharge will apply throughout 2008. If you do not smoke regularly at any time between now and the next enrollment period in 12 months, the smoker surcharge will not apply for 2010.*
- *Anyone found falsifying this arrangement may be subject to disciplinary action up to and including termination of benefits in accordance with the Martin Marietta Code of Ethics and Standards of Conduct Policy.*

8. I am physically addicted to tobacco and cannot quit. What can I do?
If it is unreasonably difficult due to a medical condition for you to achieve the standards to avoid the surcharge under this program, or if it is medically inadvisable to attempt to achieve these standards, call us at 1-877-651-5353 and we will assist you with other recommendations. We will require a signed affidavit stating the above circumstances are true in order for us to waive the surcharge.

9. Why is Martin Marietta implementing the "spouse with other coverage surcharge?"
The purpose of this surcharge is to help preserve Martin Marietta medical benefit resources for our employees and their families who depend on our coverage.

10. How does the "working spouse surcharge" work?
If you have a working spouse who has medical coverage available to them from another employer and/or your spouse is Medicare eligible and he/she elects the Martin Marietta Materials medical plan, you will pay a pre-tax surcharge equal to $70.00 per month or $840.00 per year for 2008. For 2009, the pretax surcharge will be $90.00 per month or $1080.00 per year.

11. What are my choices with this surcharge?
A working spouse with other coverage available, including Medicare, has the choice of remaining in the Martin Marietta plan and paying the pre-tax surcharge, or waiving our plan and electing his/her own employer’s medical plan. This surcharge does not impact you if you do not cover your spouse under our plan, if your spouse does not have other coverage available or you are single.

12. May I add a Common Law Spouse to my benefits?

You may add a Common Law Spouse to your benefits, if you currently reside in a State that recognizes it. You must first complete the Common Law Marriage Affidavit and have it notarized. Coverage for your Common Law Spouse will not be effective until a completed affidavit is submitted and approved. You can obtain this form via this web site on the forms tabs or contact the Martin Marietta Materials Benefits Connection. Once you have completed the document and have it notarized, please mail it to:

Martin Marietta Materials Benefits Connection P.O. Box 7862 Ocala, FL 34478-7862

You can also fax the completed and notarized form to: 856-770-3451.

The states which recognize Common Law Marriage are Alabama, Colorado, District of Columbia, Iowa, Kansas, Montana, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, and Utah.

MEDICAL

1. Are there any pre-existing condition exclusions under the plan?

No, there are no pre-existing condition exclusions under the plan.

2. How do I coordinate benefits between my plan and my spouse's plan?

If you or your spouse are eligible for benefits through other group plans, the Blue Cross Blue Shield Plan will coordinate its payments with those of the other plans so benefits paid may add up to, but will not exceed 100% of the total expense incurred.

If the charges are for you, your plan pays primary and your spouse's plan pays secondary. If the charges are for your spouse, your spouse's plan will pay primary and your plan will pay secondary applying the non-duplication method of coordination of benefits.

If your spouse reaches age 65 while you are an active employee, your plan continues to pay primary and Medicare will pay secondary as long as you are an active employee.

When a dependent child is covered by both parents (as long as both parents are not Martin Marietta Materials employees), the plan of the parent whose date of birth (month/day) falls first in the calendar year will pay primary and the other parent's plan will pay secondary.

DENTAL

1. How do I coordinate benefits between my plan and my spouse's plan?

   If you or your spouse are eligible for benefits through other group plans, the MetLife Dental Plan will coordinate its payments with those of the other plans so benefits paid may add up to, but will not exceed 100% of the total expense incurred.

   If the charges are for you, your plan pays primary and your spouse's plan pays secondary. If the charges are for your spouse, your spouse's plan will pay primary and your plan will pay secondary applying the non-duplication method of coordination of benefits.

   When a dependent child is covered by both parents (as long as both parents are not Martin Marietta Materials employees), the plan of the parent whose date of birth (month/day) falls first in the calendar year will pay primary and the other parent's plan will pay secondary.

REIMBURSEMENT ACCOUNTS

Health Care

1. What is a Health Care Reimbursement Account (HCRA)?

   A health care reimbursement account allows you to use before-tax dollars to pay for eligible out-of-pocket health care expenses. This gives you a big tax advantage by lowering your taxable income, which reduces the amount you have to pay in taxes. The minimum you must contribute is $100 annually and the maximum you can contribute is $3000 annually. Under your HCRA, you can file reimbursement claims for eligible dependents that depend on you for support and you can claim on your tax return.

2. How do I set up a Health Care Reimbursement Account?

   You can elect to participate when you are initially hired or each year during the annual enrollment period.

   You cannot change your contribution amounts throughout the year unless you experience a qualifying event that allows you to make changes. You also cannot transfer funds between the health care and the dependent care reimbursement accounts.

3. What happens if there is unused money in a HCRA at the end of the year?

   IRS regulations require that amounts not used for eligible expenses incurred during the Plan Year (January 1 - December 31) will be forfeited. You have 120 days from the end of the plan year to file claims for expenses incurred

during the previous calendar year. Participants will have until February 28 of the following year to incur expenses and until April 30 of the following year to file claims. Please carefully consider your contribution elections so you do not have to worry about the "use it or lose it" provision.

4. What expenses are eligible for reimbursement from a HCRA?
   The following is a partial listing of expenses that would be eligible for reimbursement. The list does not include every possibility. For a complete listing of eligible expenses, please refer to IRS Publication 502, "Medical and Dental Expenses", available at your public library or from the IRS Website at www.irs.gov

- *Health care insurance deductibles and copayments/coinsurance*
- *Medical, dental or vision expenses that are not covered by a health plan*
- *Charges above the amounts allowed by your health plan*
- *Uninsured expenses for glasses or contacts*
- *Hearing aids*
- *Home health care*
- *Prescription drugs*
- *Contact Interactive Medical Services for additional information*

Dependent Care

1. What is a Dependent Care Reimbursement Account (DCRA)?
   A dependent care reimbursement account allows you to use before-tax dollars to pay for eligible out-of-pocket dependent care expenses. This gives you a big tax advantage by lowering your taxable income, which reduces the amount you have to pay in taxes. The minimum you must contribute is $100 annually and the maximum you can contribute is $5,000 annually. Under your DCRA, you can file reimbursement claims for eligible dependents as follows:

- *Your child under age 13 for whom you have custody and are entitled to claim as a deduction on your tax return or who is mentally or physically unable to care for himself or herself, regardless of the age (this includes a disabled spouse or relative), even if he or she does not entitle you to a deduction on your Federal Tax return.*
- *An incapacitated spouse or parent residing in your home fulltime and claimed by you as a dependent on your Federal Tax return.*

2. How do I set up a Dependent Care Reimbursement Account?
   You can elect to participate when you are initially hired or each year during the annual enrollment period.

   You cannot change your contribution amounts throughout the year unless you experience a qualifying event that allows you to make changes. You also cannot transfer funds between the health care and the dependent care

reimbursement accounts.

3. What happens if there is unused money in a DCRA at the end of the year?
   IRS regulations require that amounts not used for eligible expenses incurred during the Plan Year (January 1 - December 31) will be forfeited. You have 120 days from the end of the plan year to file claims for expenses incurred during the previous calendar year. Participants will have until February 28 of the following year to incur expenses and until April 30 of the following year to file claims. Please carefully consider your contribution elections so you do not have to worry about the "use it or lose it" provision.

4. What expenses are eligible for reimbursement from a DCRA?
   The following is a partial listing of expenses that would be eligible for reimbursement. The list does not include every possibility. For a complete listing of eligible expenses, please refer to IRS Publication 503, "Child and Dependent Day Care Expenses", available at your public library or from the IRS Website at www.irs.gov

- *Care at a licensed day care facility*
- *Care at an unlicensed facility caring for less than seven people*
- *Private school tuition expenses for dependents through kindergarten*
- *In-home babysitting services*
- *Day care costs while in day camp*
- *Adult care for an incapacitated spouse or parent (this includes ONLY the cost of the day care expenses)*

5. The Flex convenience debit card

- *Enables employees to only pay for eligible FSA expenses wherever Mastercard or Visa is accepted*
- *Physicians, dental offices, pharmacies, vision service locations, daycare facilities (if they accept Mastercard or Visa)*
- *If there is enough money credited to the FSA account, the transaction will be approved.*
- *No direct payment or reimbursement to the participant*
- *Card looks like a typical credit or debit card issued under the Mastercard or Visa system*
- *Only accepted at specific types of merchant or provider locations as defined by merchant category codes (MEC)*
- *Account is established for MMM and a sub-account, indicating the amount of available coverage, is established for each participant*
- *Can replace paper claim forms in most cases*

6. More detailed information about the Flexible Spending Accounts, along with a comprehensive listing of eligible expenses can be found in the link below.

- FSA BROCHURE WITH CARDS

LIFE INSURANCE PLAN

1. What benefits are available under the Life Insurance Plan?
   Eligible employees and their dependents may elect coverage as follows:

   Employee:
- *Hourly - $15,000, 1, 1.5, 2, 3, 4, 5, 6 or 7 x your annual salary, not to exceed $2,000,000*
- *Salary - 1.5, 2, 3, 4, 5, 6 or 7 x your annual salary, not to exceed $2,000,000*

   Spouse:
- *$10,000, $25,000, $50,000, $75,000 or $100,000*

   Child:
- *$5,000, $10,000 or $15,000*

   In addition, the insurance company, ING, reduces your insurance amount as follows:
- *Age 70-74, ING pays 65% of benefit*
- *Age 75 and after, ING pays 45% of benefit*

2. Do I have to provide Evidence of Insurability (EOI)?
   An EOI (proof of good health) is required as follows:
- *To increase the amount of your life insurance coverage more than one benefit level or an amount that exceeds a $100,000 increase of coverage*
- *To increase the amount of dependent spouse and/or child insurance by more than one benefit level*
- *For new hires, to elect life insurance coverage more than 4 times the salary or an amount that exceeds $1,000,000*
- *If you are required to provide an EOI, your current life insurance and contribution will remain in effect until your EOI is approved.*
- *For new hires, to elect dependent spouse insurance for more than $50,000*