MY CHOICES BENEFIT

HEALTHCARE BENEFIT HANDBOOK

GROUND, FLIGHT ATTENDANT & FLIGHT DISPATCHER RETIREES AND THEIR SURVIVORS

Retirement Date Was 01/01/2008 or Earlier

PILOT RETIREES AND THEIR SURVIVORS

Retirement Date Was 06/01/2006 or Earlier

Disabled & 60th Birthday Was 06/01/2006 or Earlier

Delta Family-Care Medical Plan and Delta Pilots Medical Plan
Summary Plan Descriptions (SPD)
Effective as of January 1, 2008

Take Great Care Of You & Your Family

DELTA

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INTRODUCTION AND PLAN INFORMATION

Your health and well-being are your most important assets. That is why Delta offers you the opportunity to enroll in many types of healthcare benefits.

The Delta healthcare plans enable you to choose the type and level of coverage that is right for you and your family. Therefore, you may choose to enroll yourself, along with your eligible dependents — such as your spouse, domestic partner/same sex spouse and/or your children — or you may choose to waive coverage.

Except where noted that only a specific group may be eligible for certain plans or options (such as the Delta Pilots Medical Plan) the benefits described in this Summary Plan Description (SPD) apply to the following groups.

- Eligible flight attendant, ground and flight dispatcher retirees under age 65 with a retirement date of 01/01/2008 or before and their dependents and survivors who are under age 65
- Eligible survivors of active and inactive flight attendant, ground and flight dispatcher employees who died before 2/01/2008, if the survivor is under age 65
- Pilot retirees with a retirement date of 06/01/2006 or earlier and their survivors
- Inactive or terminated pilots (including those on disability) who were age 60 or over as of 6/1/06 and their survivors
- Inactive or terminated pilots (including those on disability) who were under age 60 as of 6/1/06 and not on the seniority list as of 1/1/07 and their survivors
- Survivors of pilots who died from active status prior to 1/1/97 or from disability that began before 1/1/97
- Survivors of pilots who died from active status on or after 1/1/97 and would have been age 60 or over as of 6/1/06, if living
- Survivors of pilots who died from disability that began on or after 1/1/97 and would have been age 60 or over as of 6/1/06, if living
- Individuals on COBRA continuation coverage with open enrollment rights to options under the Delta Family-Care Medical Plan and Delta Pilots Medical Plan

The following chart outlines the various options under the Delta healthcare plans in which these eligible retirees and survivors may enroll. Refer to the “Eligibility” and “Enrolling for Healthcare Benefits” sections of this SPD for specific eligibility details about these plans and options.

Coverage	Vendor	Plan Name
Medical	UnitedHealthcare (UHC)	Delta Family-Care Medical Plan (DFCMP) • Standard Medical Option • Out-of-Area (OOA) Medical Option • High Value Medical Option Delta Pilots Medical Plan (DPMP)
	Hawaii Medical Service Association (HMSA)	Health Plan Hawaii
	Humana Health Plan	Humana Health Plan of Puerto Rico
Dental	Metropolitan Life Insurance Company (MetLife)	DFCMP • Comprehensive Dental Option • Preventive Dental Option DPMP Comprehensive Dental Option (not a separate election from DPMP coverage)
	CIGNA	CIGNA Dental Care (CDC)
Vision	Davis Vision	Davis Vision Plan

PLAN INFORMATION AND NOTICE

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain kinds of benefit plans be described to the participants of those plans in an SPD. This document is the SPD for the Delta Family-Care Medical Plan and the Delta Pilots Medical Plan, as applicable to certain retirees and survivors. The SPD for the Delta Vision Plan and the medical and dental HMOs is made up of both this document and the summary prepared and distributed by the insurer or HMO.

The SPD is only a summary of the healthcare benefits provided by the plans named above (the "Plans"); its purpose is to give you an overview of the major features of the Plans and does not cover all the terms of the Plans. The provisions of the Plans are defined in the official Plan documents, which govern the terms and operation of the Plans. The summary in this SPD does not take the place of those documents. If there is any conflict between the information in this SPD and the Plan documents, the Plan documents will govern.

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

Updates

In addition to this SPD, you may, from time to time, be notified of the posting of updates or Summaries of Material Modifications (SMMs) that describe changes to the benefits of the Plans described here. You should always timely refer to these updates, as well as the material in this SPD, to obtain the most recent information available about these benefits.

Notice of Company Rights

As with all Delta benefits, subject to collective bargaining provisions, Delta reserves the right to amend, modify, suspend or terminate all or any part of the Plans in its sole discretion at any time and for any reason. Any such amendment, modification, suspension or termination may apply to active employees, their dependents and beneficiaries, as well as former employees, inactive employees, retirees, disabled employees, employees on a leave of absence or furlough, as well as survivors and COBRA participants, and each of their dependents. Any amendment or modification may be applied prospectively or retroactively, and may be applied only to one group of participants, such as retirees, but not to other groups of participants.

In the event that a Plan is terminated, assets of the Plan, if any, will first be distributed to the claims of participants and beneficiaries that have been incurred and submitted to the Plan as of the termination date. However, there can be no assurance that the assets of a Plan, if any, will be sufficient to fully provide benefits to such participants and beneficiaries. Any remaining assets of the Plan will be disbursed to participants or beneficiaries who become eligible for benefits at a later date; however, in no event will any assets revert to Delta. The Delta Vision Plan is an insured plan and does not have plan assets to be distributed as described here.

The Plans may be amended or modified by resolution of the Board of Directors of Delta or by any person or persons authorized by the Board of Directors to take such actions. Delta and its vendors have the right to recover overpayments, regardless of the cause, nature or source of the overpayments.

Nothing in any of these Plans, including the receipt of benefits, is to be construed as a contract or guarantee of benefits.

Effective Date

This SPD summarizes the benefits available to eligible retirees and survivors under the Plans as of January 1, 2008, unless otherwise noted.

Obtaining a Printed Copy of This SPD

If you would like to have a printed copy of this SPD, call the Delta Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** to learn how you can receive a printed copy.

Other Information

If you have questions after reviewing this SPD, refer to “Where to Get More Information” section at the back of this SPD.

ELIGIBILITY

ELIGIBILITY

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

Eligible Participants

The following groups and their eligible dependents are eligible to participate in the Delta healthcare benefit described in this SPD:

- Eligible flight attendant, ground and flight dispatcher retirees under age 65 with a retirement date of 01/01/2008 or before and their dependents and survivors who are under age 65
- Eligible survivors of active and inactive flight attendant, ground and flight dispatcher employees who died before 2/01/2008, if the survivor is under age 65
- Pilot retirees with a retirement date of 06/01/2006 or earlier and their survivors
- Inactive or terminated pilots (including those on disability) who were age 60 or over as of 6/1/06 and their survivors
- Inactive or terminated pilots (including those on disability) who were under age 60 as of 6/1/06 and not on the seniority list as of 1/1/07 and their survivors
- Survivors of pilots who died from active status prior to 1/1/97 or from disability that began before 1/1/97
- Survivors of pilots who died from active status on or after 1/1/97 and would have been age 60 or over as of 6/1/06, if living
- Survivors of pilots who died from disability that began on or after 1/1/97 and would have been age 60 or over as of 6/1/06, if living
- Individuals on COBRA continuation coverage with open enrollment rights to options under the Delta Family-Care Medical Plan and Delta Pilots Medical Plan

Under Age 65

Medical and dental benefits under the DFCMP are available to retirees and their eligible dependents and survivors under age 65. If you are a pilot retiree or survivor, you also have the option of coverage under the DPMP. Vision benefits are also available to retirees and their eligible dependents and survivors under age 65.

Ground, Flight Attendant and Flight Dispatcher Survivors

Survivors of retirees who retired on or before July 1, 2003 (or on or before January 1, 2006 for flight dispatchers) or survivors of employees who died from active service or disability before July 1, 2003 (or before January 1, 2006 for flight dispatchers)

Eligible survivors of Delta regular full-time, regular part-time ground, flight attendant or flight dispatcher employees and retirees who retired at age 52 or older are eligible for medical, dental and vision coverage during the time they are receiving monthly survivor income benefits from the Delta

Family-Care Disability and Survivorship Plan. Eligible survivors are determined under the terms of the Delta Family-Care Disability and Survivorship Plan and may include legal spouses or domestic partner/same sex spouses, as well as the employee's or retiree's dependent children under age 19 (or age 23 if a full-time student). Retirees who retired prior to age 52 are not eligible for monthly survivor income benefits so their family members will not be eligible for medical, dental or vision coverage after the retirees' death.

Survivors of retirees who retired after July 1, 2003 (or after January 1, 2006 for flight dispatchers) and on or before January 1, 2008 or survivors of employees who died from active service or disability on or after July 1, 2003 (or on or after January 1, 2006 for flight dispatchers) and before February 2, 2008

The monthly income survivor benefit from the Delta Family-Care Disability and Survivorship Plan for the survivors of ground, flight attendant and flight dispatcher employees who died from active or disabled status after July 1, 2003 (or January 1, 2006 for flight dispatchers) or retirees that retired after July 1, 2003 (or after January 1, 2006 for flight dispatchers) at age 52 or older is paid for a maximum of 10 years following the retiree's or employee's death. During the time that the survivors are receiving monthly survivor income benefits from the Delta Family-Care Disability and Survivorship Plan, they will be eligible for Delta medical, dental and vision benefits. However, when those survivor income benefits stop due to reaching the 10-year maximum period, the survivors of those retirees and employees who had 10 or more years of service as of their retirement date (or if the employee died from active service or disability at the time of his or her death) will continue to be eligible for Delta medical, dental and vision benefits while they meet the eligibility standards of the medical plan (see Dependent Eligibility section below), but generally until age 19 for children (or age 23 if they are a full time student) and age 65 for an eligible spouse (regardless of whether the spouse remarries after the retiree's or employee's death). The survivors of retirees and employees who did not have 10 years of service as of the applicable time, will not be eligible for medical, dental and vision benefits following the 10-year period in which monthly survivor income benefits are paid. In addition, the family members of retirees who retired before age 52 are not eligible for Delta medical, dental or vision coverage after the retiree's death.

Pilot Survivors

Eligible survivors of Delta pilots and pilot retirees who are eligible to receive monthly survivor income benefits from the Delta Pilots Disability and Survivorship Plan are eligible for Delta medical, dental and vision coverage during the time they are receiving monthly survivor income benefits from the Delta Pilots Disability and Survivorship Plan. Eligible survivors are determined under the terms of the Delta Pilots Disability and Survivorship Plan and may include legal spouses or domestic partner/same sex spouses, as well as the employee's or retiree's dependent children under age 19 (or age 23 if a full-time student). Generally, those family members who meet the following requirements are eligible for monthly survivor income benefits from the Delta Pilots Disability and Survivorship Plan, and therefore Delta medical, dental and vision coverage:

- The legal spouse/domestic partner (only for retirees who retired on 1/1/02 or after) at the time of the Delta pilot's death, but not a spouse/domestic partner whom the pilot or acquired after retirement, while disabled or while not actively at work (unless the pilot returned to active work after such marriage), or
- The natural born or legally adopted child of the deceased pilot (for whom the pilot provided more than 50% support at the time of his or her death)

In some circumstances, evidence that the pilot was in good health between the date of marriage/domestic partnership formation or adoption and the last day the pilot worked may be required before the family member will be considered a survivor.

Ex-Spouses of Disabled or Retired Pilots

If you are a disabled or retired pilot who divorced the spouse to whom you were married at the time you became disabled or retired — and the spouse was eligible for the plan and on record in Delta's Human Resources system at the time of your retirement or disability — that ex-spouse remains eligible for Delta medical or medical/dental coverage after the divorce. He or she is responsible for payment of any applicable Premiums for this coverage.

However, medical and/or dental coverage ends for that spouse at the time of your death, or in the case of the ex-spouse of a disabled pilot, when he or she remarries. Following your death, your ex-spouse may be eligible to elect COBRA coverage; see the "COBRA Continuation Coverage" section of this SPD for details.

Age 65 or Older

You and/or your eligible dependents age 65 or older are not eligible to enroll in DFCMP medical or dental coverage, or in Delta vision coverage. However, if you are a pilot retiree or survivor you may enroll for the DPMP after reaching age 65, or if you are a lifetime COBRA participant you may continue to be enrolled in the DFCMP medical options.

Lifetime COBRA Participants

Certain participants in the Delta retiree healthcare plans may be eligible for lifetime COBRA continuation coverage if they elected that coverage when it was offered to them during Delta's bankruptcy and have continued the coverage. If a retiree is continuing lifetime COBRA at the time of his or her death, the retiree's dependents who were covered under the lifetime COBRA coverage on the day before the retiree's death may elect an additional 36 months of COBRA coverage within an election period. No COBRA rights will extend beyond 36 months following the retiree's death.

Eligible Dependents of Retirees

Medical, dental and vision benefits also are available to the eligible dependents of retirees. A retiree's eligible dependents include family members that meet the following requirements. Note that, unless a HIPAA new dependent special enrollment event applies and the retiree notifies Delta within 30 days of that event, new dependents acquired after retirement will not be eligible for Delta medical, dental and vision coverage. See the "Life Events" section of this SPD for information about the HIPAA new dependent special enrollment event and the requirements that must be followed by the retiree. Eligible dependents are:

- Your legal spouse
- Your domestic partner/same sex spouse (this applies to ground, flight attendant retirees who retired after October 5, 2000 and pilot retirees or disabled pilots who retired or became disabled on or after January 1, 2002. See Domestic Partner/Same Sex Spouses later in this section for details)
- Your eligible children (as defined by the medical plan):
  - Natural born or legally adopted children up to age 19 if they:
    - > Have never been married (no exemption for annulments)
    - > Are not employed full-time
    - > Reside permanently in your household, or
    - > Reside outside your household, and you provide more than 50% support

  - Natural born or legally adopted children age 19 to 23 if they:
    - Are full-time students or involved in qualified missionary service (see Young Adults Aged 19 to 23 later in this section for details)
    - Have never been married (no exemption for annulments)
    - Are not employed full-time
    - Reside permanently in your household, or
    - Reside outside your household and you provide more than 50% support
- Stepchildren who have lived in your household (the Delta retiree's home) for 30 full and continuous days (other than time spent living at school) if they meet the other criteria for natural born and legally adopted children
- Children of your domestic partner/same sex spouse who live in your household, if they meet the other criteria for natural born and legally adopted children
- Children, regardless of age, who are incapable of self-support due to mental or physical handicaps if the handicap occurred before meeting the plan's maximum age limits (age 19, or 23 if a full-time student/qualified missionary); incapacitation approval is required before reaching age limits
- Children for whom you have been appointed legal guardian by a court, who meet the other criteria for natural born and legally adopted children, and who live permanently in the Delta retiree's home (other than time spent living at school)
- Children who are alternate recipients under a Qualified Medical Child Support Order (QMCSO) who have been approved by the Plan Administrator

Qualified Medical Child Support Orders (QMCSOs)

The plans maintain written procedures governing the intake and approval of QMCSOs. You have the right to receive, without charge, a copy of the QMCSO procedures. You may request a copy of these procedures by contacting the Delta Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)**.

Attention, Delta Couples

If both you and your spouse or domestic partner/same sex spouse are retired from Delta, you cannot be covered as both a retiree *and* a dependent. Also if you are a Delta retiree and married to an active Delta employee, you cannot be covered as both a retiree and a dependent of an active employee. Your coverage options are:

- You may each be covered as a retiree/employee only, or
- You may be covered as a retiree, and your spouse or domestic partner/same sex spouse may be covered as your dependent (or vice versa)

Children may be covered by one parent only.

Domestic Partners/Same Sex Spouses

Ground, flight attendant and flight dispatcher retirees who retired after October 5, 2000 and pilot retirees or disabled pilots who retired or became disabled on or after January 1, 2002 may enroll their domestic partner/same sex spouse for medical, dental or vision benefits through Delta. Retirees with retirement dates (and disabled pilots with disability dates) before those stated above are not eligible to enroll domestic partners or same sex spouses in Delta medical, dental or vision benefits.

You must complete an Affidavit of Domestic Partnership, which you may obtain online by clicking on "Forms" on the Employee Connection site on DeltaNet or by calling the ESC at **1-800 MY DELTA (1-800-693-3582)**. The affidavit asks you to certify that your domestic partner meets all of the following eligibility criteria:

- You and this dependent are the same gender
- This dependent is at least 18 years old
- You and this dependent are not legally married or the common law spouse of any other person
- If you and this dependent reside in a state that recognizes same-sex marriage, that you have been and are married to each other
- You and this dependent are not engaged in another domestic partnership
- You and this dependent are not related by blood or law
- You and this dependent reside in the same permanent residence and have lived in a spouse-like relationship for at least six continuous months
- You and this dependent are financially interdependent

You also may be required to provide some supporting documentation, such as joint banking information and/or proof of joint residency for a period of six or more consecutive months.

Children of Domestic Partners/Same Sex Spouses

The children of an eligible domestic partner/same sex spouse also may be eligible for medical, dental and vision coverage through Delta, if they meet the other criteria for natural born and legally adopted children and reside permanently in the household of you, the Delta retiree.

If you enroll your domestic partner/same sex spouse or an eligible child of your domestic partner/same sex spouse, you pay 100% of the cost of the coverage for this dependent.

Young Adults Aged 19 to 23

As a retiree, your children ages 19 to 23 will be eligible for healthcare coverage if they are either full-time students or in missionary service and meet the other eligibility requirements of the plan as described earlier.

Full-Time Students

Your dependent must meet the following eligibility criteria to be considered a full-time student:

Institution of study

- Your dependent must attend high school full-time at a school with a regular teaching staff, course of study, and a regularly enrolled body of students in attendance. This does not include home schooling, or
- Your dependent must attend, in person or via online courses, an accredited university or college that offers graduate and/or undergraduate courses toward a degree program and is accredited by an accreditation agency recognized by the United States Department of Education. A foreign university or college is acceptable if it meets its country's accreditation requirements. The college or university can be on a semester, quarter, or 4-1-4 system*; or
- Your dependent must attend, in person, a vocational/technical school accredited by a nationally recognized accreditation agency recognized by the Department of Education

* 4-1-4 students attend fall and spring term and a one-month term during January. Each credit at 4-1-4 school system is equivalent to four semester hours or six quarter hours. Students normally enroll in four courses for the fall and spring terms, and can take up to 2.25 courses during the summer.

Type of study

- Your dependent may be enrolled in a traditional course of study
- Your dependent may be enrolled in a full-time work/study program accredited as a Cooperative Education Program (Co-op), provided that the program is full-time and offered through a college or university that meets the requirements of the previous section ("Institution of study")
- Your dependent may participate in a full-time internship program under which undergraduate and graduate students receive credits that apply toward their degrees
- Your dependent is not considered a full-time student if he or she is enrolled in correspondence courses
- Your dependent is not considered a full-time student if he or she is enrolled in online courses on less than a full-time basis and/or if the institution offering these online courses does not meet the requirements of "Institution of study," which appears earlier in this section

Required course load / attendance requirements

- Your dependent must enroll in and complete a minimum of two-thirds of the school's required hours/credits to be considered a full-time student (under the school's requirements, based on records in the registrar's office)
- If your dependent attends a school that offers year-round classes, the child is entitled to take one quarter or semester off each calendar year (based on whether the school has quarters or semesters) without losing his or her status as a full-time student. However, if the school does not offer classes year-round, your dependent may only take off the summer session without losing his or her full-time student status. Note that your dependent cannot take off two consecutive quarters/semesters without losing his or her eligibility under the plans
- Your dependent also may be employed full-time as long as he or she meets all of the requirements for full-time student status during the time that he or she is employed

Approved time off from classes

- If your dependent stops his or her studies in the middle of a quarter/semester, then he or she is eligible under the plans as a full-time student for the remainder of that quarter/semester. However, that quarter/semester counts as your dependent's one free quarter/semester for the calendar year
- If, on your dependent's 19th birthday, he or she is not attending school full-time, he or she remains a full-time student under the plan during a 90-day grace period
- If your dependent graduates from high school or a college/university and is scheduled to attend a college/university or graduate degree program in the fall semester or quarter, he or she is allowed to take off the length of the summer session for the institution he or she plans to attend, even if that period is longer than 90 days
- If the child follows a 4-1-4 calendar system, he or she may take one semester/quarter off each calendar year

Documenting full-time student status

If you are required to submit verification of full-time student status to the ESC, you must provide the following acceptable forms of documentation:

- Your most recent tax return noting full-time student status, or
- 1098-T Form, or
- Paid tuition receipt for the current semester that displays the name of the educational institution, or
- Most recent report card that displays the name of the educational institution, or
- Most recent transcript that displays the name of the educational institution
  and
- Registration indicating student status or number of credit hours for the current semester, or
- Class schedule for the current semester

Missionary Service

Missionary service is defined as voluntary, unpaid, full-time work devoted to a ministry (preaching, education or medical work) commissioned by a church or other religious organization for the purpose of propagating its faith or carrying on humanitarian work. "Unpaid" means that the individual in missionary service does not directly or indirectly receive any salary, pay allowance, expenses or other remuneration or compensation while, or on account of, performing the service. It is intended that an individual who is in qualified missionary service be primarily dependent upon the retiree for support while in such service.

If you are required to submit verification of missionary service to the ESC, you must provide a letter of missionary service that is satisfactory to the plan(s) and that is prepared and certified by the church or religious organization for which the missionary service is performed. The letter must contain:

- A detailed description of:
  - The missionary service performed by your dependent
  - The purpose of such missionary work
  - The name of the church or other religious organization for which such missionary service is performed

- The time period that your dependent is committed to perform such missionary service. Note that the plan only covers your qualified dependent for up to 24 months of missionary service
- The place (city/state/country) where the missionary service is performed
- Descriptions of any room, board, allowance, expenses, etc. that are to be paid to or on account of your dependent while in such missionary service
- A description of the church/religious organization for which the missionary service is performed and its purpose
- A statement indicating that the missionary service is voluntary

Initial Certification of Continued Eligibility on Dependent's 19th Birthday

Special certification requirements apply to dependents aged 19 to 23. On the first of the month before your dependent's birthday month, you will be sent a notification (for example, your child's birthday is February 15; therefore, the notice will be mailed January 1) that you must complete and return, along with the required documentation, to the ESC within 30 days. If you do not respond to the notification within 30 days or you are not able to certify that your dependent is a full-time student or in missionary service, your dependent's eligibility will end at the 90th day after his or her 19th birthday and, if eligible, a COBRA continuation election will be extended to him or her.

Continued Verification of Dependent's Eligibility

At six month intervals (in February and September), you will receive a "Full-time Student/Qualified Missionary Service Verification" notice from the ESC advising that it is time to again verify your dependent's full-time student/missionary service status through an online process on the Benefits Direct enrollment site on DeltaNet. You will be asked a series of questions to which you must provide "yes" or "no" answers. If you are not able to verify that your dependent continues to be a full-time student or in missionary service — or you do not complete the online verification process by the verification deadline — your dependent's eligibility for the plan will end on the coverage expiration date noted in your verification notice. In addition, COBRA continuation coverage will not be extended to your dependent.

Following online verification, Delta will conduct a random audit of the population that has completed the verification. If you are selected, you will receive a Full-Time Student/Qualified Missionary Service Verification notice from the ESC for audit purposes. You will be required to complete the enclosed "Full-Time Student/Qualified Missionary Service Verification Form" and provide documentation to substantiate eligibility. If you are unable to provide the requested documentation, the documentation provided is not acceptable, or you do not respond by the verification deadline stated in the notice, your dependent's eligibility for the plan will be retroactively cancelled and COBRA continuation coverage will **not** be offered to your dependent.

The coverage cancellation date is:

- The last date that full-time student/qualified missionary service verification was completed, or
- The date that your dependent was last verified as a full-time student, or
- The date that your dependent last completed a qualified missionary service

If, at any time, your child no longer meets the full-time student or missionary service qualifications, it is your responsibility to report the dependent's loss of eligibility through the online reporting feature "Change Coverage" on Benefits Direct. See the "Life Events" section of this SPD for more details on loss of eligibility and how to report it. If you do not report this loss of eligibility in a timely manner, or if you falsify any eligibility verification information, this may result in collection of overpaid benefits and possible termination of benefits.

New Dependent Documentation Requirements

To add most new dependents to your health benefits, you must access the Benefits Direct online enrollment tool on DeltaNet. (See the "Life Events" section of this SPD for more information about when you may add a new dependent.) The online process will walk you through a series of questions to which you answer "yes" or "no." At the end of the process, you will be notified whether your dependent meets the eligibility requirements based on your answers.

A random audit is performed of those individuals who reported a life event change online during the same time frame that you did. If you are chosen to be audited, you will be required to provide documentation to substantiate your dependent's eligibility. If you are not able to provide this documentation, the documentation is not acceptable, or you do not complete the "Dependent Coverage Audit" form and respond in a timely manner, your dependent's eligibility for the plan will be cancelled retroactive to the date your dependent was recently added to coverage through Benefits Direct. COBRA continuation coverage will **not** be offered for failure to respond timely or completely to the audit request.

The timely reporting of some life event changes will continue to require you to complete a Family Status Change Form that you must submit to the ESC, along with proper documentation of eligibility. See the "Life Events" section of this SPD for a list of the types of new dependent qualifying events that require completion of the form.

Acceptable forms of proof are outlined in the following chart, as well as on the Benefits Direct online enrollment tool (which is where you add your dependent).

Acceptable Proof of Eligibility for Certain Covered Dependents	
Dependent	**Acceptable Documentation**
Spouse	A marriage certificate showing the names of you and your spouse If your marriage did not occur in the current year, a copy of the first page of your federal tax return from the prior year, or two alternate documents demonstrating financial interdependence (for example, joint bank account statement, mortgage statement, lease, credit card statement)
Domestic Partner	Proof of financial interdependence, such as joint mortgage, lease or deed records, joint banking or credit card accounts, designation of the domestic partner as durable power of attorney or other similar documentation; **and** A notarized Affidavit of Domestic Partnership (completed and notarized within the last 30 days). An Affidavit of Domestic Partnership form can be found on DeltaNet's Employee Connection, in "Forms" on Employee Self-Service
Same Sex Spouse	A marriage license in states with same-sex marriages If your marriage did not occur in the current calendar year, provide two documents demonstrating proof of financial interdependence (such as joint bank account, mortgage lease, credit cards)
Child (Natural Born)	A birth certificate showing you as the parent; **and** A Social Security card for this dependent (for a newborn, you may not have this card yet); **and** Documentation verifying residency (first page of most recent tax return, or if divorced and not claiming the child on your tax return, the divorce decree or court order showing that the retiree has full custody of child)

Acceptable Proof of Eligibility for Certain Covered Dependents	
Dependent	**Acceptable Documentation**
Child (Natural Born, Out of House)	A birth certificate showing you as the parent; **and** A Social Security card for this dependent (for a newborn, you may not have this card yet); **and** Documentation verifying financial support, including one of the following: acceptable divorce decree, custody agreement or court order showing the name of the child and the level of support the retiree provides — or proof of a pattern of support in the form of cancelled checks for a recent six-month period; **and** If you claim this child as a dependent on your tax return, proof that you are the non-custodial parent claiming the child as a dependent (your most recent tax return)
Child (Step)	A birth certificate or adoption order showing your spouse as the parent; **and** A Social Security card for this dependent (for a newborn, you may not have this card yet); **and** Documentation verifying residency (first page of your most recent tax return, or if divorced and not claiming the child on your tax return, the divorce decree or court order showing that your spouse has full custody of the child)
Child (Adopted)	An adoption placement order, a petition to adopt, or an adoption finalization order; **and** A Social Security card for this dependent; **and** Documentation verifying residency (first page of your most recent tax return, or if divorced and not claiming the child on your tax return, the divorce decree or court order showing that the retiree has full custody of the child)
Child (Adopted, Out of House)	An adoption placement order, a petition to adopt or an adoption finalization order; **and** A Social Security card for this dependent; **and** Documentation verifying financial support (one of the following: acceptable divorce decree, custody agreement or court order showing the name of the child and the level of support that the retiree provides — or proof of a pattern of support in the form of cancelled checks for a recent six-month period)
Child of Domestic Partner/ Same Sex Spouse	A birth certificate showing your domestic partner or same sex spouse as the parent, or an adoption placement order, petition to adopt, or adoption finalization order; **and** A Social Security card for this dependent (for a newborn, you may not have this card yet); **and** Documentation verifying residency (first page of your most recent tax return, or if divorced and not claiming the child on your tax return, the divorce decree or court order showing your domestic partner/same sex spouse has full custody of the child)

For more information about proving dependent eligibility, you may contact the ESC at **1-800 MY DELTA (1-800-693-3582)**, Monday – Friday 8 a.m.-5 p.m., Eastern time. You also can access Benefits Direct through Employee Connection, 24 hours a day, seven days a week.

Non-Qualifying Dependents

Your dependent may not meet the criteria for an eligible dependent. For instance, you may have a child who does not meet the principal residency requirement because he or she lives with another relative for the majority of the year.

You have a "non-qualifying dependent" if you have a natural born or adopted child who meets the requirements for child eligibility discussed in this SPD, except he or she does not share your principal residence for more than one-half of the calendar year, but lives instead with the child's relative (other than the child's other parent). You may enroll your non-qualifying dependents in Delta healthcare benefits. However, you are required to pay the full Premium for such a child (unless you are already doing so).

Covering Children in Separate Households

If you cover children in more than one household, you are required to pay an additional monthly Premium of $35 in addition to your other healthcare paycheck deductions. The separate household Premium remains in effect for the entire calendar year unless you have a qualifying life event (such as marriage, divorce or the birth of another child). See the "Life Events" section of this SPD for more details.

Who Is Not Eligible

The following groups are not eligible to enroll themselves or their dependents in the Delta Family-Care Medical Plan These individuals may be eligible for the Delta Account Based Healthcare Plan (and, if a pilot, the DPMP). (See the *Healthcare Benefit Handbook for Active, Inactive, COBRA and Certain Retiree and Survivor Participants*.)

- Eligible pilot, flight attendant, ground and flight dispatcher employees on active payroll status
- Eligible pilot, flight attendant, ground and flight dispatcher employees on an inactive pay status, other than certain inactive pilots who were not on the seniority list on 6/1/06
- Individuals on standard COBRA continuation coverage with open enrollment rights to options under the Delta Account-Based Healthcare Plan
- Eligible flight attendant, ground and flight dispatcher employees who retire on or after 2/01/2008 and their survivors, if under age 65
- Eligible survivors of active and inactive flight attendant, ground and flight dispatcher employees who die on or after 2/01/2008, if under age 65
- Eligible pilots who retired after 6/01/2006 and their survivors
- Eligible survivors of pilots who were on the seniority list on 6/1/2006 and died while on active or disabled status
- Certain eligible survivors of post-97 pilots who died while on active or disabled status
- Certain eligible disabled pilots who have been removed from the seniority list due to having reached 10 years on disability

When Coverage Begins

When you retire or your spouse dies, if you are eligible you have the option of electing 18 months of COBRA coverage (retirees), a Delta retiree or survivor medical and/or dental option or waiving coverage. If you elect Delta retiree coverage, your coverage will be retroactive back to your retirement date once you complete your retiree 30-day enrollment period.

If you elect COBRA, your coverage is retroactive back to your retirement date once you have completed the COBRA enrollment application and made payment to the COBRA administrator — Ceridian COBRA Continuation Services.

Whenever your COBRA coverage period ends (typically, at the end of 18 months), you may immediately enroll in a Delta retiree medical option without having to wait for the annual open enrollment period. This means that, as long as your COBRA Premiums are timely paid and you follow the proper enrollment procedures in a timely manner (for instance, you notify the ESC within 30 days of the end of your COBRA coverage), you should not have any lapse in coverage.

When Coverage Ends

For You

Your coverage for medical, dental and vision coverage ends on the *earliest* of the following:

- The last day of the month in which a retiree dies (review the survivor information that appears earlier in this “Eligibility” section)
- The first day of month in which you reach age 65, if you are a retiree or survivor (or the first day of the previous month if your birthday is on the first of the month)
- The last day of month you fail to pay required Premiums by the specified deadline
- The start of a plan year in which you have selected the “No Coverage” option
- The day the plan is terminated

If the loss of coverage event listed above is a COBRA qualifying event, you will be sent a COBRA election package that enables you to elect to continue your coverage for up to 18 (or 36) months.

For Your Dependents

For your dependents, medical, dental and vision coverage ends on the *earliest* of the following:

- The day the retiree’s coverage ends
- The end of the month in which you voluntarily drop coverage for your dependent
- The start of a plan year in which you elect not to cover a dependent
- The day your dependent dies (only coverage for that dependent ends)
- The first day of the month in which your dependent turns age 65 (or the first day of the previous month if your dependent’s birthday is on the first of the month)
- The end of the month in which your dependent no longer meets the plan’s eligibility rules (including not qualifying for survivor income benefits or the termination of survivor income benefits)

- The end of the month for which you failed to make any required Contributions for your dependent's coverage
- The end of the month for which you did not provide requested proof of your dependent's eligibility
- The effective date of any amendment causing your dependent to lose eligibility for coverage
- The day the plan is terminated

If your legal relationship with a spouse or a domestic partner/same sex spouse is ending, benefits coverage for that individual ends on:

- The date of your final divorce decree, or
- The date of an affidavit affirming the end of your domestic partnership

For dependent children, coverage for benefits ends on the last day of the month in which:

- They marry
- They become ineligible due to age, student status or qualified missionary status
- They become employed full-time
- They move out of your household and no longer rely on you for 50% or more support, or you no longer provide 50% support for of an out-of-house child
- In the case of stepchildren, you are no longer married to the child's parent
- Any other eligibility requirement is not met

Coverage ends for ex-spouses of disabled or retired pilots on the last day of the month when:

- Your ex-spouse remarries, or
- You (the retiree or disabled pilots) die at which point, your ex-spouse may elect COBRA continuation coverage

Coverages End Due to Non-Payment of Premium

Your coverage ends — and you are no longer eligible to enroll in Delta healthcare benefits — if you do not pay your Premiums on time. Your healthcare coverage ends if you are more than 90 days late with retiree or survivor benefit Premiums (payments are due on the first day of the month for that month's coverage).

You might miss paying a Premium for a variety of reasons, such as:

- You did not mail a Premium payment (if you pay via direct bill)
- Your account cannot cover your Premium payment for reasons such as insufficient funds, stop payment orders, bad account information, errors written on a check, and closing of the account
- Your Direct Debit Authorization Form (if you have submitted one to the ESC) has errors that prevent your direct debit arrangement from being processed, or you did not submit a cancelled check
- You sent your Premiums to the wrong address. The correct address is:

  ACS HR Solutions for Delta Air Lines
  Box 382119
  Pittsburgh, PA 15251-8119

If You Do Not Pay Your Premiums or Pay Late

- If full payment is not received within 60 days of the payment due date, a $25 late fee is added to your account and is reflected on your next invoice
  - If you are a direct debit participant, your payment method may be switched to direct bill if Delta is unable to process a deduction for your benefits coverage. A debit failure may occur for many reasons, including incorrect account information, insufficient funds or a closed account. If your debit is rejected because of insufficient funds, a $25 fee is charged to your account. After you have sent a check for the full amount owed, you may re-elect the direct debit payment method via Benefits Direct or by contacting the ESC to request a new Direct Debit Authorization Form
- If full payment is not received within 90 days of the payment due date, your benefit coverage is terminated retroactively to the end of the last month for which full payment was received. Once coverage is terminated for late or missing payments, your coverage cannot be reinstated, and you become responsible for the cost of any claims incurred as of the coverage termination date. Any payments received after your coverage is terminated will be returned to you
  - You will receive a HIPAA Certificate of Creditable Coverage as proof that you had Delta healthcare coverage (see below for more information)
  - You are not eligible for COBRA continuation coverage

Future Enrollment Rights

If your coverage is terminated for nonpayment, you and your dependents become excluded from future enrollment opportunities and unable to reenroll for lost coverage **under any circumstances**.

Requesting a Review of Your Coverage Termination

You or a representative designated in writing by you may request that the Administrative Subcommittee of the Delta Family-Care Medical Plan and/or the Delta Pilots Medical Plan review your medical and/or dental coverage termination. Direct your written request to:

Secretary, Administrative Subcommittee/
Delta Family-Care Medical Plan/Delta Pilots Medical Plan
Delta Air Lines, Inc.
Department 844
P.O. Box 20706
Atlanta, GA 30320-6001

Certificates of Coverage

If your medical coverage ends for any reason or length of time — even temporarily — Delta, through the ESC, provides the affected person with a “certificate of coverage,” also commonly called a “HIPAA notice/certificate.” This notice certifies the period during which that person was covered under the Delta healthcare plan. The person to whom it is issued can use this certificate when he or she tries to gain coverage under another plan that has a Pre-Existing Condition limitation.

Federal law requires that the plan provide a certificate of creditable coverage if you or a dependent loses coverage under the plan. In some circumstances, the certificate is sent to you automatically. On request, the plan provides the certificate as long the request is made while you, your spouse, domestic partner/same sex spouse or your dependent is covered under the plan or within 24 months after plan coverage terminates. The request also can be made by someone else on behalf of you, your spouse, domestic partner/same sex spouse or your dependent. For example, a dependent that was

previously covered under the plan may authorize his or her new healthcare plan to request a certificate of creditable coverage relating to prior coverage under the plan.

You, your domestic partner/same sex spouse and your dependents are entitled to receive a certificate of creditable coverage on request even if the plan has previously provided one. To make a request, contact the ESC at **1-800 MY DELTA** or **1-800-693-3582.**

Your request must include:

- The name of the individual for whom the certificate of creditable coverage is requested
- The last day that the individual was covered by the plan
- If the request is for a domestic partner/same sex spouse or child, the name of the retiree under whom the dependent was enrolled
- The name of the person making the request and, if applicable, evidence of authority to request and receive the certificate of creditable coverage on behalf of another individual
- The address to which the certificate of creditable coverage should be sent
- The requester's signature

ENROLLING FOR HEALTHCARE BENEFITS

ENROLLING FOR HEALTHCARE BENEFITS

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

Enrolling During Annual Open Enrollment

Each fall, an Annual Open Enrollment is held for eligible retirees, survivors and COBRA participants. The benefit decisions you make during Annual Open Enrollment are effective during the following plan year (from January 1 to December 31). You may not change your elections during the year unless you have a qualified life event change. See the "Life Events" section of this SPD for more details.

Different enrollment rules may apply, as outlined here.

- **Under age 65:** Medical and dental benefits under the Delta Family-Care Medical Plan (DFCMP) and Delta vision benefits are available to you and/or your eligible dependents under age 65. If you are a pilot retiree or survivor, you also have the option of coverage under the Delta Pilots Medical Plan (DPMP)
- **Age 65 or older:** You and/or your eligible dependents age 65 or older are not eligible to enroll in Delta Family-Care Medical Plan (DFCMP) medical or dental coverage or in Delta vision coverage. However, if you are an eligible pilot retiree or survivor, you may enroll in the Delta Pilots Medical Plan (DPMP) or if you are a lifetime COBRA participant you may continue to be enrolled by one of the lifetime COBRA Delta medical plans
- **COBRA participants:** COBRA participants may be eligible for either the Delta Family-Care Medical Plan (DFCMP) or the Delta Pilots Medical Plan (DPMP), as noted in the COBRA Open Enrollment materials that they receive in the mail from Ceridian (the COBRA administrator). If a COBRA participant waives COBRA coverage during an enrollment, that COBRA coverage cannot be reinstated in the future

While enrolled in COBRA coverage, you have the same enrollment rights as other similarly situated participants in the plan. You are required to continue paying applicable Premiums on a timely basis. If you fail to pay your required Premiums on a timely basis, your COBRA coverage will lapse and cannot be reinstated.

Rehires

If you are rehired by the company after having terminated employment with Delta (including rehired retirees), you are eligible to enroll for medical, dental, vision and Flexible Spending Accounts as an active employee. Any retiree coverage you had in effect before your rehire will cease when you are reemployed.

How to Enroll

You should complete your enrollment online. If you need help with the online enrollment tool, you may contact the Delta Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** before the enrollment deadline. International callers should dial **404-677-8000**.

Step 1: Enroll Online or Call

Visit DeltaNet online at **http://dlnet.delta.com**. You can use any computer with Internet access. You need a valid Delta Passport Password. (If you can access TravelNet or if you have home access to DeltaNet, you have a valid Passport Password.) If you do not know your Passport Password, go to **http://register.delta.com**.

After going to **http://dlnet.delta.com**, the Delta Extranet home page will be displayed. Enter your 9-digit employee number (Username), along with your Delta Passport Password to get to the DeltaNet home page. Once on the DeltaNet home page, go to Employee Connection at the top of the page. Select "Self-Service" from the drop-down menu. In the left navigation area, look for Benefits Direct under HR Applications.

Step 2: Review Your Options

Details about your benefit options, coverage levels and plan costs are available on Benefits Direct. There, you can review your current coverage on the online Enrollment Worksheet and make sure you are signed up for the options that best meet your needs. Be sure to look at the online Enrollment Worksheet to see the coverage you will receive if you don't make any elections during Annual Open Enrollment.

Also, in the same area of Benefits Direct where you enroll, you will find links to provider Web sites. This makes it easy to learn if your doctor or provider is in the plan's network.

Step 3: Update Your Elections

Once you have determined what is available and best meets your needs, make your elections. You must make your elections by the deadline communicated to you. If you do not make changes during your enrollment period, you are automatically enrolled in the default coverage shown on your online Enrollment Worksheet on Benefits Direct.

You will not have another opportunity to change your elections until the next annual open enrollment period, unless you experience a qualified life event change.

If you are currently enrolled but wish to decline coverage, you must actively enroll in the "No Coverage" option.

Step 4: Submit Elections

After you have updated your elections, click "Submit Changes" to ensure that any changes you have made are received. If you do not see a message confirming that your elections have been saved, your changes will not be effective.

Step 5: Confirm, Revise If Needed

Be sure to print the online confirmation page so you have a record of the elections you have made.

If you want to change those elections before the end of the enrollment period, go back to the enrollment area of Benefits Direct and make new elections. When you are done, click "Submit Changes" and print your confirmation page again. Remember, when you make a change, you should print your confirmation page so you have a record of your elections.

> Enrollment Problems?
>
> If you need help getting to the benefits enrollment site or have questions about enrollment, you may call the ESC at **1-800 MY DELTA (1-800-693-3582)** for assistance. International callers should dial **404-677-8000**.

If You Do Not Enroll

Be sure you understand what happens if you do not enroll for benefits or if you enroll in the "No Coverage" option. Also refer to "Waiving Coverage" later in this "Enrolling for Healthcare Benefits" section of this SPD.

During Annual Open Enrollment

If you are enrolled in Delta benefits and you do not actively make a benefit election during Annual Open Enrollment, you are automatically enrolled in the coverage shown in the default coverage chart on your online Enrollment Worksheet. You are assigned the coverage in effect at the end of the previous year, provided that particular benefit plan is still offered. Default coverage requires you to pay applicable Premium Contributions.

If you wish to decline coverage and avoid incurring such costs, you must actively enroll in the "No Coverage" option during the annual open enrollment period. Before deciding not to actively enroll, be certain the default coverage meets your needs. Also, remember that you have the option to "opt in" and to "opt out" of benefit coverage each year during the annual open enrollment period, until you reach age 65, as long as you remain eligible for retiree/survivor benefits. (Pilot retirees and survivors continue to be eligible to elect the DPMP after reaching age 65.)

You will not have another opportunity to change your elections until the next annual open enrollment period, unless you experience a qualified life event (marriage, birth of a child, divorce, etc.).

Waiving Coverage

You have the option of selecting the "No Coverage" medical and/or dental option. If you waive medical and/or dental coverage during the annual open enrollment period, it is important to note the following.

If You Are ...	And You Choose the "No Coverage" Option ...
A retired participant	You waive medical and/or dental coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot get coverage for the calendar year unless: • You or your dependent experiences eligible special enrollment events (see the "Life Events" section of this SPD); or • You die and your survivors are eligible for monthly survivor benefits under the Delta Disability and Survivorship Plan* (D&S Plan)
A retired employee and you die	Your eligible survivors (as determined by the Delta Disability and Survivorship Plans for monthly survivor benefits) may enroll in coverage when you die and during future annual open enrollments as long as they remain eligible for monthly income survivor benefits under both a Delta Disability and Survivorship (D&S) Plan* and a Delta Medical Plan. Those eligible family members who are not eligible for monthly survivor income benefits may be eligible for COBRA continuation coverage after your death for up to 36 months.
A survivor eligible for Delta medical benefits*	You waive medical and/or dental coverage for the entire year
A COBRA participant**	You waive your right to elect Delta medical or dental coverage forever

Note: The Delta Family-Care Medical Plan is offered only to eligible retirees, disabled participants, survivors, or dependents **under age 65**.

* The survivors of some ground retirees are eligible for monthly income survivor benefits for a limited period of time (up to ten years). To address what happens to eligibility for medical and or dental coverage after this period ends, the eligibility criteria for ground employee survivor medical and dental benefits have been updated. See the "Eligibility" section of this SPD for details.

** Retirees who elect COBRA may be able to elect Delta retiree medical coverage upon the expiration of COBRA rights. See the "COBRA Continuation Coverage" section for more information on electing COBRA coverage, when coverage ends and electing retiree medical coverage.

Changing Your Coverage During the Year

After you initially enroll for benefits, you may not make changes to your benefit elections or changes to the dependents you have covered until each fall's annual open enrollment period (with elections effective the following January 1, unless you have a qualified life event, such as marriage or the birth of a child.) See the "Life Events" section of this SPD for more details.

If you have declined enrollment and elected the "No Coverage" option for yourself or your dependents (including your spouse or domestic partner/same sex spouse) because of other health insurance coverage, and that other coverage later ends, you may be able to enroll yourself or your dependents in Delta coverage. This is a Health Insurance Portability and Accountability Act (HIPAA) loss of other coverage event, and you should report it within 30 days after your other coverage ends. See the "Life Events section" of this SPD for a definition of a HIPAA event.

In addition, if you are a retiree enrolled in coverage and have new dependents as a result of marriage, birth, adoption or placement for adoption, you may be able to add and enroll your eligible dependents to coverage, provided you report the life event and make new elections within 30 days of its occurrence. This is a Health Insurance Portability and Accountability Act (HIPAA) new dependent special enrollment event.

If you are a retiree, you must be enrolled in coverage to have the new dependent special enrollment right. Moreover, as a retiree, if your request for enrollment is not received within 30 days of the marriage, birth, adoption or placement for adoption, you may never add the new dependent to coverage.

Delta retirees not enrolled in Delta coverage and all eligible Delta survivors and ex-spouses of disabled/retired employees cannot add any newly acquired dependents.

The new dependent special enrollment event (not the loss of other coverage HIPAA event) applies to COBRA participants currently enrolled in medical coverage. If a COBRA participant waives his or her coverage, he or she relinquishes the right to COBRA continuation coverage forever for himself or herself. This is why the loss of other coverage HIPAA event does not apply.

See the “Life Events” section of this SPD for more details.

Call the ESC for More Information

If you have questions, you may call the ESC at **1-800 MY DELTA (1-800-693-3582)**.

How Long Elections Are Effective

Retirees and survivors currently enrolled in Delta benefits — The benefit elections you make during Annual Open Enrollment become effective on January 1 of the following year and remain in effect throughout the calendar year.

COBRA participants — If you are extending your Delta coverage by making a COBRA election you may change your benefit elections at the time of the COBRA enrollment by notifying the ESC. The COBRA enrollment package that you receive from Ceridian COBRA Continuation Services reflects the coverage in place on your last day of employment with Delta for you and your covered dependents. See the “COBRA Continuation Coverage” section of this SPD for more details about the amount of time that you are eligible to continue coverage though COBRA.

Log on to Benefits Direct on DeltaNet (**http://dlnet.delta.com**) to review your benefits coverage.

Paying for Coverage

There are two ways you can make Premium payments for your healthcare benefits: direct bill and pension/survivor/disability deduction.

Direct Bill

You can pay your Delta healthcare Premiums through direct bill payments (if you have not signed up for direct debit, see below) or for when no other method of payment is available, such as a pension, survivor or disability paycheck.

Direct bill is only set up for retired ground, flight attendant and flight dispatcher employees and pilot and ground survivors who do not have enough funds in their pension and/or disability or survivor check to cover their healthcare Premiums. Retired pilots are automatically set up for direct bill.

You can expect to receive your invoice around the 15th of the month. Payment is due on the first of the following month. Charges reflected on the invoice include any previous outstanding balance or credit, and the charges for the next month's Premiums.

Enrolling in Direct Debit

If you participate in direct bill and you can provide account information for a U.S. bank account, you may elect the direct debit payment method. Direct debit withdraws Premiums directly from your checking, savings, money market or credit union account, according to an established schedule.

To enroll in the direct debit payment method, log onto Benefits Direct on DeltaNet. If you do not have Internet access, you can enroll by completing a Direct Debit Authorization Form. To obtain the form, contact the ESC at **1-800 MY DELTA (1-800-693-3582)**. Complete and return the Direct Debit Authorization Form to:

Delta Employee Service Center
P.O. Box 52045
Phoenix, AZ 85072

Direct debit participants may modify their direct debit account information at any time.

Once enrolled in direct debit, you receive a statement indicating the amount that is set to be debited from your designated account. The amount debited from your bank account is always the total balance due. If your account cannot be debited for the full amount, the debit will be rejected. See "Coverages End Due to Nonpayment of Premium" later in this section for details.

Pension/Disability Deduction

If you receive a pension/disability/survivor benefit from Delta, the monthly cost for healthcare coverage is deducted from your pension/disability/survivor check. Deductions occur on the first of the month for that month's coverage.

When you newly retire as a non-pilot, you are automatically set up to have Premiums deducted from your monthly pension/disability check. When a participant's status changes from dependent to survivor, the survivor is automatically set up to have Premiums deducted from his or her monthly survivor benefit check.

Newly retired pilots are automatically set up to pay Premiums through direct bill, but Premium deductions can be taken from a pilot's disability check or the survivor benefit check of a pilot's surviving dependent.

There is an exception to this rule. If your Premium deduction amounts to 70% or more of your monthly pension/disability/survivor benefit, your Premium is not deducted from your pension/disability/survivor check. Instead, your payment method is switched to direct bill. If your pension/disability/survivor check increases or your monthly Premium deductions decrease, and therefore, your pension/disability/survivor check is able to support your total monthly Premium amount, you can request to have your payment method changed back to a pension/disability survivor check deduction — or you can elect to change your payment method to direct debit.

You always have the right to stop the deductions from your disability, survivor or retirement check for any reason by notifying the ESC. You will then be placed on direct bill.

If you are a COBRA participant, you must pay the Premium yourself (there are no deductions from pay or benefit checks). Refer to the "COBRA Continuation Coverage" section in this SPD for details.

Direct Bill/Direct Debit Participants:

Report Life Event Changes Within 30 Days

If you pay your Premiums through direct bill or direct debit, it is very important that you report any life event changes within 30 days of the event. See the "Life Events" section of this SPD to determine if you must complete a Family Status Change form or if you can report the event online on Benefits Direct. If such changes are not reported, ineligible dependents may continue to be covered, resulting in overpayments that you must repay.

Call the ESC at **1-800 MY DELTA or 1-800-693-3582**.

Refunds

If you cancel coverage or have overpaid, you may call the Employee Service Center to request a refund of your credit balance.

You may automatically receive a Premium refund if:

- Your status changes back to active and a credit balance exists
- You cancel coverage or you die with a credit balance
- You cancel coverage and a credit balance exists

Generally, changes to your payment method are timed so that refunds are not necessary. For example, a change from direct bill to direct debit is effective the first month for which no payment has been received.

To ensure that refunds are not issued for funds that may be recalled by the bank (due to non-sufficient funds), Delta waits 21 days after your funds have been deposited before issuing you a refund.

Once Delta determines that you are eligible for a refund, Delta verifies that your funds were deposited at least 21 days earlier. If your deposit was made fewer than 21 days earlier, your refund is delayed until the next refund cycle. If your deposit was made later, your refund is generated.

LIFE EVENTS

LIFE EVENTS

You may find that a major life event — such as a marriage — changes your benefit needs. For instance, you might want to add your new spouse to your Delta healthcare coverage.

In general, once you enroll in or waive coverage, your benefit elections and covered dependents stay in effect for the entire calendar year. However, under certain circumstances, you may enroll in certain coverages, add or remove covered dependents, or change certain coverages during the year.

Read this section for details on the changes you can make due to "life events." Note that some disabled pilots over age 60 who are off the seniority list participate in the plans. Accordingly, the term retiree as used in this SPD Section also includes these disabled pilots.

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

Delta's Retirees Can "Opt In" and "Opt Out" of Coverage

With Delta retiree healthcare, you are free to enroll in other insurance programs without losing your eligibility to one day re-enroll in Delta's healthcare benefits program. This is called "opting in" and "opting out" of Delta coverage.

As long as you and your dependents remain eligible, you may enroll in a Delta retiree healthcare benefit option during a future annual open enrollment period without being subject to any Pre-Existing Conditions limitations. You may be asked to provide proof that your other medical coverage has ended. Also, if your Delta retiree coverage ends due to failure to pay premiums, you will not be eligible for future enrollment in the Delta plans.

Once you or your eligible dependent reaches age 65, the over-age 65 family member is no longer eligible to participate in Delta retiree medical, dental and vision benefits, and cannot opt in and out of Delta coverages (there are two exceptions: pilot retirees continue to have the DPMP available to them and lifetime COBRA participants continue to have the Delta plans available to them).

If you enroll in a Delta retiree medical plan and you want to drop your Delta coverage mid-year, you may be asked to show proof to the ESC that you have other coverage. This means that you can provide an insurance card with an effective date or a letter from an insurance company showing that you have other coverage. If you do drop coverage, you may not reenroll again during that calendar year unless you qualify for a HIPAA special enrollment right.

When You May Change Your Medical/Dental/Vision Benefits

If you are a retiree, disabled pilot or survivor enrolled in coverage, you may make certain changes to your medical/dental/vision elections mid-year if you experience an event that permits that change (a "**qualified life event change**") and you report the change within 30 days of the event. **Note this 30-day window is a one-time chance to add a newly eligible dependent to Delta medical or dental coverage. If you do not report the event within this 30-day period, that new dependent can *never* be added to Delta coverage.**

A qualified life event change for retirees and survivors who are enrolled under the plan include the following events:

- Retiree adding a spouse due to marriage
- Retiree adding a domestic partner/same sex spouse (applicable to ground retirees who retired after October 5, 2000 and pilot retirees or disabled pilots who retired or became disabled on or after January 1, 2002.)
- Retiree losing a spouse/same sex spouse due to divorce, annulment or death
- Retiree losing a domestic partner due to death or dissolution of the domestic partnership
- Retiree adding a spouse/same sex spouse or dependent child due to marriage, birth, adoption or placement for adoption
- Retiree adding a dependent child due to a Qualified Medical Child Support Order (QMCSO)
- Retiree or survivor losing a covered child due to death of the child
- Any change that results in a dependent child losing his or her dependent status, such as marriage, gaining full-time employment, loss of student status or a child reaching the maximum age for coverage
- A change that results in a retiree's dependent child regaining his or her dependent status under the plans, such as a child resuming full-time student status (Note: This is limited to dependent children who were eligible at the time of the retiree's retirement. It does not allow the retiree to add newly eligible children)
- Retiree, retiree's spouse or survivor acquires other health insurance coverage mid-year
- Changes to correspond with a change made under another employer plan during that plan's annual open enrollment period if the other employer plan has a different plan year
- Changes because you or a dependent enrolled in or dropped Medicare or Medicaid coverage

Retirees and survivors who have opted out of coverage cannot make the above changes. The only event that will permit such retirees or survivors to enroll in the plan is the loss of other group health coverage that qualifies for a HIPAA special enrollment right (see section below). Therefore a retiree who has opted out of coverage at the time he marries, has a child, or adopts a child may not ever add that spouse or child to Delta coverage.

Any change you make to your medical, dental and vision elections must be consistent with the type of event you experience. For example, assume you are single when you first enroll, and you elect medical and dental coverage for yourself only. If you later get married, you can add your new spouse (and any eligible stepchildren) to your healthcare coverages within 30 days, but you cannot enroll in a different medical option. For more information on what types of medical, dental and vision benefit election changes are consistent with various qualified life events, see the Life Event Change Grid. (The Life Event Change Grid is available on the Forms and Documents page on Benefits Direct, as well as on the My Health & Insurance site located on Employee Connection on DeltaNet.)

Report Your Change Within 30 Days

All qualified life events must be reported within **30 days** of the qualified life event change for your requested benefit elections/changes to be considered valid. All participants (retirees, survivors and COBRA participants) have the same 30-day deadline. **Note that if an enrolled retiree's new dependent is not reported within 30 days of the qualified life event, that new dependent may never be added to Delta medical or dental coverage throughout retirement.**

Even If You Are Not Changing Benefits …
You must report life event changes even if you do not want to change your benefit elections, or even if you are not enrolled in Delta benefits coverage. You should do this because your life event change might affect other Delta benefits, such as pass privileges for you or your dependents.

See "How to Report a Life Event" later in this section of the SPD to learn the various ways that you may report your qualified life events and make applicable changes to your benefits.

Contact the Delta Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** with questions about reporting qualified life events.

HIPAA Special Enrollment Rights

The following information and rules are required by federal law under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You and/or your dependent(s) are eligible for a HIPAA special enrollment under the following circumstances.

Loss of Other Health Coverage

If you, your spouse or dependent were eligible but declined enrollment in Delta medical and/or dental coverage previously (when initially eligible, at annual open enrollment or when a qualified life event change occurred) because of other medical or dental coverage, and employer contributions toward the other medical or dental coverage end — or you and your dependents lose eligibility for the other coverage due to any of the following reasons:

- Divorce or legal separation
- Death
- The plan is changed so that you, your spouse or your dependent are no longer eligible
- Termination of employment
- Reduction in hours

Note: Loss of coverage due to nonpayment of Premiums, voluntarily discontinuing that coverage or fraud is not a special enrollment event. Also, special enrollment rights do not apply to vision coverage.

The special enrollment rights last for 30 days only. Therefore, you must enroll within 30 days after your or your dependents' other medical or dental coverage ends (or after the employer stops contributing toward the other medical or dental coverage) to have this right.

Exhaustion of COBRA Continuation Coverage

If you or a dependent are enrolled in medical or dental COBRA continuation coverage under another group health plan when you decline coverage under the Delta plan, you and/or your dependent must exhaust that COBRA continuation coverage before qualifying for a HIPAA special enrollment. This means you must continue your COBRA coverage for the maximum COBRA period. If you or a dependent lose COBRA coverage due to nonpayment of COBRA Premiums or failure to pay those Premiums timely, you are not eligible for a special enrollment in the Delta plan. COBRA terminating for cause (such as fraud) also is not a special enrollment event.

If you lose coverage under another group health plan (as explained above) and qualify for a special enrollment right, you can add yourself and any dependents that also lost that other coverage — and who satisfy the plan's eligibility rules — to Delta medical and dental coverage. You may add yourself to coverage so that you may enroll your eligible dependents that lost eligibility for their other coverage even if you did not lose other coverage yourself. If you want to add only yourself to coverage, you must have experienced a loss of eligibility for the other coverage for a HIPAA-qualified reason.

New Dependent Special Enrollment (Marriage, Birth, Adoption or Placement for Adoption)

A new dependent special enrollment is granted to retirees and COBRA participants ***enrolled*** in Delta medical and dental coverage at the time of the event. It does not apply to vision coverage.

This special enrollment right allows you to add a new dependent that meets the Delta plans' eligibility requirements if you acquired that dependent as a result of marriage, birth adoption or placement for adoption, as long as you, the Delta retiree or COBRA participant, are currently enrolled in coverage at the time of the HIPAA event. If you are not enrolled in Delta coverage at that time, you may not add that dependent to your medical and dental coverage.

You have to enroll or report the dependent within 30 days after marriage, birth, adoption or placement for adoption. If you enroll within 30 days, coverage is effective on the day of the event that qualified you for a special enrollment. You may be required to provide a copy of a certificate or other official paperwork showing the date of the event or proving the loss of other coverage.

Delta's Life Event Grid

Look Up Your Change … Learn What to Do

Do you think you have experienced a qualified life event? Look up your life event on Delta's Life Events Change Grid to learn which benefit election changes you may be eligible to make.

The Life Event Change Grid is available on the Forms and Documents page on Benefits Direct and on the My Health & Insurance site on Employee Connection on DeltaNet.

How to Report a Life Event

Qualified life event changes are reported in different ways depending on the nature of the change. Following are the two methods available to all retirees, survivors and lifetime COBRA participants.

Online Via Benefits Direct

You can go to Benefits Direct to report the following life events and make appropriate benefit election changes:

- Marriage
- Birth
- Adoption/placement for adoption
- Dependent gains eligibility
- Dependent loses eligibility
- Dependent changes full-time student status
- Loss of other coverage under HIPAA
- Change in spouse's work or benefit coverage

On Benefits Direct, click on the "Change Coverage" link to learn about or report a qualified life event change. If you are eligible, you can make benefit elections according to plan rules.

You may be asked to provide documentation confirming your dependents' eligibility for any events that you report online via Benefits Direct. Therefore, you should maintain all documentation as detailed on Benefits Direct. If you are unable to provide requested documentation, your life event change may be retroactively terminated, and you may be liable for claim costs paid by the plans for the ineligible family member.

Changing Your Benefits Online as a Result of a Qualified Life Event

Step 1: Go to **http://dlnet.delta.com**; the Delta Extranet home page will be displayed

Step 2: Enter your 9-digit employee number (Username), along with your Delta Passport password to get to the DeltaNet home page

Step 3: Once on the DeltaNet home page, click the link for Employee Connection at the top of the page

Step 4: Locate "Manage My …" (in the left navigation area), then click on "Insurance, Disability & Retirement Benefits" on Benefits Direct. This site allows you to review your current coverage and dependents, and make your elections

It is your responsibility to maintain complete and accurate dependent data. Your failure to do so may result in the denial of eligibility.

With a Family Status Change Form

To report the following events, you must complete and submit a Family Status Change Form to the ESC, along with supporting documentation, before any benefit election changes can occur. You can access this form on the Resource Materials/Documents & Forms section of Benefits Direct. Mail or fax completed forms to the address or fax number on the form.

- Divorce
- Death of a spouse
- Death of a child
- Establishing incapacitated status for a child
- Adding a domestic partner/same sex spouse
- Dropping a domestic partner/same sex spouse

Within 72 hours after you submit your Family Status Change Form, you must call the ESC to make sure your form was received. You can reach the ESC at **1-800 MY DELTA (1-800-693-3582)**.

Direct Bill and Direct Debit Participants

If you pay your Premiums through Direct Bill or Direct Debit invoicing, it is very important that you report any life event changes for a spouse/domestic partner or other dependent within 30 days of the event. If you do not do so, ineligible dependents may continue to be covered, resulting in possible overpayments from the plan that you must repay.

If you are a retiree or survivor, you must continue to pay all required Premiums in full on a timely basis to be eligible for future enrollment opportunities, including annual open enrollment. If benefits are cancelled for non-payment of Premiums, you **cannot** re-enroll in retiree/survivor benefits during a future annual open enrollment period.

If You Do Not Report Your Life Event Within 30 Days

Retirees and Survivors

If, **within 30 days of the qualified life event change**, you do not report the event and make changes to your benefits via online reporting, or if the ESC does not receive your completed Family Status Change Form (including the required documentation), you can never add the late-reported dependent to your retiree medical or dental coverage. If you (the Delta retiree) are not enrolled in coverage at the time you report the qualified life event, you cannot enroll your newly qualified dependent in medical and dental benefits throughout your retirement.

COBRA Participants

If, **within 30 days of the qualified life event change**, you do not report the event to Ceridian COBRA Services, you cannot change your benefits to accommodate the life event or add the dependent to your COBRA coverage during the year. However, at the next annual COBRA enrollment, you may be able to add the dependent to coverage or change your elections.

The ESC Can Process Your Life Event

When you have a major life event, you can call the ESC at **1-800 MY DELTA (1-800-693-3582)** to learn:

- Whether your event qualifies as a life event change
- Whether you report your event on Benefits Direct or through the ESC Family Status Change Form
- If your ESC Family Status Change Form has been received by the ESC
- If you qualify to make benefit changes consistent with your life event
- How you can make benefit changes

COORDINATION OF BENEFITS

COORDINATION OF BENEFITS

Your health coverage coordinates with other healthcare coverage that you and/or your dependents may have. Called "coordination of benefits," this feature helps prevent duplication of benefit payments for the same services. It is your responsibility to notify the applicable benefits administrator (such as UHC or MetLife) if you or your dependents are covered by other medical and/or dental plans or Medicare.

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

Coordinating Benefits With Other Health Plans

The following types of plans normally coordinate benefits:

- Any group insurance program that provides healthcare benefits or services, including self-insured plans
- Student coverage sponsored by or provided through an educational institution
- No fault insurance and personal injury protection (PIP) coverage
- Medicare or other government-sponsored programs, as permitted by law

Your health coverages consider any benefits to which you may be entitled from other group plans (even if you do not request payment from them) when determining the benefit payments made under the plans offered by Delta.

How Coordination With Other Group Plans Works

If you are covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then the other plan(s) pay benefits.

If your health coverage under the Delta plan is your primary plan, the Delta plan pays benefits up to the limits described in this SPD. When the Delta coverage is the secondary plan, it figures its regular benefit as if it was primary, subtracts from that amount the primary plan's benefits, and then pays the difference, if any.

Determining the Order of Payment

When benefits coordinate, the plans determine which one pays benefits first and which pays second. The following guidelines generally determine which plan is primary:

- If one plan has no coordination of benefits provision, it automatically is primary
- The plan covering the person as an employee rather than as a dependent is primary

- When both married parents' plans cover a dependent, the plans use the birthday rule to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If both parents have the same birthday, the primary plan is the one that covered the parent longer
- In the case of a divorce or separation, the plan of the parent who has custody of the dependent child pays benefits first. If the parent with custody remarries, the step-parent's plan pays second, and the plan of the parent without custody pays third. However, if there is a court order requiring a parent to take financial responsibility for the child, that parent's plan always is primary
- If these rules do not determine the order of payment, the plan that has covered the person the longest is the primary plan

How Secondary Benefits Are Determined

If Delta is the secondary plan and:

- *The primary plan pays benefits that are lower than Delta plan benefits,* the Delta plan secondary benefits are the difference between what the Delta plan would have paid as the primary plan and what the primary plan actually paid
- *The primary plan pays benefits that are equal to or higher than Delta plan benefits,* the Delta plan pays nothing

Filing Claims With Two Group Plans

To speed up reimbursement of claims when you or your dependent are covered under more than one group plan, file the claim with the primary plan first. When that process is complete and you have received the Explanation of Benefits (EOB) from the primary plan, submit the claim with a copy of the itemized bill and a copy of the EOB to the secondary plan. The secondary plan cannot process the claim without the EOB from the primary plan.

Right to Information

The claims administrator of the Delta plans has the right to exchange information about benefit payments with other insurance companies, organizations or individuals in order to coordinate benefits. The claims administrator also can make or recover payments. In addition, the claims administrator of the Delta plans has the right to request from you or your covered dependents information about other plans in which you or your dependent may participate. If you or your covered dependent does not provide requested information within 90 days, the claim may be denied.

How Coordination With Medicare Works

Your medical benefits may coordinate with Medicare. How the plan coordinates with Medicare depends on your age and whether you are a disabled employee, a retiree or survivor.

Currently, you and your dependents become eligible for Medicare at age 65. If you become disabled, you may become eligible for Medicare before age 65. Please notify the Delta Employee Service Center (ESC) at **1 800-MY DELTA (1-800-693-3582)** once you or your dependent begin receiving Medicare benefits.

If You Are a Disabled Employee

If you are receiving disability benefits (and, as a result, are no longer considered in current employment status), and you or your dependent/spouse is Medicare eligible, then Medicare pays primary for you and any Medicare eligible dependents.

If You Are Under Age 65

If you are a retiree or survivor and under age 65, eligible for the Delta medical plans and approved for Medicare, Medicare is primary for you and the Delta medical plans are secondary.

Also, if you are a retiree and your spouse is under age 65 and eligible for Medicare, then Medicare is primary for your spouse and the Delta medical plans are secondary.

If you are a retiree and both you and your dependent/spouse are under age 65 but are otherwise Medicare eligible, Medicare is primary for both of you and the Delta medical plans are secondary.

You are responsible for notifying Delta if you or your dependent / spouse becomes Medicare eligible.

If You Are Age 65 or Older

Generally the Delta medical plans do not cover retirees or survivors age 65 or older, except that:

- Pilots may continue to be enrolled in the Delta Pilots Medical Plan (DPMP) after reaching age 65, and
- Those retirees and their dependents eligible for and currently enrolled in lifetime COBRA DFCMP and DPMP medical options.

On the first day of the month of your 65th birthday (or on the first day of the previous month if your birthday falls on the first of the month), Medicare will be your primary insurance. If you are enrolled in Delta coverage at that time, your secondary medical coverage will automatically be changed to the DPMP Out-of-Area option (for DPMP participants) or the lifetime COBRA DFCMP or DPMP Out-of-Area medical option (depending on which plan you are enrolled in under COBRA). At that time, your under-age-65 covered family members will continue to be enrolled in their current medical option (assuming all eligibility requirements continue to be met).

If you are eligible for Medicare, the Delta medical plans pay benefits based on the Medicare benefits – even if you do not enroll for Medicare or apply for Medicare benefits. So it is important to enroll for Medicare when you are eligible.

How Benefits are Calculated when Medicare is Primary

If the Delta plan is secondary to Medicare, your Delta benefits are calculated based on the amount Medicare pays. Remember, even if you are not enrolled in Medicare, the Delta benefit is calculated as if you are:

- First, your benefit is calculated as if the Delta plan were primary based on the Medicare approved rate of coverage, if applicable
- Then, the amount of the Medicare benefit is subtracted from the amount the Delta plan would have paid if it had been primary
- Your Delta benefit is the difference between what the Delta plan would have paid (after your Deductible and Out-of-Pocket Maximums are met) had it been primary and the amount Medicare pays

Refer to the "Eligibility" section of this SPD for details about benefits eligibility for Delta retirees, their spouses and survivors under and over age 65.

For complete information on Medicare eligibility and benefits:

Contact your local Social Security office or visit the Medicare Web site at **www.medicare.gov**.

Questions About Coordinating Medicare and Delta Benefits?

Call UnitedHealthcare at **877-683-8555**.

Subrogation and Right of Recovery

Subrogation and Right of Recovery Terms

The following terms are specifically used and referred to with regard to the information on subrogation and the right of recovery for the Delta Family-Care Medical Plan (DFCMP) and the Delta Pilots Medical Plan (DPMP).

"Responsible Party" means any party actually, possibly or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any Insurance Coverage.

"Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile insurance coverage or any first party insurance coverage.

"Covered Person" includes anyone on whose behalf the plan pays or provides any benefits, including, but not limited to, the minor child or dependent of a plan participant or person entitled to receive any benefits from the plan.

DFCMP Subrogation and Right of Recovery

Subrogation

These subrogation provisions apply to all Delta medical and dental options under the DFCMP.

Immediately or upon paying or providing any benefit under the plan, the plan will be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to the Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which the Responsible Party is liable. The lien is imposed on any recovery, whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits.

The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claims

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that the plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages.

The plan will be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole, or to compensate the Covered Person, in part or in whole, for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire Subrogation and Right of Recovery provision will apply, and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical, prescription drug or dental benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical, prescription drug and dental expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

As a condition of receiving benefits under the plan, you or your covered dependent must:

- Notify the claims administrator in writing of any claim against a third party or under an insurance policy or program, within 31 days of making the claim(s)
- Complete any reimbursement agreement provided by the claims administrator
- Notify the third party and/or the issuer of the insurance policy or program that the Delta medical plan has a lien on any amounts payable by such third party and/or under the insurance policy or program to the extent covered expenses are paid by the Delta medical plan; and
- Provide any information about the claim to the claims administrator on request

If a Covered Person fails to complete any of the steps listed here, the Covered Person will not be eligible for benefits from the plan with respect to any covered expenses attributable, directly or indirectly, to the injury, illness or condition that is, or could be, the subject of a claim against the third party or under an insurance policy or program.

The plan is not responsible for paying any expenses the Covered Person incurs while pursuing a claim, including legal fees and costs, unless the applicable claims administrator has agreed, in writing, and in advance, to pay those expenses.

A Covered Person will do nothing to prejudice the plan's subrogation or recovery interest, or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from taking any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to notify a Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of the plan's Subrogation and Right of Recovery provisions are ambiguous, or questions arise concerning the meaning or intent of any of its terms, the claims administrator for the plan will have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting benefits, the Covered Person submits to such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

DPMP Subrogation and Right of Recovery

Subrogation

These subrogation provisions apply to all Delta medical and dental options under the DPMP.

Upon paying or providing any benefit under the plan, the plan will be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any third party actually, possibly or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the plan. This includes the liability insurer or other Insurance Coverage of such third party.

Reimbursement

In addition, if a Covered Person receives any payment from any third party actually, possibly or potentially responsible for the Covered Person's injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the Covered Person receives from the third party, its liability insurer or other Insurance Coverage of such third party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any third party, its liability insurer or other Insurance Coverage of such third party, as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which the third party, its liability insurer of Other Insurance Coverage, is liable. The lien will be imposed upon any recovery, whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits.

The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; the third party, the third party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claims

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that the plan's recovery rights are a first priority claim against all third parties and their insurers or Insurance Coverage, and are to be paid to the plan before any other claim for the Covered Person's damages.

The plan will be entitled to full reimbursement on a first-dollar basis from any payments by the third party, its insurers or Insurance Coverage, even if such payment to the plan will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole or to compensate the Covered Person, in part or in whole, for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The plan's Subrogation and Right of Recovery provision will apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any third party, its insurer or Insurance Coverage, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical, prescription drug or dental benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical, prescription drug and dental expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

As a condition of receiving benefits under the plan, you or your covered dependent must:

- Notify the claims administrator in writing of any claim against a third party or under an insurance policy or program, within 31 days of making the claim(s)
- Complete any reimbursement agreement provided by the claims administrator

- Notify the third party and/or the issuer of the insurance policy or program that the Delta medical plan has a lien on any amounts payable by such third party and/or under the insurance policy or program to the extent covered expenses are paid by the Delta medical plan; and
- Provide any information about the claim to the claims administrator upon request

If a Covered Person fails to complete any of the steps listed here, the Covered Person will not be eligible for benefits from the plan with respect to any covered expenses attributable, directly or indirectly, to the injury, illness or condition that is, or could be, the subject of a claim against the third party, its insurer, or under an insurance policy or program of the third party.

The plan is not responsible for paying any expenses the Covered Person incurs while pursuing a claim, including legal fees and costs, unless the applicable claims administrator has agreed, in writing, and in advance, to pay those expenses.

A Covered Person will do nothing to prejudice the plan's subrogation or recovery interest, or to prejudice the plan's ability to enforce the terms of its subrogation and recovery rights. This includes, but is not limited to, refraining from taking any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible third party. The plan reserves the right to notify a responsible third party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

MEDICAL BENEFITS

MEDICAL BENEFITS

Delta Air Lines is pleased to offer comprehensive medical options to retirees and survivors.

Without adequate medical coverage, the financial impact of a serious illness or injury can be devastating. To protect your health — and your wallet — Delta's medical coverage is designed to help make a major illness or injury easier to handle economically and to provide financial protection for minor medical problems. In addition, Delta's medical coverage encourages regular Preventive Care by making available — fully covered or with only an office visit Copay — services such as annual physicals, mammograms, well baby care and much more.

Through Delta, you can choose medical coverage that provides benefits for a wide range of medically necessary services and supplies.

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

Medical Options

In this section, you can find detailed coverage information on these medical plans, administered by UnitedHealthcare (UHC):

- Delta Family-Care Medical Plan (DFCMP)
  - Standard Medical Option
  - Out-of-Area (OOA) Medical Option
  - High Value Medical Option (HVO)
- Delta Pilots Medical Plan (DPMP)
  - Network option
  - Out-of-area option

You also can find information in this SPD on Health Plan Hawaii and Humana Health Plan of Puerto Rico, which are not Delta-provided coverage. Health Plan Hawaii is a fully-insured medical option that is offered by Hawaii Medical Services Association and available to eligible individuals who are residents of Hawaii. Humana Health Plan of Puerto Rico is a fully-insured medical option that is available to eligible individuals who are residents of Puerto Rico.

The medical plans described in this book offer several approaches for you to manage your healthcare benefits. To learn which medical plans and options are right for you, you should carefully read this section and consider your choices.

For each plan, a summary appears below. A full description of Covered Services appears later in this section of the SPD.

Delta Family-Care Medical Plan

The Standard Medical Option of the DFCMP generally requires you to pay a Copay for receiving Covered Services. If you use Network Providers and services, you receive a higher level of benefits. An out-of-area option with reimbursement based on Reasonable and Customary (R&C) charges is available if you live in an area not served by the UHC network. The High Value Medical Option is a high-deductible healthcare plan that may provide you with eligibility to contribute to a Health Savings Account (HSA).

The DFCMP medical options, which include prescription drug and behavioral health coverage, are administered by UnitedHealthcare (UHC).

Delta Pilots Medical Plan Medical Option (DPMP)

The DPMP is a UHC-administered option that generally requires you to pay a Copay for receiving Covered Services. If you use Network Providers and services, you receive a higher level of benefits. An out-of-area option with reimbursement based on Reasonable and Customary (R&C) charges is available if you live in an area not served by the UHC network.

Dental benefits are provided, along with medical and prescription drug coverage, as part of the DPMP.

Health Maintenance Organizations (HMOs)

Health Plan Hawaii, provided by Hawaii Medical Service Association, and Humana Health Plan of Puerto Rico are offered as medical options to eligible individuals who are residents of Hawaii or Puerto Rico. They are not options sponsored by Delta. Instead, they are managed care health maintenance organizations (HMOs) that offer eligible Hawaii and Puerto Rico residents an option that focuses on Preventive Care.

For benefits to be payable, participants must receive non-emergency care from a provider within the HMO. Participants also must coordinate all care through a Primary Care Physician (PCP) and obtain referrals to specialists.

Note that Delta has neither control over nor responsibility for the quality of HMO services rendered to members, for failure to deliver such services, for HMO providers, or for any disputes that may arise between members and their HMO. All HMO service-related complaints and appeals of denied benefit claims must be filed directly with the HMO, not with Delta. Delta has no input or responsibility for any benefits denied by an HMO. By providing this information, Delta is not endorsing any HMO product.

Your Eligibility for Delta's Medical Plans

Eligibility for one or more of these medical plans is detailed in the "Eligibility" section of this SPD. Please refer to the "Eligibility" section to understand which retirees and survivors are eligible for the following medical plans:

- **DFCMP** is available to ground, flight attendant, flight dispatcher and-pilot retirees and survivors
- **DPMP** is available to pilot retirees and survivors

Waiving Coverage

You have the option of selecting the "No Coverage" medical option. If you waive medical coverage during the annual open enrollment period, it is important to note the following.

If You Are ...	And You Choose the "No Coverage" Option ...
A disabled or retired employee, and you die	Your eligible survivors (as determined by the Delta Disability and Survivorship Plans, or D&S Plan, for monthly survivor benefits) may enroll for coverage at the time of your death and during future annual open enrollments as long as they remain eligible for monthly income survivor benefits under both a D&S Plan* and a Delta Medical Plan. Those eligible family members who are not eligible for monthly survivor income benefits may be eligible for COBRA continuation coverage after your death for up to 36 months
A retired participant	You waive medical coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot get coverage for the calendar year unless you or your dependent experiences certain special enrollment events (see the "Life Events" section of this SPD) or you die and your survivors are eligible for monthly survivor benefits under the Delta Disability and Survivorship Plan* (D&S Plan)
A survivor eligible for Delta medical benefits*	You waive medical coverage for the entire year
A COBRA participant	You waive your right to elect COBRA medical or dental coverage forever**

* The survivors of some ground retirees are eligible for monthly income survivor benefits for a limited period of time (up to ten years). To address what happens to eligibility for medical coverage after this period ends, the eligibility criteria for ground employee survivor medical benefits have been updated. See the "Eligibility" section of this SPD for details.

** Retirees who elect COBRA may be able to elect Delta retiree medical coverage upon the expiration of COBRA rights. See the "COBRA Continuation Coverage" section for more information on electing COBRA coverage, when coverage ends and electing retiree medical coverage.

Note: The Delta Family-Care Medical Plan is offered only to eligible individuals under age 65.

Network and Non-Network Coverage Choices

Most Delta medical plans have both network and non-network benefit coverage. Network benefits are available through the UHC Choice Plus Network, a comprehensive network of doctors, hospitals, facilities and other healthcare providers. In exchange for being a member of the network, providers have agreed to discount their normal fees, saving both you and Delta money. Providers who are not part of the network (Non-Network Providers) have not agreed to provide a discount from their normal fees.

You pay less if you receive services from a Network Provider. If you see a Non-Network Provider, the benefit paid by the plan is lower, and the amount you are responsible for is higher. The decision to use a Network Provider or a Non-Network Provider is always yours each time medical care is needed.

Out-of-Area Medical Options and Provider Discounts

The DFCMP's Out-of-Area Medical Option and the out-of-area option of the DPMP do not have network and non-network coverage due to an insufficient number of Network Providers in that area. Instead, these medical options offer the same coverage level for all services.

However, some UHC Network Providers may be in your area and might offer discounts on their services to UHC members. Call the number on the back of your ID card or visit **www.myuhc.com** to confirm whether a doctor or hospital is in the network — or simply ask your doctor. You may receive a list of Network Providers at no charge by contacting UHC at **877-683-8555** or by going online to **www.myuhc.com** to print one.

Network Benefits – UHC Choice Plus Providers

When you use doctors, hospitals and other medical providers who are part of the UHC Choice Plus Network, network benefits apply. Network benefits mean that covered medical services are paid at a higher percentage (generally 80%, for the DFCMP options, and 90%, for the DPMP, of allowed amounts) after the annual Deductible. Another advantage to using Network Providers is that they usually handle calling for approval when it is needed.

Allowed Amount – UHC Choice Plus Providers

Network Providers have agreed to accept certain pre-determined discounted fees as payment in full. This is known as the "allowed amount." More specifically, the allowed amount is defined as the negotiated amount of payment that a Network Provider has agreed to accept as payment in full for a Covered Service at the time your claim is processed.

Network benefit payments are based on UHC's allowed amount for medical expenses. When you use Network Providers, you only have to pay the Deductible and any Coinsurance amounts. With Network Providers, you are not responsible for any charges over the allowed amount.

Reasons to Use Network Doctors

Save Money on Your Office Visits

You receive a discounted rate if you visit doctors and hospitals in the UnitedHealthcare network. For example, while a non-network doctor may charge $85 for an office visit, a network doctor may charge a discounted rate of $65 for the same service.

Convenient Claims Submission

Network doctors submit claims on your behalf. Non-network doctors may or may not offer this convenience.

Call the number on the back of your ID card or visit **www.myuhc.com** to confirm whether a doctor or hospital is in the network — or simply ask your doctor. You may receive a list of Network Providers at no charge by contacting UHC at **877-683-8555** or by going online to print one on **www.myuhc.com**.

Find a Network Doctor, Hospital or Other Healthcare Professional

Find and compare network doctors and hospitals. Save time with a list of the most commonly searched topics, or find a doctor based on location, specialty, condition or procedure. Search and compare hospitals on quality and cost of care for specific treatments.

Identify UnitedHealth Premium® designated network physicians who are recognized for high quality and efficiency of care.

Step 1: Log on to **www.myuhc.com**

Step 2: Click the "Find a Doctor" button, or select "Physicians & Facilities" from the menu bar

Step 3: Begin a doctor and/or hospital search

Step 4: Follow the directions to search by name or by location

You also can call the number on the back of your ID card for help finding the right doctor or hospital.

With a nationwide network, your health plan travels with you: 520,000 doctors and 4,700 hospitals.

Non-Network Benefits

When you use doctors, hospitals and other medical providers who are not part of the UHC Choice Plus Network, non-network benefits apply. Non-network benefits pay a lower percentage* after you meet the separate non-network annual Deductible. You are responsible for filing claims or seeing that claims have been filed by your provider. You also are responsible for calling for pre-approval of certain outpatient services, for hospital pre-approval and for continued stay approval when necessary.

In addition, you generally pay more for a medical service when using a Non-Network Provider because he or she has not agreed to join the network and discount his or her normal fees. You are responsible for any amount a provider charges over 140% of the Maximum Non-Network Reimbursement Program (MNRP) rate or for any amount over the Reasonable and Customary charge. For definitions of MNRP and Reasonable and Customary, see "MNRP and R&C Charges for Non-Network Services" in the section below.

* For example, in the DFCMP's Standard Medical Option, the non-network benefit is 60% of 140% of the Medicare Reimbursement Rate). This is reduced from the network benefit of 80% after the Deductible.

MNRP and R&C Charges for Non-Network Services

The Delta medical options determine non-network benefits based on a percentage of the Maximum Non-Network Reimbursement Program (MNRP) or Reasonable and Customary (R&C) Charges.

MNRP

The DFCMP Standard Medical Option and the DPMP Network Option determine non-network reimbursement amounts using the MNRP. Under the MNRP, Non-Network Charges are based on a percentage of the federal Medicare-allowable charge for the applicable types of medical services and

supplies. A Medicare-allowable charge is what the federal Medicare program would allow as a covered expense. Under these medical options, reimbursement amounts for non-network services and supplies are based on the actual billed fee, but not more than 140% of the Medicare-allowable charge. This is referred to as the MNRP fee limit. MNRP applies to all non-network medical services and supplies including hospital, physician, radiology and medical supply expenses, and all other covered medically necessary non-network expenses. The MNRP does not apply to emergency care or services coordinated in advance by UHC. The covered participant is required to pay 100% of the amount billed by the provider that is in excess of the MNRP fee limit, in addition to his or her Deductible and Coinsurance amounts. The amount in excess of the MNRP is not used to satisfy any portion of your individual or family Deductible, nor is it applied toward your Out-of-Pocket Maximum.

R&C

"Reasonable and Customary" (R&C) charges determine reimbursement rates in the DFCMP's Out-of-Area Medical Option and High Value Medical Option, as well as in the DPMP's out-of-area option. For Non-Network Providers (providers who are not part of the UHC Choice Plus Network), benefit payments are based on a percentage of the R&C charge for a medical expense.

A charge is Reasonable and Customary if it is not more than the normal charge for comparable treatment, services or supplies by doctors or other providers of medical services in the same geographic area, as determined by the claims administrator.

R&C limits are based on the 90th percentile for such Reasonable and Customary charges, as determined by relevant data on behalf of the claims administrator. In determining what is Reasonable and Customary, the claims administrator may consider the complexity and degree of skill needed to provide a service. Amounts over R&C charge limits are not covered expenses under the plans and do not count toward the plans' Deductible or Out-of-Pocket Maximums. You must pay 100% of any amounts over R&C charges in addition to any other costs, Deductibles or Coinsurance amounts that are your responsibility. The amount in excess of the R&C is not used to satisfy any portion of your individual or family Deductible, nor is it applied toward your Out-of-Pocket Maximum.

Medical Plan Features

When You Must Notify UHC's Customer Service – Health Advocate Team

You must call UHC's Customer Service – Health Advocate Team before receiving certain services (listed here). If you do not notify the Health Advocate Team when it is required, a $700 non-Notification penalty is applied to your charges for each failure to notify. This $700 penalty cannot be used to satisfy any portion of your individual or family Deductible, nor can it be applied toward your Out-of-Pocket Maximum. If some of the services being requested are not approved, the applicable expenses could be entirely denied.

If you receive care through a UHC Network Provider, your Network Provider should handle the Notification. However, if you are not receiving care through a UHC Network Provider, you are responsible for notifying (or having your doctor notify) the Health Advocate Team at **877-683-8555**.

Notification must occur at least five working days before a scheduled surgery, outpatient procedure, inpatient confinement or other service. Notification allows you to: (1) confirm eligibility for you or your dependent, (2) confirm benefits that are available to you or your covered dependents, (3) have UHC interpret and explain your benefits in layperson's terms and (4) access Network Providers. To notify the Health Advocate Team, you (or your doctor) should call UHC at **877-683-8555**.

Services or Supplies Requiring Notification to UHC's Customer Service – Health Advocate Team

Notify UHC Customer Service – Health Advocate Team before receiving the following services or supplies. Be sure to read "What the Delta Medical Plans Cover," later in this section, for full coverage details about these services and supplies.

- Accident-related dental services
- Cancer treatment at a URN Cancer Resource Services (CRS) facility
- Durable medical equipment/prosthetics when cost exceeds $1,000
- Emergency health services that result in an inpatient stay
- Home healthcare
- Hospice care
- Inpatient admissions to a hospital, skilled nursing facility or inpatient rehabilitation facility
- Maternity – Pregnancy is subject to the following Notification time periods:
  - Prenatal programs – The Health Advocate Team should be notified during the first trimester (12 weeks) of pregnancy. This early Notification makes it possible for the mother to participate in the prenatal programs
  - Inpatient confinement for delivery of child – The Health Advocate Team must be notified only if the inpatient care for the mother or child is expected to continue beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section
  - For inpatient care (for either the mother or child) that continues beyond the 48-96 hour limits stated above, the Health Advocate Team must be notified before the end of these time periods
  - Non-emergency inpatient confinement without delivery of child – Confinement during pregnancy, but before the admission for delivery, that is not emergency care requires Notification as a scheduled admission
- Medical oral surgery procedures
- Mental health and substance abuse services
- Organ/tissue transplant services – You must make the Notification at least seven working days before the scheduled date of each of the following or as soon as reasonably possible.
  - The evaluation
  - The donor search
  - The organ procurement/tissue harvest
  - The transplant
- Private duty nursing
- Reconstructive surgery (excluding breast reconstruction in connection with a mastectomy)
- Surgical charges
- Vein treatment therapies (and sclerotherapy when used to treat symptoms of varicose veins that are not resolved by ligation and stripping procedures alone)

For inpatient confinement, the Health Advocate Team must be notified of the scheduled admission date at least five working days before the start of the confinement. If an admission is planned but no admission date is set, you should call the Health Advocate Team again as soon as the admission date

is set. You should contact the Health Advocate Team within two days of receiving emergency health services resulting in an inpatient stay.

For outpatient services that require Notification, you must notify the Health Advocate Team at least five working days before the service is given.

Information to Provide During Notification

The following information must be provided during Notification:

- The name of the patient and his or her relationship to you
- The retiree's/survivor's name, employee number and address
- The employer's name
- The name and telephone number of the attending physician
- The name of the medical care facility, proposed date of admission and proposed length of stay
- The diagnosis
- Type of surgery and proposed course of treatment
- The proposed rendering of listed medical services

While your doctor or the facility may call on your behalf, you are responsible for the call being made on time. Make sure your doctor, family members and anyone else who might have to call for you knows about the Notification requirement and where you keep your medical ID card.

After Notification Has Been Made

After Notification is received, the Health Advocate Team determines if the service or supply is a covered health service. A covered health service is one that is:

- Provided for the purpose of diagnosis or treatment of a sickness, injury, disease or symptom; and
- Supported by national standards of practice; and
- Consistent with conclusions of prevailing medical research; and
- The most cost-effective method that yields a similar outcome to other available alternatives not otherwise excluded (as outlined in "What the Medical Plans Do Not Cover" in this section)

Once the call has been made, UHC contacts your doctor to discuss symptoms, test results, the treatment plan and the length of stay. After your doctor provides the necessary medical information, the Notification review is completed in a matter of hours. When the Notification review is complete, you may receive a phone call from UHC. You, your doctor and the hospital also are notified by letter.

Once you are admitted to the facility, if your length of stay needs to be longer than the number of days originally approved, you must call the Health Advocate Team (or see that your doctor calls) for continued stay approval (approval of the additional days). You must call before your original length of stay ends. If your continued stay approval request is for urgent care, you must call at least 24 hours before your original length of stay ends, and you will receive a decision within 24 hours of your call. (An urgent care claim is one in which a delay could seriously jeopardize your life, health or your ability to regain maximum function or, in the opinion of a doctor with knowledge of your medical condition, could cause severe pain.) If a continued stay approval request is denied, you can appeal it. For details, see the "Claims Information and Appeals Procedures" section of this SPD.

Special Note Concerning Childbirth Benefits
Under federal law, you do not have to get pre-approval for a maternity admission if your expected hospital stay is 48 hours or fewer after a normal vaginal delivery, or 96 hours or fewer after a cesarean section. See the "Plan Administration and Legal Rights section of this SPD for details. If you are pregnant, be sure to enroll in the Healthy Pregnancy Program (outlined later in this section).

Notifying the UHC Health Advocate Team

You or your doctor should call UHC at **877-683-8555** for certain services as described earlier in this Medical section. If you do not notify UHC's Health Advocate Team before receiving treatment, a $700 penalty is applied to your charges for each service for which you did not receive advance approval.

No Pre-Existing Condition Limitations

Generally, a Pre-Existing Condition is a physical or mental condition that you or an eligible dependent received treatment for, or was diagnosed with, before coverage under a plan begins. The Delta medical plans cover Covered Expenses for a Pre-Existing Condition the same as for any other medical condition.

Lifetime Maximum Medical Benefit

You and each covered family member are eligible for a Lifetime Maximum benefit of $5,000,000 (including mental health/substance abuse treatment).

- At the beginning of each calendar year, up to $1,000 of the maximum benefit amount you have used in the previous year is restored
- The Lifetime Maximum benefit does not renew if you move between medical options during Annual Open Enrollments. All amounts paid by a Delta medical option apply toward the Lifetime Maximum benefit, regardless of the medical option in which you participate. For example, if you are a pilot who enrolls in the DPMP, your Lifetime Maximum benefit for that option is reduced by the amount of any benefits you used while enrolled in the DFCMP

ID Cards

Using and referring to your member ID card is key when you need to receive care and ensure that you are not billed unnecessarily. You and your covered family members should carry the ID card with you at all times, and present it whenever you receive services from a doctor or other healthcare professional.

DFCMP and DPMP Participants

If you enroll in a Delta medical option with UHC network and non-network coverage, you receive ID cards for yourself and your covered dependents. Present your ID card whenever you receive services, including pharmacy benefits.

If you enroll in an out-of-area medical option or the High Value Medical Option, you receive two ID cards in your name (the retiree/survivor). If you need additional cards, contact UHC at **877-683-8555** or place your order online at **www.myuhc.com**.

You should report lost or stolen ID cards to UHC.

Need a temporary ID card or a replacement card?

Step 1: Log on to **www.myuhc.com**

Step 2: Click the "Print an ID card" button

Step 3: Click "Print" to print a temporary card, *or*

Step 4: Click "Submit" to request a replacement card by mail. Your new UHC medical ID card will be mailed to the address on file with Delta's Employee Service Center (ESC).

Health Plan Hawaii and Humana Health Plan of Puerto Rico Participants

If you enroll in Health Plan Hawaii or Humana Health Plan of Puerto Rico, you receive ID cards for yourself and your covered dependents. Present your ID card whenever you receive any medical or pharmacy service. Contact Health Plan Hawaii at **808-948-6372** or visit Health Plan Hawaii at **www.hmsa.com**. Contact Humana Health Plan of Puerto Rico at **787-282-7900 ext. 5500** or visit Humana at **www.pr.humana.com**.

You should report lost or stolen ID cards to Health Plan Hawaii or Humana Health Plan of Puerto Rico.

Care Away From Home

UHC has participating providers throughout the country. If you or a covered dependent are away from home and in a UHC Choice Plus Network area, you may seek care from participating providers anywhere in the country and receive network benefits. This is called reciprocity.

For a list of UHC Network Providers in any area, call UHC Member Services toll-free at **877-683-8555**. You also may access the UHC provider directory at **www.myuhc.com**. Reciprocity may be beneficial for you if:

- You travel throughout the United States extensively
- For part of the year, you live in another area served by the UHC Choice Plus Network
- Your child(ren) attend school in another area served by the UHC Choice Plus Network
- Your child(ren) and/or spouse (or domestic partner/same sex spouse) live in another area served by the UHC Choice Plus Network

Are You Covered Outside of the United States?

You and your eligible family members have medical coverage worldwide. If you receive care while outside of the United States, contact UHC at **877-564-7510**. Unless the treatment is for a medical emergency, non-network provisions apply. You are responsible for submitting claims and providing the necessary documentation, which should include an explanation (in English) detailing the medical condition and treatment provided. Additionally, the amount of the charges should be documented in U.S. currency.

Find the Answers You Need

Call the Employee Service Center (ESC) at 1-800 MY DELTA (1-800-693-3582) for ...

- General information on the DFCMP and DPMP
- Technical and navigational support for the Benefits Direct Web site
- Plan Premiums
- Corrections to your personal information (such as birth date or Social Security number)
- Enrollment process, including enrollment dates, plan eligibility, etc.
- Non-medical benefit enrollment or general information (dental, vision and optional insurances)
- Life event changes (such as marriage, divorce or birth of a child) if you still have questions after having accessed the “Report a Qualified Family Status Change” site on Benefits Direct (which is located on DeltaNet > Employee Connection > Self Service)
- Verification of dependent eligibility related to age or student status (Review the “Report a Qualified Family Status Change” site on Benefits Direct to determine which dependent eligibility changes can be reported online on Benefits Direct)
- Requests for summary plan descriptions/benefit coverage documents
- COBRA enrollment questions

Find the Answers You Need

Call a UHC Customer Care professional at 877-683-8555 for ...

- Coverage information about the DFCMP and DPMP
  - How the benefits work, including pharmacy
  - Which providers and services are network and non-network
- Network provider search
- Claims
- Replacement medical ID cards
- Member complaints/appeals
- Coordination of benefits
- Network questions
- Medical plan questions
- Transition of care

Medical Program Phone Numbers*

NurseLine℠	**877-912-1820**
Employee Assistance Program (offered by OptumHealth Behavioral Solutions)	**800-533-6939**
Healthy Pregnancy Program	**800-411-7984**
United Resource Network (Transplant and Heart Disease)	**888-936-7246**
Cancer Support Program	**866-936-6002**

* Note: These numbers enable you to reach the programs directly, but you can also access any of these numbers by calling the NurseLine.

UHC Programs

Starting a Conversation With Your Doctor

To be an informed consumer of healthcare benefits, you must have a good relationship with your doctor.

Just as you would not buy a car without asking questions and getting all the information you need to make the right decision, the same should be true of your healthcare.

Because not everyone is comfortable questioning a doctor, here are some suggested questions to help you get started. Remember, nothing is more important than your health. You have the right to get all the information you need and to get clarification if you are confused. Once you start a conversation with your doctor, you may find that, each time you visit, your conversations become easier.

- Ask, “Are there any alternatives?” when a doctor or specialist describes a course of treatment
- Ask, “Must I absolutely have this test or procedure?” if the doctor recommends a test or procedure on the list of procedures requiring Notification. You also can ask, “What does it cost?” and “What do we do if my medical plan does not cover this test or procedure?” There might be an alternative
- For surgeries, ask “Can this be done on an outpatient basis?” As medical technology changes, more and more surgeries can be done safely on an outpatient basis, eliminating a hospital stay
- For hospital stays, ask “How long can I expect to be in the hospital?” and “Is there anything that can be done — like home healthcare — that can safely get me home sooner?”
- When your doctor suggests a prescription, ask for a generic alternative or equivalent. If a generic is available, most doctors are happy to write a prescription for it. You can find out if a medication has a lower cost alternative at **www.myuhc.com**. After you log on, select the Pharmacies & Prescriptions button in the top navigation bar, then select My Rx Choices
- Ask about Notification to the Health Advocate Team and whether the doctor’s office staff calls on your behalf. If the doctor’s office staff says they make the calls, ask for someone to call you to confirm that the Notification has been completed

Personal Health Support

Need help making smart healthcare decisions? Let your personal health support services point you in the right direction. Through UnitedHealthcare, you have access to registered nurses and other healthcare professionals 24 hours a day, seven days a week, whether you need to:

- Better manage an illness or injury
- Recognize urgent and emergency symptoms
- Locate doctors and hospitals in your area
- Understand medication interactions and how you may be able to reduce your prescription costs
- Connect with resources for pregnancy, cancer, diabetes, asthma, heart disease and more

And best of all, this is all included as part of your medical plan.

NurseLine[SM]

Speak to a live, registered nurse anytime, day or night, by calling the NurseLine at **877-912-1820**. Get health tips, answers to health questions, help choosing appropriate medical care, and access to recorded messages on thousands of health and wellness topics.

Treatment Decision Support

You also can get help evaluating your treatment options with Treatment Decision Support. In this program, an experienced registered nurse can help you:

- Learn more about your diagnosis
- Understand your treatment options
- Understand the risks and benefits of your treatment options
- Develop questions to ask your doctor
- Know what to expect from surgery

- Prepare for a successful recovery
- Discuss what kind of costs to expect

Step 1: Call **877-912-1820** or the phone number on the back of your ID card

Step 2: Follow the prompts to select your language

Step 3: Make a selection from the menu options

If you believe you are having a life-threatening medical emergency, dial 911.

Live-Nurse Chat

Connect online with a nurse 24 hours a day, seven days a week, to discuss health and well-being questions.

Step 1: Log on to **www.myuhc.com**

Step 2: Click on the "Live Nurse Chat" button

Step 3: Provide the required information

Step 4: Begin your chat

Health Advocate Program

Receive personal support for a chronic condition or complex healthcare need, and feel more confident about your treatment decisions with the Health Advocate Program. Get help from a registered nurse and learn about the diagnosis and your potential treatment options for coronary artery disease, diabetes, heart failure, asthma and more.

If you are eligible for a program, a Health Advocate nurse assigned to you will contact you by phone. To learn more about how the Health Advocate Program can help you manage your condition:

Step 1: Call NurseLine at **877-912-1820** or the phone number on the back of your ID card

Step 2: Follow the prompts to speak with a registered nurse

Use the Health Advocate Program to gain the tools and support you need to take a more active role in your health while working with your doctor.

Cancer Resource Services

Cancer Resource Services (CRS) gives you access to UnitedHealthcare Premium Network cancer programs and facilities. CRS also offers access to cancer nurses who can help you understand your diagnosis and potential treatment options, as well as provide you with information to help you maintain your health and well-being during treatment and recovery. If you have a serious medical need, specialized programs and nurse consulting are available through UHC's Cancer Centers of Excellence network programs.

To access Cancer Resource Services, call **800-847-2050** or the phone number on the back of your ID card.

Healthy Pregnancy Program

At no extra charge, expectant mothers can find help through all stages of pregnancy with the Healthy Pregnancy Program. It is best to enroll within the first 12 weeks of your pregnancy, but you can enroll through week 33 of your pregnancy. If you have a serious medical need, specialized programs and nurse consulting are available to you through the pregnancy Centers of Excellence network programs. To enroll in the Healthy Pregnancy Program:

Step 1: Log on to **www.myuhc.com**

Step 2: Click on "Benefits & Coverage"

Step 3: Click on "Maternity Care"

Step 4: A window opens, showing your maternity coverage. Scroll down to click on the Healthy Pregnancy Program link, **www.healthy-pregnancy.com**

OR

Step 1: Call **800-411-7984** or the NurseLine at **877-912-1820**

After you sign up, you receive a free book about your pregnancy and a Healthy Baby Travel bag.

Transplant and Heart Disease Support

Register with United Resource Network for transplant services or for treatment of congenital heart disease via the Web. Access the nation's leading transplant network of 183 carefully selected transplant programs in 72 medical centers throughout the country. If you have a serious medical need, specialized programs and nurse consulting are available to you through the transplant Centers of Excellence network programs.

Step 1: Log on to **www.urnweb.com**

Step 2: Click on "Request Access"

Step 3: Follow the prompts to select "Patient"

Step 4: Review the terms of the User Agreement

OR

Step 1: Call the NurseLine at **877-912-1820** or the number on the back of your ID card

DELTA FAMILY-CARE MEDICAL PLAN

The Delta Family-Care Medical Plan (DFCMP) gives you the opportunity to make healthcare benefit choices that best fit your needs.

Key Features of the DFCMP Medical Options

- Comprehensive medical options that begin paying after you meet an annual Deductible
- A medical option that offers network and non-network benefits with office visits Copayments as a key feature of the network benefit
- Care that is not required to be coordinated through a Primary Care Physician (PCP)
- Referral to a specialist that does not have to be coordinated through a PCP
- Paid Preventive Care benefits (when services received follow the U.S. Preventive Services Task Force guidelines and are performed by a UHC Network Provider) are covered at 100% of Network Charges or may only require an office visit Copay
- Benefits that include medical care, prescription drug benefits and behavioral health and substance abuse coverage
- Programs to help you manage your health — and your costs

Your DFCMP Medical Options

You may choose to enroll in a DFCMP Medical Option administered by UnitedHealthcare (UHC):

- **Standard Medical Option:** The DFCMP's network-based choice, available to individuals who live in a UHC network area
- **Out-of-Area (OOA) Medical Option:** If you live in an area where there is no UHC network availability, you may only have one choice for medical coverage: the OOA Medical Option. If you are eligible for this option, it is offered to you during your enrollment period. If you would prefer to enroll in a network option (Standard Medical Option) and you have access to Network Providers, contact the ESC during your enrollment period to enroll in one of the other network-based medical options
- **High Value Medical Option (HVO):** The HVO meets the definition of a high-deductible healthcare plan

It Pays to Use Network Providers

If you use UHC Choice Plus Network providers, you receive a higher level of benefits and your costs are based on Network Charges.

Two-Year Claims Filing Deadline

The DFCMP Medical Options have a two-year claims filing limit. All claims for medical services must be submitted to UHC within two years of the date of service. See the "Claims Information and Appeals" section of this SPD for details.

How the DFCMP Standard Medical Option and OOA Medical Option Work

Read on to learn how the following features work under the Standard Medical Option and the OOA Medical Option:

- Annual Deductible
- Copays
- Coinsurance
- Annual Out-of-Pocket Maximum (OOP Max)

Annual Deductible

The annual Deductible is the dollar amount of covered expenses that you must pay before the plan begins to pay benefits each calendar year.

For the Standard Medical Option, there is a separate Deductible amount for network services and non-network services; the non-network Deductible is higher. If you are enrolled in the OOA Medical Option, you have one Deductible to meet, regardless of whether you receive services through the UHC network.

Some covered medical services (such as prescription drug costs) are not applied to the medical Deductibles, nor are amounts above the plan's maximum reimbursement rate, as described later in this section. See "Expenses That Don't Apply Toward Your Deductible and OOP Max" for a full list.

2008 DFCMP Medical Option Annual Deductibles

	Standard Medical Option		OOA Medical Option
	Network	Non-Network	
Individual	$600	$1,200	$400
Family	$1,800	$3,600	$1,200

How Family Members Meet the Deductible

Unless you are enrolled in retiree/survivor only coverage, no one family member can meet the overall plan Deductible.

For the family level of coverage, a family member is only required to meet his or her individual Deductible of $600 network/$1,200 non-network for the Standard Medical Option, and $400 for the Out-of-Area Medical Option, before plan benefits and Coinsurance apply.

If the family Deductible is met before an individual family member reaches his or her own individual Deductible, plan benefits and Coinsurance apply for all family members.

Copayments

Generally, in the Standard Medical Option, if you use Network Providers, you pay a Copay directly to the provider of your medical services. Some services that may only require a Copay are physician office visits, specialist consultations, urgent care center visits and ER visits. The only non-network Copay that may apply is for an ER visit that meets the definition of a true emergency; otherwise, non-network services do not have Copays. You generally pay the entire cost of a non-network service and then apply to the plan for reimbursement, although your physician may, but is not required to, make the claim on your behalf.

The OOA Medical Option does not require Copays.

2008 DFCMP Medical Option Copayments

Standard Medical Option		OOA Medical Option
Network	**Non-Network**	
$20 Primary Care Physician (PCP) office consultation $50 specialist office consultation $50 Urgent Care Center visit $100 ER visit	$100 – ER visit	Not applicable

Coinsurance

Once you and/or your dependents have met your annual Deductible, you share expenses with the plan. Your portion of these expenses is called your Coinsurance.

The Standard Medical Option pays 80% of the cost of covered Network Charges, while you pay the remaining 20%. For covered Non-Network Charges, the Standard Medical Option pays 60% of 140% of the Medicare Reimbursement Rate after the non-network Deductible is met.

The OOA Medical Option pays 80% of R&C for Covered Services, while you pay the remaining 20%.

2008 DFCMP Medical Option Coinsurance

	Standard Medical Option		OOA Medical Option
	Network	**Non-Network**	
You Pay (Coinsurance)	20%	40%*	20%**
Plan Pays	80%	60%*	80%**

* Based on the non-network reimbursement rate (currently equivalent to 140% of the Medicare Reimbursement Rate). In addition to Coinsurance, you are also responsible for 100% of the difference between billed charges and the non-network reimbursement rate. The plans do not cover this difference, and these amounts do not apply to the Deductible or Out-of-Pocket Maximum.

**Based on R&C. In addition to the Coinsurance, you are responsible for 100% of the difference between billed charges and the R&C. The plans do not cover this difference, and these amounts do not apply to the Deductible or Out-of Pocket Maximum.

Annual Out-of-Pocket Maximum (OOP Max)

With the Standard Medical Option and the OOA Medical Option, the most you would be required to spend out-of-pocket on Coinsurance in any year for medical expenses is known as the Annual Out-of-Pocket Maximum (OOP Max). Once your Coinsurance payments reach the limit, the plan pays 100% for Covered Services for the remainder of the plan (calendar) year.

There are separate OOP Maximums for network and non-network services, and they do not cross apply. This means that only covered network expenses apply to the network OOP Max, and only non-network expenses apply to the non-network OOP Max. The OOA Medical Option has its own OOP Max.

The Deductible does not count toward the OOP Max, and any amounts in excess of R&C or 140% of the Medicare Reimbursement Rate are not applied to the OOP Max. You, not the plan, must always pay 100% of these excess amounts.

Also, with the Standard Medical Option and the OOA Medical Option, prescription drug Copays do not count toward the annual medical OOP Max. For details about expenses that do not count toward the OOP Max, refer to "Expenses That Don't Apply Toward Your Deductible and OOP Max," box later in this section.

2008 DFCMP Medical Option Annual Out-of-Pocket Maximums

	Standard Medical Option		OOA Medical Option
	Network	Non-Network	
Individual	$3,000	$6,000	$3,000
Family	$6,000	$12,000	$6,000

How Family Members Meet the Annual Out-of-Pocket Maximum

For the family level of coverage, a family member is only required to meet his or her annual individual OOP Max before the plan begins paying 100% for that one family member. Once the network OOP Max is met, additional covered network services are covered at 100% for the remainder of the year. Likewise, once the non-network OOP Max is met, additional covered non-network expenses are paid at 100% of 140% of the Medicare Reimbursement Rate. Any amounts charged in excess of 140% of the Medicare Reimbursement Rate are not covered under the plan and must be paid 100% by the covered individual, even if the non-network OOP Max has been met.

Example: An individual who has family coverage under the Standard Medical Option would reach the network Annual OOP Max once his or her covered network medical expenses add up to $3,000 (excluding Deductibles) for the year. This individual's covered network medical expenses would then be paid by the plan at 100% for the rest of the year. The individual would not have to wait until the entire family's covered network expenses reach $6,000 for this to happen.

IMPORTANT:
Expenses That Don't Apply Toward Your Deductible and OOP Max

- Charges that are above 140% of the Medicare Reimbursement Rate or above Reasonable and Customary (R&C)
- $700 penalty for not following UHC's Customer Service – Health Advocate Team Notification procedures
- All Copays paid to providers
- Prescription drug Copays
- Some mental health/substance abuse expenses
- Charges for services not considered covered health services and not covered by the plan

Behavioral Health and Substance Abuse Benefits

Your mental health is just as important as your physical health. Therefore, when you enroll in the Standard Medical Option or the OOA Medical Option, you automatically receive behavioral health benefits and substance abuse treatment benefits (BH/SA) through United Behavioral Health (UBH).

Covered behavioral health services received through the UHC/UBH network apply toward your Medical Option's Deductibles and Annual OOP Maximums. Notification is required for all network behavioral health services and all inpatient non-network behavioral health services. You are charged a $700 penalty for each failure to notify. For emergency admissions, you or your physician must contact UBH within one business day to receive network benefits. You may contact UBH at **877-683-8555**.

You are required to meet a separate $200 Deductible for all non-network, facility-based confinements, in addition to the annual non-network medical Deductible.

Preventive Care

Preventing disease, and detecting disease early if it occurs, is important to living a healthy life. And, the better your health, the lower your healthcare costs are likely to be. Following these guidelines, along with the advice of your doctor, can help you stay healthy. Talk to your doctor about your specific health questions and concerns, and follow his or her recommendations. If you'd like more information on Preventive Care, visit **www.preventiveservices.ahrq.gov**.

Preventive Care services such as annual check-ups and routine screenings are covered by the office visit Copay and/or 100% for services other than the office visit that are associated with the preventive service, when performed by a UHC Network Provider and received through DFCMP Medical Options — and you don't have to meet the Deductible first. You also have the choice of using Non-Network Providers with each option, but Preventive Care coverage is not 100% if you do.

Preventive Care is designed to encourage you to actively monitor your health. Annual check-ups can often catch potential problems early — and, in some cases, prevent serious illness from developing.

Examples of Preventive Care services may include:

- Annual physicals
- Annual OB/Gyn visits
- Childhood immunizations
- Mammograms
- Colonoscopies

The Delta plans cover Preventive Care services in accordance with U.S. Preventive Services Task Force guidelines. To see which preventive services are recommended for various age groups, refer to the entry for "Preventive Care" in "What the Delta Medical Plans Cover" at the end of this section, or review the guidelines on the My Health & Insurance site located on Employee Connection. Click on the link "Preventive Services Covered at 100 Percent."

A note about preventive services and provider billing:

Your provider assigns a code for your service after each doctor's visit. Occasionally, providers code a Preventive Care visit as diagnostic if they detect something they want to follow up on. If this happens, UnitedHealthcare may assume this visit was not for Preventive Care, and the visit may not be paid as a Preventive Care visit. If you encounter a network Preventive Care claim not being processed at the appropriate office visit Copay or 100% network benefit level, and you believe it to have been a true Preventive Care claim incurred through a Network Provider, contact UnitedHealthcare Member Services at **877-683-8555** and ask to have the claim reprocessed. If the claim in question falls within the U.S. Preventive Services Taskforce Guidelines, UHC reprocesses the claim at the appropriate benefit levels.

Standard Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical" section.

2008 Standard Medical Option		
	Network	**Non-Network**
Annual Deductible		
Retiree/Survivor Only	$600	$1,200
Family *(Retiree/survivor plus 2 or more family members)*	$1,800	$3,600
Copays	$20 – Primary Care Physician (PCP) office consultation $50 – Specialist office consultation $50 Urgent Care Center Visit $100 – ER Visit	$100 – ER Visit
Coinsurance *(% paid by plan after deductible is met)*	80% covered Network Charges after network Deductible, up to the network Annual OOP Max for services provided outside of a PCP/specialist office consultation and ER or urgent care visit	60% of 140% of Medicare Reimbursement Rate after the non-network Deductible is met, up to the non-network Annual OOP Max
Annual Out-of-Pocket Maximum		
Retiree/Survivor Only	$3,000	$6,000
Family *(Retiree/survivor plus 2 or more family members)*	$6,000	$12,000
Maximum Lifetime Medical Benefit	$5,000,000 (includes Behavioral Health/Substance Abuse benefits)	
Behavioral Healthcare Facility–Based Treatment	80% of Network Charge covered after Deductible	$200 Deductible per confinement in addition to meeting medical Deductible 50% of 140% of Medicare Reimbursement Rate covered after Deductible, up to $100 per day
Day Limits	None	30 days
Outpatient Care Treatment	$50 Copay per visit	50% of 140% of Medicare Reimbursement Rate covered after Deductible with maximum benefit of $25 per visit
Day Limits	None	20 days
Utilization Review *Non-Notification results in a penalty of $700*	Notification is required for all facility-based inpatient and outpatient network services or paid at the non-network benefit level plus the $700 non-notification penalty	Notification is required for all facility-based inpatient treatment services, or $700 non-notification penalty will be applied

2008 Standard Medical Option		
	Network	**Non-Network**
Chiropractic Care *20 visits per calendar year*	$50 Copay for specialist office consultation 80% covered after Deductible for services other than the office visit	Not covered
Durable Medical Equipment Some rules about durable medical equipment apply	80% of R&C covered after Deductible	60% of 140% of Medicare Reimbursement Rate covered after Deductible
Emergency Room Visits *Only covered if visit is for a medical emergency*	$100 Copay; if admitted, Copay is waived and hospitalization is paid at 80% after Deductible	$100 Copay, if admitted, Copay is waived and hospitalization is paid at 60% of 140% of Medicare Reimbursement Rate after Deductible
Hospital – Inpatient or Outpatient *Notification required*	80% covered after Deductible	60% of 140% of Medicare Reimbursement Rate covered after Deductible
Lab Work – Diagnostic	80% covered after Deductible	60% of 140% of Medicare Reimbursement Rate covered after Deductible
Maternity *Physician and facility charges*	$20 Copay for PCP office consultation to confirm pregnancy $50 Copay for specialist office consultation to confirm pregnancy 80% covered after Deductible for: • Delivery expenses • Other services (such as lab tests or ultrasounds) as ordered or performed by physician during pre- and postnatal care	60% of 140% of Medicare Reimbursement Rate covered after Deductible
Office Visit – General	$20 Copay for PCP office consultation 80% covered after Deductible for services other than the office consultation	60% of 140% of Medicare Reimbursement Rate covered after Deductible
Office Visit – Specialist	$50 Copay for specialist office consultation 80% covered after Deductible for services other than the office consultation	60% of 140% of Medicare Reimbursement Rate covered after Deductible
Preventive Care *Including preventive Lab Work and X-rays*	$20 Copay for PCP office consultation $50 Copay for specialist office consultation 100% covered; not subject to the Deductible for preventive services other than an office consultation	60% of 140% of the Medicare Reimbursement Rate covered after Deductible

2008 Standard Medical Option		
	Network	**Non-Network**
Substance Abuse *Two episodes of treatment per lifetime* Facility–Based Treatment Day Limits	80% covered after Deductible None	$200 Deductible per confinement in addition to meeting medical Deductible 50% of 140% of Medicare Reimbursement Rate covered after Deductible, up to $100/day 30 days
Outpatient Care Treatment Day Limits	$50 Copay per visit None	50% of 140% of Medicare Reimbursement Rate covered after Deductible, with maximum benefit of $25 per visit 20 days
Utilization Review for Substance Abuse *Non-Notification results in a penalty of $700*	Notification is required for all facility-based inpatient and outpatient network services or paid at the non-network benefits level plus $700 non-notification penalty	Notification is required for all facility-based inpatient treatment services or $700 non-notification penalty will apply
Surgical Charges – Inpatient/Outpatient	80% covered after Deductible	60% of 140% of Medicare Reimbursement Rate covered after Deductible
Therapies (Such as physical, occupational or speech therapies) *Limited to 30 combined network and non-network visits per calendar year per therapy*	80% covered after Deductible	60% of 140% of Medicare Reimbursement Rate covered after Deductible
X-Rays – Diagnostic	80% covered after Deductible	60% of 140% of Medicare Reimbursement Rate covered after Deductible

Out-of-Area Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical" section.

2008 Out-of-Area Medical Option	
Annual Deductible	
Retiree/Survivor Only	$400
Family *(Retiree/survivor plus 2 or more family members)*	$1,200
Coinsurance *(% paid by plan)*	Plan pays 80% of R&C charges after the Deductible is met
Out-of-Pocket Maximum (OOP Max)	
Retiree/Survivor Only	$3,000
Family *(Retiree/survivor plus 2 or more family members)*	$6,000
Maximum Lifetime Medical Benefit	$5,000,000 Includes Behavioral Health/Substance Abuse benefits
Behavioral Healthcare *Notification required for all facility-based inpatient treatment and all outpatient treatment*	80% of R&C covered after Deductible No day limits apply
Chiropractic Care *20 visits per calendar year*	80% of R&C charge after Deductible
Durable Medical Equipment *Some rules about durable medical equipment apply*	80% of R&C covered after Deductible
Emergency Room Visits *Only covered if visit is for a medical emergency*	80% of R&C covered after Deductible
Hospital – Inpatient or Outpatient *Notification required for inpatient stay*	80% of R&C covered after Deductible
Lab Work – Diagnostic	80% of R&C covered after Deductible
Maternity *Physician and facility services included*	80% of R&C covered after Deductible
Office Visit – General	80% of R&C covered after Deductible
Office Visit – Specialist	80% of R&C covered after Deductible
Preventive Care *Preventive Lab Work and X-rays included*	100% of R&C charges; not subject to the Deductible
Substance Abuse *Two episodes of treatment per lifetime* *Notification required for all facility-based inpatient treatment and all outpatient treatment*	80% of R&C covered after Deductible No day limits apply

2008 Out-of-Area Medical Option	
Surgical Charges – Inpatient/Outpatient	80% of R&C covered after Deductible
Therapies (Such as physical, occupational or speech therapies) *Limited to 30 visits per calendar year per therapy*	80% of R&C covered after Deductible
X-Rays – Diagnostic	80% of R&C covered after Deductible

Prescription Drug Benefits — Standard Medical Option and OOA Medical Option

When you enroll in the Standard Medical Option or the OOA Medical Option, you automatically receive prescription drug benefits through UHC Pharmacy Solutions.

Under the Standard Medical Option and the OOA Medical Option, prescription drug expenses are handled separately from medical expenses. This means that prescription drug Copays and expenses do not count toward your annual medical Deductible or medical OOP Max. They do count toward your lifetime maximum benefit, however.

Network Pharmacies

Prescription drugs are only covered by the Standard Medical Option and the OOA Medical Option if you obtain them from a network pharmacy or the mail order pharmacy program. You pay no Deductible for prescription drugs — instead, you pay a Copay for each prescription. The amount of your Copay depends on the type of drug you receive — generic, preferred or non-preferred — and where you buy the drug (retail network or mail order pharmacy).

Retail Network Pharmacies

You should fill short-term prescriptions (prescribed for up to 31 days) at a UnitedHealthcare UHC retail network pharmacy. You can find a list of network pharmacies at **www.myuhc.com**. Click the Pharmacies & Prescriptions link in the top navigation area.

Mail Order Pharmacies

You may fill maintenance medications (those for a 90-day supply) either through a UHC retail network pharmacy or through the UHC mail order pharmacy — the choice is yours. Keep in mind that the mail order pharmacy can save you money. This is because you pay a reduced Copay for a 90-day supply of mail order medication compared to what you would spend at a retail pharmacy for the same 90-day supply. The use of mail order is voluntary.

To obtain a mail order form, log on to **www.myuhc.com** and click on “Pharmacy and Prescriptions,” or call UnitedHealthcare at **877-683-8555**.

Prescription Drug List

A prescription drug list (PDL) is a list of Food and Drug Administration (FDA) approved brand name and generic medications. The UHC pharmacy benefit provides coverage for a comprehensive list of prescription medications.

The UHC PDL Management Committee makes tier placement decisions to help ensure access to a wide range of medications. The Committee is composed of senior level physicians and business leaders who decide the tier placement of a particular prescription medication based on clinical information from the UHC Pharmacy and Therapeutics (P&T) Committee, as well as economic and financial considerations. The Committee looks at the overall healthcare value of a particular medication to balance the need for flexibility and choice for participants with an affordable pharmacy benefit.

Medications may move to a higher tier up to three times per calendar year. Additionally, when a brand name medication becomes available as a generic, the tier status of the brand name medication and its corresponding generic are evaluated. When a medication changes tiers, you may be required to pay more or less for that medication. Drugs not on the PDL are not considered to be covered expenses.

For the most current information on your pharmacy coverage, call UHC at **877-683-8555** or visit **www.myuhc.com**.

You can view UHC's PDL on Benefits Direct, which is accessible through DeltaNet (**http://dlnet.delta.com**) and on the My Health & Insurance site located on Employee Connection. The PDL also is available on **www.myuhc.com**.

Drug Tiers

Prescription drugs costs are based on their tier. There are four tiers. Generally, Tier 1 is the lowest cost option, made up of generics and other low-cost drugs. Tiers 2-4 are typically higher cost and brand-name drugs.

Visit the "Price a Medication" tool on **www.myuhc.com** to find out on which tier your drug is classified. Note that prescription drug tier information is updated quarterly by UHC.

Standard Medical Option and OOA Medical Option Prescription Drug Benefit

Prescription Drug Benefit	
In-Network Prescription Drug Benefit	**Standard Medical Option OOA Medical Option**
	Only prescriptions purchased at network pharmacies or the mail order pharmacy are covered
Retail Pharmacy (31-day supply)	
Tier 1	$10 Copay
Tier 2	$30 Copay
Tier 3	$50 Copay
Tier 4	$70 Copay
Diabetic Kit or Single Supply	$30 Copay
Mail Order Pharmacy (90-day supply)	
Tier 1	$25 Copay
Tier 2	$75 Copay
Tier 3	$125 Copay
Tier 4	$175 Copay
Diabetic Kit or Single Supply	Not applicable

Pharmacy Management Program

This program may limit prescription quantities to certain amounts, require Notification for certain prescriptions and include the half-tab program.

Some medications are noted with N, QD, QLL or DS.

N = Notification. For a few medications, your doctor must notify UHC to make sure they are covered prescription drugs**.**

QD = Quantity Duration. Some medications have a limited amount that can be covered for specific period of time.

QLL = Quantity Level. Some medications have a limited amount that can be covered at one time.

1/2T = Eligible for Half-Tablet Program. Some medications can safely be split in half to achieve the prescribed dosage of your prescription as it is written by your physician.

Diabetic Supplies/Kit

If you purchase products to treat diabetes, you can receive a customized diabetic kit from a network retail pharmacy; kits are not available through home delivery. Your kit or individual supplies cost a $30 Copay for up to a 90-day supply. All items must be purchased at the same time. Single items are charged the $30 Copay. Kits or individual supplies may include:

- Insulin and diabetic medications
- Insulin syringes and needles
- Alcohol swabs
- Blood test strips – glucose
- Urine test strips – glucose
- Ketone tablets
- Oral anti-diabetic agents
- Glucose monitors
- Ketone test strips
- Lancets and lancet devices
- Insulin pump supplies
- Insulin pumps infusion set
- Insulin pumps minimized reservoir
- Insulin pumps extension set

How the High Value Medical Option of the DFCMP Works

With the HVO, you have comprehensive medical coverage. There are no Copayments, you may see the provider of your choice and you do not need a referral to see a specialist.

When you use covered medical, pharmacy and behavioral health services, you pay the full cost charged for such services until the HVO Deductible is met. You also pay any expenses in excess of Reasonable and Customary (R&C) charges even after your Out-of-Pocket Maximum (OOP Max) is met.

The HVO is an HDHP

The DFCMP's High Value Medical Option (HVO) is intended to meet the definition of a high-deductible healthcare plan (HDHP). This means that you may be eligible to open a Health Savings Account (HSA) — a self-funded account permitted under federal tax laws — that allows you to save money for medical or pharmacy expenses on a tax-favored basis. If you are eligible, you may deduct your HSA contributions on your tax return, up to a specified amount each year. With an HSA, you establish an account and use your own dollars to fund the account, which is available to pay eligible healthcare expenses. You can participate in the HVO with or without an HSA — the choice is yours. Because an HSA has special tax-favored status under law, it is governed by numerous mandatory tax rules and regulations. You can find more information about HSAs on the IRS Web site (**www.irs.gov**), including IRS Publication 969.

Read on to learn how the following features work under the HVO:

- Annual Deductible
- Coinsurance
- Annual Out-of-Pocket Maximum (OOP Max)
- Behavioral health and substance abuse (BH/SA) benefits
- Prescription drug benefits

Annual Deductible

The annual Deductible is the dollar amount of covered charges that you must pay before the plan begins to pay benefits each calendar year. With high-Deductible healthcare plans such as the HVO, this amount is higher than with traditional preferred provider organization (PPO) or point-of service (POS) plans.

With the HVO, there are no individual Deductibles in the retiree/survivor & spouse, retiree/survivor & child(ren) and family levels of coverage. One person's expenses, or a combination of family members' expenses, can fulfill the entire Deductible amount. Once the entire Deductible has been met, you share expenses with the plan, and the plan begins to pay the Coinsurance amount.

2008 HVO Annual Deductibles			
Retiree/Survivor Only	**Retiree/Survivor & Spouse**	**Retiree/Survivor & Child(ren)**	**Family**
$2,300	$3,400	$3,400	$4,600

Paying the Deductible

If eligible, you may use the funds in an HSA (if you have opened an HSA account and are funding it) to help pay your annual Deductible, if you would like. You pay the full cost of medical services up to the annual Deductible. If eligible, you may make a claim for reimbursement from your HSA directly with your HSA trustee. The plan does not process the HSA reimbursements.

Coinsurance

Once you and/or your dependents have met your annual Deductible, you share expenses with the plan. Your portion of these expenses is called your Coinsurance. When you have met the Deductible, the HVO pays 70% of Reasonable and Customary (R&C) charges for Covered Services, and you pay the remaining 30%, plus 100% of any amount over 100% of R&C.

2008 HVO Coinsurance	
You Pay (Coinsurance)	**Plan Pays**
30% of R&C	70% of R&C

Annual Out-of-Pocket Maximum (OOP Max)

Under the HVO, once you have met the Deductible, the HVO pays 70% of R&C charges for Covered Services, and you pay the remaining 30%. There is a limit on the amount of Coinsurance you have to pay each year. Once your Coinsurance payments reach this limit (the Out-of-Pocket Maximum, or OOP Max), the plan pays 100% for Covered Services for the remainder of the plan year. Any amounts in excess of 100% of R&C are yours alone to pay — the plan does not cover these amounts, and they do not count toward the Deductible or the OOP Max. The HVO Deductible does count toward meeting the OOP Max.

2008 HVO Annual Out-of-Pocket Maximums	
Retiree/Survivor Only	$5,600
Retiree/Survivor & Spouse	$8,400
Retiree/Survivor & Child(ren)	$8,400
Family	$11,200

How Family Members Meet the Out-of-Pocket Maximum

For retiree/survivor & spouse, retiree/survivor & child(ren) and family levels of coverage, there are no individual OOP Maximums for Covered Services. One person's covered expenses, or a combination of several family members' expenses, can accumulate and fulfill the entire OOP Max.

The OOP Max must be met in full before the plan begins paying 100% of covered expenses for any family member. There is not an individual maximum that, if reached by only one family member, can result in only that family member's Covered Services being reimbursed at 100%. Note that any covered expenses over and above 100% of R&C do not count toward the Deductible or OOP Max, and are always paid 100% by you — even if you have met the OOP Max.

IMPORTANT:
Expenses That Don't Apply Toward Your HVO Deductible and OOP Max

- Charges that are above Reasonable and Customary (R&C)
- $700 penalty for not following UHC's Customer Service – Health Advocate Team Notification procedures
- Charges for services not considered covered health services and not covered by the plan

Behavioral Health and Substance Abuse Benefits

Your mental health is just as important as your physical health. Therefore, when you enroll in the HVO, you automatically receive benefits for certain behavioral health expenses and substance abuse (BH/SA) treatment through United Behavioral Health (UBH).

Behavioral health services received through the UHC/UBH network apply toward your HVO Deductibles and OOP Max. Notification is required for all behavioral health services. You are charged a $700 penalty for each failure to notify. For emergency admissions, you or your physician must contact UBH at **877-683-8555** within one business day to receive network benefits.

Prescription Drug Benefits

Prescription drug benefits for retail prescriptions are included with the HVO. UHC administers the program.

You pay 100% of the cost of retail prescription drugs (which are discounted if you use UHC network pharmacies), up to your applicable HVO Deductible. Note that your covered prescription drug expenses count toward your annual medical Deductible. Once you meet your Deductible, the plan pays 70% of R&C of the cost (or Network Charges) of all eligible prescription drugs and medical benefits.

Pharmacy prices vary, so it is a good idea to call at least three local pharmacies for their costs before filling your prescription. Look into warehouse stores (some do not require you to buy a membership when you are only filling a prescription), as well as "big box" retailers (some of whom offer $4 generics). Also, a growing number of supermarkets offer a free 14-day supply of several antibiotics. Look in these same places for good prices on over-the-counter remedies.

High Value Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical" section.

2008 High Value Medical Option	
Annual Deductible	
Retiree/Survivor Only	$2,300
Retiree/Survivor & Spouse	$3,400
Retiree/Survivor & Child(ren)	$3,400
Family	$4,600
Coinsurance (% paid by plan)	Plan pays 70% of R&C charges after the Deductible is met
Out-of-Pocket Maximum (OOP Max)	
Retiree/Survivor Only	$5,600
Retiree/Survivor & Spouse	$8,400
Retiree/Survivor & Child(ren)	$8,400
Family	$11,200
Maximum Lifetime Medical Benefit	$5,000,000 Includes Behavioral Health/Substance Abuse benefits
Behavioral Healthcare *Notification required for all facility-based services*	70% of R&C covered after Deductible No day limits apply
Chiropractic Care *20 visits per calendar year*	70% of R&C charge after Deductible
Durable Medical Equipment *Some rules about durable medical equipment apply*	70% of R&C covered after Deductible
Emergency Room Visits *Only covered if visit is for a medical emergency*	70% of R&C covered after Deductible
Hospital – Inpatient or Outpatient *Notification required for inpatient stay*	70% of R&C covered after Deductible
Lab Work – Diagnostic	70% of R&C covered after Deductible
Maternity *Physician and facility services included*	70% of R&C covered after Deductible
Office Visit – General	70% of R&C covered after Deductible
Office Visit – Specialist	70% of R&C covered after Deductible
Prescription Drug Benefit *Prescriptions filled at any retail pharmacy* *No mail order prescription drug benefit provided*	70% of R&C covered after Deductible

2008 High Value Medical Option	
Preventive Care *Preventive Lab Work and X-rays included*	100% of R&C charges; not subject to the Deductible
Substance Abuse *Two episodes of treatment per lifetime* *Notification required for all facility-based inpatient treatment and all outpatient treatment*	70% of R&C covered after Deductible No day limits apply
Surgical Charges – Inpatient/Outpatient	70% of R&C covered after Deductible
Therapies (Such as physical, occupational and speech therapies) *Limited to 30 visits per calendar year per therapy*	70% of R&C covered after Deductible
X-Rays – Diagnostic	70% of R&C covered after Deductible

DELTA PILOTS MEDICAL PLAN

If you are an eligible retired or disabled pilot or the survivor of a Delta pilot, you and your eligible dependents have access to two Delta medical plan options. You may choose to enroll in:

- The Standard Medical Option, Out-of-Area Medical Option (if you are eligible) or the High Value Medical Option offered through the Delta Family-Care Medical Plan (DFCMP), or
- The Delta Pilots Medical Plan (DPMP)

The DPMP offers both medical and dental coverage as a package; therefore, you cannot waive dental coverage. Medical coverage is administered by UHC, and dental coverage is administered through MetLife. This section describes the medical coverage provided under the DPMP. For details about the DPMP dental coverage, see the Dental section of this SPD.

As with other Delta medical plans, prescription drug and behavioral health benefits also are included.

The DPMP covers eligible network and non-network services. If you use Network Providers, you receive a higher level of benefits and your costs are based on Network Charges. You are not required to select and notify UnitedHealthcare of a Primary Care Physician (PCP). You may select and change your physician at any time you wish. Referrals to specialist do not require coordination through a PCP. If you live in an area not served by the UHC network, the DPMP provides out-of-area (OOA) benefits based on Reasonable and Customary (R&C) charges.

To find a Network Provider or get details about your medical/dental coverage, call UHC at **877-683-8555**.

Two-Year Claims Filing Deadline

The DPMP has a two-year claims filing limit. All claims for medical services must be submitted to UHC within two years of the date of service. See the “Claims Information and Appeals” section of this SPD for details.

How the DPMP Medical Option Works

Read on to learn how the following features work with the DPMP. Specific dollar amounts associated with each of these features appear in the chart that follows.

- Annual Deductible
- Copayments
- Coinsurance
- Annual Out-of-Pocket Maximum (OOP Max)

Annual Deductible

The annual Deductible is the dollar amount of covered charges that you must pay before the plan begins to pay benefits each calendar year. There are separate Deductible amounts for network services and non-network services; the non-network Deductible is higher. If you are enrolled in the out-of-area benefit, you have one Deductible to meet, regardless of whether you receive services through the UHC network.

Some covered medical services (such as prescription drug costs) do not count toward the Deductible. For a full list, refer to "Expenses That Don't Apply Toward Your Deductible and OOP Max" box in this medical section.

Copays

Generally, if you use Network Providers, you pay a Copay directly to the provider of your medical services. Some services that may only require a Copay are physician office visits, specialist consultations, urgent care center visits and ER visits.

The only non-network Copay that may apply is for an ER visit that meets the definition of a true emergency; otherwise non-network services do not have Copays. You generally pay the entire cost of a non-network service and then apply to the plan for reimbursement, although your physician may, but is not required to, make the claim on your behalf.

The out-of-area benefit does not require Copays.

Coinsurance

Once you and/or your dependents have met your annual Deductible, you share expenses with the plan. Your portion of these expenses is called your Coinsurance.

Your Coinsurance is based on whether you receive network, non-network or out-of-area services.

Generally, for network services, the plan pays 90% of the covered Network Charges, and you pay the remaining 10%. For non-network services, you pay 30% of 140% of the Medicare Reimbursement Rate. For out-of-area services, you pay 20% of the Reasonable and Customary (R&C) rate. (These rates are defined in the "Terms to Know" section, which is at the back of this SPD.)

Note that any cost for non-network services in excess of 70% of 140% of the Medicare Reimbursement Rate, or for out-of-area coverage, more than 80% of the R&C rate, is not covered by the plan. Therefore, you pay 100% of these excess amounts, and these costs do not apply to your Deductible or Annual Out-of-Pocket Maximum.

Annual Out-of-Pocket Maximum (OOP Max)

With the DPMP, the most you are required to spend out-of-pocket on Coinsurance in any year on covered medical expenses is known as the Annual Out-of-Pocket Maximum (OOP Max). Once your Coinsurance payments reach this limit, the plan pays 100% for Covered Services for the remainder of the plan year.

For the DPMP, there are separate OOP Maximums for network and non-network services, and they do not cross apply. This means that only covered network expenses apply to the network OOP Max, and only non-network expenses apply to the non-network OOP Max. The out-of-area benefit has its own OOP Max.

The Deductible does not count toward the Annual OOP Max, nor do any amounts in excess of R&C (for out-of-area coverage) or 140% of the Medicare Reimbursement Rate (for non-network coverage). None of these expenses are applied to the Annual OOP Max. You, not the plan, must always pay these excess amounts.

Also, with the DPMP, prescription drug Copays do not count toward the medical Annual OOP Max. For a full list of expenses that do not count toward the OOP Max, refer to "Expenses That Don't Apply Toward Your Deductible and OOP Max," box below.

Meeting the Family OOP Max

For the family level of coverage, a family member is only required to meet his or her individual OOP Max before the plan begins paying 100% of covered expenses for that one family member for the year.

Example: An individual who has family coverage under the DPMP would reach the annual network OOP Max once his or her covered network medical expenses add up to $2,000 (excluding Deductibles) for the year. This individual's covered network medical expenses would then be paid by the plan at 100% for the rest of the year. The individual would not have to wait until the entire family's network expenses reach $4,000 for this to happen.

IMPORTANT:
Expenses That Don't Apply Toward Your Deductible and OOP Max

- Charges that are above 140% of the Medicare Reimbursement Rate or above Reasonable and Customary (R&C)
- $700 penalty for not following UHC's Customer Service – Health Advocate Team Notification procedures
- All Copays paid to providers
- Prescription drug Copays
- Some mental health/substance abuse expenses
- Charges for services not considered covered health services and not covered by the plan

DPMP Overview

2008 Covered Medical Services

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical" section.

2008 DPMP Medical			
	Network	**Non-Network**	**Out-of-Area**
Annual Deductible *Network Deductible only applies to network services; non-network Deductible only applies to non-network services. Deductibles do not cross apply*	$150 Individual/ $450 Family (cumulative) Excludes Copays	$350 Individual/ $1,000 Family (cumulative) Excludes Copays and some medical expenses	$200 Individual/ $600 Family (cumulative)
Copays	$15 Primary Care Physician (PCP) office consultation $25 specialist office consultation $50 urgent care center visit $100 ER visit	$100 ER visit	Not applicable
Coinsurance – Benefit Coverage Level *(% paid by plan)*	90% of covered Network Charges after the network Deductible, up to the annual network OOP Max, for services provided outside of a physician/specialist office consultation and urgent/emergency care	70% of 140% of the Medicare Reimbursement Rate covered after the non-network Deductible is met, up to the annual non-network OOP Max	80% of R&C charges covered after Deductible is met, up to the annual OOP Max Some benefit coverages only require a Copay (see the coverage charts for Behavioral Health and Prescription Drugs, later in this section)
Annual Out-of-Pocket Maximum (OOP Max) *Network and non-network OOP Maximums do not cross apply* *The OOP Max expenses of covered family members are aggregated*	$2,000 Individual/ $4,000 Family Excludes Deductibles and Copayments In meeting the $4,000 family OOP Max, no single family member must meet the individual $2,000 OOP Max	$3,500 Individual/ $7,000 Family Excludes Deductibles and some medical expenses In meeting the $7,000 family OOP Max, no single family member must meet the individual $3,500 OOP Max	$2,500 Individual/ $5,000 Family Excludes Deductibles and some medical expenses In meeting the $5,000 family OOP Max, no single family member must meet the individual $2,500 OOP Max
Maximum Lifetime Medical Benefit	$5,000,000 (includes Behavioral Health/Substance Abuse benefits)		

2008 DPMP Medical			
	Network	**Non-Network**	**Out-of-Area**
Chiropractic Care	$25 Copay for office consultation 90% after Deductible for services other than the office consultation Limited to 20 visits per calendar year	Not covered	80% of R&C charge after Deductible Limited to 20 visits per calendar year
Durable Medical Equipment *Some rules about durable medical equipment apply*	90% after Deductible	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible
Emergency Room Visits *Not covered for non-emergencies*	$100 Copay for care meeting definition of emergency/ urgent care If admitted, Copay is waived, and you must notify the Health Advocate Team within two business days Any inpatient hospitalization is paid at 90% after Deductible	$100 Copay for care meeting definition of emergency/ urgent care paid as network If admitted, Copay is waived and you must notify the Health Advocate Team within two business days Any inpatient hospitalization is paid at 70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible You must notify the Health Advocate Team within two business days If admitted
Hospital – Inpatient or Outpatient *Notification required*	90% after Deductible	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible
Lab Work – Diagnostic	90% after Deductible	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible
Maternity *Physician and facility services included*	$15 Copay for office consultation $25 Copay for Specialist office consultation to confirm pregnancy 90% covered after Deductible for: • Delivery expenses • Other services (such as lab tests and ultrasounds) ordered or performed by physician during pre- and postnatal care	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible
Office Visit – General	$15 Copay office consultation 90% after Deductible for services other than office consultation	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible

2008 DPMP Medical			
	Network	**Non-Network**	**Out-of-Area**
Office Visit – Specialist	$25 Copay for specialist office consultation 90% after Deductible for services other than office consultation	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible
Preventive Care *Preventive Lab Work and Tests included*	$15 Copay for office consultation $25 Copay for specialist office consultation 90% after Deductible for services other than office consultation	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible
Surgical Charges – Inpatient/Outpatient	90% after the Deductible	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible
Therapies (Such as physical, occupational and speech therapies) *Limited to 30 visits per calendar year per therapy*	90% after Deductible	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible
X-Rays – Diagnostic	90% after Deductible	70% of 140% of the Medicare Reimbursement Rate after Deductible	80% of R&C charge after Deductible

DPMP Prescription Drug Benefits

When you enroll in the DPMP, you automatically receive prescription drug benefits for retail and mail order prescriptions through UHC Pharmacy Solutions.

Your prescription drug expenses do not count toward your annual medical Deductible or OOP Max.

Network Pharmacies

Prescription drugs are only covered by the DPMP if you obtain them from a retail network pharmacy or the mail order pharmacy program. You pay no Deductible for prescription drugs — instead, you pay a Copay for each prescription. The amount of your Copay depends on the type of drug you receive — generic, preferred or non-preferred — and where you buy the drug (retail network or mail order pharmacy).

Retail Network Pharmacies

You should fill short-term prescriptions (prescribed for up to 31 days) at a UnitedHealthcare UHC retail network pharmacy. You can find a list of network pharmacies at **www.myuhc.com**. Click the Pharmacies & Prescriptions link in the top navigation area.

Mail Order Pharmacies

You may fill maintenance medications (those for a 90-day supply) either through a UHC retail network pharmacy or through the UHC mail order pharmacy — the choice is yours. Keep in mind that the mail order pharmacy can save you money. This is because you pay a reduced Copay for a 90-day supply of mail order medication compared to what you would spend at a retail pharmacy for the same 90-day supply. Also, your prescriptions are conveniently delivered right to your door. The use of mail order is voluntary.

To obtain a mail order form, log on to **www.myuhc.com** and click on Pharmacy and Prescriptions, or call UnitedHealthcare at **877-683-8555** for additional information on how to get started.

Prescription Drug List

A prescription drug list (PDL) is a list of Food and Drug Administration (FDA) approved brand name and generic medications. The UHC pharmacy benefit provides coverage for a comprehensive list of prescription medications.

The UHC PDL Management Committee makes tier placement decisions to help ensure access to a wide range of medications. The Committee is composed of senior level physicians and business leaders who decide the tier placement of a particular prescription medication based on clinical information from the UHC Pharmacy and Therapeutics (P&T) Committee, as well as economic and financial considerations. The Committee looks at the overall healthcare value of a particular medication to balance the need for flexibility and choice for participants with an affordable pharmacy benefit.

Medications may move to a higher tier up to three times per calendar year. Additionally, when a brand name medication becomes available as a generic, the tier status of the brand name medication and its corresponding generic are evaluated. When a medication changes tiers, you may be required to pay more or less for that medication. Drugs not on the PDL are not considered to be covered expenses. For the most current information on your pharmacy coverage, call UHC at **877-683-8555** or visit **www.myuhc.com**.

You can view UHC's PDL on Benefits Direct, which is accessible through DeltaNet (**http://dlnet.delta.com**) and on the My Health & Insurance site located on Employee Connection. It is also available on **www.myuhc.com**.

Drug Tiers

Prescription drugs costs are based on their tier. There are three tiers:

- Tier 1 — Lowest-Copay Option: Generally generic and other low-cost drugs
- Tier 2 — Mid-Range Copay Option: Moderately-priced brand name drugs
- Tier 3 — Highest-Copay Option: Drugs on this tier may have Tier 1 or Tier 2 alternative selections

	DPMP Network		Out-of Area	
	Network	**Non-Network**	**Network**	**Non-Network**
Retail Pharmacy (31-day supply)				
Tier 1	$10 Copay	Not covered	$10 Copay	Not covered
Tier 2	$25 Copay	Not covered	$30 Copay	Not covered
Tier 3	$40 Copay	Not covered	$55 Copay	Not covered
Diabetic Kit or Single Supply	$30 Copay	Not covered	$30 Copay	Not covered
Home Delivery (90-day supply)				
Tier 1	$25 Copay	Not applicable	$25 Copay	Not applicable
Tier 2	$60 Copay	Not applicable	$75 Copay	Not applicable
Tier 3	$100 Copay	Not applicable	$135 Copay	Not applicable
Diabetic Kit or Single Supply	Not applicable	Not applicable	Not applicable	Not applicable

Pharmacy Management Program

This may limit quantities to certain amounts, require Notification for certain prescriptions and include the half-tab program.

Some medications are noted with N, QD, QLL, or DS. The definitions for these symbols are listed below.

N = Notification. There are a few medications that your doctor must notify UHC of to make sure their use is a covered prescription drug.

QD = Quantity Duration. Some medications have a limited amount that can be covered for a specific period of time.

QLL = Quantity Level. Some medications have a limited amount that can be covered at one time.

1/2T = Eligible for Half Tablet Program. Some medications can safely be split in half to achieve the prescribed dosage of your prescription as it is written by your physician

Diabetic Supplies/Kit

If you purchase products to treat diabetes, you can receive a customized diabetic kit from a network retail pharmacy; kits are not available through home delivery. Your kit or individual supplies cost a $30 Copay for up to a 90-day supply. All items must be purchased at the same time. Single items are charged the $30 Copay. Kits or individual supplies may include:

- Insulin and diabetic medications
- Insulin syringes and needles
- Alcohol swabs
- Blood test strips – glucose
- Urine test strips – glucose
- Ketone tablets
- Oral anti-diabetic agents
- Glucose monitors
- Ketone test strips
- Lancets and lancet devices
- Insulin pump supplies
- Insulin pumps infusion set
- Insulin pumps minimized reservoir
- Insulin pumps extension set

DPMP Behavioral Health & Substance Abuse Benefits

Your mental health is just as important as your physical health. Therefore, when you enroll in the DPMP, you automatically receive behavioral health benefits and substance abuse treatment benefits (BH/SA) through United Behavioral Health (UBH).

You may seek behavioral health services either through or outside the UHC/UBH network, even if you are in the OOA coverage. Costs for behavioral health services you receive through UHC/UBH Network Providers apply toward your DPMP network benefit Deductibles and Out-of-Pocket Maximums. (See earlier in this section for details.) You are required to meet a separate $200 Deductible for all non-network, facility-based confinements, in addition to the annual non-network medical Deductible or to the OOA non-network BH/SA Deductible.

Notification is required for all network and inpatient non-network BH/SA services. You are charged a $700 penalty for each failure to notify. For emergency admissions, you or your physician must contact UBH at **877-683-8555** within one business day to receive network benefits.

For full coverage details about BH/SA services, refer to the section, "What the Delta Medical Plans Cover," which appears later in this "Medical" section of the SPD.

Annual Deductible

You combine your medical and BH/SA treatment charges to meet your annual medical Deductible. The network Deductible applies only to network services, while the non-network Deductible only applies to non-network services.

About the DPMP's Out-of-Area BH/SA Benefits

The DPMP OOA benefit's non-network BH/SA Deductible of $650/individual and $1,300/family is separate from and *does not* combine with the annual OOA medical Deductible (which is neither a network or non-network Deductible) because there is not a non-network feature under the OOA medical benefit.

The OOA BH/SA treatment benefit is the only benefit that can be paid either as network or non-network under the DPMP OOA benefit. Non-network services for these BH/SA benefits have a separate Deductible, Coinsurance and OOP Max. Therefore, when non-network BH/SA services are incurred, these Covered Services accumulate toward reaching a separate non-network Deductible and OOP Max — and they do not accumulate toward the OOA medical Deductible, Coinsurance and OOP Max.

Out-of-Pocket Maximum (OOP Max)

Medical and behavioral health/substance abuse (BH/SA) treatment charges combine toward reaching a network or non-network medical Out-Of-Pocket Annual Maximum (OOP Max), unless you are in the OOA benefit, where there is a non-network OOP Max that is separate from the medical OOP Max. Your Deductibles and Copays are not counted toward this Annual OOP Max.

OOP Max for Charges Incurred Under the Network Benefit

In the network medical option, all medical and BH/SA charges incurred in-network combine toward reaching the one network medical OOP Max. Medical Non-Network Charges and BH/SA Non-Network Charges combine together in the same way toward reaching the non-network medical OOP Max.

OOP Max for Charges Incurred Under the Out-of-Area Benefit

Under the OOA coverage, all medical and network BH/SA charges combine toward reaching the medical OOP Max.

In the OOA option, BH/SA benefits have a non-network OOP Max of $4,500/individual and $9,000/family. However, the OOA medical option does not have non-network medical benefits. Therefore, there is no non-network medical OOP Max for OOA non-network BH/SA charges to combine with. Instead, BH/SA non-network charges incurred in the OOA option only combine with other BH/SA non-network charges to reach the non-network BH/SA OOP Max.

Behavioral Health and Substance Abuse Benefits				
	DPMP Network		**Out-of-Area**	
	Network	**Non-Network**	**Network**	**Non-Network**
Annual Deductible *Network services only apply to the network Deductible; non-network services only apply to the non-network Deductible*	Medical Network Charges and BH/SA Network Charges combine toward reaching one network medical Deductible	Medical Non-Network Charges and BH/SA Non-Network Charges combine toward reaching one non-network medical Deductible	All OOA medical and BH/SA Network Charges combine toward reaching the one OOA medical Deductible	$650 Individual $1,300 Family Only BH/SA Non-Network Charges accumulate toward reaching the above non-network BH/SA Deductible
Annual Out-of-Pocket Maximum (OOP Max) *Excludes Deductibles and Copays*	Medical Network Charges and BH/SA Network Charges combine toward reaching the one network medical OOP Max	Medical Non-Network Charges and BH/SA Non-Network Charges combine toward reaching the one network medical OOP Max	All OOA medical and BH/SA Network Charges combine toward reaching the one OOA medical OOP Max	$4,500 Individual $9,000 Family Only BH/SA Non-Network Charges combine toward reaching the above non-network BH/SA OOP Max
Facility-Based Treatment *Residential/partial days counted at a ratio of 2:1*	90% of Network Charge after the Deductible	50% of 140% of Medicare Reimbursement Rate after Deductible is met; up to $100/day $200 Deductible per confinement in addition to meeting medical Deductible	80% of Network Charge after the Deductible	50% of 140% of Medicare Reimbursement Rate after separate BH/SA non-network Deductible is met; up to $100/day $200 Deductible per confinement in addition to meeting medical Deductible
Calendar Year Limit	None	30 days	None	30 days

Behavioral Health and Substance Abuse Benefits				
	DPMP Network		**Out-of-Area**	
	Network	**Non-Network**	**Network**	**Non-Network**
Outpatient Care Treatment Calendar Year Limit	$25 Copay per visit None	50% of 140% of Medicare Reimbursement Rate after Deductible is met; maximum benefit of $25 per visit 20 visits	$25 Copay per visit None	50% of 140% of Medicare Reimbursement Rate after separate BH/SA non-network Deductible is met; maximum benefit of $25 per visit 20 visits
Utilization Review	Notification is required for all inpatient and outpatient network services or non-network level of benefits is paid and an additional $700 non-Notification penalty will be applied. For emergency admissions, authorization must be received within the next business day to receive network benefits	Notification is required for all facility-based treatment services There is an additional $700 non-Notification penalty for failure to notify UBH of an inpatient confinement	Notification is required for all inpatient and outpatient network services or non-network level of benefits is paid and an additional $700 non-Notification penalty will be applied. For emergency admissions, authorization must be received within the next business day to receive network benefits	Notification is required for all facility-based treatment services There is an additional $700 non-Notification penalty for failure to notify UBH of an inpatient confinement
Lifetime Maximum	$5,000,000 Combined with, and as a part of, the medical Lifetime Maximum Limited to two episodes of treatment for alcohol/substance abuse			

WHAT THE DELTA MEDICAL PLANS COVER

This section describes coverage under all the Delta Family-Care Medical Plan (DFCMP) medical options, and the Delta Pilots Medical Plan (DPMP).

In general, all medical plans offered by Delta cover medically necessary hospital, surgical, physician and X-ray/laboratory services, prescription drugs, and other medical services and supplies for the treatment of non-occupational illnesses and injuries, Preventive Care and care related to other covered expenses.

The amount that the medical options pay, as well as the Coinsurance amounts required of you, varies depending on the specific medical option in which you are enrolled. Some of the medical options offered by Delta feature lower coverage levels for services received from Non-Network Providers. Also, some of the Covered Services have annual or Lifetime Maximums.

For specific details regarding network and non-network Coinsurance coverage levels, refer to each medical plan's "Overview" chart, appearing earlier in this "Medical" section. Also review the descriptions of covered benefits outlined here.

Certain services require you or your Network Provider to notify UHC's Customer Service – Health Advocate Team before receiving care for certain Covered Services. For more information about this, see "When You Must Notify UHC's Customer Service – Health Advocate Team," which appears toward the beginning of this "Medical" section of the SPD.

The services and supplies described on the following pages are covered under the plan only if they are health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and must be provided:

- When the plan is in effect
- Before the date of the individual termination conditions set forth in the plan; and
- Only when the recipient is a covered person who meets all eligibility requirements specified in the plan

These supplies and services also must meet each of the following criteria:

- It is supported by national medical standards of practice
- It is consistent with conclusions of prevailing medical research that:
  - Demonstrate that the health service has a beneficial effect on health outcomes; and
  - Are based on trials that meet the following designs:
    - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received)
    - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group)
- It is the most cost-effective method and yields a similar outcome to other available alternatives
- It is a health service or supply that is not specifically excluded in any section of this SPD

New technologies, procedures, and treatments must meet all criteria described above to be considered for coverage.

Abortion

Therapeutic abortions are covered. Voluntary or elective abortions are not covered.

Accident-Related Dental Services

If you or a dependent is enrolled in one of Delta's dental options, see the "Dental" section of this SPD for other dental care coverage. You or your doctor must always notify UHC's Customer Service – Health Advocate Team before receiving any care to ensure that dental expenses are covered. You are charged a $700 non-Notification penalty for failure to notify UHC. Eligible Non-Network Charges are covered at the network level due to limited access to Network Providers.

For accidental dental injury, the plan covers services to repair a tooth and supporting dental tissue to a functional level after the tooth and/or tissue have been accidentally injured by violent contact with an external object. This includes injury to a "sound natural tooth," as well as to a tooth that was restored previously with a filling, crown or bridge. In the case of a previously restored tooth, the plans cover services to repair the tooth to the same condition that existed before the accident. (Teeth that are cracked or broken while chewing are not covered.) A sound natural tooth is one that has not been weakened by existing dental pathology, such as decay or periodontal disease.

Acupuncture

Acupuncture is a Covered Service for the treatment of chronic pain, nausea due to chemotherapy, nausea in early pregnancy or post-operative nausea, and in lieu of conventional anesthesia. Acupuncture must be provided by an MD or DOS who is qualified in the use of acupuncture or by an acupuncturist licensed by the state or certified by the National Commission of Acupuncturists.

Treatment is limited to a total of 30 combined network and non-network visits per calendar year.

Allergy Testing and Injections

The plans cover allergy treatment including testing, sera and injections by a physician, allergist or specialist.

Ambulance

Professional ambulance service (including air ambulance) is covered from the place of injury or sickness to the first hospital where appropriate treatment is available and given (but not for the transfer of a patient at the insistence of, or for the convenience of, the patient or the patient's family), and only when determined necessary by the attending physician. Emergency ambulance service is not covered if it is not provided for an emergency. Emergency transport is based on the definition of an emergency as stated in this SPD. To ensure that expenses are covered by the plans, you or your physician should notify the UHC Customer Service – Health Advocate Team before you are transferred from one hospital to another by ambulance. Eligible Non-Network Charges are covered at the network level of coverage (Deductible, Coinsurance and Out-of-Pocket Maximum) of billed charges.

Ambulatory Surgical Center

An ambulatory surgical center is a specialized facility that is established, equipped, operated and staffed primarily to perform surgical procedures. The center must either be licensed or meet the UHC guidelines for a non-licensed facility. Surgical procedures performed in an ambulatory surgical center by properly licensed healthcare professionals are considered Covered Services.

Anesthesia

See "Hospital Care" detailed later in this list of Covered Services.

Annual Gynecological Exam

Covered expenses are based on the recommendations found in the Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force (USPSTF), published in 1996 as revised in 1998, with additional recommendations updated in the 3rd edition (2000-2003).

Network or non-network exams are limited to one exam per year. Annual gynecological exams performed by a Network Provider are paid at the appropriate office visit Copay and 100% for charges other than the office visit (not subject to the Deductible) if you are enrolled in the Standard Medical Option, and at 100% of R&C charges if you are enrolled in the OOA Medical Option or the HVO. Covered annual gynecological exam expenses are covered at the appropriate network or non-network Coinsurance (after the Deductible is met) under the DPMP.

Audiologists – Non-Preventive Care

Subject to underlying condition; audiological Preventive Care is not covered.

Behavioral Health – Mental Health, Alcohol/Substance Abuse

Behavioral health/substance abuse (BH/SA) benefits are provided through United Behavioral Health (UBH) and UnitedHealthcare.

Network and Non-Network Care (Standard Medical Option and DPMP)

The UBH Network is a group of behavioral healthcare providers and facilities available if you or a covered family member is in need of behavioral/mental health treatment. You can talk with a trained clinical specialist 24 hours a day, seven days a week, by calling UHC Member Services or UBH directly. The clinical specialist can help you choose a provider and the appropriate level of care. If you notify UBH and use the UBH Network, the plan pays higher benefits, and there are no limits to facility-based or outpatient care. You may receive a list of Network Providers at no charge by contacting UHC at **877-683-8555** or going online to print one on **www.myuhc.com**.

You may use a Non-Network Provider instead. However, if you use a Non-Network Provider, you pay more of the cost of your care, you must file a claim form to receive benefits, and benefits for facility-based or outpatient treatment are limited.

Facility-based treatment includes acute inpatient, partial hospitalization programs, residential treatment centers and facility-based intensive outpatient program services received for one continuous treatment plan. Residential/partial days are counted at a ratio of 2 to 1 to inpatient hospital days.

Outpatient care treatment includes individual and group counseling and medication management provided by a licensed private practitioner (psychiatrist, psychologist, social worker or professional counselor).

Before receiving behavioral health/substance abuse treatment, your or your doctor must notify UBH at 877-683-8555 for:

- Network benefits for all treatment (including outpatient treatment). Even if you receive care from a Network Provider, you must first notify UBH. If you do not notify UBH, the non-network Coinsurance benefit level of coverage applies, and an additional non-Notification penalty of $700 will be charged for failure to notify UBH of an inpatient confinement
- Facility–based inpatient care at non-UBH network facilities. Failure to notify UBH results in a $700 non-Notification penalty for failure to notify UBH of an inpatient confinement
- However, non-network outpatient care does not require Notification, and a penalty is not charged
- Emergency admissions (To receive the network level of benefit coverage when admitted to a network facility)

Failure to notify UBH could result in the reduction or denial of benefits. You or your doctor must notify UBH by calling UHC's Customer Service – Health Advocate Team before all inpatient stays and for network outpatient treatment. If you do not notify UBH, you are charged an additional $700 non-Notification penalty.

Once UBH is notified, a Utilization Review process is initiated. During the Utilization Review, a trained professional reviews clinical information with treatment providers to determine what level and length of care should be authorized as medically appropriate. Authorization for each treatment period is confirmed in writing to you and your doctor. As your doctor continues to provide clinical information to UBH, the approved treatment period may be extended.

Care Covered by the Out-of-Area Medical Options and the High Value Medical Option

Before receiving behavioral health/substance abuse treatment for facility–based inpatient care, your or your doctor must notify UBH at **877-683-8555**. Failure to notify UBH results in a $700 non-Notification penalty.

There are no day limits for facility-based or outpatient care.

Once UBH is notified, a Utilization Review process is initiated. During the Utilization Review, a trained professional reviews clinical information with treatment providers to determine what level and length of care should be authorized as medically appropriate. Authorization for each treatment period is confirmed in writing to you and your doctor. As your doctor continues to provide clinical information to UBH, the approved treatment period may be extended.

For specific coverage levels, turn to a particular Delta medical option's description in this "Medical" section to review the "Behavioral Health and Substance Abuse Benefits" information.

For specific coverage levels, including day limits on non-network benefits, turn to a particular Delta medical option's description in this "Medical" section to review the "Behavioral Health and Substance Abuse Benefits" information.

Birth Control Pills

Birth control pills are covered as a prescription drug benefit. The appropriate prescription drug Copay (Standard Medical Option and OOA Medical Option, and the DPMP) applies when you purchase birth control pills at a network pharmacy. Those purchased at a non-network pharmacy are not covered. Under the HVO, birth control pills are covered as a medical service.

Blepharoplasty

This corrective eyelid surgery is covered, although Notification to UHC's Customer Service – Health Advocate Team is required. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Blood/Plasma Preservation

This is covered for the purpose of preservation of autologous blood products for scheduled surgery for up to eight weeks.

Breast Reconstruction or Reduction Surgery

The Women's Health and Cancer Rights Act of 1998 (WHCRA) contains provisions for breast cancer patients who seek breast reconstruction after undergoing a mastectomy. Specifically, the medical plan participant who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction is provided with coverage for services determined by the attending physician and the patient that include (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; (4) and treatment of physical complications of the mastectomy, including lymphedemas. The reconstructive surgeries listed above are not subject to Notification requirements. However, other breast reconstructive/reduction surgery not associated with a mastectomy requires Notification to UHC's Customer Service – Health Advocate Team by you or your provider. You are charged an additional $700 non-Notification penalty for failure to notify UHC when required. These breast reconstruction surgeries are provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information on these WHCRA benefits, call UHC toll-free a **877-683-8555**.

Cancer Treatment – URN Cancer Resource Services (CRS) Facility

Travel and lodging for the patient and one family member acting as a travel companion, up to a $10,000 lifetime limit, is covered by the plan when a UnitedHealthcare URN Cancer Resource Services (CRS) Facility provides the treatment and is covered at 100% (after the Deductible) of the Network Charges. You or your doctor must notify UHC's Customer Service – Health Advocate Team in advance before you incur any travel and lodging expenses related to your cancer treatment. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Cancer Treatment – Non-URN Cancer Resource Services (CRS) Facility

Cancer treatment is considered a Covered Service; however, when a non-URN Cancer Resources Center performs the treatment, travel and lodging are not covered by the plan, and are covered at the appropriate network or non-network Coinsurance (after the Deductible is met).

Cardiac Procedures, Cardiac and Pulmonary Rehabilitation Therapy

The plan covers eligible medical, surgical or therapy services that are medically necessary and ordered by your doctor for the treatment of cardiac disease or illness. For any inpatient stay associated with a cardiac procedure or surgery, you or your doctor should notify UHC's Customer Service – Health Advocate Team before the hospital admission. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Cardiac and pulmonary rehabilitation therapy coverage is limited to 30 combined network and non-network visits per calendar year per type of therapy. After the limit has been met, additional visits are

subject to medical review. You or your doctor should notify UHC's Customer Service – Health Advocate team of your request for additional therapy visits.

Chemotherapy

Outpatient chemotherapy treatment is considered a Covered Service.

Chiropractic Care

The plans cover charges of a licensed chiropractor when the charges are for maintenance and/or treatment of a non-occupational illness, injury or disease, up to 20 visits per year for an adult. A child under age 12 is not covered, except in very limited circumstances. Massage therapy is not covered. All treatment beyond 20 visits per calendar year is not covered. Chiropractic care provided by a Non-Network Provider (Standard Medical Option and DPMP) is not a Covered Service under the plans.

Cochlear Implants

Expenses for cochlear implants are considered covered for adults and children for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination, or (2) post-lingual deafness in an adult.

Depo-Provera

Depo-Provera is covered as a prescription if purchased at a network pharmacy. The appropriate prescription drug Copay (for the Standard Medical Option, the OOA Medical Option and the DPMP) applies (see earlier sections explaining these amounts). Under the HVO, Depo-Provera is covered as a medical service. Services to implant the medication are considered covered medical services.

Dialysis

Outpatient dialysis treatment is considered a Covered Service.

Diaphragm – Device and Fitting

The device and fitting charges are Covered Services if the device is purchased and inserted in the physician's office If the device is purchased at a network pharmacy, it is covered as a prescription, and the appropriate prescription drug Copay (for the Standard Medical Option, the OOA Medical Option and the DPMP) applies. The device is covered as a medical service under the HVO.

Disposable Medical Supplies – Inpatient/Outpatient

Consumable/disposable medical supplies used while in an inpatient or outpatient hospital setting are considered Covered Services.

Disposable Medical Supplies – Retail

The retail purchase of disposable medical supplies is considered a Covered Service. This includes ostomy, dialysis and tracheal supplies, home use catheters and one pair of foot orthotic custom shoe inserts per calendar year. Orthotic shoes are not covered. Some home use supplies that were previously covered as disposable medical supplies, such as gauze, medical tape and alcohol/peroxide, are no longer covered under the plans.

Durable Medical Equipment (DME)

DME is a covered medical expense if (1) it is used primarily for medical purposes; (2) it is for repeated use; (3) it is not a consumable or disposable item; and (4) it is appropriate for use in the home. Rental of DME and surgical equipment is covered, unless it is more economical to purchase the equipment. Replacements must be covered health services. Each short-term rental or purchase of medically necessary DME costing more than $1,000 requires Notification to UHC's Customer Service – Health Advocate Team. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Examples of covered DME include, but are not limited to: crutches, hospital beds, monitoring devices, oxygen tents, respirators or other equipment for the use of oxygen, prosthetic appliances, walkers, wheelchairs, and other items as determined eligible by the claims administrator.

If you cannot obtain necessary supplies from a Network Provider, you can visit another network supplier, wait until the item is available, or contact UHC's Customer Service – Health Advocate Team to obtain authorization for reimbursement at the network benefit level from a Non-Network Provider.

In the DPMP medical options, compression hose are eligible covered equipment, but are limited to two pairs of hose per calendar year, with a maximum allowable charge of $250 per each pair of compression hose.

Emergency Care and Urgent Care

A true emergency is a sudden and severe medical condition, illness or injury (including, but not limited to, severe pain) that, if not treated immediately, could cause seriously impaired function, serious dysfunction of a bodily organ or part or death, or in the case of pregnancy, serious jeopardy to the health of the fetus. In the judgment of a reasonable person, an emergency requires immediate care and treatment to avoid jeopardy to life or health. Some examples of true emergencies include:

- Loss of consciousness
- Uncontrolled bleeding
- Poisoning or suspected overdose of medication
- Severe burns
- Severe shortness of breath
- Chest pain or oppressive squeezing in the chest
- Stroke symptoms (numbness or paralysis of an arm or leg, suddenly slurred speech, lack of responsiveness, severe headache)

In an emergency, seek care immediately. You should call an ambulance or a police emergency number, or you should go directly to a hospital. Notification to UHC's Customer Service – Health Advocate Team is required within two business days.

Urgent care is defined as not being a true emergency, but a situation that requires prompt medical attention. Some examples of urgent situations include:

- Ear infections
- Excessive vomiting
- High fever

- Minor burns
- Prolonged diarrhea
- Severe stomach pain

An urgent care center is a healthcare facility that is organizationally and financially separate from a hospital, and whose primary purpose is to provide immediate, short-term medical care.

For the Standard Medical Option and the DPMP network benefit, an emergency room Copay of $100 is charged by the hospital at the time of service for care meeting the definition of a true emergency. If admitted to the hospital from the emergency room, the Copay is waived, and the entire episode is treated as a hospital inpatient stay. UHC's Customer Service – Health Advocate Team must be notified within two business days of the admission.

If you seek care in the emergency room for a non-emergency, the service will not be covered by any of the medical options.

FAA Flight Physicals

FAA flight physicals are not covered by the DFCMP or the DPMP.

Health Assessments – Routine Physicals, Annual Gynecological Exams, Well Child Visits

Preventive Care coverage is provided for the most common conditions that threaten your health — those that, if detected early enough, can be effectively treated.

The plans' Preventive Care coverage, including the frequency of which certain services are covered, is based on the recommendations found in the Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force (USPSTF), published in 1996 as revised in 1998, with additional recommendations updated in the 3rd edition (2000-2003).

Preventive care performed by a Network Provider are paid at the appropriate office visit Copay, and 100% for charges other than the office consultation (not subject to the Deductible) if you are enrolled in the Standard Medical Option, and at 100% of R&C charges if you are enrolled in the OOA Medical Option or the HVO. Covered Preventive care expenses are covered at the appropriate network or non-network Coinsurance (after the Deductible is met) under the DPMP.

To see the U.S. Preventive Services Task Force recommendations on clinical preventive services, visit **www.preventiveservices.ahrq.gov**. A summary of some of the recommendations appears on the following pages.

GUIDELINES FOR MAINTAINING YOUR HEALTH

Screening: Children ages 0 to 18 years

Age	Screening Test	Frequency
Newborn	Newborn screening (PKU, sickle cell, hemoglobinopathies, hypothyroidism)	During newborn period
Birth-2 months	Head circumference	At each well-child visit
Birth-2 years	Length and weight	At each well-child visit
2-18 years	Height and weight	At each well-child visit
3-4 years	Eye screening	Once
Younger than 5 years	Dental health	At each well-child visit

Immunization schedule: children ages 0 to 6 years*

Range of recommended ages | Catch-up immunization | Certain high-risk groups

Vaccine	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
Hepatitis B	HepB	HepB							HepB Series		
Rotavirus			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP				DTaP
Haemophilus influenzae type b			Hib	Hib	Hib	Hib		Hib			
Pneumococcal			PCV	PCV	PCV	PCV				PCV	
										PCV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza					Influenza (yearly)						
Measles, Mumps, Rubella						MMR					MMR
Varicella						Varicella					Varicella
Hepatitis A						HepA (2 doses)				HepA Series	
Meningococcal										MPSV4	

* SOURCE: Recommended Childhood and Adolescent Immunization Schedule — United States, 2006, MMWR™, Morbidity and Mortality Weekly Report, Vol 54, No MM51;0, Centers for Disease Control and Prevention, Department of Health and Human Services.

GUIDELINES FOR MAINTAINING YOUR HEALTH continued

Immunization schedule: children ages 7 to 18 years*

Range of recommended ages	Catch-up immunization	Certain high-risk groups

Vaccine	7-10 years	11-12 year assessment	13-14 years	15 years	16-18 years
Tetanus, Diphtheria, Pertussis		Tdap	Tdap		
Human Papillomavirus (for females only)		HPV (3 doses)	HPV Series		
Meningococcal	MCV4	MCV4		MCV4	
			MCV4		
Pneumococcal	PPV				
Influenza	Influenza (yearly)				
Hepatitis A	HepA Series				
Hepatitis B	HepB Series				
Inactivated Poliovirus	IPV Series				
Measles, Mumps, Rubella	MMR Series				
Varicella	Varicella Series				

* SOURCE: Recommended Childhood and Adolescent Immunization Schedule — United States, 2006, MMWR™, Morbidity and Mortality Weekly Report, Vol 54, No MM51;0, Centers for Disease Control and Prevention, Department of Health and Human Services.

Preventive care guidelines: adults over age 18

	Range of recommended ages											
Years of Age	**18**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**
SCREENING												
Blood Pressure, Height, and Weight	At each preventive visit											
Obesity	At each visit											
Cholesterol				Men: Every 5 years								
						Women: Every 5 years						
Cervical cancer screening	Annually beginning at age 18 or age of sexual activity, and every three years after three consecutive normal tests											
Chlamydia/Gonorrhea												
Mammography					Women: every one to two years							
Prostate Cancer							Men: as directed by your doctor					
Colorectal Cancer* (Colonoscopy)							Every 5 years					
Osteoporosis										At age 65		
Alcohol Use, Depression	Periodically											
IMMUNIZATION												
Tetanus-Diphtheria (Td/Tdap)	Every 10 years											
Varicella (VZV)	Susceptibles only-two doses											
Shingles (Herpes Zoster)									One dose after age 60			
Measles, Mumps, Rubella (MMR)	Persons not already immune											
Pneumococcal										One dose		
Influenza	Yearly											
Hepatitis B/Hepatitis A	Persons at risk											
Meningococcal	For certain high-risk groups**											
Human Papillomavirus (HPV)	One dose											

Upper age limits should be individualized for each patient

* See **www.preventiveservices.ahrq.gov** for U.S. Preventive Services Task Force recommendations on colorectal cancer screening and other clinical preventive services.

** High risk is defined as adults who have terminal complement deficiencies, had their spleen removed , their spleen does not function or they have medical, occupation, lifestyle or other indications such as college freshmen living in dormitory or other group living conditions.

Individual health plans vary in preventive coverage. Generally, Delta's Account-Based Medical Options should cover immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and published by the Centers for Disease Control and Prevention. For complete immunization guidelines, visit **www.cdc.gov/nip**.

Home Healthcare

Home healthcare services and supplies are covered when they are part of a "home healthcare plan." A home healthcare plan is a written plan of care and treatment for a person in his or her home that is established and approved by a doctor. Home healthcare must be provided by or under the direction of a "home healthcare agency," and be for a condition or related condition for which the person is/was being treated in a hospital. Custodial care, maintenance and respite care are not considered to be, or covered as, home healthcare. The following services may be covered if provided by an accredited home healthcare agency:

- Visits by a skilled professional nurse and/or other participating skilled health professional
- Consumable medical supplies and durable medical equipment administered or used during a visit
- Medical social services for the terminally ill
- Drugs and medications prescribed by a covered physician

To ensure that expenses are covered by the plan, you (or your doctor) are required to notify UHC's Customer Service – Health Advocate Team. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Hospice Care

Hospice care is covered for a patient who, according to his or her doctor's diagnosis, has a terminal illness and is not expected to live more than six months. Care must be provided under a "hospice care program," which is a coordinated, interdisciplinary program to meet the physical, psychological and social needs of terminally ill patients and their families, and provides palliative and supportive medical, nursing and other health services during the illness. Hospice care services can be provided by a hospital, skilled nursing facility or similar institution, a home healthcare agency or a hospice facility. You or your doctor must notify UHC's Customer Service – Health Advocate Team before the patient is admitted to a facility for hospice care. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

The following hospice care services, when provided under a hospice care program, are covered by the plan:

- Drugs, medicines and medical supplies for pain relief treatment provided by the hospice facility or home healthcare company
- Home health aid services and lab services to ease pain
- Outpatient hospice services
- Part-time or intermittent nursing care services by a home healthcare agency
- Professional services provided by a doctor, psychologist, licensed clinical social worker (LCSW) or family counselor for individual or family counseling
- Room and board, up to the facility's most common daily rate for a semi-private room, and the medical services and supplies charged by the facility and actually used during a confinement

Hospice care does *not* include:

- Services provided by a family member, dependent's family member or another resident of your household
- Services not listed in the hospice care program

- Services for curative or life-prolonging purposes
- Services for which any other benefits are payable under the plan
- Services or supplies primarily to aid daily living
- Bereavement counseling
- Respite care
- Nutritional supplements, non-prescription drugs or substances

Notification to UHC's Customer Service – Health Advocate Team is required. For network participants, your Network Provider handles Notification. For non-network participants, you need to notify the Health Advocate Team before receiving care. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Hospital Care — Inpatient and Outpatient Services

The plan covers eligible medical and surgical charges by a hospital or other approved facility for inpatient and outpatient services and supplies provided for a non-occupational illness or injury or condition, including preadmission testing. Charges for an inpatient hospital admission and associated fees are covered if they are determined to be medically necessary treatment of a covered injury or acute illness.

The plan pays for semi-private or intensive care unit room and board during an authorized hospital confinement. If a semi-private room is not available, the Delta medical plans cover up to the average semi-private room rate charged by other hospitals in the same geographic area for a semi-private room alternative. The Delta medical plans also pay for necessary Covered Services and supplies, such as administration of anesthesia, medications and prescription drugs; Lab, X-rays and other diagnostic services including MRIs; dressings and casts; physician-prescribed private-duty services of a registered nurse (RN) or licensed practical nurse (LPN); and surgeries (including the use of operating rooms). Doctor, surgeon and anesthesiologist services, and other medical professional services performed while in the hospital or in conjunction with the use of outpatient facilities, are also considered Covered Services.

You or your doctor must notify UHC's Customer Service – Health Advocate Team before all inpatient hospital admissions (except for certain maternity admissions). You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Immunizations for Adults and Children

All immunizations (including travel immunizations) recommended by the "Recommended Childhood and Adolescent Immunization Schedule" of the U.S. Preventive Services Task Force guidelines (see "Health Assessments as Preventive Care" for a description of these guidelines) are considered Covered Services and are covered at 100%, not subject to the Deductible, under the OOA Medical Option and HVO. You will be charged the appropriate Copay for a Network Provider office visit under the Standard Medical Option and when Non-Network Providers administer the covered preventive immunizations, the services are covered at the appropriate non-network Coinsurance (after the Deductible is met). Covered preventive immunizations are covered at the appropriate network or non-network Coinsurance (after the Deductible is met) under the DPMP. Note that travel health consultations and extra doctor's charges are not covered as part of the 100% Preventive Care.

If prescription serum for the immunizations is purchased at a pharmacy, you must pay full charges and then submit a claim form for reimbursement at the appropriate level after Deductible. See "Health

Assessments as Preventive Care," previously described in this list of Covered Services, for more information on the recommended guidelines.

Infertility Treatments

The plan only covers the initial diagnosis and treatment to identify underlying systemic conditions that may be the cause of infertility. The plan does not cover infertility procedures such as artificial insemination, in-vitro fertilization, GIFT, ZIFT, cloning, micro-injection techniques, other assisted reproduction technologies, injectable or oral infertility drug treatments, or any other process associated with these procedures.

IUD

The plans cover the device if it is purchased in the physician's office. The plans also cover charges for insertion of the device.

Laboratory Work and Tests – Diagnostic

The plan covers diagnostic laboratory services performed in a lab facility, office or clinic. Diagnostic lab work and tests ordered by a Network Provider are considered Network Covered Services even if the services are performed in a non-network facility.

Laboratory Work and Tests – Preventive Care

Preventive laboratory work and tests performed at a network facility are paid at 100%, not subject to the Deductible, under the Standard Medical Option (the OOA Medical Option and the HVO pay at 100% regardless of the use of network facilities). Covered preventive laboratory expenses are covered at the appropriate network or non-network Coinsurance (after the Deductible is met) under the DPMP. All covered preventive laboratory expenses are based on the recommendations found in the Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force (USPSTF), published in 1996, as revised in 1998, with additional recommendations updated in the 3rd edition (2000-2003).

Mammograms – Diagnostic

Mammograms for diagnostic purposes are considered eligible covered expenses when deemed to be necessary and ordered by your doctor.

Mammograms – Preventive Care

Preventive/routine mammograms, starting at age 40, performed at a network facility, are paid at 100%, not subject to the Deductible, for an office consultation Copay under the Standard Medical Option (the OOA Medical Option and the HVO pay at 100% without a copay regardless of the use of network facilities). Covered preventive mammograms are covered at the appropriate network or non-network Coinsurance (after Deductible is met) under the DPMP. A covered preventive/routine mammogram is based on the recommendations found in the Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force (USPSTF), published in 1996, as revised in 1998, with additional recommendations updated in the 3rd edition (2000-2003).

Maternity Care – Physician Services and Facility Services Including Birthing Center

Medical, surgical and hospital care are covered during the term of the pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous and legal therapeutic abortions, and complication of pregnancy.

Maternity services include:

- Hospital expenses, including nursery charges for the newborn child
- Obstetrical fees for normal delivery, cesarean section, abdominal operation for extra-uterine pregnancy or miscarriage
- Certified or licensed nurse midwife services performed under a physician's supervision in an approved facility
- Diagnostic testing during pregnancy
- Pre- and postnatal care of the mother
- Charges for circumcision

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to fewer than 48 hours following a vaginal delivery or fewer than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48-hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). Accordingly if the mother's or the newborn's length of stay is in excess of 48 hours (or 96 hours if a cesarean section) Notification to UHC's Customer Service – Health Advocate Team is required. You are charged an additional $700 non-Notification penalty for failure to notify UHC under these circumstances.

Nutritional/Dietary Supplements

These supplements are covered if they are the *only* form of sustenance.

Nutritionists/Dieticians

Services of a nutritionist or dietician are considered eligible covered expenses. Coverage is limited to three consultations per calendar year for each condition and/or diagnosis (such as for diabetes, anorexia or bulimia), and are subject to medical review.

Obesity Surgery

A network inpatient hospital stay in conjunction with obesity surgery (including gastric stapling and diversion) is covered by the DPMP, the Standard Medical Option and the OOA Medical Option when UHC is notified in advance of the surgery; Notification to UHC's Customer Service – Health Advocate Team is required. For network participants, your Network Provider handles Notification. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Fees that the surgeon or assistant surgeon may charge in conjunction with the surgery are not considered Covered Services.

Obesity Surgery and any associated charges are not covered by the High Value Medical Option of the DFCMP.

Office Visits – Primary Care Physicians and Specialists

The plans cover charges for visits to a doctor's office, or a doctor's (an internist, general physician, family practitioner, pediatrician and specialist) visit to your home, for diagnosis, care and treatment of illness or injury, in connection with pregnancy, for Preventive Care (as outlined in the "Health

Assessments as Preventive Care" entry of this list of Covered Services), as well as care related to other covered expenses such as diagnostic lab and X-ray work performed during a visit.

Oral Surgery

Some oral surgery is considered to be a medical expense, while other oral surgery is considered to be a dental expense. In some cases, charges are split between medical and dental benefits — meaning that some portions of the charge may be considered for payment under your dental option, while other portions may be considered under your medical option.

Before you undergo any oral surgery procedure, you and/or your doctor/dental specialist should consult the Oral Surgery Chart ("Attachment A" featured at the end of the "Dental" section of this SPD. Oral surgeries (Category II and certain portions of Category III – facility charges) are covered under medical coverage. If you need further information or clarification, you can contact both UHC and MetLife at **877-683-8555**. Eligible Non-Network Charges are covered at the network level due to limited access to Network Providers.

For medical oral surgery procedures only, you or your provider must notify UHC's Customer Service – Health Advocate Team. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Generally, if you are covered under the CIGNA Dental Care plan, you may have no coverage for certain procedures determined to be dental services, such as some oral surgeries. For details, contact CIGNA at **800-367-1037**.

Organ Transplants – United Resource Networks (URN) Facility

The plan covers charges for, or in connection with, approved organ transplant services, including immunosuppressive medication, organ procurement costs related to procurement of an organ from a cadaver or a donor having a blood relationship with the recipient, and the donor's medical costs.

UnitedHealthcare offers the United Resource Network (URN) in association with organ and tissue transplant services. Participation in the URN program is voluntary.

Travel and lodging for the patient and one family member acting as a travel companion, up to a $10,000 lifetime limit, is covered by the plan when a UnitedHealthcare URN Organ Transplant Facility provides the services, and is covered at 100% (after the Deductible) of the Network Charges. You or your doctor must notify UHC's Customer Service – Health Advocate Team in advance before you incur any travel and lodging expenses related to your transplant. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Organ Transplants – Non-URN Facility

Organ transplants are generally considered a Covered Service; however, when a non-URN organ transplant facility performs the service, no travel or lodging benefits are provided by the plan and are covered at the appropriate network or non-network Coinsurance (after the Deductible is met).

You or your doctor must notify UHC's Customer Service – Health Advocate Team before you are hospitalized for an organ transplant, whether the procedure is network or non-network, and at a URN facility or not. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Orthoptic Training

Medical services for opthoptic training (exercise for the eye muscles) are considered Covered Services when medically necessary and ordered by your doctor.

Pain Management

Medical services for pain management are considered Covered Services as long as they are for the direct care of the patient. Educational services or group therapy are not covered.

Podiatry Care

Podiatry care is covered when medically necessary for the treatment of metabolic or peripheral vascular disease. Routine and preventive foot care is not covered.

Prescription Drugs

The term "prescription drugs" is defined as a medication, product or device that has been approved by the Food and Drug Administration and can, under federal or state law, be dispensed only by direction of a prescription order or refill for the treatment of an injury or an illness.

For all Delta medical options, with the exception of the HVO, UHC/UnitedHealthcare Pharmacy Solutions provides you with prescription drug benefits through UnitedHealthcare's Prescription Drug List (PDL), which can be viewed on Benefits Direct, accessible through DeltaNet (**http://dlnet.delta.com**) or on the My Health & Insurance site located on Employee Connection. The PDL is a comprehensive list of the covered drugs and injectable medications. There are separate and different PDLs for the Delta Family-Care Medical Plan and for the DPMP.

Under the HVO, prescription drugs are covered as a medical service under UnitedHealthcare.

For specific coverage details, turn to a particular Delta medical option's description in this "Medical" section to review the "Prescription Drug" information.

Preventive Care

See "Health Assessments as Preventive Care" earlier in this list of Covered Services.

Pre-Admission Testing

Pre-admission tests are performed before a hospital confinement. The tests must be related to a scheduled surgery and ordered by a physician after a condition requiring surgery has been diagnosed. The patient must be later hospitalized for the services to be considered Covered Services.

Private Duty Nursing

Coverage for private duty nursing is available only when ***all*** of the following guidelines have been met:

- Services are received on an outpatient basis
- Services are ordered by an attending physician
- Services are necessary to the treatment (rather than for the convenience of — or at the insistence of — the patient or patient's family), and

- Services are provided by a registered nurse (RN) who is licensed/certified to perform the particular services needed. Services may be performed by a licensed practical nurse (LPN) under certain circumstances:
  - A recognized hospital uses an LPN for private duty nursing
  - The attending physician has prescribed a 24-hour nursing service, and a combination of RNs and LPNs are used to fill the 8-hours shifts, or
  - The services of an RN are medically necessary but unavailable (this must be verified by the attending physician or nurse registry)
- Services must be medically necessary for the treatment of a non-occupational disease or injury, and must require the medical training and technical skills of an RN
- Services should be for 24-hour care
- Charges must be for nursing services only

Custodial care is not covered. Additionally, the RN or LPN must not reside in the patient's home or be a member of the patient's immediate family.

Notification to UHC's Customer Service – Health Advocate Team is required. For network participants, your Network Provider handles Notification. For non-network participants, you need to notify the Health Advocate Team before receiving care. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Prosthetic Medical Appliances

The plan covers the purchase, maintenance and repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts. Artificial joints, artificial heart valves, cardiac pacemakers and intraocular lenses are examples of covered internal prosthetic appliances.

The plan also covers the purchase and fitting of certain external prosthetic devices that replace or substitute a missing body part and are necessary to alleviate or correct an illness, injury or congenital defect. Artificial eyes, arms and legs, and terminal devices such as a hand or hook, are examples of external prosthetic devices covered for their initial purchase and fitting.

For covered prosthetic devices, the plan covers replacement of an initial prosthetic device only if it is needed due to normal body growth or normal wear and tear, and if it is determined to be medically necessary by the claims administrator.

Reconstructive Surgery

Reconstructive surgery is covered when it is performed to improve the function of a body part when the malfunction is the direct result of one of the following:

- Birth defects
- Congenital defects and birth abnormalities, including premature births
- Accidental injury
- Reconstructive breast surgery following a necessary mastectomy

- Surgery to treat an accidental injury, congenital defects and/or birth abnormalities, including premature births
- Reconstructive surgery to remove scar tissue from the neck, face or head

Cosmetic procedures are not covered. Procedures that correct a congenital anomaly — a physical developmental defect that is present at birth and identified within the first 12 months of life — without improving or restoring physiologic function, are considered cosmetic procedures. Psychological or socially avoidant behavior related to an injury, sickness or congenital anomaly does not classify the surgery or other procedures performed to relieve such behavior as a reconstructive procedure.

You or your doctor needs to notify UHC's Customer Service – Health Advocate Team before your reconstructive surgery is performed. This verifies whether your surgery is considered to be a reconstructive procedure rather than a cosmetic procedure. No Notification to UnitedHealthcare is required for breast reconstruction following cancer surgery (see "Breast Reconstruction or Reduction Surgery," earlier in this list of Covered Services).

You are charged a $700 non-Notification penalty for failure to notify UHC when required.

Second Surgical Opinion

Second surgical opinions are voluntary and are not required to obtain benefits for eligible Covered Services.

Skilled Nursing Facility – Convalescent / Inpatient Rehabilitation

To receive skilled nursing facility benefits, treatment must be prescribed by a physician. You must remain under a physician's care, and your care must be expected to improve your condition and facilitate discharge. Benefits are not available for confinements that are primarily custodial in nature or in connection with drug addiction, chronic brain syndrome, alcoholism, mental retardation or other mental disorders.

To be considered a "skilled nursing facility," the provider must be approved by Medicare or must be:

- Operated under applicable licensing and other laws
- Under the supervision of a licensed physician or registered nurse (RN) who is devoted full-time to supervision
- Engaged in providing skilled nursing care, along with room and board continuously during a 24-hour day, to sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness. (Note: this term is used in connection with newborn children, and includes congenital defects and birth abnormalities, such as premature birth)
- One that maintains a daily medical record for each patient under the care of a licensed physician
- Authorized to administer medication to patients on the order of a licensed physician

A skilled nursing facility is not, other than incidentally, a home for the aged, blind or deaf, nor is it a hotel, domiciliary care home, maternity home, home for the mentally ill, assisted living facility, or home for those suffering from drug or alcohol addictions.

A skilled nursing facility that is a part of a hospital is considered to be an approved skilled nursing facility.

A rehabilitation facility must be accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Coverage is limited to 60 days combined network and non-network benefits per calendar year. Additional days are subject to medical review. You or your doctor must notify UHC's Customer Service – Health Advocate Team before receiving skilled nursing facility services. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Substance Abuse

Two episodes per lifetime for alcohol and other substance abuse treatment are considered Covered Services. One episode is defined as an admission into any combination of acute inpatient, partial, residential and facility-based intensive outpatient programs with a substance abuse program followed by 180 days during which no facility-based care is received. (The discharge date or the date that care was terminated counts as day one when calculating the 180 days.) Alcoholics Anonymous, aftercare and outpatient treatment do not count as an episode of care.

Individuals who need substance abuse care after having exhausted their two covered episodes should contact United Behavioral Healthcare (UBH). A UBH representative can help determine the best treatment option.

Facility-based treatment includes acute inpatient, partial hospitalization programs, residential treatment centers and facility-based intensive outpatient program services received for one continuous treatment plan. Residential/partial days are counted at a ratio of 2 to 1 to inpatient hospital days.

Outpatient care treatment includes individual and group counseling and medication management provided by a licensed private practitioner (psychiatrist, psychologist, social worker or professional counselor).

Before receiving substance abuse treatment, you or your doctor must notify UBH at **877-683-8555** for:

- Network benefits for all treatment (including outpatient treatment). Even if you receive care from a Network Provider, you must first notify UBH. If you do not notify UBH, the non-network Coinsurance benefit level of coverage applies, and an additional non-Notification penalty of $700 will be charged for failure to notify UBH of an inpatient confinement
- Facility–based inpatient care at non-UBH network facilities. Failure to notify UBH results in a $700 non-Notification penalty
- However, non-network outpatient care does not require Notification, and a penalty is not charged
- Emergency admissions (to receive the network level of benefit coverage when admitted to a network facility)

Failure to notify UBH could result in the reduction or denial of benefits. You or your doctor must notify UBH by calling UHC's Customer Service – Health Advocate Team before all inpatient stays and for network outpatient treatment. If you do not notify UBH, you are charged an additional $700 non-Notification penalty.

Once UBH is notified, a Utilization Review process is initiated. During Utilization Review, a trained professional reviews clinical information with treatment providers to determine what level and length of care should be authorized as medically appropriate. Authorization for each treatment period is confirmed in writing to you and your doctor. As your doctor continues to provide clinical information to UBH, the approved treatment period may be extended.

For specific coverage details, turn to a Delta medical option's description in this "Medical" section to review the "Behavioral Health and Substance Abuse Benefits" information.

Surgical Charges – Inpatient/Outpatient

The plans cover charges by physicians and assistant physicians for surgical procedures (with the exception of a physician and assistant physician's fee in conjunction with obesity surgery). The plans also cover charges by an anesthesiologist or your physician for the administration of anesthesia in connection with a covered surgical procedure. Also covered are services by a doctor in the appropriate surgical specialty, consultation, and charges for X-rays, laboratory, exam and minor surgical procedures that are routinely performed in a doctor's office (as long as the procedure or charge is not for a cosmetic or dental surgical procedure that is excluded by the plans).

The plans do not cover charges by a surgical assistant (assistant surgeon, physician assistant or registered nurse) during surgery, that are above 20% of the surgeon's fee.

Multiple surgical procedures is defined as more than one surgical procedure being performed during the same operative session. Covered expenses for multiple surgical procedures are limited as follows:

- A secondary procedure is limited to 50% of the charge that would otherwise have been considered had the procedure been performed during a separate operative session
- Another additional subsequent procedure is limited to 25% of the charge that would otherwise have been considered had it been performed during a separate operative session

Notification to UHC's Customer Service – Health Advocate Team is required. For network participants, your Network Provider handles Notification. For non-network participants, you need to notify the Health Advocate Team before receiving care. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Therapy — Physical, Occupational, Speech, Outpatient Rehabilitation

Rehabilitative physical, occupational and speech therapy are covered only under very specific circumstances. For physical and occupational therapy, the therapy must be for the purpose of training the patient to perform the activities of daily living; and charges for services must be performed by an occupational or physical therapist who is licensed/certified to perform the particular therapy. Benefits are available only for therapy that is expected to result in significant physical improvement in your condition.

Additionally, if physical or occupational therapy is required when bodily function is lost or impaired as a result of disease or accidental injury, *all* of the following requirements must be met:

- A specific occupational or physical therapy treatment program, which details the type, frequency and expected duration of the therapy to be administered, is prescribed by a covered physician
- The services of the occupational or physical therapist are rendered while the patient remains under the care of a covered physician
- There is a reasonable expectation that the prescribed occupational or physical therapy will result in significant improvement of bodily function; and
- There is a periodic reevaluation of the treatment program to confirm that a significant improvement in bodily function has occurred and is expected to continue, and that the services of the therapist are still being provided in accordance with specific orders from the attending physician

Massage therapy is not a covered benefit.

For speech therapy, coverage is available if it is prescribed, controlled and directed by a covered physician.

Coverage is limited to 30 combined network and non-network visits per calendar year per type of therapy. After the limit has been met, additional visits are subject to medical review. You or your doctor should notify UHC's Customer Service – Health Advocate team of your request for additional therapy visits.

Tubal Ligation

Tubal ligation is covered when it is performed in an outpatient surgical facility or an inpatient surgical facility. Surgical reversal of this procedure is not covered.

Vasectomy

Vasectomy is covered when performed in a physician's office. Surgical reversal of this procedure is not covered.

Vein Treatment – Sclerotherapy

Sclerotherapy is covered when it is used to treat symptoms of varicose veins that are not resolved by ligation and stripping procedures alone.

You or your doctor must notify UHC's Customer Service – Health Advocate Team before this procedure is performed. You are charged an additional $700 non-Notification penalty for failure to notify UHC.

Well Child Examinations

See "Health Assessments as Preventive Care" earlier in this list of Covered Services.

Covered expenses for well child exams and immunizations are based on the recommendations found in the Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force (USPSTF), published in 1996 as revised in 1998, with additional recommendations updated in the 3rd edition (2000-2003).

Wigs

Wigs are covered when purchased as a result of burns, chemotherapy, radiation therapy, and alopecia areata and totalis, subject to a maximum benefit of $500 per episode. Replacement costs for wigs are covered up to $500 only if needed due to normal body growth or normal wear and tear, and if determined to be medically necessary by the claims administrator.

X-Rays – Diagnostic and Therapeutic Procedures

Covered X-ray and diagnostic and therapeutic procedures may include CAT scan, electrocardiogram, electroencephalogram, mammogram, MRI, radiation therapy and ultrasound.

To be considered Covered Services, X-rays and diagnostic and therapeutic procedures can be performed in your physician's office or at another healthcare facility such as a hospital or imaging center. You or your doctor should notify UHC's Customer Service – Health Advocate Team before you receive selected diagnostic and therapeutic procedures (such as an MRI). The Health Advocate Team verifies that the services are medically necessary and the treatment provides the proper level of care.

What the Delta Medical Plans Do Not Cover

The Delta medical options do not cover the following:

- Services and supplies that do not meet the definition of a covered health service
- Services rendered that were not recommended and approved by the attending physician
- Expenses not resulting from direct treatment of a specific accidental bodily injury, illness or disease
- Amounts greater than 140% of the Medicare Reimbursement Rate
- Amounts greater than Reasonable and Customary (R&C) as determined by UnitedHealthcare
- Claims for charges that are more than two years old
- Expenses for services rendered by a family member or for which the patient is not required to pay, or charges that would not have been made in the absence of coverage
- Charges made by a hospital owned by or performing services for the U.S. government if the charges are directly related to a sickness or injury connected to military service
- Expenses attributable, directly or indirectly, to an injury, illness or condition that is, or could be, the subject of a claim against a third party or under an insurance policy or program if:
  - UHC or the plan's other agent is not notified in writing of any claim against a third party or under an insurance policy or program, within 31 days of making the claim(s)
  - The participant does not complete any reimbursement agreement provided by UHC or the plan's agent
  - The participant does not notify the third party and/or the issuer of the insurance policy or program that the Delta medical plan has a lien on any amounts payable by such third party and/or under the insurance policy or program to the extent covered expenses are paid by the Delta medical plans; and
  - The participant does not provide information requested about the claim to UHC or the plan's agent

In addition, the medical options do not cover the following services, treatments, supplies and items (listed in alphabetical order) even if they are recommended by a physician, and they are the only available treatment for your condition. The services, treatments, items or supplies listed in this section are not covered health services (except as may specifically be provided for in this SPD) including:

- Abortions that are non-therapeutic (including drug-induced pregnancy termination)
- Abdominoplasty
- Alternative treatments including aromatherapy, hypnotism, rolfing and other forms of alternative treatments as defined by the Office of Alternative Medicine of the National Institutes of Health
- Amniocentesis, ultrasound or any other procedures requested solely for sex determination of a fetus, unless necessary to determine the existence of a sex-linked genetic disorder
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Behavioral health treatment that may be mandated by a court-order, custodial care when there is no expectation the treatment will alter the condition, or diagnostic assessments of children with learning disabilities/problems

- Boarding schools, including those providing a therapeutic environment
- Breast implant replacements if the earlier breast implant was performed as a cosmetic procedure (however, replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a mastectomy)
- Chelation therapy, except to treat heavy metal poisoning
- Christian Science practitioners
- Colonic lavage/irrigation
- Cosmetic procedures and surgery. Procedures that correct a congenital anomaly (a physical developmental defect that is present at birth, and is identified within the first 12 months of birth) without improving or restoring physiologic function are considered cosmetic procedures. The fact that psychological consequences or socially avoidant behavior results from an injury, sickness or congenital abnormality does not classify a surgery or procedure done to relieve such consequences or behavior as a reconstructive procedure
- Custodial services not intended primarily to treat a specific injury or sickness. Additional custodial services not covered are:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered healthcare professional
  - Education or training
  - Domiciliary care, respite care and rest cures
  - Private duty nursing (except as described under Covered Services)
- Drugs: Prescription and non-prescription drugs, except as provided under UHC/UnitedHealthcare Pharmacy Solutions
- Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, a nursing home or an assisted living facility
- Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals, except when the sole source of nutrition
- Exercise equipment (use, rental or purchase) or health club/spa membership fees
- Experimental, investigational or unproven services that are medical, surgical, diagnostic, psychiatric, substance abuse or other healthcare services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be:
  - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
  - Subject to review and approval by any institutional review board for the proposed use; or

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed
- UnitedHealthcare, in its judgment, may deem an experimental, investigational or unproven service covered under this plan for treating a life-threatening sickness or condition if it is determined by UnitedHealthcare that the experimental, investigational or unproven service at the time of the determination:
  - > Is proved to be safe with promising efficacy
  - > Is provided in a clinically controlled research setting
  - > Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health

  (For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment)

- Eyeglasses, contact lenses and eye refractions unless required due to accidental injury or cataract surgery. Replacements of contact lenses that are lost, damaged or required solely due to refractive changes are not covered. Charges for extra lenses are not covered. Charges for replacement lenses are covered when the existing lenses wear out and cannot be repaired, or when they are required because of a change in the patient's physical condition (not including refractive changes). Surgical treatment for correction of refractive errors, including radial keratotomy and LASIK surgery, are not covered
- FAA flight physicals are not covered by the Delta Family-Care Medical Plan or the Delta Pilots Medical Plan
- Fee forgiveness: No benefits are provided for health services for which any Copayments, Deductibles or fees are waived
- Foot care except when needed for severe systemic disease. The following are not covered: routine foot care (including the cutting or removal of corns and calluses, and nail trimming, cutting or debriding), hygienic and preventive foot care (cleaning and soaking of the feet, applying skin creams to maintain skin tone, other services that are performed when there is not a localized illness, injury or symptom involving the foot), treatment of flat feet and treatment of subluxation of the foot
- Hearing aids or examinations
- Herbal medicine, holistic or homeopathic care, including drugs
- Holistic medicine
- Hormone pellet implantation that is not FDA approved
- Infertility: Artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), cloning, micro-injection, any other assisted reproductive technologies, and any processes or charges associated with these procedures
- Inpatient private duty nursing
- Laser eye surgery and all associated services and supplies

- Massage therapy
- Membership costs for health clubs, weight loss clinics and similar programs
- Nutritional counseling and nutrition-based therapy
- Obesity (bariatric) surgery including gastric stapling, diversion or any other services (or drugs) for the purpose of weight reduction are not covered by the High Value Medical Option of the DFCMP. An inpatient hospital stay in conjunction with obesity surgery is covered by the DPMP, the Standard Medical Option and the OOA Medical Option when UHC is notified in advance of the surgery; however, the fees of the surgeon and assistant surgeon are not Covered Services
- Occupational injury/disease: Expenses related to/arising from an occupational injury/disease
- Orthotics: Charges for orthotics, custom molded shoes, orthopedic shoes or prefabricated shoes designed with special characteristics such as inserts, lifts or wedges, except as specified previously under “Durable Medical Equipment”
- Personal or comfort items, such as personal care kits, television and telephone rental in hospitals
- Physical conditioning and fitness programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation including facility charges and exercise equipment
- Pregnancy/maternity services for dependent children
- Private hospital rooms (except as described previously under Hospital Care — Inpatient and Outpatient Services)
- Prostheses, certain internal or external prostheses, except as specified previously under “Durable Medical Equipment” or “Prosthetic Medical Appliances”
- Radial keratotomy and all associated services and supplies
- Reports, evaluations, examinations or hospitalizations not required for health reasons, such as employment or insurance examinations
- Reversal of voluntary sterilization procedures
- Sensitivity training, educational training therapy or treatment for an education requirement
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a participant under this plan and is undergoing a covered transplant
- Services given by a pastoral counselor
- Supplies not considered durable medical equipment, such as humidifiers, dehumidifiers, air purifiers, heating pads, etc.
- Teeth: Treatment of the teeth or periodontium, except for charges associated with accidental injury or certain oral surgeries as described in this “Medical” section
- Telephone consultations
- Therapy to improve general physical condition — including massage therapy
- Transsexual surgery and related services, including medical or psychological counseling and hormonal therapy to prepare for or after any such service
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Vision exam/vision screening

- Weight loss products, treatments or programs including food supplements for weight loss, and personal trainers

Other expenses not listed may or may not be covered under UHC guidelines. Contact UHC at **877-683-8555** if you have questions about Covered Services.

What the Pharmacy Plan Does Not Cover

No benefits are paid under the DPMP and the Standard Medical Option and OOA Medical Option of the DFCMP when purchased at a non-network retail pharmacy or not filled via the UHC Pharmacy Solutions mail order program. The HVO, however, does consider prescriptions purchased through non-network pharmacies as Covered Services.

The following list of drugs, items and expenses not covered by the plans is a sample and may be modified or added to at any time. The prescription drug benefit does not cover the following (even if they are prescribed by a doctor):

- Any prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician's order
- More than a 31-day supply when dispensed in any one prescription order through a participating retail pharmacy
- More than a 90-day supply when dispensed in any one prescription order filled through a participating mail order pharmacy
- Medication that is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution that operates, or allows to be operated, on its premises a facility for dispensing pharmaceuticals
- Prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation law or any public program other than Medicaid
- Expenses incurred to the extent that payment for them is unlawful where the person resides when the expenses are incurred
- Charges that the person is not legally required to pay
- Charges that would not have been made if the person were not covered by these benefits

In addition to other items not covered in accordance with United Pharmacy Management guidelines, the following are not covered under the plan:

- Anabolic steroids
- Cosmetic drugs — Drugs used for cosmetic purposes, including, but not limited to, topical minoxidal (Rogaine) and tretinoin (Renova). Retin-A is not covered when prescribed for a covered individual over the age of 35
- Experimental drugs or drugs labeled "Caution — limited by federal law to investigational use"
- Immunization agents, biological serum, blood or blood plasma. (Note: Blood and blood plasma are covered under the medical portion of the plans)
- Non-legend drugs, except insulin
- Nutritional or dietary supplements, anti-obesity drugs or anorexiants. (Note: Nutritional/dietary supplements are covered under the medical portion of the plans if they are the only form of sustenance)

- Over-the-counter medications, except prenatal vitamins, that do not require a prescription order or refill by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over-the-counter drug. Contact Member Services for more information about drugs that are therapeutically equivalent to over-the-counter medications
- Smoking cessation products, including nicotine gum and patches, except when covered as a part of participation in Free & Clear's Quit for Life® Program
- Therapeutic devices or appliances, support garments and other non-medicinal substances
- Progesterone suppositories
- Appetite suppressants and other weight-loss products
- General and injectable vitamins. (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections that are covered)
- Medication or health services associated with the use of non-surgical or drug-induced pregnancy termination
- Growth hormones when used to treat idiopathic short stature

The law of the jurisdiction where you live when a claim occurs may prohibit some benefits. If so, those benefits cannot be paid.

HEALTH MAINTENCE ORGANIZATIONS (HMO)

Health maintenance organizations (HMOs) provide comprehensive healthcare with an emphasis on Preventive Care.

Eligibility for Health Plan Hawaii and Humana Health Plan of Puerto Rico

If you live within the Health Plan Hawaii or Humana Health Plan of Puerto Rico service areas, and otherwise meet the eligibility requirements for the medical plans (see the "Eligibility" section of this SPD), you are eligible to enroll in Health Plan Hawaii or Humana Health Plan of Puerto Rico.

In addition to enrolling through Delta, Health Plan Hawaii and Humana Health Plan of Puerto Rico require *new members* to complete a member application form. You must contact the HMO's Member Services department to get the form. When you complete the form, you must indicate the same dependents that you elected to cover for your Delta benefits. Make a copy of the completed form for your records, and return the form to the HMO. **Remember that you must enroll through Delta as well as through Health Plan Hawaii or Humana Health Plan of Puerto Rico.** If you submit an application to the HMO but fail to enroll in the HMO through Delta, that HMO application is not valid.

When you choose HMO coverage during the annual open enrollment period, that coverage remains in effect for the following calendar year unless:

- You move out of the HMO service area
- You are a member of an HMO that ceases operation or ceases to be offered
- You fail to meet eligibility requirements for Delta medical coverage
- You fail to pay required Contributions to continue coverage
- Other reasons for ineligibility as set forth in the "Eligibility" section of this SPD apply

How an HMO Works

With an HMO, a set of doctors and other providers offer a total managed healthcare program.

Read on to learn how to use an HMO.

HMO Providers

As a participant, you must receive care from a provider within your HMO. No benefits are payable if you receive non-emergency care from a non-HMO provider. If you use healthcare providers that are not affiliated with the HMO, you are responsible for paying the entire cost unless the treatment is approved by the HMO.

Typically, you must coordinate your healthcare through a Primary Care Physician (PCP) and obtain referrals to see specialists.

Also, if you cover an eligible family member who lives outside the HMO service area, or if you live in another location for part of the year, you or your covered family member must return to the service area for treatment through the HMO's doctors or facilities.

Emergency Care

While there is generally no coverage for care received outside the HMO, there is coverage for emergency or urgent care. You should know how your HMO covers emergency and urgent care both inside and outside the HMO's service area. Contact your HMO for specific coverage information.

Oral Surgery

Some oral surgery procedures may be considered medical expenses, rather than dental expenses. Contact your HMO's Member Services department for detailed coverage information. Understand that, because some HMOs consider oral surgeries dental expenses while the Delta plans consider them medical expenses, in some cases this could leave you with no coverage for those expenses.

Prescription Drug and Behavioral Health Coverage

As an HMO member, you receive all prescription drugs and behavioral healthcare coverage through your HMO (not through UHC Pharmacy Solutions or United Behavioral Health). Contact your HMO for specific information about coverage for prescription drugs and mental healthcare.

Delta has neither control over nor responsibility for the quality of HMO services rendered to members, for failure to deliver such services, for HMO providers, or for any disputes that may arise between members and their HMO. All HMO service-related complaints and appeals of denied benefit claims must be filed directly with the HMO, not Delta. Delta has neither input nor responsibility for any benefits denied by an HMO. By providing this information, Delta is not endorsing any HMO product.

Health Plan Hawaii

Health Plan Hawaii 2008 HMO Benefit Option	
2008 Benefits/Features	**Coverage**
PROFILE	
Member Services	**808-948-6372** — Current Members **808-948-5128** — Prospective Members Monday–Friday: 8 a.m.– 4 p.m.
Health Plan Web Site	**www.hmsa.com**
Accreditation Status as of July 31, 2007	Excellent
Is a Member Application Required If You Are a New Member?	Yes
HEALTHCARE BENEFITS	
PCP/Specialist Office Visit	$14 Copay
Pre- and Postnatal Visits	Covered at 100%
Routine Physical Exam	Covered at 100%
Well Baby/Well Child Exams	Covered at 100% to age 6
Ob/Gyn Exams and Mammograms	Covered at 100%; office visit Copay may apply
Prostate Screening	Covered at 100%; office visit Copay may apply
Outpatient X-Ray and Lab	X-ray: Covered at 90% Lab: Covered at 100%
Outpatient Surgery	$14 Copay
Emergency Room	$25 Copay statewide; 80% covered worldwide
Urgent Care Centers	$14 Copay
Inpatient Semi-Private Room and Board	Covered at 100%
Inpatient Surgery	Covered at 100%
Delivery and Newborn Charges	Covered at 100%
Mental Health Inpatient Treatment	Covered at 100% for facility; 80% for physician charges, up to 30 days per year
Mental Health Outpatient Treatment	$14 Copay per visit, up to 24 visits per year
Substance Abuse Inpatient Treatment	Covered at 100% for facility, 80% for physician charges
Substance Abuse Outpatient Treatment	$14 Copay
Chiropractic Care	Not covered
Durable Medical Equipment	Covered at 50%
PRESCRIPTION DRUGS	
Formulary	Open
Retail Generic	$5 Copay for up to a 30-day supply
Retail Brand	Formulary: $10 Copay for up to a 30-day supply Non-Formulary: $10 Copay plus $35 other brand name cost share, for up to a 30-day supply
Mail Order Generic	$10 Copay for up to a 90-day supply
Mail Order Brand	Formulary: $20 Copay for up to a 90-day supply Non-Formulary: Not covered

Humana Health Plan of Puerto Rico

Humana Health Plan of Puerto Rico 2008 HMO Benefit Option	
2008 Benefits/Features	**Coverage**
PROFILE	
Member Services	**808-948-6372** — Current Members **808-948-5128** — Prospective Members Monday–Friday: 8 a.m.– 4 p.m.
Health Plan Web Site	**www.pr.humana.com**
Accreditation Status as of July 31, 2007	None
Is a Member Application Required If You Are a New Member?	Yes
HEALTHCARE BENEFITS	
PCP/Specialist Office Visit	$5 Copay
Pre- and Post-Natal Visits	$5 Copay
Routine Physical Exam	$5 Copay
Well Baby/Well Child Exams	$5 Copay
Ob/Gyn Exams and Mammograms	Exams: $ Copay Mammograms: Covered at 100%
Prostate Screening	Covered at 100%
Outpatient X-Ray and Lab	Covered at 100%
Outpatient Surgery	Covered at 100%
Emergency Room	$20 Copay; waived if admitted
Urgent Care Centers	$20 Copay
Inpatient Semi-Private Room and Board	Covered at 100%
Inpatient Surgery	Covered at 100%
Delivery and Newborn Charges	Covered at 100%
Mental Health Inpatient Treatment	Covered at 100%
Mental Health Outpatient Treatment	$5 Copay
Substance Abuse Inpatient Treatment	Covered at 100%, up to 30 days per year
Substance Abuse Outpatient Treatment	$5 Copay per visit, up to 14 visits per year
Chiropractic Care	$5 Copay per visit, up to 15 visits per year
Durable Medical Equipment	Covered at 50%
PRESCRIPTION DRUGS	
Formulary	Open
Retail Generic	$2.50 Copay for up to a 30-day supply
Retail Brand	$5 Copay for up to a 30-day supply
Mail Order Generic	$5 Copay for up to a 90-day supply of maintenance drugs
Mail Order Brand	$10 Copay for up to a 90-day supply of maintenance drugs

DENTAL BENEFITS

DENTAL BENEFITS

Brushing after meals and routinely flossing are important to maintaining the health of your teeth. Other measures to prevent tooth decay and loss, including regular visits to your dentist, also are part of a healthy dental care routine. The dental coverage offered by Delta encourages routine preventive services and good dental health.

The Delta Family-Care Medical Plan (DFCMP) offers you a choice of two dental plan options — the Preventive Dental Option and the Comprehensive Dental Option — administered by Metropolitan Life Insurance Company (MetLife). Because MetLife administers these options, they are sometimes referred to as "MetLife Options" in this SPD. Although they are not insured by MetLife, claims are paid by Delta.

Each option varies in the level and type of coverage provided.

If you are enrolled in the DPMP, you are offered your own dental option. Your dental benefits are included with your medical coverage.

Depending on your ZIP code, you may be eligible to participate in the CIGNA Dental Care (CDC) option. This is a dental HMO and is insured by CIGNA.

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

Coverage Level

Under the plans, the coverage level you elect for dental benefits does not have to be the same as the level you elect for your medical and/or vision coverage. For example, you may elect dental coverage for yourself only and vision coverage for yourself and your spouse. With the DPMP, however, you must elect both medical and dental coverage because they are a bundled package.

Refer to the "Eligibility" section of this SPD for eligibility criteria for dental coverage.

Waiving Coverage

In the DPMP, you cannot waive medical coverage while electing dental coverage, or vice versa. This is because medical and dental coverages are bundled together. You either have to enroll for both coverages or enroll for neither.

In the DFCMP, you may enroll in dental coverage and waive medical coverage. Or you may choose to enroll in medical coverage and waive DFCMP dental coverage. You waive dental coverage for yourself and your dependents by selecting the "No Coverage" dental option during enrollment. Before you waive dental coverage, you should be aware of the consequences, as outlined in the following chart.

If You Are ...	And You Waive Dental Coverage ...
A retired participant	You waive dental coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot get coverage for the calendar year unless: • You or your dependent experiences eligible special enrollment events (see the "Life Events" section of this SPD); or • You die and your survivors are eligible for monthly survivor benefits under the Delta Disability and Survivorship Plan* (D&S Plan)
A disabled or retired employee and you die	Your eligible survivors (as determined by the Delta Disability and Survivorship Plans for monthly survivor benefits) may enroll in coverage when you die and during future annual open enrollments as long as they remain eligible for monthly income survivor benefits under both a Delta Disability and Survivorship (D&S) Plan* and a Delta Medical Plan. Those eligible family members who are not eligible for monthly survivor income benefits may be eligible for COBRA continuation coverage after your death for up to 36 months.
A survivor eligible for Delta dental benefits*	You waive dental coverage for the entire year
A COBRA participant	You waive your right to elect COBRA dental coverage forever**

Note: The Comprehensive and Preventive Dental Options of the DFCMP are offered only to eligible retirees, disabled participants, survivors, or dependents under age 65.

* The survivors of some ground retirees are eligible for monthly income survivor benefits for a limited period of time (up to ten years). To address what happens to eligibility for medical coverage after this period ends, the eligibility criteria for ground employee survivor medical benefits have been updated. See the "Eligibility" section of this SPD for details.

** Retirees who elect COBRA may be able to elect Delta retiree medical coverage upon the expiration of COBRA rights. See the "COBRA Continuation Coverage" section for more information on electing COBRA coverage, when coverage ends and electing retiree medical coverage.

Overview of Dental Options

Through the DFCMP, you can choose coverage under the Comprehensive Dental Option or the Preventive Dental Option. If you are enrolled in the DPMP, you automatically receive DPMP dental coverage. Refer to the following chart for coverage details about these options.

DFCMP Comprehensive Dental Option

- Provides comprehensive dental coverage, including:
  - 100% coverage before the deductible for preventive services
  - 70% coverage of R&C charges for basic restorative services after you meet the deductible
  - 50% coverage of R&C charges for major restorative services after you meet the deductible
  - 50% coverage of R&C charges for orthodontic services after you meet the deductible
- You receive care from your choice of dentists
- The annual maximum benefit is $2,500 per person
- The lifetime orthodontia maximum benefit is $2,500 per person
- This option is administered by MetLife

DFCMP Preventive Dental Option

- Covers preventive dental services only (such as cleanings and X-rays)
- You receive care from your choice of dentists
- Benefits for covered preventive services are payable at 100% of R&C charges with no deductible
- The annual maximum benefit is $200 per person
- This option is administered by MetLife

DPMP Dental Option

- Provides comprehensive dental coverage, including
  - 100% coverage before the deductible for preventive services
  - 70% coverage of R&C charges for basic restorative services after you meet the deductible
  - 50% coverage of R&C charges for major restorative services after you meet the deductible
  - 50% coverage of R&C charges for orthodontic services after you meet the deductible
- You receive care from your choice of dentists
- The annual maximum benefit is $2,500 per person
- The lifetime orthodontia maximum benefit is $2,500 per person
- This option is administered by MetLife

CIGNA Dental Care Option – a Dental HMO

- A dental Health Maintenance Organization (HMO) available if you live within a CIGNA Dental network service area
- Provides comprehensive dental coverage
- You must receive care from a network dentist to receive coverage
- Many preventive services have no patient charge — the cost for other dental procedures is a fixed charge according to a patient charge schedule
- No deductible to meet
- No claim forms to file
- This option is insured by CIGNA

Key Features of the MetLife Dental Options

The MetLife Preferred Dentist Program

The MetLife Preferred Dentist Program is a Preferred Provider Organization (PPO) with a nationwide network of nearly 90,000 participating dentist locations consisting of credentialed general and specialty dentists.

If you enroll in the Preventive Dental Option, Comprehensive Dental Option or DPMP option, you may want to consider a dentist or orthodontist who participates in the MetLife PPO. This is because, if you select a dentist who participates in MetLife's Preferred Dentist Program, you receive discounted services. Also, there are no claim forms to fill out — your Preferred Dentist handles all of the paperwork. MetLife directly reimburses the Preferred Dentist the amount of the plan benefit. (It is your responsibility to pay a non-participating dentist and file a claim for reimbursement because the non-participating dentist is not required to file for you.)

A list of dentists who participate in the Preferred Dentist Program is available on MetLife's Web site at **www.metlife.com/dental**. You also may call MetLife's Member Services at **877-683-8555** and select the dental prompt.

Comprehensive Dental Option Benefits (DFCMP Participants)

2008 Dental Benefit	Comprehensive Dental Option
Annual Maximum Benefit	$2,500 Individual
Annual Deductible	$60 Individual/$240 Family
Preventive Services	100% of R&C charges; not subject to the deductible
Basic Restorative Services *(Such as fillings, extractions, root canals, periodontal procedures)*	70% of R&C charges after deductible
Major Restorative Services *(Such as crowns, bridges, implants, inlays, onlays)*	50% of R&C charges after deductible
Dental Oral Surgeries	70% of R&C charges after deductible
Orthodontia Services	50% of R&C charges after deductible
Lifetime Orthodontia Maximum Benefit	$2,500 per person

Preventive Dental Option Benefits (for DFCMP Participants)

2008 Dental Benefit	Preventive Dental Option
Annual Maximum Benefit	$200 per person
Annual Deductible	None
Preventive Services	100% of R&C charges
Basic Restorative Services *(Such as fillings, extractions, root canals, periodontal procedures)*	Not covered
Major Restorative Services *(Such as crowns, bridges, implants, inlays, onlays)*	Not covered

Dental Benefits for DPMP Participants

If you are enrolled in DPMP medical coverage, you also are enrolled in DPMP dental coverage.

Benefit	Coverage
Annual Maximum Benefit	$2,500 per person
Annual Deductible	$60 Individual/$240 Family
Preventive Services	100% of R&C charges, not subject to the deductible
Basic Restorative Services *(Such as fillings, extractions, root canals, periodontal procedures)*	70% of R&C charges after deductible
Major Restorative Services *(Such as crowns, bridges, implants, inlays, onlays)*	50% of R&C charges after deductible
Dental Oral Surgeries	70% of R&C charges after deductible
Orthodontia Services	50% of R&C charges after deductible
Lifetime Orthodontia Maximum Benefit	$2,500 per person

How the Dental Options Work

Using Preferred Dentists

While the percentage that the plan pays for certain covered expenses is the same regardless of whether you use a dentist who participates in MetLife's Preferred Dentist Program, you can reduce the amount you pay out of pocket and the amount Delta pays simply by using a Preferred Dentist.

Preferred Dentists have agreed with MetLife to use discounted negotiated charges. When you use a non-participating dentist, your share of covered expenses is based solely on the Reasonable and Customary (R&C) charge. Because a non-participating dentist's charges can be higher than the negotiated charges, you may pay more for the same service or supply when you use a non-participating dentist.

Negotiated Charges

The negotiated charges agreed to by MetLife's Preferred Dentists are based on factors such as geographic area and level of care.

In most cases, negotiated charges paid to dentists in the Preferred Dentist Program are discounted and are less than the R&C charges for the same service paid to dentists who do not participate in the program.

Reasonable & Customary (R&C) Charges

Benefit payments for dental care, treatment, services and supplies provided by non-participating dentists are based on R&C charges. A charge is R&C if it is not more than the normal charge for comparable treatment, services or supplies by dentists or other providers of dental services in the same geographic area, as determined by the claims administrator (MetLife). Amounts over the R&C charge limits are not covered expenses under the plan — you must pay 100% of those amounts. In addition, amounts over the R&C charge limits do not count toward your deductible.

For example, suppose the plan pays 70% for a Covered Service. If the R&C charge for that service is $400 and you have met your deductible, typically your share would be $120 (30% of $400) plus any amount over the R&C charge. However, if the negotiated fee for that service is $250 because you use a Preferred Dentist, your share would be only $75 (30% of $250).

How Much the Plan Pays

The plans classify different dental procedures as Preventive, Basic Restorative, Major Restorative and Orthodontic. A list of which procedures fall under each category can be found in "What the Dental Options Cover," later in this "Dental" section.

The percentage of a covered expense that the plan pays differs by the category of that expense. To learn the benefit levels that each dental option offers by category, refer to the coverage charts that appear earlier in this "Dental" section.

You must satisfy the plan's deductible before benefits are paid for Basic Restorative, Major Restorative and Orthodontic covered expenses.

Deductibles

The deductible is the amount you, a covered dependent or your family has to pay each calendar year before the plan starts paying benefits.

You, your covered dependent or your family has to meet a new deductible each calendar year. For specific deductible amounts, refer to the coverage charts that appear earlier in this "Dental" section.

You do not have to meet a deductible with the Preventive Dental Option.

However, the Comprehensive Dental Option has both individual and family deductibles:

- The individual deductible is the amount you pay for each person's covered expenses each calendar year before the plan begins to make payment for that person's expenses (excluding services categorized as Preventive, which are not subject to the deductible)
- The family deductible is the maximum you pay in deductibles for yourself and all covered dependents. You pay the expenses for each covered dependent until that person's expenses reach the individual deductible amount. However, if the amount you pay toward deductibles for yourself and covered dependents reaches the family deductible amount, you do not need to pay any more toward deductibles for the remainder of the calendar year

Some expenses do not count toward the deductibles:

- Expenses for Preventive services
- Expenses above R&C charges
- Services not covered by the plan

Meeting the Family Deductible

To determine when the family deductible has been met, combine the amounts used to meet the individual deductibles for covered family members. Keep in mind that no one person can contribute more than the individual deductible amount toward the family deductible.

Once the family deductible has been met, the plan starts paying benefits for every covered member of your family for the rest of that calendar year, at the applicable Coinsurance rate.

Benefit Maximums

Some dental benefits and services are subject to maximums, as outlined here.

Annual Maximum Benefit

For each covered person, the dental plan has an annual maximum benefit for all covered expenses combined:

- Comprehensive Dental Option: $2,500
- Preventive Dental Option: $200
- DPMP option: $2,500

Lifetime Orthodontia Maximum Benefit

For covered orthodontic expenses, there is no annual maximum benefit. However, the plan pays no more than $2,500 in a covered person's lifetime for covered orthodontic expenses.

Benefits previously paid under another Delta dental option for orthodontic services count in determining when the lifetime orthodontia maximum has been reached.

Amounts applied toward a covered person's orthodontia maximum do not count when determining whether a person has met his or her annual maximum benefit.

Pre-Treatment Estimate

Before you have dental work, you should get a pre-treatment estimate from MetLife so you know what the plan will cover and how much it will pay for your treatment. The pre-treatment estimate is valid for six months and is voluntary (although highly recommended for orthodontia and dental oral surgery).

Here is how to get a pre-treatment estimate:

- At least 30 days before a scheduled dental procedure or treatment costing $300 or more, ask the dentist to send a claim form to MetLife, the dental claims administrator
  - On this form, be sure your dentist describes the dental treatment, services and charges, and checks the box indicating that this is a pre-treatment estimate
- MetLife determines how much the plan will pay by considering alternate procedures, services or courses of treatment (based on accepted dental standards) that could provide the same or similar results. MetLife then notifies both you and your dentist of what is payable

Once you have the pre-treatment estimate, you can discuss it with your dentist before treatment begins.

Note that the actual amount paid by the plan may differ from the amount of MetLife's pre-treatment estimate. This may happen for a variety of reasons, such as your treatment changing from what had been outlined in the pre-treatment estimate or changing circumstances. You can avoid such discrepancies by getting a revised pre-treatment estimate if your dentist later changes your treatment plan.

If you or your covered dependent does not get a pre-treatment estimate, you may find that you have to pay more out of your own pocket than you expected. Keep in mind that you are always responsible for payment of any treatment costs not covered by the plan or in excess of R&C amounts.

Alternate Benefit

Many dental conditions can be treated effectively in more than one way. However, some treatment methods may be more expensive than is necessary for good dental care.

The plans pay dental benefits for the least expensive method (called the "alternate benefit") if more than one method can provide professionally satisfactory results. Authorized benefits are in accordance with accepted dental standards for adequate and appropriate care. If you or your dentist decides to use a more expensive procedure or material, you must pay any additional cost.

For example, if your dentist recommends an implant but the missing tooth can be replaced with a removable partial denture or a fixed bridge, the plan's coverage for the implant procedure is often limited to one of these traditional choices. The dollar amount payable for the final stage of the implant procedure (crown placed on the implant) would be based on the amount payable for the partial denture or fixed bridge. There would be no payment for the actual surgical placement of the implant,

because this was your choice, and considered elective. The balance of the implant charge would remain your responsibility.

You and your dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for any expenses that exceed covered expenses. To avoid surprises, use the pre-treatment estimate process (described earlier in this "Dental" section) to learn in advance what the plan is expected to cover.

Extended Dental Benefits When Coverage Ends

You or a covered family member might undergo dental work that is not complete until after your dental coverage ends. Your expenses related to this dental work may be covered *only* if they are for:

- **Installation of fixed bridgework and full or partial dentures:** The first impression must be taken and/or abutment of teeth fully prepared while you or your family member are covered. Also, the device must be installed or delivered to the individual within three calendar months after coverage ends
- **Installation of crowns, inlays or onlays:** The tooth must be prepared while you or your family member is covered. Also, the crown, inlay or onlay must be installed within three calendar months after coverage ends
- **Root canal therapy:** The pulp chamber of the tooth must be opened while you or your family member is covered. The treatment must be completed within three calendar months after coverage ends

There is no extension of benefits for any dental service that is not described above.

What the Dental Options Cover

To be covered, dental care treatment, services and supplies must be essential for the necessary care of the teeth and provided by or under the direction of a dentist. Covered dental charges include expenses for dental care and treatment resulting from a non-occupational disease, defect or accidental injury. To qualify as a covered charge, an expense must be all of the following:

- For services received while the person is covered by the dental plans
- Ordered by a licensed dentist, and
- Included in the description of covered dental services outlined later in this "Dental" section

Preventive and Diagnostic Services

DFCMP Preventive Dental Option, DFCMP Comprehensive Dental Option and the DPMP Option

- Two oral examinations per calendar year
- Routine cleanings (oral prophylaxis) — two per calendar year
- Periodontal maintenance cleanings — two per calendar year following active periodontal therapy (the number of covered periodontal maintenance cleanings and the number of covered oral prophylaxis cleanings cannot exceed four cleanings in a calendar year)
- Fluoride treatment — one each calendar year for covered children under age 14
- Sealants — one topical application per posterior (back) tooth in a three-year period for covered participants under age 19

- Bitewing X-rays — two sets per calendar year for covered children under age 14 and one set per calendar year for adults **(Comprehensive Dental Option and DPMP option only)**
- Bitewing X-rays — one set per calendar year for all covered participants **(Preventive Option only)**
- Full mouth X-rays — one set every 36 months; includes panoramic and bitewing X-rays completed in one visit **(Comprehensive Dental Option and DPMP option only; this is not covered by the Preventive Dental Option)**

Basic Restorative Services

DFCMP Comprehensive Dental Option and the DPMP Option

- Fillings — amalgam and composite
- Extractions
- Root canal treatment
- Periodontal services for treatment of tissue supporting the teeth
- Periodontal scaling and root planing
- Administration of anesthesia, when necessary, as determined by MetLife under terms of generally accepted dental standards in connection with oral surgery, extractions or other covered dental services
- Injections of antibiotic or chemotherapeutic drugs administered by the attending dentist before treatment
- Repair or re-cementing of crowns, inlays or onlays, dentures or bridgework
- Space maintainers
- Treatment of TMJ
- Prosthetic repairs, relines and adjustments
- Re-mineralization

Major Restorative Services

DFCMP Comprehensive Dental Option and DPMP Option

- Services needed to replace one or more natural teeth, including installation of fixed bridgework and partial or full removable dentures
- Replacement of temporary full denture by a new permanent full denture when the existing denture cannot be made permanent, and the permanent denture is installed within 12 months after the existing denture
- Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed
- Inlays, onlays and crown restorations, but not more than one such restoration to the same tooth surface within five years of the prior restoration

Oral Surgery

DFCMP Comprehensive Dental Option and DPMP Option Participants

To determine whether your procedure is medical only, dental only or both, you should consult the Oral Surgery Chart (Attachment A) at the end of this "Dental" section of the SPD. This chart is divided into three sections:

- **Category I Procedures** – All of these procedures are considered dental oral surgeries
- **Category II Procedures** – All of these procedures are considered medical oral surgeries
- **Category III Procedures** – These are dental oral surgeries in which the surgical charges are considered for coverage under the dental benefit. However, all facility and facility-related charges would be considered for payment under the Delta medical benefit

Your dental provider should consult this chart and submit a pre-treatment estimate along with any diagnostic X-rays, materials and narratives to MetLife for Category I and Category III procedures. Once approved, MetLife sends its pre-treatment estimate to you and your dental provider, informing you of the plan benefit for the procedure.

If your dental oral surgery requires any facility or facility-related charges (a Category III procedure), these are considered medical expenses by UHC (provided you are enrolled in a UHC-administered Delta medical option).

Also, you or your provider must notify UHC (at **877-683-8555**) of the oral surgery. If you or your provider fails to notify UHC about an inpatient facility confinement associated with your oral surgery, you are charged a $700 non-Notification penalty. This is not applied to your deductible or Out-of-Pocket Maximum. To authorize any facility confinement, you need to provide UHC with a copy of your approved MetLife pre-treatment estimate. Details about pre-treatment estimates are provided earlier in this "Dental" section.

Covered expenses paid by the plan for dental oral surgery do apply toward the annual dental maximum, and are paid at 70% of the R&C charge after you meet the annual dental deductible. If you are enrolled in a UHC-administered Delta medical option, all facility or related charges require notification to UHC and are paid under your medical plan at the appropriate Coinsurance level after you meet the deductible.

Also, note that dental services necessary because of accidental injury to sound natural teeth are considered medical expenses. For more information regarding accident-related dental services, read the "Medical" section of this SPD.

HMO Participants Enrolled in the Comprehensive Dental Option

Some oral surgeries and expenses related to oral surgeries that are considered medical in nature may *not* be covered by an HMO. If you are in an HMO that does not cover oral surgery or related charges, you have no coverage for the oral surgery and/or related charges, and you are required to pay for 100% of the applicable charges. If you are planning an oral surgery, consult with your HMO and MetLife to see what is covered.

Before you enroll in a HMO option, you may want to review the Oral Surgery Chart (Attachment A at the end of this "Dental" section of the SPD) to determine what to expect from the Delta dental coverage (and HMO coverage) if you need oral surgery.

Orthodontia

Orthodontic benefits include expenses related to the prevention and correction of irregularities of the teeth and associated malocclusion (including simple extraction for orthodontic purposes or crown required for occlusal purposes).

The Comprehensive Dental Option and DPMP option pay 50% of R&C charges for covered orthodontic services, up to a $2,500 lifetime maximum benefit, after the annual individual dental deductible of $60 is met for each covered plan member.

Before you obtain services, your orthodontist should complete and submit to MetLife a pre-treatment estimate that includes the:

- Diagnosis of the problem being treated
- Approximate length of time treatment is necessary
- Proposed payment plan (including items such as the initial amount and monthly payment)
- Breakdown of the initial charge for the preparation of the braces and the date of the charges

Benefit payments for covered full-banded orthodontic treatment up to the maximum benefit are made in quarterly installments. To determine your initial payment, MetLife estimates the entire cost of your treatment and applies 25% of the covered amount to the installation of the appliance. Subsequent payments are prorated over the estimated duration of the treatment.

Payments are made only for services performed while covered under the Comprehensive Dental Option or DPMP option. If coverage or orthodontic treatment stops during the month, the amount payable for that month is prorated. If the treatment or payment plan extends into a second calendar year, a new $60 annual deductible is applied.

What the Dental Options Do Not Cover

The dental options do not cover the following:

- Charges for treatment by a person other than a dentist, except for cleaning or scaling of teeth, which may be performed by a licensed hygienist, if such treatment is received under the supervision and direction of a dentist
- Charges for dental services that are not considered necessary in terms of generally accepted dental standards
- Amounts greater than the R&C charge
- Expenses in excess of the cost of the least expensive professionally adequate restoration
- Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures
- Charges for prosthetic devices (including bridges and crowns) and their fitting for individuals who became eligible for coverage after the device was installed
- Charges for prosthetic devices (including bridges and crowns) and their fitting that were ordered while the participant was not an eligible covered family member but were delivered or installed after the individual became a covered participant — or which were ordered while the individual was an eligible covered family member but are not installed or delivered to the individual until three or more calendar months after coverage terminated

- Charges for crowns, inlays/onlays, bridges, dental implants or other services if a less expensive restoration is determined to be professionally adequate
- Charges for the replacement of a lost or stolen prosthetic device
- Home fluoride
- Bite registrations, precision or semi-precision attachments, or splinting
- Charges for infection control as a separate service
- Expenses for services performed by a family member or for which the patient is not required to pay
- Sealants for children on or after reaching their 19th birthday
- Fluoride treatment for participants age 14 and over
- Expenses related to occupational injury/disease
- Restorative services, oral surgery or orthodontic expenses under the Preventive Dental Option
- Claims more than two years old
- Charges in excess of the annual maximum limit
- Charges in excess of the lifetime orthodontic maximum benefit limit
- Charges for dental services or supplies that are included as covered medical services under the plans. If you have questions about whether a service is covered under medical or dental benefits, contact MetLife at **877-683-8555**. You also may refer to the Oral Surgery Chart (Attachment A) following this "Dental" section
- Expenses attributable, directly or indirectly, to an injury, illness or condition that is, or could be, the subject of a claim against a third party (or under an insurance policy or program) if:
  - MetLife or the plan's other agent is not notified in writing of any claim against a third party (or under an insurance policy or program), within 31 days of making the claim(s)
  - The participant does not complete any reimbursement agreement provided by MetLife or the plan's agent
  - The participant does not notify the third party (and/or the issuer of the insurance policy or program) that the Delta medical plan has a lien on any amounts payable by such third party (and/or under the insurance policy or program) to the extent covered expenses are paid by the Delta dental plans; and
  - The participant does not provide information requested about the claim to MetLife or the plan's agent
- Charges in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate Dental Specialty Society
- Other expenses that are not listed but are excluded under MetLife guidelines
- Under the Preventive Dental Option, all restorative services and procedures, and dental oral surgery

CIGNA Dental Care (CDC) Option

Depending on where you live, you may be eligible to enroll in the CIGNA Dental Care (CDC) option. The CDC option is a dental HMO insured and administered entirely by CIGNA. With the CDC option, you have no deductible to meet, no annual or lifetime maximums, and no claim forms to file. However, you must use a provider in the CIGNA Dental Care network to receive benefit coverage.

Network Dentists

For services to be covered, you must choose a primary care dentist from CDC's nationwide network and receive your dental work from him or her. Each covered family member may choose a different primary care dentist. To find a network provider, visit **www.mycigna.com** or call **800-367-1037**. If you do not select a network dentist, CDC assigns one to you.

When you select your network dentist, you receive a dental benefits identification card (ID card) featuring the name of your network dentist.

You may change your network dentist at any time by contacting CIGNA Member Services. This change becomes effective the first day of the following month.

If your primary care dentist determines that you need specialty care, your primary care dentist must give you a referral to a specialty dentist. If you do not receive a referral, CDC does not pay the expenses you incur with the specialist.

You are required to use network providers to receive benefits. If you do not use network providers, you must pay the entire cost of your services (unless your treatment was for an emergency, as determined by CIGNA).

What CIGNA Dental Care Covers

The CDC option emphasizes preventive dental care, so many services such as oral examinations and X-rays have no patient charge. You pay a pre-set charge for other dental procedures as shown in the Patient Charge Schedule. For details on the services that are covered by the CIGNA Dental Care option, visit **www.myCIGNA.com** or call CIGNA Member Service at **800-367-1037** to request a copy of the schedule.

CDC participants receive only the benefits provided through CDC. The benefits described for the Comprehensive and Preventive Dental Options and the DPMP option do not apply to CDC participants.

Oral Surgery

The UHC-administered medical plans consider many oral surgeries and related procedures to be dental expenses, not medical expenses. CDC may consider some of these same oral surgeries to be medical expenses, not dental expenses. If CDC does not cover an oral surgery procedure that UHC considers a dental procedure, you are left with no coverage for that surgery, and you must pay 100% of the applicable charges. If you are planning an oral surgery, consult with UHC and CDC to learn what is covered. Before you enroll in the CDC option, you may want to review the Oral Surgery Chart (Attachment A at the end of this "Dental" section of the SPD) to determine oral surgery coverage.

Customer Service

If you have questions or comments about CDC — including issues related to service, quality, costs, provider locations and disputes between you and your provider — you must contact CIGNA Dental Member Service at **800-367-1037**.

CDC is not a Delta-sponsored plan. Delta has no control over CDC plan administration — and is not responsible for issues arising with CDC dental coverage. Therefore, if you become dissatisfied with CDC's services, complaints must be filed directly with CDC. Delta cannot file complaints or resolve disputes related to CDC coverage.

Questions?

MetLife Dental Options

DFCMP Comprehensive Dental Option, DFCMP Preventive Dental Option and the DPMP option:

- Call **877 683-8555** (choose the dental prompt) or
- Visit **www.metlife.com/dental**

CIGNA Dental Care Option

To get a list of CDC Network dentists, to change your dentist or to request a Patient Charge Schedule:

- Call **800-367-1037** or
- Visit **www.myCIGNA.com**

ORAL SURGERY CHART – ATTACHMENT A

This list may be subject to change as the dental codes change and new procedures are introduced or considered as covered oral surgeries. These charts also may change as UHC's and/or MetLife's guidelines change with regard to these procedures.

Category I: Dental Oral Surgeries

The following procedures are considered for payment as dental expenses under the DFCMP Comprehensive Dental Option and the DPMP Comprehensive Dental Option administered by MetLife.

Code	Description
D4210	Gingivectomy – Per Quadrant
D4211	Gingivectomy – Per Tooth
D4220	Gingival Curettage – Per Quadrant
D4240	Gingival Flap Procedure – Per Quadrant
D4245	Apically Positioned Flap
D4249	Clinical Crown Lengthening
D4260	Osseous Surgery – Per Quadrant
D4263	Bone Replacement Graft – First Site in Quadrant
D4264	Bone Replacement Graft – Each Additional Site in Quadrant
D4266	Guided Tissue Regeneration – Resorbable Barrier
D4267	Guided Tissue Regeneration – Non-Resorbable Barrier
D4268	Surgical Revision Procedure – Per Tooth
D4270	Pedicle Soft Tissue Graft
D4271	Free Soft Tissue Graft
D4273	Subepithelial Connective Tissue Graft
D4274	Distal or Proximal Wedge Procedure
D6010	Surgical Placement of Implant Body: Endosteal Implant
D6040	Surgical Placement: Eposteal Implant
D6050	Surgical Placement: Transosteal Implant
D7210	Extract Tooth, Surgical, Erupted
D7220	Extract Tooth, Surgical, Soft Tissue Impacted
D7230	Extract Tooth, Surgical, Partial Bony Impacted
D7240	Extract Tooth, Surgical, Full Bony Impacted
D7241	Extract Tooth, Surgical, Full Bony, Unusual Surgical Complications
D7250	Surgical Removal of Residual Root(s)

Code	Description
D7260	Oral Antral Fistula Closure/ Intra-Alveolar
D7270	Tooth Reimplantation/Stabilization
D7272	Tooth Transplantation
D7280	Surgical Exposure, Orthodontic Reasons
D7281	Surgical Exposure of Impacted Tooth
D7290	Surgical Repositioning
D7291	Transseptal Fiberotomy
D7310	Alveolplasty With Extractions – Per Quadrant
D7320	Alveolplasty Without Extractions – Per Quadrant
D7340	Vestibuloplasty, Secondary Epithelialization
D7350	Vestibuloplasty, Including Grafts (Harvest of Graft May Be Medical)
D7450	Removal Odontogenic Cyst, Up to 1.25 Cm
D7451	Removal Odontogenic Cyst, Over 1.25 Cm
D7471	Removal Of Exostosis – Per Site
D7510	Incision & Drainage, Intraoral
D7520	Incision & Drainage, Extraoral
D7950	Osseous, Osteoperiosteal or Cartilage Graft
D7955	Repair of Maxillofacial Soft\Hard Tissue Defect
D7960	Frenulectomy
D7970	Excision of Hyperplastic Tissue – Per Arch
D7971	Excision of Pericoronal Gingiva
D7995	Synthetic Graft, Mandible or Facial Bones, By Report

Category II: Medical Oral Surgeries

The following procedures are considered for payment as medical expenses under a UHC-administered Delta medical plan (including the DFCMP's Standard Medical Option, Out-of-Area Medical Option and High Value Medical Option, as well as DPMP medical coverage), if you are enrolled.

Code	Description
D7285	Biopsy, Hard Tissue
D7286	Biopsy, Soft Tissue
D7410	Radical Excision, Up to 1.25 cm
D7420	Radical Excision, Over 1.25 cm
D7430	Excision of Tumor, Up to 1.25 cm
D7431	Excision of Tumor, Over 1.25 cm
D7440	Excision of Malignant Tumor, Up to 1.25 cm
D7441	Excision of Malignant Tumor, Over 1.25 cm
D7460	Removal of Nonodontogenic Cyst, Up to 1.25 cm
D7461	Removal of Nonodontogenic Cyst, Over 1.25 cm
D7465	Destruction of Lesion
D7480	Partial Ostectomy
D7490	Radical Resection of Mandible
D7530	Removal of Foreign Body, Skin or Subcutaneous Tissue
D7540	Removal of Foreign Body – Musculoskeletal
D7550	Sequestrectomy
D7560	Maxillary Sinusotomy
D7610	Maxilla – Open Reduction
D7620	Maxilla – Closed Reduction
D7630	Mandible – Open Reduction
D7640	Mandible – Closed Reduction
D7650	Malar/Zygomatic – Open Reduction
D7660	Malar/Zygomatic – Closed Reduction
D7670	Alveolus – Stabilization of Teeth, Open
D7680	Facial Bones, Complicated Reduction
D7710	Maxilla – Open Reduction, Compound
D7720	Maxilla – Closed Reduction, Compound
D7730	Mandible – Open Reduction, Compound
D7740	Mandible – Closed Reduction, Compound
D7750	Malar/Zygomatic Arch, Open Reduction, Compound
D7760	Malar/Zygomatic Arch, Closed Reduction, Compound
D7770	Alveolus, Stabilization of Teeth
D7780	Facial Bones Complicated
D7810	Open Reduction of Dislocation
D7820	Closed Reduction of Dislocation
D7830	Manipulation Under Anesthesia
D7840	Condylectomy
D7910	Suture of Small Wounds, Up to 5 cm
D7911	Complicated Suturing, Up to 5 cm
D7912	Complicated Suturing, Over 5 cm

Code	Description
D7920	Skin Graft
D7980	Sialolithotomy
D7981	Excision of Salivary Gland
D7982	Sialodochoplasty
D7983	Closure of Salivary Fistula
D7990	Emergency Tracheotomy
D7995	Synthetic Graft, Mandible or Facial Bone
D7996	Implant, Mandible – for Augmentation
D7997	Arch Bar Removal/Surgical Appliance Removal

Category III: Dental Oral Surgeries

The following procedures are considered for payment as dental expenses under the DFCMP Comprehensive Dental Option and the DPMP Comprehensive Dental Option, both administered by MetLife.

Any facility or facility-related charges associated with these surgeries are considered for payment as medical expenses under a UHC-administered Delta medical plan (including the DFCMP's Standard Medical Option, Out-of-Area Medical Option and High Value Medical Option, as well as DPMP medical coverage), if you are enrolled.

Code	Description
D7850	Surgical Discectomy, With/Without Implant (TMJ)
D7852	Disc Repair (TMJ)
D7854	Synovectomy (TMJ)
D7856	Myotomy (TMJ)
D7858	Joint Reconstruction (TMJ)
D7860	Arthrotomy (TMJ)
D7865	Arthroplasty (TMJ)
D7870	Arthrocentesis (TMJ)
D7871	Non-Arthroscopic Lysis and Lavage (TMJ)
D7872	Arthroscopy, Diagnosis, With or Without Biopsy (TMJ)
D7873	Arthroscopy, Surgical, Lavage & Lysis (TMJ)
D7874	Arthroscopy, Surgical Disc Repositioning (TMJ)
D7875	Arthroscopy, Surgical, Synovectomy (TMJ)
D7876	Arthroscopy, Surgical Discectomy (TMJ)
D7877	Arthroscopy, Surgical Debridement (TMJ)
D7940	Osteoplasty (Orthognathic)
D7941	Osteotomy – Mandibular Rami (Orthognathic)
D7943	Osteotomy – Mandibular Rami – With Bone Graft (Orthognathic)
D7944	Osteotomy, Segmented/Subapical (Orthognathic)
D7945	Osteotomy, Body of Mandible (Orthognathic)
D7946	Le Fort I (Maxilla, Segmented) (Orthognathic)
D7948	Le Fort II or III – Without Bone Graft (Orthognathic)
D7949	Le Fort II or III – With Bone Graft (Orthognathic)
D7991	Coronoidectomy

VISION BENEFITS

VISION BENEFITS

Vision care is an important part of any comprehensive benefits program. Caring for your eyes involves more than occasionally changing your glasses prescription — it also includes regular checkups that may alert you to vision issues that could turn into serious problems if they go untreated.

Delta offers this insured vision plan through Davis Vision, Inc., a national provider of vision and eye care services.

About This Summary

If you enroll in the Vision coverage, you will be provided an SPD (also known as a coverage certificate) from Davis Vision. For your convenience, a summary of vision benefits is included here. However, this document does not override or supersede the SPD provided by Davis Vision.

Who Is Eligible

See the "Eligibility" section in this SPD. Eligibility for vision care benefits is determined by the same rules that apply to the Delta medical and dental benefits.

Generally, retirees and survivors who meet the requirements in the "Eligibility" section are eligible to participate in the vision plan.

Enrollment

You may enroll in Delta's vision plan, and add or drop dependents to your coverage every year during the annual open enrollment period. If you qualify to change your benefits because you have a qualified life event change, you may be eligible to change your vision coverage. (See the "Life Events" section of this SPD for more details.)

Enrollment in the vision plan is also controlled by the coverage change rules of Davis Vision's contract with Delta.

Preferred Retail Provider Network

Both major retailers and independent practitioners participate in the Davis Vision Preferred Retail Provider Network (the "network"), including:

- Wal-Mart
- Sears
- Pearle Vision
- Target

To find a Davis Vision Preferred Retail Provider Network member, either:

- Call the Davis Vision automated phone service at **800-947-9955**, or
- Visit **www.davisvision.com**, enter your Delta Client Control Code (2732) and click on "Find a Doctor"

How to Receive Services From a Network Provider

Using the program is easy.

- Call the Network Provider of your choice to schedule an appointment
- Identify yourself as a Davis Vision Member and a Delta retiree/survivor or covered dependent
- Provide the provider's office with the retiree's/survivor's Delta employee identification number and the date of birth of any covered dependents needing services

The provider's office verifies your eligibility for services. No claim forms or ID cards are required.

How Vision Coverage Works

The Davis vision plan encourages eye health by providing benefits for routine exams, frames, lenses and contacts. You can visit the provider of your choice — in or out of the Davis Vision Preferred Retail Provider Network. However, you typically receive greater benefits through Network Providers.

Network eye exams, eyeglass lenses and frames from a select collection are 100% covered by the vision plan after you make the required Copayment. When you buy contact lenses or frames that are not from the select collection, you receive a retail credit from Network Providers toward your purchase. Covered non-network exams and supplies (such as lenses, frames and contacts) are reimbursed up to specific amounts. See the following chart for details.

Key Features of the Vision Plan

Covered Expenses	Network Benefits	Non-Network Benefits
Routine Eye Exams (One exam every calendar year)	100% covered after $10 Copay	Reimbursed up to $30
Prescription Lenses (One pair of eyeglass lenses every calendar year)	100% covered after $15 Copay	Single vision lenses are reimbursed up to $25 Bifocal lenses are reimbursed up to $35 Trifocal lenses are reimbursed up to $45 Lenticular lenses are reimbursed up to $60
Frames for Eyeglasses (One frame every 24 months)	100% covered with no Copay for Designer Selection frames from Tower Collection, or up to $120 toward a Network Provider frame	Reimbursed up to $30
Elective Contact Lenses (May be selected instead of a complete pair of eyeglasses; one pair every calendar year)	Up to $105 retail credit with no Copay	Reimbursed up to $75

Covered Plastic Eyeglass Lenses and Coatings

The following are covered by the plan:

- Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range
- Glass grey #3 prescription lenses
- Oversized lenses
- Post-cataract lenses
- Fashion, sun or gradient tinted plastic lenses
- Polycarbonate lenses for eligible dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater

Costs for Optional Frames, Lens Types and Coatings

- $20 for a Premier frame from the "Tower Collection;" the Designer Selection from the "Tower Collection" is available at no additional Copayment
- $30 for polycarbonate lenses
- $20 for scratch-resistant coating
- $20 for Photogrey Extra (photosensitive) glass lenses
- $12 for ultraviolet (UV) coating
- $35 for standard ARC (anti-reflective coating); premium ARC is $48
- $75 for polarized lenses
- $20 for blended invisible bifocals
- $65 for plastic photosensitive lenses
- $55 for high-index (thinner and lighter) lenses
- $50 for standard progressive addition multifocal lenses; premium progressive addition multifocal lenses are $90*

* Progressive addition multifocals can be worn by most people. Conventional bifocals are supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses; however, the Copayment cannot be refunded.

Wal-Mart Prices

Note that prices at individual Wal-Mart stores may vary slightly, due to Wal-Mart's Every Day Low Price (EDLP) program.

When You Should Receive Your Eyewear

Generally, the laboratory sends your eyewear to your provider within two to five business days. More delivery time may be needed if you select out-of-stock frames, ARC (anti-reflective coating), specialized prescriptions or non "Tower Collection" frames.

Discounts Off Additional Pairs of Eyeglasses

You may receive a discount of 20% off usual and customary retail cost of additional pairs of eyeglasses purchased at a participating facility, or you may use the Value Advantage Program (a discounted fee schedule for additional eyewear purchases from the "Tower Collection"). To take advantage of the Value Advantage Program, call **800-947-9955** to speak with a Davis Vision Member Service representative.

Mail Order Contact Lenses

When you enroll in the Vision Plan, you and your covered dependents are automatically enrolled in the Lens 123 mail order program. Lens 123 is a fast and convenient way to purchase replacement contact lenses. For information, call **800-LENS-123 (800-536-7123)** or visit **www.Lens123.com**.

Laser Vision Correction Services

You and your eligible dependents may receive laser vision correction services at discounts through a network of experienced, credentialed surgeons. You receive savings of up to 25% off usual and customary fees, or an additional 5% discount on any advertised specials, whichever cost is lower. Note that some providers have flat fees that are equivalent to these discounts. For more information, call Davis Vision at **800-947-9955** or visit **www.davisvision.com**.

Receiving Non-Network Benefits

You receive the greatest value and maximize your benefit dollars if you select a provider who participates in the Davis Vision network.

Even so, you may receive services from a Non-Network Provider. If you choose a Non-Network Provider, you must pay the provider directly for all charges and submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

For a claim form, visit **www.davisvision.com** or call **800-947-9955**. Note that only one claim per service may be submitted for reimbursement each benefit cycle.

What the Vision Plan Does Not Cover

Vision coverage does not include:

- Medical treatment of eye disease or injury
- Vision therapy
- Special lens designs or coatings, other than those previously described
- Replacement of lost eyewear
- Non-prescription (plano) lenses
- Services not performed by licensed personnel
- Contact lenses and spectacle lenses in the same calendar year
- Two pairs of eyeglasses in lieu of bifocals

Vision Plan Questions?

Call Davis Vision Customer Service at **800-947-9955** Monday through Friday, 8 a.m.-8 p.m., and Saturday, 9 a.m.-4 p.m. Eastern time.

COBRA CONTINUATION COVERAGE

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a temporary extension of coverage under the plans after you or your eligible dependents lose group health coverage in certain circumstances. COBRA continuation coverage is available for medical, dental, and vision coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you, your spouse, domestic partner/same sex spouse and to your dependent children who are covered under the plans when you, your spouse, domestic partner/same sex spouse or your dependent children would otherwise lose health coverage under the plans.

This section generally explains COBRA continuation coverage, when it may become available to you, your spouse, domestic partner/same sex spouse and your dependent children, and what you need to do to protect the right to receive it. (Note that while COBRA itself does not apply to domestic partners/same sex spouses, Delta has elected to provide continuation coverage to domestic partners/same sex spouses.)

COBRA is administered by Ceridian COBRA Continuation Services. You can reach Ceridian with this contact information:

Ceridian COBRA Continuation Services
P.O. Box 534099
St. Petersburg, FL 33747
Customer Service: **800-877-7994** (Monday – Friday, 8 a.m.-8 p.m. Eastern time)
Fax: 727-865-3648
www.ceridian-benefits.com

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

COBRA Eligibility

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event occurs and any required notice of that event is properly provided, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your spouse or domestic partner/same sex spouse, and your dependent children could become qualified beneficiaries if coverage under the plans is lost because of a qualifying event. Under the plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The following is a description of the qualifying events under the COBRA law that may be applicable to retirees and their dependents, or survivors.

If you are the spouse or domestic partner/same sex spouse of a retiree, you will become a qualified beneficiary if you lose coverage under the plans because any of the following qualifying events occur:

- Your spouse or domestic partner/same sex spouse dies
- You become divorced from your spouse or your domestic partnership terminates
  - Also, if your spouse eliminates your coverage in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though you lost coverage earlier. If you notify the Delta Employee Service Center (ESC) within 60 days after the divorce and can establish that the coverage was eliminated earlier in anticipation of the divorce, then COBRA continuation coverage may be available for the period after the divorce

Your dependent children (including your domestic partner's/same sex spouse's children and children participating under a Qualified Medical Child Support Order) will become qualified beneficiaries if they lose coverage under the plans because any of the following qualifying events occur:

- Parent – retiree dies
- Parents become divorced
- Child stops being eligible for coverage under the plans as a dependent child

Notification of Qualifying Events

COBRA continuation coverage will be offered to qualified beneficiaries only after the plans are notified that a qualifying event has occurred. When the qualifying event is the retiree's death and the death is timely reported to Delta, then Delta automatically notifies the plans.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce, termination of a domestic partnership or a dependent child's losing eligibility for coverage), you, your spouse, domestic partner/same sex spouse or dependent child must notify the ESC.

Depending on the type of qualifying event, notice of the event may be made online at Benefits Direct on DeltaNet or by submitting the proper form (along with any required supporting documentation). Verbal notice, including notice by telephone, is not sufficient. If the qualifying event is a divorce or termination of domestic partnership, notice of the qualifying event must be made by completing and submitting to the ESC a Family Status Change Form. Further, in case of divorce, in addition to the completed Family Status Change Form, you must provide a copy of the first and last pages of the divorce decree or legal document, as well as any pages that apply to medical and dental coverage in cases of a medical child support order. If the qualifying event is a dependent's loss of eligibility, notice of the qualifying event may be reported online at DeltaNet on the Benefits Direct site, where you will report the loss on the "Change Coverage" link.

No matter which notification method is used, you must notify the ESC within 60 days after the later of:

- The date of the qualifying event, or
- The date on which you or your dependent lose, or would lose, coverage under the terms of the plans as a result of the qualifying event

You, your spouse, domestic partner/same sex spouse or your dependent child must provide notice in a timely manner. If mailed, your notice must be received by the ESC no later than the last day of the 60-day election period described above. Otherwise, it must be received no later than that day. If you, your spouse, domestic partner/same sex spouse or dependent child fails to provide notice to the ESC during this 60-day notice period, you, your spouse, domestic partner/same sex spouse or dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.

Note that a child born to, adopted by or placed for adoption with a participant during a period of COBRA continuation coverage is eligible for coverage as a qualified beneficiary. You must notify the ESC within 60 days of the child's birth, adoption or placement for adoption with the participant.

Life events that make you or your eligible dependents eligible for COBRA continuation coverage must be reported to the ESC within 60 days, as noted above. Be aware, however, that for other purposes under the plans, you may need to report life events, including qualifying events, within 30 days of the event. For instance, if you experience a life event that may qualify you to make changes to your or your eligible dependent's benefit coverage, this life event must be reported to Delta/ESC/online at Benefits Direct within 30 days. Please see the "Life Events" section of this SPD for details regarding the reporting of life events.

Electing COBRA Continuation Coverage

This is the process to follow if you and/or any other qualified beneficiary decide to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA contribution coverage on behalf of their spouses or domestic partners/same sex spouses, and parents may elect COBRA continuation coverage on behalf of their covered children.

- The following information will be provided to qualified beneficiaries at the time of the qualified event — as long as timely notice of such event was received by the Delta ESC:
  - The ESC sends you a Notice of Right to Elect COBRA Continuation Coverage letter informing you that you have 60 days to enroll for COBRA benefits
  - In addition to the notice described above, under separate cover Ceridian sends you a COBRA qualifying event package that reflects your healthcare coverage options in effect at the time your coverage was terminated
  - Note that, even though the Ceridian package will show only the healthcare coverage options that you were enrolled in before your qualifying event, you may elect COBRA continuation coverage under a different medical and/or dental option available under the plans. The list of the options available to you and the cost of such options is included with the ESC Notice of Right to Elect COBRA Continuation Coverage, described previously. However, if you were not enrolled in a particular benefit before your qualifying event, you will not be offered COBRA continuation coverage for that benefit. For example, if you were not enrolled in vision coverage before your qualifying event, you will not be eligible to add vision coverage through COBRA
- If you decide to elect COBRA continuation coverage, your election must be made by the election rights expiration date shown on the Ceridian package. This date is either 60 days from the date coverage was lost, or if later, 60 days from the date the Ceridian package is postmarked

- If you want to enroll for COBRA continuation coverage without making changes to your elections, you have 60 days to enroll through the Ceridian Web site (**www.ceridian-benefits.com**), the Ceridian IVR (**800-877-7994**, Monday – Friday, 8 a.m.-8 p.m. ET) or by completing and mailing to Ceridian the Continuation of Group Health Coverage Election Agreement form
- If you want to change your benefit coverage option during the 60-day enrollment period — and you are eligible to do so — call the ESC at **1-800 MY DELTA (1-800-693-3582)**. With a service center representative, you can review available plans and costs. The service center representative records your new benefit elections and sends your request for change of coverage to Ceridian
- If you and/or any other qualified beneficiary do not submit a completed COBRA election form by the deadline, you or the qualified beneficiary will permanently lose the right to elect COBRA continuation coverage. You, your spouse, domestic partner/same sex spouse or dependent child are encouraged to follow up with Ceridian to ensure your COBRA election form has been timely received
- Once your COBRA elections have been processed, Ceridian will send you a welcome package that contains your first COBRA invoice
- Ceridian will post your Premium payment within 30 days after you send it

Adding Dependents After COBRA Coverage Begins

You may add a new spouse, domestic partner/same sex spouse, newborn or adopted child to your COBRA coverage, provided you do so within 30 days of the marriage, birth, adoption or placement for adoption and pay the required Premium. If notification to Delta or Ceridian of the qualifying life event occurs after the 30-day window, you will have an opportunity to add your eligible dependent during the next Ceridian annual open enrollment period (provided you continue to be eligible for COBRA continuation coverage) Benefits elected during the annual open enrollment period will be effective January 1 of the next year.

When COBRA Coverage Begins

For each qualified beneficiary who timely elects COBRA continuation coverage, and makes timely and proper payment of required Premiums (as described below), your elected coverage becomes retroactively effective to the date when you lost coverage. You do not experience a gap in coverage when transitioning from active to COBRA continuation coverage.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage that lasts up to a specified number of months, depending on the type of qualifying event experienced. If timely payment for COBRA continuation coverage is made, and the qualifying event is:

- The death of the employee, your divorce, or a dependent child losing eligibility, then COBRA continuation coverage can last up to a total of 36 months for the spouse or dependent children
- The end of employment (including retirement), then COBRA continuation coverage generally lasts up to a total of 18 months for the retiree, spouse and dependent children
- The employee's employment ends, and the covered employee became entitled to Medicare benefits fewer than 18 months before the qualifying event, then COBRA continuation coverage under the plans for qualified beneficiaries (other than the employee/retiree) can last up to 36 months after the date of Medicare entitlement

Example: Rosa becomes entitled to Medicare benefits eight months before her retirement date. Rosa will be eligible for COBRA continuation coverage for a maximum period of 18 months. However, COBRA continuation coverage for Rosa's husband and daughter can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months of COBRA continuation coverage after Rosa's last day of work (36 months minus eight months)

- Substantial reduction in coverages within a year either before or after filing of a bankruptcy petition under Chapter 11, then COBRA continuation coverage can last for the lifetime of the retiree or survivor or 36 months for the retiree's spouse and/or eligible dependents following the death of the retiree

Lifetime COBRA is Administered by Delta

Lifetime COBRA is offered to certain retirees, their eligible dependents and to certain survivors as additional medical and dental options. When lifetime COBRA coverage is elected via Delta's Benefits Direct, all administration of this coverage is handled by Delta and the Employee Service Center (ESC). Contributions for elected coverage are taken from pension and/or disability checks, or billing and payment is made through Direct Billing. All issues and inquires regarding coverage, payment of premium contributions and continuation of lifetime COBRA coverage should be directed to the ESC at **1-800 MY DELTA (1-800-693-3582)**.

Ceridian COBRA Continuation Services is not responsible for the administration of lifetime COBRA.

Extension of Coverage

If the maximum period of COBRA continuation coverage you are eligible for is 18 months, there are two ways in which this 18-month period can be extended. If the maximum period of COBRA continuation coverage you are eligible for is 36 months, no extensions are available.

Second Qualifying Events for Spouse, Domestic Partner /Same Sex Spouse or Dependent Children

If any of your family members who are qualified beneficiaries (your spouse or domestic partner/same sex spouse and/or dependent children only) experience another qualifying event while already receiving 18 months of COBRA continuation coverage, they may elect to extend the period of COBRA continuation coverage for an additional 18 months, up to a maximum total period of 36 months from the start of the original COBRA period, if notice of the second qualifying event is timely given to Ceridian.

Such second qualifying events may include the death of a covered employee, divorce from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the plans. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plans if the first qualifying event had not occurred.

You must notify Ceridian in writing within 60 days after a second qualifying event occurs if you want to extend your COBRA continuation coverage.

All participants experiencing second qualifying events receive a HIPAA Certificate of Creditable Coverage, along with any conversion information that may be applicable. Participants may obtain a duplicate HIPAA Certificate of Creditable Coverage at any time by contacting Ceridian and requesting a copy. Call Ceridian at **800-877-7994**, Monday – Friday, 8 a.m.-8 p.m. Eastern time.

Disability Extension Under COBRA

If you or anyone in your family who is a qualified beneficiary covered under the plans is determined by the Social Security Administration (SSA) to be disabled and you notify Ceridian in a timely fashion, you and those in your family who are also qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum total period of 29 months.

To be eligible for this extension, the disability would have to have started at some time before the 61st day after your termination of employment (including retirement) or reduction in hours and must last at least until the end of the 18-month period of COBRA continuation coverage. Each qualified beneficiary who has elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them qualifies.

You must notify Ceridian in writing that a qualified beneficiary has been determined by the SSA to be disabled. This notice must be furnished before the end of the first 18 months of COBRA continuation coverage and no later than the date that is 60 days after the latest of:

- The date of the disability determination by the SSA; or
- The date of the qualifying event (the covered employee's termination of employment or retirement); or
- The date on which the qualified beneficiary loses (or would lose) coverage under the plans as a result of the qualifying event

A copy of the SSA's official disability determination, showing the date of such award, must accompany the qualified beneficiary's notice to Ceridian.

If the qualified beneficiary is determined by the SSA to no longer be disabled, you or the affected qualified beneficiary must notify Ceridian in writing of that fact within 30 days of the SSA's determination. If you do not timely notify Ceridian, your coverage will still be discontinued as of the date of the SSA's determination, and all claims made for the period thereafter will be denied.

Cost of COBRA Continuation Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary is required to pay may not exceed 102% of the cost to the group health plan (including both employer and retiree/survivor Contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

Initial Payment for COBRA

If you or another qualified beneficiary elects COBRA continuation coverage, you or the qualified beneficiary does not have to send any payment with the COBRA Continuation of Group Health Coverage Election Agreement form. However, you or the qualified beneficiary must make the first payment for COBRA continuation coverage no later than 45 days after the date of the election.

COBRA continuation coverage will not start until Ceridian has timely received the initial Premium payment. If you or a qualified beneficiary does not make the first payment for COBRA continuation coverage in full by no later than 45 days after the date of the election, then you or the qualified beneficiary will lose all COBRA continuation coverage rights under the plans.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the plans would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period.

Consider contacting the ESC to confirm the correct amount of the first payment.

Send the first payment — and all payments that follow — for COBRA continuation coverage to:

Ceridian COBRA Continuation Services
P.O. Box 534099
St. Petersburg, FL 33747

Periodic Payments for COBRA

After you or a qualified beneficiary makes the first payment for COBRA continuation coverage, you or the qualified beneficiary is required to make monthly payments for each subsequent month of coverage.

Ceridian COBRA Continuation services bills your COBRA Premiums monthly, on or about the 19th of each month. You are charged a Premium that amounts to 100% of the cost of your next month's coverage, plus a 2% administration fee.

Be sure that your Premium payments are postmarked by the first day of each month. If Ceridian receives the Premium payment on or before the first day of the month to which it applies, coverage under the plans continues for that month without any break in coverage.

Grace Period for Periodic Payments

Although monthly payments are due on the first of each month, you or a qualified beneficiary will be given a grace period of 30 days after the first day of the month to make each periodic payment. COBRA continuation coverage is provided for each month as long as payment for that month is made before the end of that payment's grace period. If you or the qualified beneficiary fails to make a periodic payment before the end of the grace period for that month, the following month's bill shows the outstanding balance for the previous month in addition to the current month's Premium.

If you or a qualified beneficiary do not pay the outstanding Premium, a third reminder is sent eight business days before the end of the grace period, warning that your coverage will be cancelled if payment is not received.

If a Premium payment is submitted after the due date, but within the grace period (based on the postmark date), the payment is accepted and credited to your or the qualified beneficiary's account. If the payment is submitted after the grace period expiration date (based on the postmark date), the payment is returned to you or the qualified beneficiary without being cashed, coverage is cancelled and a termination of COBRA continuation coverage letter is sent. **If COBRA continuation coverage is cancelled for nonpayment, coverage cannot be reinstated, and you, your spouse, domestic partner/same sex spouse or dependent child have no further rights to COBRA continuation coverage**.

Benefit administrators (medical, dental, and/or vision, as applicable) will be notified that coverage is terminated as of the last day for which Premium payments were received.

When an insignificant shortfall (which is defined as the lesser of $50 or 10% of the total monthly COBRA Premium) occurs and the balance is not paid in full, the partial payment cannot be posted as payment. For example, your Premium payment for the period of April 1-30 has an insignificant shortfall. You are sent a bill for the shortfall and given 30 days to make that payment (per the grace period procedure described earlier). If payment is not postmarked by the grace period deadline, your coverage is cancelled as of March 31 and the Premiums that you had paid for April are returned to you.

When COBRA Coverage Ends

Generally, COBRA continuation coverage ends on the last day of the maximum coverage period (18, 29, or 36 months or lifetime). COBRA continuation coverage (including lifetime COBRA rights) will be terminated before the end of the maximum coverage period if:

- The qualified beneficiary voluntarily cancels COBRA by contacting Ceridian
- Any required Premium is not paid on time
- A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not impose any Pre-Existing Condition exclusion for a Pre-Existing Condition of the qualified beneficiary
- A qualified beneficiary becomes entitled to Medicare benefits (including Part A, Part B or both) after electing COBRA continuation coverage
- Delta no longer provides any group health coverage

COBRA coverage also may be terminated for any reason the plans would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud). In addition, COBRA continuation coverage also may be terminated if a qualified beneficiary recovers from a Social Security approved disability that extended COBRA continuation coverage. **Once COBRA coverage is canceled, it cannot be reinstated.**

Electing Retiree Medical Coverage Once Your COBRA Continuation Coverage Ends

If you are enrolled in Delta medical coverage when you retire, you are eligible to elect COBRA continuation coverage, which generally lasts for up to 18 months. You also may elect retiree coverage right away, if you like, but many retirees who are offered COBRA continuation coverage choose to take advantage of the COBRA continuation coverage.

Whenever your COBRA coverage period ends (typically, at the end of 18 months), you may immediately enroll in a Delta retiree medical option without having to wait for the annual open enrollment period. This means that, as long as your COBRA Premiums are timely paid and you follow the proper enrollment procedures in a timely manner (for instance, you notify the ESC within 30 days of the end of your COBRA coverage), you should not have any lapse in coverage.

If a COBRA participant waives COBRA coverage at any time, that coverage cannot for any reason be reinstated in the future.

Manage Your COBRA Coverage

Go to **www.ceridian-benefits.com** to:

- Elect COBRA continuation coverage
- Add/drop dependents
- Change information about COBRA-eligible dependents
- Update your address
- Print forms
- View the status of your account
- Look up payment dates and amounts
- Review COBRA start/end dates

Call Ceridian at **800-877-7994**, Monday – Friday, 8 a.m.-8 p.m. Eastern time.

Lifetime COBRA for certain retirees, dependents or survivors is not administered by Ceridian. These COBRA participants should contact Delta with all questions or issues such as payment dates and amounts.

Direct all inquires the ESC at:

1-800 MY DELTA (1-800-693-3582)

Send all lifetime COBRA premium payments to:

ACS HR Solutions for Delta Air Lines
P.O. Box 382119
Pittsburgh, PA 15251-8119.

Special Considerations When Deciding Whether to Elect COBRA

In considering whether or not to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your (or any other qualified beneficiaries') future rights under federal law.

First, you can lose your right to avoid having Pre-Existing Condition exclusions apply to you by other group health plans if you have more than a 63-day gap in health coverage, election of COBRA continuation coverage may help you not have such a gap.

Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such Pre-Existing Condition exclusions if you do not maintain COBRA continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event described above. You also will have the same special enrollment right at the end of COBRA continuation coverage if you keep COBRA continuation coverage in effect for the maximum time available to you.

COBRA Beneficiaries

During the annual open enrollment period, you and any qualified beneficiaries have the same rights as similarly situated non-COBRA beneficiaries to change medical options and covered dependents under the plans.

To protect your rights and your family's, you should keep the ESC and Ceridian informed of any changes to your or a family member's home address. For your records, you also should keep a copy of any notices you send Ceridian or the ESC.

Special "Trade Act" Rules Concerning Tax Credit for COBRA Continuation Coverage

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance, and for certain retired employees who receive pension payments from the Pension Benefit Guaranty Corporation (PBGC) ("eligible individuals"). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of Premiums paid for qualified health insurance, including COBRA continuation coverage.

If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center at **866-628-4282**. TTD/TTY callers may call 866-626-4282. More information about the Trade Act is available at **www.doleta.gov/tradeact/2002act_index.cfm.**

Questions About Your Rights?

If you have questions concerning your COBRA continuation coverage rights, contact:

Ceridian COBRA Continuation Services
P.O. Box 534099
St. Petersburg, FL 33747
Customer Service: **800-877-7994**, Monday – Friday, 8 a.m.-8 p.m. ET
Fax: 727-865-3648

Lifetime COBRA participants should contact Delta with their questions or issues regarding lifetime COBRA rights.

Direct all inquires to the ESC:

1-800 MY DELTA (1-800-693-3582)

CLAIMS INFORMATION & APPEALS

CLAIMS INFORMATION & APPEALS

This "Claims Information & Appeals" section is divided into two parts. The first part describes the claims review and appeal procedures applicable to all healthcare benefits available under the plans, except dental coverage through CIGNA Dental Care (CDC) and vision coverage through Davis Vision. The second part describes the claims review and appeal procedures for CDC and Davis Vision coverages, as well as other procedures for resolving issues involving COBRA continuation coverage and Direct Bill (Premium Pay) disputes.

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

Part 1 – ERISA Claims and Appeals Procedures

Filing Initial Claims

If you are enrolled in any of the plans outlined in this SPD, you may need to submit a claim to receive benefits under the plans. Information about filing specific types of claims and the time frames within which you must submit the claims appears below. When you submit any healthcare claim, it should be accompanied by a completed claim form as well as any required supporting documentation, such as itemized bills. Be sure to make copies of all completed claim forms and any accompanying supporting documentation for your records.

Once a claim is timely received, the appropriate claims administrator will provide you with a response — an Explanation of Benefits (EOB) or Health Statement — and, if appropriate, reimbursement within the time frames set forth below. Typically, benefits are paid as soon as the claims administrator receives the proof needed to support your claim. If you already have paid for services, benefits are usually payable directly to you; however, benefit payments for hospital services or other providers are generally paid directly to the hospital or provider. At your request, the claims administrator may pay benefits directly to the provider of services.

Authorized Representative

You may authorize an individual to act on your behalf in pursuing a claim or appeal. This individual is known as an "authorized representative." For information about how to designate an authorized representative, contact the appropriate claims administrator. For claims administrator information, see the charts at the end of this "Claims Information & Appeals" section of the SPD.

Deadlines for Filing Claims

All medical, prescription drug, behavioral health/substance abuse, including the DPMP dental claims, must be submitted to the appropriate claims administrator within two years of the date of service. All DFCMP dental option claims have a one-year claim filing deadline in which claims can be submitted to MetLife.

When you file healthcare benefit claims, keep in mind that the charges are incurred on the date that the care, services or supplies are rendered or furnished — not the date on which they are billed.

Medical and Prescription Drug Claims

UnitedHealthcare (UHC) is the claims administrator for medical and prescription drug benefits under the plans.

When you obtain medical treatment from a UHC network provider, present your UHC identification (ID) card when receiving services and the provider will submit your claim for you automatically. Payment of your claim will be made directly to the provider.

When you obtain medical treatment from a Non-Network Provider, in most cases, you will be required to pay the provider for your medical care at the time you are treated. In order to receive benefits from the plans, you must submit your medical claim to UHC.

The plans only cover prescription drugs obtained from network pharmacies (non-network prescription drug charges are, however, covered under the High Value Medical Option). When you obtain a prescription from a network pharmacy, present your UHC ID card and the pharmacy will submit your claim for you automatically. In most instances, you do not need to submit a prescription drug claim to UHC for reimbursement.

If you are unable to provide your UHC ID card or identification number when you obtain a Covered Service, medical treatment or a prescription at a participating pharmacy, you may be required to pay for that service or prescription in full and submit a claim to UHC for benefits.

You may obtain a medical and/or prescription drug claim form online at **www.myuhc.com** or on Benefits Direct through DeltaNet. If you have questions about the claims filing process for a medical or prescription drug claim, contact UHC at **877-683-8555**.

Behavioral Health and Substance Abuse Claims

United Behavioral Health (UBH) is the claims administrator for behavioral health and substance abuse benefits under DFCMP and DPMP. The information below describes how to file a claim with UBH for these benefits. Behavioral health and substance abuse benefits under the HVO medical option of the DFCMP are considered to be medical claims, and therefore, the administrator is UnitedHealthcare (UHC). See the section above to learn how to file a claim with UHC, including behavioral health or substance abuse claims.

When you obtain behavioral health or substance abuse treatment from a UBH Network Provider, present your UHC identification (ID) card at the time you receive services, and the provider will submit your claim for you automatically. Payment of your claim will be made directly to the provider.

When you obtain behavioral health and substance abuse treatment from a Non-Network Provider, in most cases, you will be required to pay for your care at the time you are treated. In order to receive behavioral health or substance abuse benefits from the plans, you must submit your claim to UBH.

If you are unable to provide your UHC ID card or identification number when you obtain a behavioral health or substance abuse Covered Service or treatment, you may be required to pay for that service or treatment in full and submit a claim to UBH for benefits.

You may obtain a medical/behavioral health claim form online at **www.myuhc.com** or on Benefits Direct through DeltaNet. If you have questions about the claims filing process for a behavioral health or substance abuse claim, contact UBH at **877-683-8555**.

Dental Claims – MetLife

MetLife is the claims administrator for the dental options available under the DFCMP and DPMP. If you use a dentist who participates in the MetLife Preferred Dentist Program (PDP), the dentist will usually submit claims for you. However, PDP dentists are not contractually obligated to file claims on your behalf. Therefore, you should verify with your dentist who will be responsible for submitting your claims.

If your dentist is not a PDP provider, or if your PDP dentist does not file claims on your behalf, you will need to pay your charges in full at the time service is rendered and submit a claim to MetLife for dental benefits under the plans.

You may obtain a dental claim form online at the MetLife Web site at **www.metlife.com/dental** or on Benefits Direct on DeltaNet (**http://dlnet.delta.com**). If you have questions about filing a dental claim, contact MetLife at **800-942-0854**.

Notice of Benefit Determination

After your claim is reviewed, the applicable claims administrator will provide you with a notice of its benefit determination within the time frames specified below. For urgent care and pre-service claims, you will receive a notice of benefit determination whether or not your claim is denied. For post-service and concurrent care claims, you are entitled to a notice if the claims administrator denies or makes an adverse determination on your claim for benefits.

The time frames for providing notice of a benefit determination generally start when a claim for benefits is received by the claims administrator. Notice of a benefit determination may be provided by mail or electronic delivery such as email. However, as described below, in some urgent cases, oral notification is permitted. Note, that the reference to “days” means calendar (not business) days.

Time Frames for Responding to Claims

Urgent Care Claims

Once an urgent care claim is submitted, the applicable claims administrator will notify you of its decision on your claim — whether it is approved or denied — as soon as possible, but no later than 72 hours after receipt of the claim, unless the claim was incomplete or improperly filed. This notification may be made to you orally, followed up by a written or electronic notification of the decision within three days of the oral notification.

If your claim is incomplete, the claims administrator will notify you of this, in writing or by phone, and inform you what information is necessary to properly complete your claim. The claims administrator

will do this as soon as possible, following receipt of your incomplete claim, but no later than 24 hours after such receipt.

If additional information is required, you will have a reasonable amount of time to provide the information, taking into account the circumstances, but not less than 48 hours. The claims administrator will notify you of its decision as soon as possible, but no later than 48 hours after the earlier of its receipt of the requested information or the period given you to provide the requested information. The claims administrator may provide you with notification of its decision orally, but must follow up with a written or electronic notification within three days after the oral notification.

In addition, if your claim is not filed in accordance with these claims procedures, the claims administrator will notify you of this and the procedures that must be followed as soon as possible, but no later than 24 hours after receipt of the claim. This notification can be made orally, unless you request written notification.

Pre-Service Claims

Once a pre-service claim is submitted, the applicable claims administrator will notify you of its decision on your claim — whether it is approved or denied — as soon as possible, but no later than 15 days after receipt of the claim. This period may be extended by 15 days if the claims administrator determines, due to reasons beyond its control, that it needs extra time to process your claim. If the claims administrator needs additional time, it will notify you before the expiration of the initial 15-day period of the reasons for the extension and the date it expects to make its decision.

If an extension is needed because the claims administrator needs additional information from you to make its decision, the extension notice will describe the required information. In such case, you will have at least 45 days from the receipt of the notice to provide the requested information. The claims administrator's extension period will begin when you respond to the request for additional information (or upon the expiration of the 45 days given to you to make such response). The claims administrator will then notify you of its decision within 15 days of the earlier of your response or the expiration of the 45-day period.

In addition, if your claim is not filed in accordance with these claims procedures, the claims administrator will notify you of this and the procedures that must be followed as soon as possible, but no later than five days after receipt of the claim. This notification can be made orally, unless you request written notification.

Post-Service Claims

Once a post-service claim is submitted, the applicable claims administrator will notify you of its decision to deny your claim as soon as possible, but no later than 30 days after receipt of the claim. This period may be extended by 15 days if the claims administrator determines, due to reasons beyond its control, it needs extra time to process your claim. If the claims administrator needs additional time, it will notify you before the expiration of the initial 30-day period of the reasons for the extension and the date it expects to make its decision.

If an extension is needed because the claims administrator needs additional information from you to make its decision, the extension notice will describe the required information. In such case, you will have at least 45 days from the receipt of the notice to provide the requested information. The claims administrator's extension period will begin when you respond to the request for additional information (or upon the expiration of the 45 days given to you to make such response). The claims administrator will then notify you of its decision within 15 days of the earlier of your response or the expiration of the 45-day period.

Concurrent Care Decisions

If a claim is made to extend a previously approved concurrent care decision, the claim will be decided within the same time periods as any other pre-service, urgent care or post-service claim. However, if the claim involves extending a concurrent care decision involving urgent care, and the claim is made at least 24 hours before the end of the approved period of time or number of treatments, the claims administrator must decide the claim within 24 hours after its receipt of the claim.

If a reduction or termination of any course of treatment is made before the end of the previously-approved time period or number of treatments, this is considered a denial of benefits. In such case, the claims administrator must notify you of this denial in advance of the termination or reduction to allow you time to appeal this decision before the reduction or termination occurs.

If Your Claim Is Denied

If your claim for healthcare benefits is denied, in whole or in part, the applicable claims administrator will provide you with notice of its decision, including:

- The specific reason or reasons for the denial of the claim
- Reference to the specific plan provision(s) on which the denial is based
- A description of any materials or information necessary for your claim to be approved, and an explanation of why such materials or information is necessary
- A description of the plans' claim review procedures and the time limits under those procedures, including a statement regarding your right to file a civil action under Section 502(a) of ERISA following a denial of your appeal(s)
- If applicable, a copy of the internal rule, guideline or protocol, or similar criterion that was relied on in making the claim determination
- If the denial is based on an exclusion for medical necessity or experimental treatment or similar exclusion limitation, a statement explaining the scientific or clinical judgment relied on in making the claim determination
- In the case of an urgent care claim, a description of the expedited review process applicable to such claims

Informal Claims Inquiries

If you are not satisfied with a medical, behavioral health or substance abuse benefit determination, or if you have questions about the determination, you may contact UnitedHealthcare/United Behavioral Health Member Services at **877-683-8555**.

Member Service representatives generally are available Monday through Friday during regular business hours. If you call outside of business hours, you may leave a voice message and a Member Services representative will return your call. If the Member Services representative is unable to resolve your issue during your telephone conversation, you may initiate the formal claims appeal procedure by putting your conversation — along with supporting documentation — in writing.

Appealing Denied Claims

If you disagree with the decision made by a claims administrator about your claim, you may appeal this decision in accordance with the appeal procedures described below. It is important that you strictly follow these procedures. Your failure to do so may cause you to lose certain legal rights.

What to Include in Your Appeal Request

Unless otherwise indicated, your appeal request must be in writing and should include all the facts and arguments that you want considered. In addition, your appeal request should include:

- The patient's name and the identification number from the applicable provider ID card
- The name of the provider/physician/dentist/hospital
- *For pre-service appeals:*
  - The date an original pre-service request was made, the date of the proposed service, hospital admission or prescription, and the nature of the proposed service, admission or prescription
  - The reason you believe the care or prescription requiring pre-service approval should be approved or authorized
- *For post-service appeals:*
  - The date the service(s) or prescription was received and the nature of the service or prescription
  - The reason you believe the claim should be paid
- All documentation or other written information to support your request for claim payment

Access to Information

On request, you are entitled to receive, free of charge, reasonable access to and copies of the following:

- Documents, records and information relevant to your claim
- Any internal rule, guideline, protocol, or other similar criterion that was relied on in making the initial claim or appeal determination
- If the claim was denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applied to the circumstances at issue in the claim

About the Appeal Process

All levels of appeal will be reviewed by a new decision-maker — referred to in this section as the claims reviewer. This means that the first level of appeal will not be conducted by the individual who denied the initial claim or by that person's subordinate and, in cases when a second-level of appeal is given, the second-level appeal will not be conducted by the individual who denied the first-level appeal of the initial claim, or that person's subordinate.

The appeal process will take into account all information regarding the denied claim (whether or not presented or available when the original decision was made). The claims reviewer will not give deference to the original decision made about your claim. That is, the reviewer will give your claim a "fresh look" and make an independent decision about the claim.

If your claim was denied based on medical judgment (including determinations regarding whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the claims reviewer will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the claim. The healthcare professional will not be the same person (or a subordinate of the person) who was consulted on the initial decision. If the advice of any medical, dental or vocational experts is obtained in connection with your claim denial, upon your request, these experts will be identified, regardless of whether their advice is relied upon in deciding the appeal.

For appeals involving urgent care claims, you may request that all necessary information (including the decision) between you and the claims reviewer be transmitted by telephone or fax instead of by written or electronic means.

Medical Claim Appeals

UnitedHealthcare is the claims reviewer for medical benefits under the DFCMP and the DPMP and also for behavioral health/substance abuse benefits under the HVO medical option. If your claim is denied by the claims administrator, you have the right to file an appeal in accordance with the process described below.

There are two levels of appeal available for the medical and behavioral health/substance abuse claims handled by UHC. While the first-level appeal is mandatory, the second-level appeal is voluntary.

First-Level Appeal Process

Non-Urgent Care Claim Process

If you wish to appeal a claim denial involving a non-urgent care claim, you must request an appeal within 180 days of the date you received your claim denial from the claim administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but no later than the following:

- Pre-Service Claims: 30 days after the receipt of your request
- Post-Service Claims: 60 days after the receipt of your request

Urgent Care Claim Process

If you wish to appeal a claim denial involving an urgent care claim, your request *does not have to be made in writing*. You or your provider should call the claims reviewer as soon as possible to request an expedited appeal of the claim denial. An urgent appeal will be reviewed, a decision made, and you and your provider will be notified within 72 hours of the receipt of your request.

Second-Level Appeal Process – Voluntary External Review

If you have completed the first-level appeal and you are not satisfied with the claim determination involving clinical issues, you may request a voluntary external review. External reviews are conducted by a physician external review group independent of the claims administrator and the claims reviewer.

You can initiate this process as it is outlined in the outcome letter of the first-level appeal. This request must be made in writing within 60 days of the date of the letter.

The voluntary external review will be completed within 60 days of the receipt of your request. If your appeal is identified as clinically urgent, the review will be completed within 72 hours of the receipt of your request.

Behavioral Health and Substance Abuse Claim Appeals

United Behavioral Health is the claims reviewer for behavioral health and substance abuse benefits, other than the HVO medical option, under the plans. If your behavioral health or substance abuse claim under these plans is denied by the claims administrator, you have the right to file an appeal with the claims reviewer in accordance with the process described below.

There are two levels of appeal available for behavioral health or substance abuse claims. Both levels of appeal are mandatory.

First-Level Appeal Process

Non-Urgent Care Claim Process
If you wish to appeal a claim denial involving a non-urgent care claim, you must request an appeal within 180 days of the date you received your claim denial from the claim administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but no later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Urgent Care Claim Process
If you wish to appeal a claim denial involving an urgent care claim, your request *does not have to be made in writing*. You or your provider should call the claims reviewer as soon as possible to request an expedited appeal of the claim denial. An urgent appeal will be reviewed, a decision made, and you and your provider will be notified within 72 hours of the receipt of your request.

Second-Level Appeal Process

Non-Urgent Care Claim Process
If your first-level appeal request was a non-urgent review, and you remain dissatisfied with the outcome of that review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted in writing within **60 days** of the date you received notification from the claims reviewer of the outcome of your first-level appeal. Once you have filed your second-level appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Urgent Care Claim Process
If your first-level appeal request was an urgent review, and you remain dissatisfied with the outcome of that review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted as soon as possible after you receive notification from the claims reviewer of the outcome of your first-level appeal. This second-level appeal request *does not have to be made in writing*. You or your provider should call the claims reviewer as soon as possible to request an expedited appeal of the first-level appeal denial. An urgent appeal will be reviewed, a decision made, and you and your provider will be notified within 72 hours of the receipt of your request.

Prescription Drug Claim Appeals

UnitedHealthcare is the claims reviewer for prescription drug benefits under the plans. If your prescription drug claim is denied by the claims administrator, you have the right to file an appeal with the claims reviewer in accordance with the process described below. Note that all prescription drug claims are considered post-service claims.

There is only one level of appeal available for prescription drug claims, and it is mandatory.

Appeal Process

If you wish to appeal a claim denial, you must request an appeal within 180 days of the date you received your claim denial from the claim administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but no later than 60 days after the receipt of your request.

Dental Claim Appeals – MetLife

MetLife is the claims reviewer for dental benefits under the plans (excluding dental benefits provided by CIGNA Dental Care). If your dental claim is denied by the claims administrator, you have the right to file an appeal with the claims reviewer in accordance with the process described below.

There are two levels of appeal available for dental claims, and both levels are mandatory.

First-Level Appeal Process

Non-Urgent Care Claim Process

If you wish to appeal a claim denial involving a non-urgent care claim, you must request an appeal within 180 days of the date you received your claim denial from the claim administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but no later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Urgent Care Claim Process

If you wish to appeal a claim denial involving an urgent care claim, your request *does not have to be made in writing*. You or your dentist should call the claims reviewer as soon as possible to request an expedited appeal of the claim denial. An urgent appeal will be reviewed, a decision made, and you and your dentist will be notified within 72 hours of the receipt of your request.

Second-Level Appeal Process

Non-Urgent Care Claim Process

If your first-level appeal request was a non-urgent review, and you remain dissatisfied with the outcome of that review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted in writing within 60 days of the date you received notification from the claims reviewer of the outcome of your first-level appeal. Once you have filed your second-level appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Urgent Care Claim Process

If your first-level appeal request was an urgent review, and you remain dissatisfied with the outcome of that review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted as soon as possible after you receive notification from the claims reviewer of the outcome of your first-level appeal. This second-level appeal request *does not have to be made in writing*. You or your dentist should call the claims reviewer as soon as possible to request an expedited appeal of the first-level appeal denial. An urgent appeal will be reviewed, a decision made, and you and your dentist will be notified within 72 hours of the receipt of your request.

If Your Appeal Request Is Denied

If your appeal request is denied, in whole or in part, the applicable claims reviewer will provide you with a written or electronic notice of its decision, including:

- The specific reason or reasons for the denial of the appeal
- Reference to the specific plan provision(s) on which the denial is based
- A statement that you are entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A description of any voluntary appeal procedures available to you under the plan and your right to obtain information about such procedures and the time limits under those procedures, and a statement regarding your right to bring an action under Section 502(a) of ERISA
- If applicable, a copy of the internal rule, guideline, protocol or similar criterion that was relied on in making the claim determination
- If the denial is based on an exclusion for medical necessity or experimental treatment or similar exclusion limitation, a statement explaining the scientific or clinical judgment relied upon

Claims Involving Eligibility to Participate

If your claim for benefits is denied because you are not eligible to participate in the DFCMP or DPMP, you will be notified of such denial in writing by the Delta Employee Service Center (ESC).

The Administrative Subcommittee is the claims reviewer for eligibility determinations under the plans. If you or your dependent were denied eligibility under the plans, you have the right to file an appeal with the claims reviewer in accordance with the process described below.

There is only one level of appeal available for plan eligibility claims, and it is mandatory.

Appeal Process

If you wish to appeal an eligibility claim denial, you must request an appeal within 90 days of the date you received your claim denial from the ESC. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible, but no later than 60 days after the receipt of your request.

Other Important Information About Appeals

The plans use the claims and appeal procedures outlined in this section to ensure that the plans' provisions are correctly and consistently applied. The decisions of the final claims reviewers are conclusive and binding. Once you exhaust the mandatory levels of appeal, no further review of your claim is available under the terms of the plans.

Exhaustion of Administrative Remedies

Before starting legal action to recover benefits, or to enforce or clarify rights, you must completely exhaust the plans' claims and appeal procedures. This means that you must complete all mandatory levels of appeal described in this SPD before you may sue for benefits under the plans.

Grievances (For Pilot Retirees/Survivors Only)

After following the preceding claims and appeal procedures, if your claim is still denied in whole or in part, you may be able to file a grievance under the terms of your collective bargaining agreement.

Part 2 – Other Claims and Appeals Procedures

Dental Claims and Appeals – CIGNA

The CIGNA Dental Care (CDC) option is administered by CIGNA. All claims and appeals of denied claims are handled exclusively by CDC. Contact CIGNA Member Services at **800-367-1037** for details about claims and appeal procedures.

Vision Claims and Appeals

The vision plan is administered by Davis Vision. All claims and appeals of denied claims are handled exclusively by Davis Vision. Contact Davis Vision Member Services at **800-947-9955** for details about claims and appeal procedures.

COBRA (Ceridian) Coverage Cancellation/Denial Appeals

If Ceridian cancels or denies your coverage, as a COBRA participant, you have the right to initiate a formal review by Ceridian of the cancellation or denial.

Initiating a Review

You begin the review process by calling the Ceridian call center at **800-877-7994**. The call center representative will ask you to send a written review request to Ceridian's Compliance Office. There is no time limit for you to submit this request.

The Compliance Office reviews your request and provides you with a written determination within approximately 14 days of receipt of the request.

If the initial cancellation/denial is upheld by Ceridian, you will be advised of your option to appeal to Delta's Administrative Subcommittee.

Appealing Review Determinations

If you decide to appeal the review determination, you or your authorized representative have 90 days to submit a written appeal to the Administrative Subcommittee. The date reflected at the top of Ceridian's notification letter counts as the first day in determining the 90-day period. The Administrative Subcommittee expressly reserves the right to refuse any tardy appeals.

Once you have submitted your appeal, the Administrative Subcommittee will notify you of its decision as soon as possible, but no later than 60 days after the receipt of your request.

Appealing Coverage Termination Due to Nonpayment

Termination for Nonpayment

When your outstanding premium balance is 90 or more days delinquent, a Termination for Nonpayment Notice will be mailed to you. When terminated for nonpayment, all of your coverages will be cancelled, except for benefits with zero cost (due to waiver of Premium or because they are Delta-paid benefits). This cancellation will be effective on the last date in which the Premiums for a *full* month are paid. If you have made a partial Premium payment, the partial payment will be refunded during the regularly scheduled refund process, because partial payments are not accepted.

Retirees and survivors whose coverage is terminated for nonpayment of Premiums will not be allowed future enrollment rights under the plans. See "Paying for Coverage" in the "Enrolling for Healthcare Benefits" section of this SPD for details.

Appealing Coverage Terminations Due to Nonpayment

If you believe that your medical, dental or vision coverage was terminated in error, you may appeal the termination due to nonpayment of Premiums if you are a retiree, survivor or disabled participant only.

If your coverage is terminated due to nonpayment of Premiums, you will receive a Termination for Nonpayment Notice. This notice will inform you that you have 90 days to submit a written appeal to the Administrative Subcommittee. The date at the top of the Termination for Nonpayment Notice counts as the first day in determining the 90-day period. Once you have submitted your appeal, the Administrative Subcommittee will notify you of its decision as soon as possible, but no later than 60 days after the receipt of your request.

The Administrative Subcommittee expressly reserves the right to refuse any tardy appeals. A review is made only upon the written record.

Claims and Appeals General Information

Claims Review and Appeals Information at a Glance

	Claims Administrator	Claims Reviewer	Contact Information
Medical Claims			
DFCMP DPMP	UnitedHealthcare (UHC)	UHC Member Services	UnitedHealthcare Claims Department P.O. Box 740800 Atlanta, GA 30374-0800 **877-683-8555** UnitedHealthcare Appeals Department P.O. Box 30432 Salt Lake City, UT 84130 *UPS/Fed Ex Delivery Address:* United Healthcare Appeals Department 510 W. Parkland Drive Sandy, UT 84070
Health Plan Hawaii (HMO)	Health Plan Hawaii	Health Plan Hawaii Member Services	Member Services **808-948-6372** Monday – Friday: 8 a.m.–4 p.m.
Humana Health Plan of Puerto Rico	Humana Health Plan	Humana Health Plan of Puerto Rico Member Services	Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave F D Roosevelt San Juan, Puerto Rico 00918-2131 **787-282-7900 ext. 5500**

Claims Review and Appeals Information at a Glance			
	Claims Administrator	**Claims Reviewer**	**Contact Information**
Behavioral Health & Substance Abuse Claims			
DFCMP DPMP	United Behavioral Health (UBH)	UBH Member Services	United Behavioral Health Appeals & Complaints Unit Employer Division P.O. Box 32040 Oakland, CA 94604 **877-683-8555** *UPS/Fed Ex Delivery Address:* United Behavioral Health Appeals & Complaints Unit Employer Division 425 Market Street San Francisco, CA 94105
High Value Medical Option/DFCMP	UnitedHealthcare (UHC)	UHC Member Services	UnitedHealthcare Claims Department P.O. Box 740800 Atlanta, GA 30374-0800 **877-683-8555** UnitedHealthcare Appeals Department P.O. Box 30432 Salt Lake City, UT 84130 *UPS/Fed Ex Delivery Address:* United Healthcare Appeals Department 510 W. Parkland Drive Sandy, UT 84070
Health Plan Hawaii (HMO)	Health Plan Hawaii	Health Plan Hawaii Member Services	Member Services **808-948-6372** Monday – Friday: 8 a.m.–4 p.m.
Humana Health Plan of Puerto Rico	Humana Health Plan	Humana Health Plan of Puerto Rico Member Services	Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave F D Roosevelt San Juan, Puerto Rico 00918-2131 **787-282-7900 ext. 5500**

Claims Review and Appeals Information at a Glance

	Claims Administrator	Claims Reviewer	Contact Information
Prescription Drug Claims			
DFCMP DPMP	UnitedHealthcare (UHC)	UHC Member Services	UnitedHealthcare Claims Department P.O. Box 740800 Atlanta, GA 30374-0800 **877-683-8555** UnitedHealthcare Appeals Department P.O. Box 30432 Salt Lake City, UT 84130 *UPS/Fed Ex Delivery Address:* UnitedHealthcare Appeals Department 510 W. Parkland Drive Sandy, UT 84070
Health Plan Hawaii (HMO)	Health Plan Hawaii	Health Plan Hawaii Member Services	Member Services **808-948-6372** Monday – Friday: 8 a.m.–4 p.m.
Humana Health Plan of Puerto Rico	Humana Health Plan	Humana Health Plan of Puerto Rico Member Services	Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave F D Roosevelt San Juan, Puerto Rico 00918-2131 **787-282-7900 ext. 5500**
Dental Claims			
DFCMP DPMP	MetLife	MetLife Member Services	MetLife Group Dental Claims P.O. Box 981282 El Paso, TX 79998 **877-683-8555** (Choose the dental prompt) Fax: 859-389-6505 MetLife Group Dental Appeals P.O. Box 981282 El Paso, TX 79998 *UPS/Fed Ex Delivery address:* MetLife Dental 6 Founders Blvd - Suite E El Paso, TX 79906

Claims Review and Appeals Information at a Glance

	Claims Administrator	Claims Reviewer	Contact Information
CIGNA Dental Care (CDC)	CIGNA Dental Care	CDC Member Services	CIGNA Dental Claims & Appeals Department P.O. Box 188047 Chattanooga, TN 37422-8047 Claims: **800-367-1037** Appeals: **800-CIGNA24** Fax: 423-485-9013 *UPS/Fed Ex Delivery Address:* CIGNA Dental c/o National Appeals Unit 5772 Brainerd Road Chattanooga, TN 37411
Vision Claims			
Davis Vision	Davis Vision	Davis Vision Member Services	Davis Vision Quality Assurance Member Grievances/Appeals 159 Express Street P.O. Box 9104 Plainview, NY 11803-9004 **800-947-9955** *UPS/Fed Ex Delivery Address:* Davis Vision Attention: Appeals 159 Express Street Plainview, NY 11803-9004 Appeals Phone Numbers: **800-328-4728** Fax: 800-584-2329
COBRA Coverage Cancellation/Denial			
Ceridian COBRA Coverage	Ceridian COBRA Continuation Services – Member Services	Ceridian COBRA Continuation Services – Member Services	*Review of Cancelled/Denied Coverage:* Ceridian **800-877-7994** compliance@ceridian.com *Appeal:* Secretary, Administrative Subcommittee Delta Air Lines, Inc. Department 844 P.O. Box 20706 Atlanta, GA 30320 **404-715-2600** Fax: 404-773-1362

Claims Review and Appeals Information at a Glance			
	Claims Administrator	**Claims Reviewer**	**Contact Information**
Eligibility Issues			
Eligibility for Delta Benefits	Administrative Subcommittee of Delta Air Lines	Administrative Subcommittee of Delta Air Lines	*Claim Review and Appeal:* Secretary, Administrative Subcommittee Delta Air Lines, Inc. Department 844 P.O. Box 20706 Atlanta, GA 30320 **404-715-2600** Fax: 404-773-1362 *For Eligibility Claim Questions:* Employee Service Center **1-800 MY DELTA** **(1-800-693-3582)**

PLAN ADMINISTRATION AND LEGAL RIGHTS

PLAN ADMINISTRATION AND LEGAL RIGHTS

Definitions of Capitalized Words

The capitalized terms used in this SPD have special meaning. Refer to the "Terms to Know" section at the end of this SPD for definitions.

This section contains a description of general administrative and legal information applicable to the plans of which medical, dental and vision benefits are a part.

Plan Information

This SPD describes the following plans. These are referred to collectively in this section as "the plans."

Benefit	Formal Plan Name	Plan Number	Plan Type	Administration	Fiscal Year
Medical, Prescription Drug and Dental	Delta Family-Care Medical Plan	501	Welfare benefit plan providing medical, prescription drug and dental benefits	Contract administered	July 1 – June 30
	Delta Pilots Medical Plan	503			
Vision	Delta Vision Plan	532	Welfare plan providing vision benefits	Insurer administered	Jan. 1 – Dec. 31

Plan Sponsor/Employer/EIN

The Plan Sponsor and employer is Delta Air Lines, Inc. You may contact the Plan Sponsor at the following address:

Delta Air Lines, Inc.
P.O. Box 20706
Atlanta, GA 30320-6001

The Employer Identification Number (EIN) of the Plan Sponsor is 58-0218548.

Labor Organization Members Covered by the Plans

The Delta Pilots Medical Plan is maintained pursuant to the terms of a labor agreement between Delta and the Air Line Pilots Association.

Air Lines Pilots Association (ALPA)
535 Herndon Parkway
Herndon, VA 20170

Participants and beneficiaries covered by the labor agreements may obtain a copy of the applicable agreement by sending a request to:

Secretary, Administrative Committee
Delta Air Lines, Inc.
Department 844
P.O. Box 20706
Atlanta, GA 30320-6001

The ALPA agreement also may be examined by participants and their beneficiaries in the offices of the Delta Flight Operations Department, Delta Air Lines, Inc., P.O. Box 20706, Department 029, 1010 Delta Boulevard, Atlanta, GA 30320-6001.

Agent for Service of Legal Process

The agent for service of legal process on the plans, and the address where process can be served, is:

Secretary, Administrative Committee
Delta Air Lines, Inc.
Department 971
P.O. Box 20574
Atlanta, GA 30320-6001

Legal service of process for the Delta Family-Care Medical Plan and Delta Pilots Medical Plan also can be made upon the Trustee of the trusts for those plans.

Plan Administrator

The Administrative Committee of Delta Air Lines, Inc. (“Delta”) is the plan administrator of the plans. It is the named fiduciary for administration of the plans and is responsible for:

- Operation and administration of the plans (except for purposes of formulating and managing the investment policies and controlling the plans’ assets, if any, that are instead the responsibilities of the Benefit Funds Investment Committee of Delta)
- Exclusive power to construe and to interpret the plans and determine questions of eligibility for participation and receipt of benefits
- Determining the amount, the manner and the time of payment of benefits
- Authorizing the payment of benefits and reasonable expenses for administering the plans
- Carrying out the provisions of the plans pertinent to the responsibility of the Administrative Committee
- Delegation of any of its fiduciary authority to determine and review claims

In exercising its functions, the Administrative Committee or its delegate has the broadest discretionary authority permitted under law. Members of the Administrative Committee are appointed by the Vice President – Compensation, Benefits and Services of Delta. The Administrative Committee members may be substituted or removed from their positions at the sole discretion of the Vice President – Compensation, Benefits and Services. They receive no compensation in their capacities as members, but receive compensation as employees of Delta.

The address and telephone number of the Administrative Committee is:

The Administrative Committee of Delta Air Lines, Inc.
Department 844
P.O. Box 20706
Atlanta, GA 30320-6001
404-715-2600

Claims Administrator

The following insurers are claims administrators for the plans and process claims payments. In addition, Davis Vision insures the vision plan, and, therefore, is financially responsible for the benefits of that plan. Likewise, CIGNA Dental Care insures the dental HMO benefits, Hawaii Medical Service Association insures the HMSA medical HMO benefits, and Humana insures Humana Health Plan of Puerto Rico medical HMO benefits. These entities are, therefore, financially responsible for those benefits.

Plan	Claims Administrator / Insurer
Delta Family-Care Medical Plan – medical benefits and **Delta Pilots Medical Plan** – medical benefits **HMO medical benefits**	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 **877-683-8555** Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave F D Roosevelt San Juan, Puerto Rico 00918-2131 **787-282-7900 ext. 5500** Hawaii Medical Service Association 818 Keeaumoku Street Honolulu, HI 96814 **808-948-6372**
Delta Family-Care Medical Plan – dental benefits and **Delta Pilots Medical Plan** – dental benefits **Dental HMO Benefits**	Metropolitan Life Insurance Company (MetLife) Group Dental Claims P.O. Box 14093 Lexington, KY 40512-4093 **800-942-0854** CIGNA Dental Care 300 NW 82nd Avenue Suite 700 Plantation, FL 33324 **800-367-1037** **www.mycigna.com**

Plan	Claims Administrator / Insurer
Delta Vision Plan	Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12201 **800-947-9955**

Discretionary Authority of the Plan Administrator and the Claims Administrator

The Administrative Committee has delegated to UnitedHealthcare, MetLife and their affiliates ("Claims Administrators") the authority to determine claims eligibility and benefit amounts in accordance with the Plans' terms. As such, the Claims Administrators have the broadest discretionary authority permitted under law to interpret the provisions of the plans and determine eligibility for benefits.

The Claims Administrator serves as the final reviewer under the plans and has sole and complete discretionary authority to determine conclusively any and all questions concerning the administration and interpretation of the plans, including questions about eligibility to participate in the plans; eligibility for benefits; the relevant facts; the amount and type of benefits payable to any participant; and the construction of all terms of the plans. Notwithstanding the foregoing, the Plan Administrator will have sole and complete discretionary authority to determine questions relating to eligibility of healthcare benefits pursuant to the voluntary appeal process available for such benefits under the plans.

Respective decisions by the Plan Administrator and the Claims Administrator will be final, conclusive and binding on all parties claiming to have an interest in the plans and not subject to further review by Delta. Benefits will be paid under the plans only if the Claims Administrator or the Plan Administrator decides, in its sole authority, that the participant or other claimant is entitled to them.

Plan Fiduciaries

The members of the Administrative Committee are the named fiduciaries for purposes of operation and administration of the plans. However, the Administrative Committee delegated the complete and broadest discretion to decide and review certain benefit claims to its Claims Administrators, as previously described.

The members of the Benefit Funds Investment Committee are the named fiduciaries for formulating the investment policies and managing/controlling the assets of the plans, if any. Among its duties, the Benefits Fund Investment Committee or its delegate appoints (and discharges) investment managers and trustees to manage and maintain custody of the assets of the plans.

Source of Contributions and Funding

The healthcare benefits under the Delta Family-Care Medical Plan and Delta Pilots Medical Plan are self-funded by Delta through Trusts associated with those plans. These plans are also funded through the Contributions of participants and beneficiaries of the plan. The benefits under the Delta Vision Plan, the CIGNA Dental Plan, the HMSA Hawaii HMO and the Humana Health Plan of Puerto Rico HMO are insured products, and the benefits of those plans are not funded by Delta. However, the participant, and in some cases, Delta, makes Premium payments to the insurer for those benefits. Active and inactive participant contributions are determined annually by the Company, or in the case of the Delta Pilots Medical Plan, based on the terms of the applicable labor agreement. Retiree and survivor Premiums are a percentage of the applicable cost of each plan, and such cost changes on an annual basis.

Retiree Premiums

Retiree Premiums for medical/dental coverage are determined by a number of factors. They are a percentage of the full cost of the coverage as determined by Delta, or in accordance with the applicable collective bargaining agreement, in the case of the DPMP. The full cost of the coverage is determined by the plans' actuary, who takes into account the retiree population claims experience, expected medical inflation, plan design and other factors in setting the rates. The retiree's Contribution amount also is based on the options chosen and the number of dependents covered. For your current year deductions, visit Benefits Direct on DeltaNet, click on "Health, Disability and Insurance," and then the link on the left side of the page titled "Coverage Details."

Organizations That Accumulate Assets or Provide Benefits

The Delta Pilots Medical Plan is funded through the Delta Pilots Medical Trust, a 501(c)(9) voluntary employee beneficiary association, to which the Company contributes. Participant contributions to this plan are also placed in the Trust. Likewise, the Delta Family-Care Medical Plan is funded through the Delta Family-Care Medical Trust, to which the Company contributes and participant contributions are placed in the Trust. In addition to the assets of the plans that are in trust funds, some benefits are provided through an insurance company and through the general assets of the companies listed under "Plan Information" earlier in this section. The trustees, the insurance companies and the companies listed under "Plan Information" earlier in this section make benefit payments as directed by the Administrative Committee or its delegates.

Medical benefits for participants electing the HMSA HMO option or the Humana Health Plan of Puerto Rico HMO option are provided by the health maintenance organization (HMO), and the dental benefits of participants electing the CIGNA Dental HMO are provided by the dental HMO. The Delta Vision Plan is an insured plan that is insured by Highmark, Inc. and administered by Davis Vision, Inc. (a subsidiary of Highmark, Inc.).

Plan Trustee

The following entity serves as the trustee of the Delta Family-Care Medical Trust and the Delta Pilots Medical Trust:

J.P. Morgan Bank
4 Chase MetroTech Center
18th Floor
Brooklyn, NY 11245

Electronic Media

The Plan Administrator may use electronic media, such as e-mail, in accordance with the provisions of ERISA to satisfy all disclosure and recordkeeping obligations imposed on the plans under Title I of ERISA.

Assignment of Benefits

Except as required by law, no benefit, payment or distribution under the plans will be subject to the claim of any creditor of a participant, or to any legal process by any creditor of the participant, and the participant will not have any right to alienate, commute, anticipate or assign all or any portion of any benefit, payment or distribution under the plans.

However, a participant may make a voluntary and revocable assignment, but only for such purposes as the Plan Administrator may specify from time to time.

Assistance in Reading the English Language

If, due to language translation difficulties, a participant needs assistance in interpreting this SPD, he or she may contact the Delta Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** for assistance. A service center representative will be pleased to work with the participant to provide the necessary explanations of rights and obligations under the plans, as well as the procedures to be followed in obtaining needed assistance.

Right to Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Under certain circumstances, participants may have the right to continue coverage under COBRA continuation coverage. For details, refer to the “COBRA Continuation Coverage” section that appears earlier in this SPD.

Filing Claims and Appealing Denied Claims

Refer to the “Claims Information & Appeals” section for information about filing claims, requesting a review of a denied claim, and appealing denied claims.

Statement of ERISA Rights

As a participant in the benefit plans described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all benefit plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations such as worksites, all documents governing the plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the plans, including insurance contracts, copies of the latest annual report (Form

5500 series) and updated SPD. The Plan Administrator may impose a reasonable charge for the copies

- 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 Group Health Plan Coverage

- Continue healthcare coverage for yourself, your spouse, or dependent if there is a loss of coverage under a health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plans for the rules governing your COBRA continuation coverage rights
- Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan, if you have creditable coverage from another plan
- You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plans, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of employee benefit plans. The people who manage Delta's benefit plans, 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 Delta or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 request a copy of plan documents or the latest annual report from the plans and do not receive it within 30 days, you may file suit in 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 for 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 state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a Qualified 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 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 (if, for example, it finds your claim is frivolous).

Assistance With Your Questions

If you have any questions about any of the healthcare benefit plans offered by Delta, you should contact the Plan Administrator. If you have any 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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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. You also may visit the EBSA's Web site at **www.dol.gov/ebsa**.

Other Legal Notices

The Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to fewer than 48 hours following a vaginal delivery, or fewer than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act went into effect on January 1, 1999. This law contains protections for breast cancer patients who seek breast reconstruction after undergoing a mastectomy. Specifically, the medical plan participant who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction will be provided with coverage for services determined by the attending physician and the patient that include:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

For more information regarding specific coverage levels, refer to your medical option's description of Breast Reconstruction or Reduction Surgery included in the "Medical" section of this SPD. If you are a participant in a Delta-offered HMO, contact your HMO for more information (see the "Where to Get More Information" section at the back of this SPD).

HIPAA Privacy Notice

This notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. You have the legal right to receive this Notice. It is available on Benefits Direct, or you may request a copy by calling **1-800 MY DELTA (1-800-693-3582)**. Please review it carefully.

Introduction

We understand that medical information about you is personal and must be appropriately safeguarded. A federal law called HIPAA requires that health plans and healthcare providers protect the privacy of certain medical information. This Notice covers the medical information practices of the Delta Air Lines, Inc. sponsored group health plans (the "Plans"). This Notice is intended to inform you, in a summary fashion, of your rights under the privacy provisions of HIPAA and the HIPAA obligations imposed on the Delta Air Lines, Inc. sponsored Plans.

Only health information that may specifically identify you and is used or disclosed by the Plans is protected by HIPAA. This health information is called "protected health information," and we refer to it throughout this Notice as "PHI." Health information that Delta Air Lines, Inc. receives about you as an employer is not PHI. Thus, your sick leave records, FMLA leave information, drug testing results, Workers' Compensation files, disability, life insurance and OSHA records are not PHI and are not covered by this Notice.

Third parties (such as UnitedHealthcare, MetLife or your HMO) assist the Plans in administering your health benefits. These entities keep and use most of the medical information maintained by the Plans, such as information about your health condition, the healthcare services you receive and the payments for such services. They use this information to process your benefit claims. They are required to use the same privacy protections as the Plans.

The members of the departments defined by Delta Air Lines, Inc. and identified at the end of this notice who assist with administration of the Plans have limited access to medical information about you. This information is generally limited to: (1) whether you are enrolled in the Plans or are eligible; (2) the family members you cover under the Plans; (3) the amount you contribute for your healthcare coverage; and (4) information about certain claims, claim denials and appeals. The Human Resource Department positions that have limited access to PHI are: Director – Health Strategy & Resources, Manager – Health Plans, Manager – Health Plans Administration, Specialist – Vendor Performance, Specialist – Health Plans, Analyst – Health Plan Programs, and Analyst – ERISA Benefits. The Information Security/Privacy Office also has limited access to PHI.

The Plans consist of Delta Air Lines, Inc. sponsored medical and dental coverages extended to certain retired employees of Delta Air Lines, Inc. and survivors of Delta employees, as well as their family members. If you have coverage under a "fully insured" benefit option such as an HMO, you will receive a separate Notice of Privacy Practices from the insurance carrier regarding your medical information.

Remember, the Plans do not maintain all of your medical information. Your healthcare providers (such as doctors and hospitals) also maintain some of your information. You should ask your healthcare providers directly if you have any questions about medical information maintained by them.

You may request to receive communications from the Plans by alternative means or at alternative locations. For example, you may ask that the Plans call you only at work rather than at home. You must provide the Plans with the reasons for the alternative contact and to which information the request applies.

How the Plans May Use and Disclose Medical Information About You

This section describes how the plans use and disclose medical information to administer benefits. Please note that this Notice does not list every use or disclosure; instead, it gives examples of the most common uses and disclosures.

Primary Uses and Disclosures of PHI

The Plans may disclose your PHI so that your doctors, dentists, pharmacies, hospitals and other healthcare providers may provide you with medical treatment. The Plans also may send your healthcare information to doctors for patient safety or other treatment-related reasons.

The Plans may use and disclose your PHI for benefit payment such as to see if you are eligible for benefits, to calculate your benefits under the Plans, to pay your healthcare providers for treating you, to calculate your Copays and Coinsurance amounts, to decide claims appeals and inquiries, or to coordinate coverage. For example, the Plans may disclose information about your medical history to a physician (including your physician) to determine whether a particular treatment is experimental, investigational or medically necessary, or to decide if the Plans will cover the treatment. The Plans also may share medical information with a Utilization Review or pre-certification service provider. Likewise, the Plans may share medical information with another entity to coordinate payment of your benefits (such as under your spouse's plan). The Plans also share your information to assist with subrogation or recovery of your claims.

The Plans may use and disclose PHI about you for additional related healthcare operations as necessary to operate the Plans. For example, the Plans may use PHI in connection with:

- Underwriting and soliciting bids from potential insurance carriers
- Merger and acquisition activities
- Setting Premiums
- Deciding employee Premium contributions
- Submitting claims to the Plans' stop-loss (or excess loss) carrier, if any
- Conducting or arranging for medical review
- Legal services
- Audit services
- Fraud and abuse detection programs

The Plans also may use your PHI for administrative activities such as business planning and development, cost management, business management and conducting quality assessment and improvement activities.

The Plans may use your medical information to contact you or give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plans may disclose your medical information to its third-party administrators to assist in these activities.

Other Uses and Disclosures of Your PHI

- The Plans are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA
- The Plans will disclose PHI about you when required to do so by federal, state or local law
- The Plans may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person
- If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation

- If you are a member of the armed forces, the Plans may release your PHI as required by military command authorities
- The Plans may release your PHI for Workers' Compensation or similar programs
- The Plans may disclose your PHI for public health activities such child abuse and neglect, threats to public health and safety, and national security
- The Plans may disclose your PHI to a health oversight agency for activities authorized by law (such as audits, investigations, inspections and licensure)
- If you are involved in a lawsuit or a dispute, the Plans may disclose your PHI in response to a court or administrative order. The Plans also may disclose your PHI in response to a subpoena, discovery request, or other lawful process to someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested
  - The Plans may release your PHI if asked to do so by a law enforcement official
  - The Plans may release medical information to a coroner or medical examiner
  - The Plans may release your PHI to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans may release your PHI to the correctional institution or law enforcement official
- Using its best judgment, the plans may disclose your PHI to a family member, other relative, close friend or other personal representative. Such a use will be based on how involved the person is in your care, or payment that relates to that care. The plans may release claims payment information to spouses, parents or guardians

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization at any time in writing. However, your revocation will only stop future uses and disclosures that are made after the plans receive your revocation. It will not have any effect on the prior uses and disclosures of your PHI. The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal ERISA preemption, the plans will comply with the stricter law.

Your Rights Regarding Your PHI

You have the following rights regarding PHI the Plans have about you:

You have the right to inspect and copy your PHI that may be used to make decisions about your benefits. To inspect and copy your PHI that may be used to make decisions about you, you must submit your request in writing to the appropriate privacy contact listed at the end of this notice. If you request a copy of this information, the Plans may charge a fee for the costs of copying, mailing or other supplies associated with your request.

The Plans may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. The Plans will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to your PHI, you may request a review of the denial.

If you feel that PHI the Plans have about you is incorrect or incomplete, you may ask the Plans to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plans. To request an amendment, you must submit your request in writing to the appropriate privacy contact listed at the end of this notice. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete.

The Plans may deny your request for an amendment if it is not in writing or does not list why it is incorrect or incomplete. In addition, the Plans may deny your request if you ask the Plans to amend information that: (1) is not part of the medical information kept by or for the Plans; (2) was not created by the Plans or its third-party administrators; (3) is not part of the information that you would be permitted to inspect and copy; or (4) is accurate and complete.

If the Plans deny your request, they must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

You have the right to request an "accounting of disclosures" of your PHI — a list of disclosures the Plans have made of your PHI. This list will not include disclosures to you or your personal representative, ones you authorized in writing, or disclosures made for treatment, payment or healthcare operations. The Plans will not include in your accounting any of the disclosures for which there is an exception.

To request this list of disclosures, you must submit your request in writing (to ensure appropriate authentication, e-mails are not considered acceptable) to the appropriate privacy contact listed at the end of this notice. Your request must state the time period for the disclosures (for example, all disclosure between July 2007 and August 2007). The time period cannot be longer than six years, nor include dates before April 14, 2003.

You may request one accounting in any 12-month period free of charge. The Plans will impose a fee for each subsequent request within the 12-month period. The Plans will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to request that the Plans communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plans only contact you at work or by mail. The Plans will only accommodate these requests if you inform them that disclosure of your PHI could endanger you. To request confidential communications, you must submit your request in writing to the appropriate privacy contact listed at the end of this notice. Your request must specify how or where you wish to be contacted.

You also may request that the Plans disclose your PHI to your personal representative. A personal representative is an individual you designate to act on your behalf and make decisions about your medical care. If you want the Plans to disclose your PHI to your personal representative, submit a written statement giving the Plans permission to release your PHI to your personal representative and documentation that this individual qualifies as your personal representative under state law, such as a power of attorney. Submit this request in writing to the appropriate privacy contact listed at the end of this notice.

Changes to This Notice

The Plans have the right to change this Notice at any time. The Plans also have the right to make the revised or changed Notice effective for medical information the Plans already have about you as well as any information received in the future. The Plans will post a copy of the current Notice on the company's Web site. All Notices will contain the effective date on the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plans or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. To file a complaint with the Plans, contact the Delta Air Lines, Inc. Privacy Officer at the address listed below. All complaints must be submitted in writing to:

Chief Privacy Officer
Information Security/Privacy Office, Department 002
Atlanta, GA 30320

Notice of Special Enrollment Rights

If you decline medical plan enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in the plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you are a retiree and have a new dependent as a result of marriage, birth, adoption or placement for adoption, and you are enrolled in the plan at the time of this event, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth adoption or placement for adoption.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

This document appears on the following pages.

DELTA

Important Notice from Delta Air Lines, Inc. About Your Prescription Drug Coverage and Medicare

Please read this Notice carefully and keep it for future reference. We are required to send it to you if you and/or your eligible dependents are eligible for Medicare. This Notice has information about your current prescription drug coverage with Delta Air Lines, Inc. ("Delta") and your options under Medicare's prescription drug coverage. It also explains where to find more information to help you make a decision about your prescription drug coverage. If you enroll in a Medicare prescription drug plan, you may need to give a copy of this Notice when you join to show that you are not required to pay a higher premium amount.

What is Medicare Part D?

In 2006, prescription drug coverage became available to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. These Medicare drug plans are commonly referred to as *Medicare Part D plans*. All Medicare drug plans will provide at least a standard level of coverage set by Medicare. Some Medical Part D plans might also offer more coverage for a higher monthly premium.

Why am I getting this Notice?

In this Notice, Delta is required to give you certain information about the prescription drug coverage that you have under the various options of the Delta health plans and how that coverage compares to the Medicare Part D coverage. Specifically, we have to inform you whether the prescription drug coverage under the various Delta health plan options is "Creditable Coverage" or "Non-Creditable Coverage" and what that means to you and your Medicare Part D coverage. The first section of this Notice describes Creditable Coverage. The second section of this Notice describes Non-Creditable Coverage. Since whether or not you will have Creditable Coverage depends on the Delta health plan option that you elect, you should read both sections of this Notice. You should also read the question and answer at the end of the Notice ("What Should I do Next?")

CREDITABLE Coverage
Applies to all options other than the High Value & Health Savings Account (HSA) Medical Options

The medical benefit options under the Delta health plans – the Delta Family-Care Medical Plan (FCMP), the Delta Account-Based Medical Plan (ABMP) and the Delta Pilots Medical Plan (DPMP) - provide prescription drug benefits even when participants are eligible for Medicare Part D benefits. Delta has determined that, *other than the High Value Option under the FCMP and the HSA Medical Option under the ABMP*, the prescription drug coverage available under all of the options of the FCMP, ABMP and coverage under the DPMP are, on average for all plan participants, expected to pay

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out as much as the standard Medicare Part D prescription drug coverage will pay. Therefore, the prescription drug coverage for these medical options is considered "Creditable Coverage" as defined by Medicare. This means that because your available Delta coverage under these options is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan.

People with Medicare can enroll in a Medicare Part D plan when they first become eligible for Medicare and each year from November 15th through December 31st. This means that you may have to wait to join a Medicare Part D plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium as long as you have Medicare Part D coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty day Special Enrollment Period because you lost creditable coverage to join a Medicare Part D plan.

When you make your decision, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Part D coverage in your area. If you decide to join a Medicare Part D plan, you will still be eligible for Delta coverage at the next open enrollment. See below for more information about what happens to your current coverage if you join a Medicare prescription drug plan.

Nonpilot participants age 65 and over who retire after January 1, 2008 will only have access to the Delta ABMP through COBRA continuation coverage. As of January 1, 2007, nonpilot participants age 65 and over only have access to the Delta FCMP through COBRA continuation coverage, provided such participants elected COBRA continuation coverage for 2007 and continue such coverage in future years.
Pilot participants age 65 or over may have COBRA continuation coverage and are also eligible to enroll in the Delta Pilots Medical Plan (DPMP) for 2008. If you enroll in COBRA coverage for the Standard Option, or Out of Area option of the FCMP, the Gold HRA, Silver HRA or GOLD OOA HRA Medical Option of the ABMP or the DPMP, the prescription drug coverage under these options for 2008 is "creditable coverage".

If you drop or lose your coverage with Delta. and do not enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you may pay more to enroll in Medicare Part D coverage later. If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium for Medicare Part D may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage.

> ***EXAMPLE:*** *If you go nineteen months without coverage, your premium may consistently be at least 19% higher than your base benefit premium.*

This higher premium may continue as long as you have Medicare Part D coverage. In addition, you may have to wait until the next November to enroll.

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NON-CREDITABLE Coverage
Applies to the High Value & Health Saving Account (HSA) Medical Options Only

Delta has determined that the prescription drug coverage available under the High Value Option of the Delta Family-Care Medical Plan (FCMP) and the Health Savings Account (HSA) Medical Option of the Delta Account-Based Medical Plan (ABMP) are, on average for all plan participants enrolled in this option, NOT expected to pay out as much as the standard Medicare Part D prescription drug coverage will pay. Therefore, the prescription drug coverage for the High Value Option and the HSA Medical Option is considered "non-creditable coverage" as defined by Medicare. This is important, because for most people, enrolling in Medicare Part D means you will get more assistance with drug costs.

As of January 1, 2007, nonpilot participants age 65 and over only have access to the Delta FCMP through COBRA continuation coverage, provided such participants elected COBRA continuation coverage for 2007 and continue such coverage in future years. Pilot participants age 65 and older may also have COBRA continuation coverage and are also eligible to enroll in the Delta Pilots Medical Plan (DPMP) for 2008 If you enroll in COBRA coverage for the High Value Option or the HSA Medical Option, the prescription drug coverage under that option for 2008 is "non-creditable coverage".

You might want to consider enrolling in Medicare Part D prescription drug coverage if you are or will be enrolled in the High Value Option or the HSA Medical Option, because the prescription drug coverage you will have under this option is **NOT** expected to pay out as much as the standard Medicare Part D prescription drug coverage. People with Medicare can enroll in a Medicare Part D plan when they first become eligible for Medicare and each year from November 15th through December 31st. **This may mean that you will have to wait to enroll in Medicare Part D prescription drug coverage and that you may pay a higher premium (a penalty) if you join later. You will pay that higher premium as long as you have Medicare prescription drug coverage.**

If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your Medicare D premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. Since being enrolled in the High Value Option or the HSA Medical Option is equivalent to having no prescription drug coverage for purposes of this late enrollment penalty, then if you enroll in the High Value Option or the HSA Medical Option but do not enroll in Medicare Part D during your initial open enrollment period, you will have to pay the higher Medicare Part D premium if you later enroll.

EXAMPLE: If you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium,
This higher premium may continue as long as you have Medicare Part D coverage. In addition, you may have to wait until the next November to enroll which may mean that the number of months you have to wait for coverage will be longer, which could make your premium higher.

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What Should I Do Next?

Compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Part D prescription drug coverage in your area.

- **If you are a Medicare eligible pilot participant or a non-pilot participant under age 65 and are eligible for and decide to enroll in a Medicare Part D plan and drop your Delta prescription drug coverage (which would also include dropping your medical coverage), be aware that you will not be able to elect to get Delta medical and prescription drug coverage back until the next annual enrollment period, to be effective the following January 1st. For instance, if you drop Delta coverage effective January 1, 2008 you will not be able to reenroll until January 1, 2009. If you are eligible for Delta COBRA coverage and decline enrollment in COBRA coverage or drop it during an enrollment, you will have waived your right to such COBRA coverage forever and cannot reinstate it at a later time**
- **If you do decide to continue your Delta prescription drug coverage (including medical coverage) and then also enroll in a Medicare Part D plan, be aware that your Medicare Part D plan will be your primary prescription drug coverage and your Delta coverage will be secondary to the Medicare Part D plan. However, your Delta medical option also covers health expenses in addition to prescription drugs, and you will still be eligible to receive health and prescription drug coverage secondary to Medicare, if you choose to enroll in a Medicare prescription drug plan *and* maintain your Delta medical benefit option as well. Remember the Delta medical benefits coordinate with Medicare Part A and Part B as they always have and the prescription drug benefit will coordinate such that it does not duplicate Medicare.**

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To Learn More About the Medicare Part D Prescription Drug Plans or Your Delta Prescription Drug Coverage Access the Following Resources

Medicare Part D Prescription Drug Benefit

More detailed information about Medicare Plans that offer prescription drug coverage is in the "Medicare & You" handbook, available from Medicare. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans from these places:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048
- http://www.medicare.gov
- Your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number).

Certain people with limited resources and income may be able to receive extra help paying for a Medicare Part D plan. Contact the Social Security Administration for more information by calling 1-800-772-1213 (TTY 1-800-325-0778) or visit them online at www.socialsecuritygov.

Delta FCMP ABMP & DPMP Prescription Drug Benefit

For more information about your prescription drug coverage under the Delta plans see the following:

- **For Pharmacy Tiers & Copays: 2008 Benefit Options Brochure – SMM 10,** for active and inactive employees – posted on *Benefits Direct* or included in your inactive 2008 open enrollment package and SMM10B the 2008 Benefits Options Brochure for Pre-65 Retirees and Survivors - as provided in retiree/survivor enrollment packages and also posted on *Benefits Direct*.
- **For Other Prescription Benefit Information: the 2002 Benefits Handbook Update – SMM 7 A & B**
- **www.myuhc.com** –website (use delta/delta as your User name and password) to view the current UHC prescription drug list.
- **UnitedHealthcare -** 1-877-683-8555

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Note: You may receive this Notice at other times in the future, such as before the next Medicare Part D enrollment period, if this coverage changes, if new dependents are added to a participant's medical coverage and when a Delta employee is first eligible for medical coverage under the Delta FCMP, ABMP and/or the DPMP.

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Date:	**November 12, 2007**
Name of Sender:	**Delta Air Lines, Inc.**
Contact:	**Delta Employee Service Center (ESC)**
Address:	**P.O. Box 52045** **Phoenix, AZ 85072**
Phone Number:	**1 800 MY DELTA**

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TERMS TO KNOW

TERMS TO KNOW

Coinsurance

Coinsurance is the amount of Covered Services to be paid by you, expressed as a percentage of the cost. For example, in an 80/20 plan, the plan pays 80% of a covered hospital service and you pay 20% Coinsurance, after the Deductible has been met.

Copay(ment)

A Copay is the fixed amount you pay directly to a Network Provider at the time you receive a Covered Service. For example, under the DPMP or the Standard Medical Option, during a physician's office visit, you must pay the specified dollar amount of your Copay ($15/$25) to the network physician for the physician's consultation. Some services that may only require a Copay are physician office visits, specialist consultations, urgent care center visits and ER visits.

The DFCMP OOA Medical Option or DPMP's OOA benefit and the HVO do not require Copays.

Covered Services

Covered Services are the health services, supplies or equipment covered under the terms of your medical plan that are provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom. A Covered Service does not include amounts charged by non-Network Providers that are in excess of R&C or 140% of the Medicare Reimbursement Rate, whichever is applicable.

Deductible

This term means slightly different things for different options.

For the DFCMP's Standard Medical Option, the OOA Medical Option and the DPMP, the annual Deductible is the dollar amount of covered expenses that you must pay before the plan begins to pay benefits each calendar year. For the Standard Medical Option, there is a separate Deductible amount for network services and non-network services; the non-network Deductible is higher. If you are enrolled in the OOA Medical Option, you have one Deductible to meet, regardless of whether you receive services through the UHC network. Some covered medical services (such as prescription drug costs) are not applied to the medical Deductibles, nor are amounts above the plan's maximum reimbursement rate.

With the HVO, there are no individual Deductibles in the retiree/survivor & spouse, retiree/survivor & child(ren) and family levels of coverage. One person's expenses, or a combination of family members' expenses, can fulfill the entire Deductible amount. Once the entire Deductible has been met, you share expenses with the plan, and the plan begins to pay the Coinsurance amount. Accordingly, once the entire non-network Deductible is met, you share non-network expenses with the plan, and the plan begins to pay the non-network Coinsurance amount.

Under the DPMP, the Deductible is the amount of money you must pay each calendar year for network Covered Services or, separately, non-network Covered Services, before your medical plan begins to pay any of the charges (other than any such charges that are not subject to the Deductible). Copays (if applicable) and some other amounts, including any amounts you are required to pay for failing to follow Notification requirements, do not count toward the Deductible.

High-Deductible Healthcare Plan

You must have coverage under a High-Deductible Healthcare Plan to contribute to an HSA. Generally, this is health coverage that does not cover first dollar medical expense which has a very high deductible (higher than most traditional medical plans) and has specific out-of-pocket maximum limits. The deductible must apply to all medical expenses, including prescriptions covered by the plan. However, the plan can pay for preventive care services on a first-dollar basis (with or without a copay). The HVO is a high-deductible health plan.

Health Savings Account (HSA)

An HSA is a self-funded account permitted under federal tax law that allows you to save money for medical or pharmacy expenses on a tax-favored basis. An HSA is an individual account that belongs to you and is not part of Delta's medical plan. HSAs may earn interest or investment returns, based on the terms of the HSA. Because the HSA has a special tax-favored status under law, it is governed by numerous mandatory tax rules and regulations.

Lifetime Maximum

The Lifetime Maximum is the maximum amount that the Delta medical plans pay for Covered Services for any one individual during his or her lifetime.

Medicare Reimbursement Rate

The Medicare Reimbursement Rate is the maximum allowable out-of-network reimbursement rate for non-network services, as established by the Maximum Non-Network Reimbursement Program (MNRP). The program uses a geographically-based reimbursement system (similar to R&C standards, and references rates and systems used by Medicare) that applies to non-emergency charges of both physicians and facilities. This is the amount a doctor or supplier is paid by Medicare. It may be less than the actual amount charged by the doctor or supplier.

Expenses for services charged by a doctor or supplier over and above 140% of the Medicare Reimbursement Rates do not apply to an individual's Deductible or OOP Max, and are not paid by the plan. You pay 100% of this amount. Be aware that charges exceeding 140% of the Medicare Reimbursement Rate can double or triple what you assumed you would pay.

Network Charges

Network Charges are the amount that a Network Provider has agreed to charge for Covered Services under a contract with the third-party administrator (for example, UHC). Network Charges that have been negotiated are discounted from the R&C charges and represent the reimbursable amount for a network service, as well as the amount on which your Coinsurance is based. Network Charges are also the amount that you pay 100% of before meeting your Deductible if you use network services.

Network Providers

Network Providers are a group of healthcare professionals who have entered into a formal contract with a third-party administrator (such as UHC) to provide services and supplies at specified (negotiated) rates. When you use Network Providers, you generally are reimbursed at a higher rate for Covered Services and supplies than if you seek care from Non-Network Providers. Also, Network Providers generally submit your claims for you.

Non-Network Charges

Non-Network Charges are the amount charged by a provider that does not participate in a network under a contract with a third-party administrator (such as UHC). Non-Network Charges are compared to the allowable reimbursement rates determined by 140% of the Medicare Reimbursement Rate (see this term as it is defined earlier) or on the Reasonable and Customary charge (see this term as it is defined later) to determine the amount that will be covered under the plan.

Non-Network Providers

Non-Network Providers do not participate in a network under a contract with a third-party administrator (such as UHC). When you use Non-Network Providers, you generally are reimbursed at a lower rate for Covered Services and supplies than if you seek care from Network Providers. Also, Non-Network Providers are not responsible for submitting your claims.

Notification

You or your physician must call UHC's Customer Service – Health Advocate Team within a certain amount of time before you receive certain supplies or services. After UHC receives notice, it determines if the service or supply is covered. If you do not follow Notification requirements of the plan, you are charged an additional amount that does not apply toward the plan Deductible or Out-of-Pocket Maximum.

Out-of-Pocket Maximum (OOP Max)

The OOP Max is the amount you have to pay per person, per year for covered network services, or separately, Non-Network services, not including Deductible and Copayments, before the plan begins to pay at a rate of 100%. Once you have paid the OOP Max amount, your medical plan pays 100% of your covered Network Charge — or, if you have met the Non-Network Deductible, 100% of the R&C charge or 140% of the Medicare Reimbursement Rate (as applicable), up to the plan's Lifetime Maximum for the remainder of the calendar year. Any amounts you are required to pay for failing to follow Notification requirements, does not apply to the OOP Max. The plan, however, does not pay any amount over R&C charges or over 140% of the Medicare Reimbursement Rate, even if you have met your OOP Max.

Pre-Existing Condition

Generally, a Pre-Existing Condition is a physical or mental condition that you or an eligible dependent received treatment for, or was diagnosed with, before coverage under a plan begins.

The Delta healthcare plans cover eligible expenses for a Pre-Existing Condition the same as for any other medical condition.

Preventive Care

Preventive Care includes age- and gender-appropriate routine examinations and screenings that are based on the recommendations found in the Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force (USPSTF), published in 1996 as revised in 1998, with additional recommendations updated in the 3rd edition (2000-2003).

In the DFCMP's Standard Medical Option, these screenings are 100% covered when performed by a UHC Network Provider, not subject to the Deductible for services other than an office consultation which requires a copay. In the OOA Medical Option and the HVO, Preventive Care given by any provider is covered at 100% of R&C charges, not subject to the Deductible.

The DPMP covers in-network Preventive Care at 90% after the Deductible for services other than office consultation which requires a copay. Preventive Care performed out of network is covered at 70% after the Deductible has been met.

Primary Care Physician

A Primary Care Physician (PCP) is a general practitioner, internist or pediatrician who acts as your family doctor. Your PCP is responsible for overseeing and coordinating your care with other healthcare providers. You are not required to select a PCP or to notify UHC of your PCP selection. To obtain information about providers in UHC's network, access UHC's Web site at **www.uhc.com/findaphysician.htm** or UHC's pre-enrollment Web site, **www.myuhc.com** (Username: *delta*, Password: *delta*).

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order that directs the Plan Administrator to cover a child for benefits under the medical, dental or vision plans. A QMCSO may be issued in a divorce or legal separation proceeding, and may require the provision of healthcare coverage for a child who is not in your custody. The plans have specific rules and procedures that a QMCSO must meet. Among them, a QMCSO may not require the plans to provide coverage for any type or form of benefit not otherwise provided under the plans. Although the plans' usual enrollment deadlines do not apply in the case of a QMCSO, you must notify the Employee Service Center (ESC) and enroll your child as soon as reasonably possible.

Reasonable and Customary (R&C)

The Reasonable and Customary (R&C) charge is based on the amount charged by providers for the same service or supply in the same geographic area where the service is received. You are required to pay 100% of the cost above what is determined to be Reasonable and Customary.

A charge is Reasonable and Customary if it is not more than the normal charge for comparable treatment, services or supplies by doctors or other providers of medical services in the same geographic area, as determined by the claims administrator. R&C limits are based on the 90th percentile for such Reasonable and Customary charges, as determined by the data collection vendor on behalf of the claims administrator. In determining what is Reasonable and Customary, the claims administrator may consider the complexity and degree of skill needed to provide a service. Amounts over Reasonable and Customary Charge limits are not covered expenses under the plan and do not count toward the plan's Deductible or Out-Of-Pocket Maximums. You must pay 100% of any amounts over Reasonable and Customary charges in addition to any other costs that are your responsibility.

Utilization Review

Utilization Review is the evaluation of the medical necessity, appropriateness and efficacy of the use of healthcare services, procedures and facilities under the provisions of the plan. Sometimes it is called "utilization management."

WHERE TO GET MORE INFORMATION

WHERE TO GET MORE INFORMATION

If you have questions about the information in this SPD, contact the vendors listed below. You can find additional frequently called phone numbers on DeltaNet (**http://dlnet.delta.com**).

Benefit Type	Contact
Medical • Delta Family-Care Medical Plan (DFCMP) - Standard Medical Option - Out-of-Area (OOA) Medical Option - High Value Medical Option • Delta Pilots Medical Plan (DPMP)	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 **877-683-8555** **www.myuhc.com**
• Health Plan Hawaii	Hawaii Medical Service Association 818 Keeaumoku Street Honolulu, HI 96814 Current Members: **808-948-6372** Prospective Members: **808-948-6111** **www.hmsa.com**
• Humana Health Plan of Puerto Rico	Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave F D Roosevelt San Juan, Puerto Rico 00918-2131 **787-282-7900 ext. 5500** **www.pr.humana.com**
Dental • DFCMP - Comprehensive Dental Option - Preventive Dental Option • DPMP Comprehensive Dental Option	Metropolitan Life Insurance Company (MetLife) Group Dental Claims P.O. Box 14093 Lexington, KY 40512-4093 **800-942-0854** **www.metlife.com/dental**
• CIGNA Dental Care	CIGNA Dental Care **800-367-1037** **www.mycigna.com**
Vision	Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12201 **800-947-9955** **www.davisvision.com**

Benefit Type	Contact
COBRA Continuation Benefits • Medical Options • Dental Options • Davis Vision Plan	Ceridian COBRA Continuation Services P.O. Box 534099 St. Petersburg, FL 33747 **800-877-7994**, 8 a.m.-8 p.m. ET Fax: **727-865-3648**
Eligibility and Enrollment Issues **Qualified Life Events**	Delta Air Lines, Inc. Employee Service Center P.O. Box 52060 Phoenix, AZ 85072 **1-800 MY DELTA (1-800-693-3582)**
Premium Payments	For questions about premium payments, call the ESC: **1-800 MY DELTA (1-800-693-3582)** Send all premium payments to: ACS HR Solutions for Delta Air Lines P.O. Box 382119 Pittsburgh, PA 15251-8119