HEALTHCARE BENEFITS HANDBOOK: RETIREE MEDICAL ACCOUNT (RMA)

Summary Plan Description (SPD)
Effective June 1, 2020

WINNING TOGETHER
PEACE OF MIND

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INTRODUCTION AND PLAN INFORMATION

Introduction

The Delta Air Lines Retiree Medical Account Plan ("RMA" or "Plan") was first effective on June 1, 2012 and the participants of the Plan were Delta employees who participated in the RMA Option and the Pilot Retiree Medical Account Program, both offered in 2012.

The Plan was amended effective June 1, 2020 to account for additional participants who will become eligible for the Plan on and after August 1, 2020 as a result of their participation in voluntary retirement incentive programs offered by Delta in 2020, including the Enhanced Retirement Program and Enhanced Retirement Program for Ready Reserve Employees, part of the 2020 Delta Voluntary Departure Programs.

This Summary Plan Description (SPD) describes some key features of the RMA. The SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

This SPD only addresses the Retiree Medical Account Plan and not the healthcare benefits that may be offered to you as a retiree of Delta Air Lines, Inc. under other Delta health benefit plans. Those plans have separate Summary Plan Descriptions that may be accessed through Deltanet https://deltanet.delta.com or by calling the Employee Service Center at 1-800-MY DELTA.

If you have any questions after reading this material or for other questions about the Delta Retiree Medical Account, please call UnitedHealthcare (UHC) at 877-298-2305.

Definitions of Capitalized Words

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

Plan Information

The Retiree Medical Account (RMA) is a retiree-only Health Reimbursement Arrangement (HRA) for use in an employee's retirement years. The RMA allotment is available to reimburse you for specified Eligible Healthcare Expenses such as unreimbursed medical, prescription drug, dental and vision expenses for you, your spouse and your eligible dependent children. You may use the RMA to reimburse COBRA premiums, Delta retiree or other post-tax premiums you pay for healthcare coverage. When you are enrolled in Medicare, you may use your RMA to reimburse Medicare premiums and other out of pocket costs for you and your spouse.

This SPD is only a summary of the healthcare benefits provided by the RMA plan. Its purpose is to give you an overview of the major features of the RMA and does not cover all the terms of the Plan. The provisions of the Plan are defined in the official Plan documents, which govern the terms and operation of the Plan. 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 document, the Plan document will govern.

Retiree Medical Account Description

The Retiree Medical Account:

- consists of a one-time allotment (Benefit Dollars) to the notional (recordkeeping) RMA at the time of your retirement;
- allows you to submit for reimbursement of Eligible Healthcare Expenses and/or Premium Expenses of you and your Dependents that are incurred after you retire from Delta (but not before August 1, 2020 for 2020 Participants);
- does not require you to be enrolled in the Delta retiree healthcare or COBRA coverage in order to qualify for reimbursement;
- allows your eligible surviving spouse to access your RMA if you die.

Important Note: RMA and Health Savings Accounts

If you participate in a high deductible health plan after you retire (such as the Delta Gold, Silver or Bronze HSA Options) and wish to contribute to a Health Savings Account (HSA) during a calendar year, then you will be considered to have disqualifying coverage for purposes of the HSA contribution rules unless you suspend your full participation in the RMA in advance of a calendar year. This suspension of your full participation will apply to all healthcare expenses other than: vision expenses, dental expenses, expenses for preventive care, and amounts paid in excess of the HDHP's deductible. Contact Optum once your HDHP deductible has been met in order to activate your RMA for reimbursement of amounts paid in excess of the deductible. You will need to renew the suspension of your full participation in the RMA annually if you wish to participate in a high deductible health plan in future years.

Important Note: Impact of Your RMA on Marketplace Plan Subsidies

If you are under 65 and plan to enroll for health insurance coverage in a marketplace plan provided by the Affordable Care Act (ACA) and you qualify for a subsidy, you will need to contact UnitedHealthcare at 877-298-2305 to suspend your RMA participation since you would not be eligible for the federal subsidy if you remain in the RMA.

Generally, the marketplace subsidies are available to individuals and families whose household income is between 100% - 400% of the federal poverty line (FPL). However, in order to be eligible, an individual cannot be offered other health coverage that meets certain requirements. The federal agencies that are charged with implementing the Affordable Care Act (ACA) have ruled that accounts like your RMA is coverage that will prevent you from qualifying for the federal subsidies.

Eligibility

You are an Eligible Retiree if you retired from Delta Air Lines, Inc. under one of the following voluntary retiree incentive programs that offered eligibility for this RMA Plan:

- 2012 Retiree Medical Account Option (eligible ground and flight attendant retirees only)
- 2012 Pilot Retiree Medical Account (RMA) Program (eligible pilot retirees only) (together with the 2012 RMA Option these participants are called "*2012 Participants*" in this SPD)

- 2020 Enhanced Retirement Program, Enhanced Retirement Program for Ready Reserve Employees or similar 2020 retirement incentive programs that provide eligibility for the RMA plan (together, these participants are called "*2020 Participants*" in this SPD).

Only you, the Eligible Retiree, may submit Eligible Healthcare Expenses and/or Premium Expenses of you or your Dependents to the RMA. However, when you die, any remaining RMA allocation may be used by your surviving spouse as described in the next section.

RMA Eligibility Following the Death of the Retiree

Upon your death, the remaining allocation in your RMA may continue to be used by your surviving eligible spouse (if you have been in the marriage for a year (365 days) or more at the time of your death) to reimburse his or her Eligible Healthcare Expenses and/or Premium Expenses and those of your surviving eligible children. To be eligible for reimbursements, the surviving spouse and children must meet the eligibility requirements of Delta's healthcare plan *and* must be on file with Delta at the time of your death. No new spouse or child of the surviving spouse is eligible for the RMA.

Following the death of the surviving spouse, any remaining RMA allocation will be forfeited. Eligible expenses of the surviving spouse or eligible surviving child of the retiree must be submitted within one year of the date the expenses were incurred (expenses must be incurred prior to the death of the surviving spouse).

If there is not an eligible surviving spouse (because the retiree is single, has not been married for at least one year (365 days) at the time of the retiree's death, or was predeceased by his spouse) any RMA allocation will be forfeited following the retiree's death unless COBRA rights apply and COBRA coverage is elected.

ALLOCATIONS TO THE RMA AND YOUR BENEFIT DOLLARS

Delta Allocations

The allocations made to 2012 Participants are described in Appendix B to this SPD

For 2020 Participants, there are two allocations that can be made to the RMA. They include a Base RMA Amount consisting of Benefit Dollars and, for some participants, a supplemental RMA amount.

Benefit Dollars

Your one-time RMA allocation (also called Benefit Dollars in this SPD) is based on your proximity to Medicare eligibility (age 65) as of your retirement date, as follows:

Medicare Eligibility	Years Until Eligible for Medicare (age 65) – Measured at Retirement Date	Base RMA Amount*
Not Eligible for Medicare	Greater than 4 Years	$150,000
	Greater than 3 Years, equal to or less than 4 Years	$140,000
	Greater than 2 Years, less than or equal to 3 Years	$130,000
	Greater than 1 Year, less than or equal to 2 Years	$120,000
	1 Year or Less	$110,000
Eligible for Medicare	N/A	$100,000

*In addition to the amounts shown above, additional RMA amounts may be provided for completed Delta Health Reward actions for 2020 Participants that are not eligible for Medicare and participate in the Delta Account Based Health Care Plan during the 24 months following retirement.

Supplemental RMA Amount

For each whole month an employee or their spouse is eligible for Medicare (age 65) in the 24 months following retirement, a supplemental RMA value equal to $625 will be credited to their RMA at the time of retirement, along with the Base RMA Amount. (The Supplemental RMA amount is in lieu of employer paid premiums provided for non-Medicare eligible employees who participated in the 2020 Programs.)

RMA Availability

Your entire RMA allotment will be available for use within 45 days of when you retire from Delta. Keep in mind once you receive your RMA allotment, you may use the RMA at any time (unless you have suspended it due to HSA eligibility see section above called *Important Note: RMA and Health Savings Accounts*) for any qualified healthcare expenses for you, your spouse and eligible dependents.

When you request an eligible reimbursement from the RMA it is payable solely from the general assets of Delta Air Lines; the RMA is not funded. There is no interest earned on the balance and generally there are no additional allocation will be made to the RMA. The RMA allocation is reduced each time that an Eligible Healthcare Expense and/or Premium Expense is reimbursed. There is no limit on the amount of the RMA allocation that may be used each year.

You can keep track of the Benefit Dollars in your RMA by going online to:

https://www.uhcretireeaccounts.com/ by calling the toll-free number 877-298-2305 or by checking your explanation of benefits (EOB) sent to you by UnitedHealthcare.

USING THE BENEFIT DOLLARS IN YOUR RMA

Your Benefit Dollars may be used to reimburse the amounts you pay for Eligible Healthcare Expenses and/or Premium Expenses incurred after your retirement from Delta Air Lines, Inc. (*but not before August 1, 2020 in the case of 2020 Participants)*. When you go to your Provider, you should have your claim processed through your applicable health insurance. If you owe any portion of that claim to the Provider, you pay that amount to the Provider and then submit a reimbursement form and substantiating documentation as described under the section, *Requesting Reimbursement From Your Retiree Medical Account* to UnitedHealthcare, the Claims Administrator. Your claim will be reviewed by the UnitedHealthcare and if it is an Eligible Healthcare Expense and all documenting information is included it will be reimbursed from your RMA. The amount paid for this claim will reduce your RMA Benefit Dollars accordingly.

The following are types of Eligible Healthcare Expenses that may be reimbursed from your Benefit Dollars:

- Deductible Amounts;
- Out-of-Pocket Maximums;
- Coinsurance;
- Copays;
- Prescription Medicines and Drugs not reimbursed by insurance;
- Over-the-counter medications and supplies;
- Other expenses which are Section 213(d) only covered expenses (see the *Section 213(d) Only Medical Expenses* below).

Premium Expenses that may be reimbursed from the RMA include:

- *Medical, dental, prescription drug and vision premiums;
- *COBRA premiums or Delta retiree healthcare premiums;
- Medicare Part B (covers non-hospital expenses);
- Medicare Part D (covers prescription drug expenses);
- Medicare Advantage (sometimes called Medicare Part C);
- Medigap (private insurance that supplements Medicare); and
- Eligible long term care premiums as defined in section 213(d)(10) of the Internal Revenue Code that are paid for a qualified long-term care insurance contracts (limitations apply)

*COBRA premiums paid to maintain the RMA and healthcare premiums paid on a pre-tax basis may not be reimbursed through the RMA.

IMPORTANT NOTES:

- Any expense for which you have received reimbursement through your RMA cannot be used as a medical expense deduction on your federal income tax return or cannot be reimbursed under any plan covering health benefits, including a spouse's or dependent's plan.
- To be eligible, a claim for reimbursement must be filed within one year of the date the expenses or premiums are incurred. If filed later than this one-year filing deadline, the claim for reimbursement will not be paid.
- Once the RMA balance is $0, there will be no further reimbursement from the RMA.
- There is no maximum amount that can be reimbursed for Eligible Healthcare Expenses and/or Premium Expenses from the RMA each year. It is up to you how quickly you draw down the RMA Benefit Dollars and how much you use each year will most likely be driven by the amount and timing of Eligible Healthcare Expenses and Premium Expenses you, your spouse and your eligible dependents incur.

Section 213(d) Only Medical Expenses

You may choose to use the funds in your RMA to pay for certain medical expenses that are typically not covered by retiree-sponsored health plans or other health plans but may be reimbursed from your RMA Benefit Dollars. These additional medical expenses must be considered a medical expense under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time, and must also be for "medical care". "Medical care", as defined under Section 213(d), means services and supplies for the diagnosis, cure, mitigation, treatment or prevention of disease, and for treatments affecting any part or function of the body. This definition is subject to change if the tax laws or regulations change in the future. **A description of, and a listing of many items which may constitute eligible medical expenses, is available in IRS Publication 502, which is available from any regional IRS office or IRS website at www.irs.gov.**

If you choose to use your RMA funds to pay for any Section 213(d) expenses, you may be required to pay the provider for services and submit a reimbursement form, as described under *Requesting Reimbursement From Your Retiree Medical Account.*

The following list shows some of the 213(d) medical expenses that are payable under your RMA. Again, only the portion of the expense for the services that you pay may be reimbursed from the RMA. Any portion covered by your medical, dental or vision coverage is not eligible under the RMA.

The Internal Revenue Service has specific guidelines that must be followed for many of these items. For more information on how a specific service below is covered please call UnitedHealthcare at 877-298-2305.

- acupuncture;
- Alcoholics Anonymous including transportation costs to and from meetings;

- amounts in excess of any health coverage limits;
- Braille books and magazines, the difference in cost compared to a regular printed edition;
- cardiac rehabilitation classes;
- Christian Science practitioners;
- contact lens solution;
- contact lenses, including all necessary supplies and equipment;
- dental treatment (does not include dental treatment which is for cosmetic purposes such as teeth whitening);
- dentures;
- diaper service needed to relieve the effects of a certain disease;
- difference between brand and generic prescription drugs;
- drug abuse treatment centers;
- eyeglasses;
- full body scans;
- guide dog or other animal used by a visually or hearing-impaired person;
- hearing aids and hearing aid batteries;
- home construction needed for the installation of special, medically necessary equipment;
- laser eye surgery;
- lead-based paint removal to prevent a child from contracting lead poisoning;
- legal fees needed to authorize treatment for mental illness;
- lodging while receiving medical care up to $50 per night;
- medical information plans;
- modification of a car for use by a disabled dependent;
- nursing home expenses, for medical reasons;
- optometrists/ophthalmologists;

- prescription drug (Rx) expenses not covered under the Health Coverage*;
- routine eye examinations;
- lab and x-rays performed for medical reasons;
- smoking cessation programs. This includes prescription drugs related to the program;
- special home for a mentally disabled dependent;
- special telephones or televisions for hearing impaired individuals;
- sterilization unless prohibited by law;
- transportation needed to obtain medical care, this may include bus or taxi fare, cost of gas, tolls, parking admission and transportation to a medical conference which concerns the chronic illness of a member;
- weight loss program when prescribed by a Physician to treat an existing disease, such as heart disease. This includes prescription drugs related to the program.

Cosmetic procedures are not Section 213(d) expenses and are not reimbursable from the RMA. Any eligible medical expense for which you are reimbursed from your RMA cannot be included as a deduction or credit on your federal income tax return.

*Note: A Payment Card may be used to pay for prescription drug (Rx) expenses obtained at a pharmacy. See the RMA Welcome Kit or call UnitedHealthcare at 877-298-2305.

ELIGIBLE DEPENDENTS

You may submit Eligible Healthcare Expenses and Premium Expenses for yourself, your eligible spouse and your eligible children, including your:

- Natural born or legally adopted children through the end of the month in which they turn 26 years old. For a legally adopted child to be covered, the legal adoption must have occurred before the child turned 18 years old
- Stepchildren through the end of the month in which they turn 26 years old
- Children through the end of the month in which they turn 26 years old and for whom you have been appointed legal guardian by a court prior to the child's 18th birthday
- Foster children through the end of the month in which they turn 26 years old

Your spouse and children do not have to be enrolled in Delta healthcare coverage to use the RMA, but they must appear in Delta's records on file as eligible to be enrolled in Delta healthcare coverage. Eligibility files are sent to UnitedHealthcare and eligibility may be verified periodically.

You may add a new spouse or eligible child for purposes of eligibility for reimbursement of expenses from your RMA following retirement, just like you have the ability to add this spouse or child to Delta's healthcare plans if you are enrolled in them. You must report the new spouse or new dependent child to the Delta Employee Service Center within 60 days of the event (such as a

marriage or birth) in order for him/her to be considered eligible. **This is a one-time opportunity and if the 60-day period is missed, that spouse or child will not be eligible for their expenses to be reimbursed from the RMA.**

REQUESTING REIMBURSEMENT FROM YOUR RETIREE MEDICAL ACCOUNT

Filing a Claim

Your total Benefit Dollars are available within approximately 45 days of your retirement date. You can request reimbursement for Eligible Medical Expenses and Premium Expenses up to your total Benefit Dollars as soon as such Eligible Medical Expenses or Premium Expenses have been incurred (subject to the requirement that this date not be before August 1, 2020 for 2020 Participants). To submit a claim, use the Retiree Reimbursement Request Form and include the information described under "Required Information for Filing a Claim" section, below. Requests for reimbursements will be processed at least weekly.

One-Year Claim Filing Deadline

A claim for reimbursement must be received within 365 days following the date(s) of service or premium due date and while you or your eligible dependents that incurred the expense are eligible under the Plan. For 2020 Participants, amounts incurred prior to August 1, 2020 are not eligible. If you don't provide your claim to UnitedHealthcare by the one-year filing deadline, your claim will not be eligible for reimbursement, even if there are Benefit Dollars available in your RMA.

Required Information for Filing a Claim

To be reimbursed from your RMA, submit a reimbursement form, called a Retiree Reimbursement Request Form, for the Eligible Medical Expenses and/or Premium Expenses that have been incurred. A Retiree Reimbursement Request Form is available from the Retiree Medical Account (RMA) web site at UHCretireeaccounts.com or you can contact a Customer Support Professional at 877-298-2305 to request a form. For reimbursement from your RMA, you must include proof of the expenses incurred. For Premium Expense reimbursement you must attach a copy of the paid premium receipt with your reimbursement form or cancelled check (applicable only to health plan premiums when a receipt is not available). For Eligible Medical Expenses, proof can include a bill, an invoice, third party/provider proof of expense or an Explanation of Benefits (EOB) from any group medical/dental/vision plan or Medicare plan under which you are covered. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental plans.

A Claim for Reimbursement for eligible healthcare expenses can be submitted by mail, fax, or online at UHCretireeaccounts.com (with scanned upload of supporting documents). Submit completed forms by mail to UnitedHealthcare, P.O. Box 30516, Salt Lake City, UT 84130-0516; or to FAX number (855) 244-5016.

Recurring Expenses Reimbursement

You can arrange an automatic reimbursement for a regularly recurring healthcare expense, such as Premium Expenses, by submitting a Recurring Expense Reimbursement Request Form. If you decide to use your RMA to be reimbursed for eligible recurring expenses you don't need to request reimbursement each month, you just have to complete the Recurring Expense Reimbursement Request Form once a year and you will be automatically reimbursed each month during that year.

To request an automatic reimbursement, complete and return the Recurring Expense Reimbursement Request Form. Contact Customer Support at 877-298-2305, TTY: 711 to request a form or download and print a form from UHCretireeaccounts.com.

You will need to provide the amount of the expense and the date you make the payment each month. The automatic reimbursement will continue until the funds in your account are used up, you drop, add or change your coverage, the plan year ends, or you submit a written request to stop the automatic reimbursement. Once a recurring reimbursement has been set up, you will receive a letter confirming that a recurring reimbursement has gone into effect. You will receive more information on setup in your RMA welcome kit.

Receiving Reimbursements – Paper Checks or Direct Deposit

You can receive reimbursements via a standard paper check or via direct deposit into your checking or savings account. To authorize direct deposit of your reimbursement to your savings or checking account you must complete the Direct Deposit Request Form available online at UHCretireeaccounts.com or you can contact Customer Support 877-298-2305 to request a form. Sign the form and return it via FAX to (855) 244-5016; or mail it to UnitedHealthcare, PO Box 30516, Salt Lake City, Utah 84130-0516. Include a copy of a voided check or savings deposit slip with the form (make sure you include the nine-digit routing number usually found on the lower left hand side of the check).

Prescription Only Payment Card

You will receive a Prescription Payment Card to purchase your prescription drugs. Instead of requesting a reimbursement each time you pay for an eligible prescription, you can use the Payment Card to pay for reimbursable prescription drugs at a participating pharmacy. You can contact Customer Support 877-298-2305, TTY: 711 to request a form or download and print it from the RMA web site at UHCretireeaccounts.com.

NOTE:

You can view your RMA information online via UHCretireeaccounts.com. This website includes many features such as the option to:

•View your RMA summary page detailing the amount in your RMA;

•View your RMA Claims Summary including claim transaction details.

WHEN THE RMA ENDS

An Eligible Retiree's RMA terminates if:

- He or she dies and there is no eligible surviving spouse at that time, COBRA rights may apply.
- He or she is rehired by Delta.
- The RMA account balance reaches zero ($0).
- The eligible surviving spouse dies.

When your Dependent's Eligible Healthcare Expenses and Premium Expenses are No Longer Eligible for the RMA

A spouse will no longer be eligible for the RMA on the date of divorce from the Eligible Retiree. Divorce should be reported to the Delta Employee Service Center within 60 days of the court order granting the divorce. Children will no longer be eligible for the RMA upon reaching their 26th birthday (unless the child is incapacitated and has been approved as such through the Delta health plan process). Details about COBRA continuation coverage are contained in the sections below and Appendix A to this SPD.

COBRA continuation coverage for the RMA

See Appendix A of this SPD for important information about COBRA continuation coverage rights and procedures.

CLAIM DENIALS AND APPEALS

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare (UHC) at 877-298-2305 before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial of Benefits. This written communication should include:

- the patient's name;
- the provider's name;
- the date of medical service or expense;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

If you wish to request a formal appeal of a denied claim for reimbursement, you should call 877-298-2305 to obtain the UnitedHealthcare address where the appeal should be sent.

Review of an Appeal

UnitedHealthcare (UHC) will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare (UHC) upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Note: Upon written request and free of charge, any eligible retiree may examine documents relevant to their claim and/or appeals and submit opinions and comments regarding their appeal. UnitedHealthcare (UHC)will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

The table below describes the time frames which you and UnitedHealthcare (UHC) are required to follow.

CLAIM DENIALS AND APPEALS	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare (UHC) must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare (UHC) within:	**45 days** after receiving an extension notice*
If UnitedHealthcare (UHC) denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare (UHC) must notify you of the appeal decision within:	**30 days** after receiving the appeal

* UnitedHealthcare (UHC) may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Limitation of Action

You cannot bring any legal action against the Plan, Plan Administrator or the Claims Administrator to recover reimbursement until after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If, following the appeal of your claim, you wish to bring a legal action against the Plan or Plan Administrator, you must do so within one year from the date of the denial of your appeal. You must bring any legal action in the United States District Court for the Northern District of Georgia, Atlanta Division.

IMPORTANT ADMINISTRATIVE INFORMATION AND LEGAL NOTICES

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA.

Plan Sponsor

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**.

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
- 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 plan
- 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 and its or its delegate's determinations are final, binding and conclusive. Members of the Administrative Committee are employees of Delta and are appointed by Delta's Executive Vice President – Human Resources and Chief People Officer. The Administrative Committee members may be substituted or removed from their positions at the sole discretion of the Executive Vice President – Human Resources and Chief People Officer. 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 are:

The Administrative Committee of Delta Air Lines, Inc. Department 844
P.O. Box 20706
Atlanta, GA 30320-6001
(404) 715-2600

Claims Administrator

UnitedHealthcare (UHC) is the Plan's Claims Administrator and is delegated its duties by the Administrative Committee of Delta Air Lines, Inc. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at 877-298-2305 or in writing to the address below:

United Healthcare (UHC)
P.O. Box 30516
Salt Lake City, UT 84130-0516

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Secretary, Administrative Committee
Delta Air Lines, Inc.
Department 981
1030 Delta Boulevard
Atlanta, GA 30354

Labor Organization Members Covered by the Plans

Members of the Air Line Pilots Association participate in the Plan pursuant to the terms of a labor agreement.

Air Lines Pilots Association (ALPA)
535 Herndon Parkway
Herndon, VA 20170

Professional Airline Flight Control Association
(PAFCA)
P.O. Box 20762
Atlanta, GA 30320

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

Notice to Employees

This booklet describes the Employer-sponsored Delta Air Lines, Inc. Retiree Medical Account (RMA) Plan (the "Plan") effective August 1, 2020.

UnitedHealthcare (UHC) processes reimbursements and provides certain other administrative services pertaining to the Plan, including claim appeals.

UnitedHealthcare (UHC) does not insure the benefits described in this booklet. These benefits are paid from the general assets of Delta Air Lines, Inc.

Notice of Company Rights

This SPD is not to be construed as a contract for employment. If there should be an inconsistency between the contents of this summary and the contents of the plan, your rights shall be determined under the plan and not under this summary.

Effective Date

This handbook summarizes the benefits available to eligible employees under the plan as of June 1, 2020 unless otherwise noted.

Discretionary Authority of the Plan Administrator and the Claims Administrator

The Administrative Committee has delegated to Claims Administrators the authority to determine claims eligibility and benefit amounts in accordance with the plans' terms. As such, the Claims Administrator has the broadest discretionary authority permitted under law to interpret the provisions of the plan 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 Plan, including questions about eligibility to participate in the Plan; eligibility for benefits; the relevant facts; the amount and type of benefits payable to any participant; and the construction of all terms of the Plan.

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 Plan and not subject to further review by Delta. Benefits will be paid under the Plan 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 Administrator, as previously described.

Source of Contributions and Funding

The benefits under the Plan are self-funded by Delta through its general corporate assets, There are no employee contributions under the Plan.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through a third party claims administrator.

Plan Name:	Delta Air Lines Retiree Medical Account Plan
Plan Number:	ERISA Plan Number 549
Employer ID:	58-0218548
Plan Type:	Welfare benefit plan
Plan Year:	August 1 - December 31, 2020 and then January 1 - December 31 each year thereafter
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employer
Source of Benefits:	General Assets of the Company

Patient Protection and Affordable Care Act (the Affordable Care Act)

The Plan is not subject to the Affordable Care Act due to its status as a retiree only plan.

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 files, life insurance and OSHA records are not PHI and are not covered by this Notice.

Third parties (such as, UnitedHealthcare) 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, General Manager – Health & Welfare Plans, Manager – Health Plans, Lead Program Manager – Health Plans, Program Leader – Health Plans, Specialist – Health Plans, and Sr. Coordinator – Health & Welfare Advocacy. The Information Security/Privacy Office also has limited access to PHI.

The plans consist of Delta Air Lines, Inc. sponsored medical, dental and healthcare Flexible Spending Account and EAP coverage extended to certain active, disabled, former and retired employees of Delta Air Lines, Inc. and their family members.

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.

Your ERISA Rights

As a participant in the Plan described in this handbook, 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 shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified places, such as worksites, all documents governing the Plan, including insurance contracts 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 (EBSA);

  Obtain, upon 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 summary plan description. The Plan Administrator may request 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

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 operate the Company'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 the Company or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health and 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 Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator
- If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in federal court consistent with the requirements of the Plan.
- If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (if, for example, it finds your claim is frivolous)

Assistance With Your Questions

If you have any questions about the Plan, 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 you can write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866)-275-7922. You also may visit EBSA's website at **www.dol.gov/ebsa**.

TERMS TO KNOW

Benefits – Plan payments for Eligible Medical Expenses and/or Premium Expenses, subject to the terms and conditions of the Plan.

Benefit Dollars – the name for the one-time allotment made to your RMA generally within 45 days of your retirement date. Benefit Dollars may be used only to reimburse you for Eligible Healthcare Expenses and/or Premium Expenses.

Claims Administrator – UnitedHealthcare and its affiliates, who provide certain claim administration services for the Plan.

COBRA – the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated. See Appendix A for important information about COBRA rights and responsibilities.

Coinsurance – the percentage of Eligible Medical Expenses you are required to pay under a health plan.

Company – Delta Air Lines, Inc.

Copayment (or Copay) – the set dollar amount you are required to pay for Eligible Medical Expenses under a health plan.

Dependent – a spouse, or child of an Eligible Retiree who meets the eligibility requirements specified under the Delta Account-Based Healthcare Plan (for ground and flight attendant retirees) or the Delta Pilots Medical Plan (for pilot retirees) and is on file with Delta when the Eligible Healthcare Expense or Premium Expense is incurred.

Deductible – the amount you must pay for Eligible Medical Expenses under a health plan for the Plan Year before the Plan will begin paying Benefits in that Plan year.

Eligible Healthcare Expenses – an expense incurred by an Eligible Retiree or his Dependent that is a medical or prescription drug expense included under Section 213(d) including those expenses not typically reimbursed by a health plan, (for example amounts paid to doctors, medical labs, hospitals, pharmacies, and mental health centers that fall within the plan deductible or your share of the medical expense, such as coinsurance (percentage of medical expense that you pay) and co-payments, but only to the extent that the person who incurred the expense is not reimbursed for the expense (nor is the expense reimbursable) through a medical benefit plan, other insurance, or any other accident or medical plan.

Eligible Retiree – a retiree of Delta Air Lines Inc. who retired under either the 2012 Delta Retiree Medical Option; the 2012 Pilots Retiree Medical Program or the 2020 Enhanced Retirement Program, Enhanced Retirement Program for Ready Reserve Employees or similar 2020 retirement incentive programs that provide eligibility for the RMA plan

Employer – Delta Air Lines, Inc.

EOB – see Explanation of Benefits (EOB).

Explanation of Benefits (EOB) – a written statement provided to a participant after a claim has been reported, indicating the benefits and charges covered or not covered by the benefit plan.

Out-of-Pocket Maximum – the maximum amount you are required to pay under a health plan for covered expenses during a Plan Year.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under this Plan or any health plan.

Plan – The Delta Air Lines Retiree Medical Account Plan, including all its amendments.

Plan Administrator –the Administrative Committee of Delta Air Lines, Inc. or its delegate.

Plan Sponsor – Delta Air Lines, Inc.

Plan Year – the calendar year.

Premium Expense - expense incurred by an Eligible Retiree or his Dependent to maintain coverage under a plan or Medicare (including after-tax health plan premiums*, after-tax dental plan premiums, Medicare premiums and Medicare Supplement Policy Premiums) but only to the extent that the Covered Person who incurred the expense is not reimbursed for the expense (nor is the expense reimbursable or paid on a pre-tax basis) through a medical benefit plan, other insurance, or any other accident or medical plan.

*For 2012 participants only, active employee healthcare premiums that were paid by you or your spouse on a pre-tax basis and are reimbursed from your RMA will be subject to taxes that Delta will pay through a special payroll process.

Provider – a health care professional, Physician or healthcare facility.

Retiree Medical Account (RMA) - a retiree-only Health Reimbursement Arrangement (HRA). It is an Internal Revenue Section 105 and 106 plan. It can only be used to reimburse a participant for Eligible Healthcare Expenses and Premium Expenses incurred during retirement.

WHERE TO GET MORE INFORMATION

If you have any questions concerning the information in this handbook, please refer to the appropriate contact listed below. Additional frequently called phone numbers can be accessed on Deltanet.

Benefit Type	Contact
Claims and RMA Balance	UnitedHealthcare P.O. Box 30516 Salt Lake City, UT 84130-0516 1-877-298-2305 https://www.uhcretireeaccounts.com/
COBRA Premium Payments	For questions about COBRA premium payments, call Employee Service Center (ESC): 1-800 MY DELTA (1-800-693-3582) For correspondence only: Delta Employee Service Center P.O. Box 52045 Phoenix, AZ 85072 Send all Direct Bill/premium payments to: Conduent HR Services LLC for Delta Air Lines P.O. Box 382119 Pittsburgh, PA 15251-8119
Eligibility Issues **Qualified Life Events such as new dependents**	Delta Air Lines, Inc. Employee Service Center P.O. Box 52045 Phoenix, AZ 85072 1-800 MY DELTA (1-800-693-3582)

APPENDIX A

Continuation Coverage Rights Under COBRA

You are receiving this notice and other information because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you or your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events applicable to this Plan are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost for COBRA continuation coverage.

If you are an Eligible Retiree of the RMA Plan, you will not lose your coverage due to a qualifying event because your RMA is available until your death (unless the Benefit Dollars under that Account reach zero before your death). Since depleting your Benefit Dollars is not a qualifying event under COBRA and since the RMA coverage for the Eligible Retiree is not lost for any other reason, there are no COBRA rights for the Eligible Retiree.

If you are the spouse partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The child stops being eligible for coverage under the plan as a "child" because he or she reaches age 26 and is not qualified as eligible as an incapacitated child.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan sponsor, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the commencement of a proceeding in bankruptcy with respect to the employer the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For divorce of the retiree and spouse, *you* must notify the Plan Administrator within 60 days after the qualifying event occurs. Notice of the event may be made online through Benefits Direct, which is located on the Employee Self Service site of 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. In the 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.

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 lose, or would lose, coverage under the terms of the plans as a result of the qualifying event
- The date on which the Eligible Retiree dies, and you have not been married or in your partnership for at least one year as of that date.

You, your 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 or dependent child fails to provide notice to the ESC during this 60-day notice period, you, your spouse or dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is divorce or the child reaching age 26, COBRA continuation coverage lasts for up to a total of 36 months.

Electing COBRA Continuation Coverage

- Once the ESC is informed that the qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their 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 the ESC sends you a COBRA qualifying event package that reflects your healthcare coverage options in effect at the time your coverage was terminated
    - Note that the Enrollment Worksheet in your COBRA qualifying event package will show all healthcare coverage options available to you, including 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, or the same option that you were enrolled in before your qualifying event. However, if you were not enrolled in a particular benefit type (for example, medical, dental, etc.) 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 COBRA election package. This date is either 60 days from the date coverage was lost, or if later, 60 days from the date the package is postmarked
- If you want to enroll for COBRA continuation coverage, you have 60 days to enroll through Benefits Direct (which is located on the Self Service site of Deltanet) or by calling the ESC
- If you, your Spouse and/or any other qualified beneficiary do not submit completed COBRA elections by the deadline, you, your Spouse or the qualified beneficiary will permanently lose the right to elect COBRA continuation coverage
- Once your COBRA elections have been processed, the ESC will send you your first COBRA invoice. Conduent HR Services will post your Premium payment within 30 days after you send it

How to Enroll

To access Benefits Direct, go online to https://deltanet.delta.com. You can use any computer with Internet access. You will 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.)

You also can log on directly to Benefits Direct (for example, if you don't have a valid Delta Passport password) at www.benefitsweb.com/delta.html.

If you have questions about online enrollment, or if you experience difficulty enrolling, contact the ESC at 1-800 MY DELTA (1-800-693-3582) Monday through Friday, 8 a.m. to 5 p.m. Eastern time. International callers should dial 404-677-8000.

When COBRA Coverage Begins

For each qualified beneficiary who elects COBRA continuation within the required timeframe, and makes payment of required Premiums (as described below) by the deadlines for receipt, elected coverage becomes retroactively effective to the date when coverage was lost. 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 divorce; death of the Eligible Retiree; or a dependent child losing eligibility, then COBRA continuation coverage can last up to a total of 36 months.

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 employee 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 a 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 Conduent HR Services 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 within 45 days after the date of the election, then you or the qualified beneficiary will lose all COBRA continuation coverage rights under the plan.

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. You may consider contacting the ESC at 1-800 MY DELTA (1-800-693-3582) to confirm the correct amount of the first payment.

Send the first payment — and all payments that follow — for COBRA continuation coverage to:

Conduent HR Services LLC for Delta Air Lines
P.O. Box 382119
Pittsburgh, PA 15251-8119

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.

Conduent HR 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 Conduent 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 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 canceled and a termination of COBRA continuation coverage letter is sent. **If COBRA continuation coverage is canceled for nonpayment, coverage cannot be reinstated; your spouse or dependent child have no further rights to COBRA continuation coverage.** The claim administrator 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 above). If payment is not postmarked by the grace period deadline, your coverage is canceled 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). COBRA continuation coverage will be terminated before the end of the maximum coverage period if:

- Coverage is voluntarily canceled by contacting the ESC
- Any required Premium is not paid on time as described above
- 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 group health coverage to any employees

COBRA coverage also may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as the RMA allocation reaching zero).

Once COBRA coverage is canceled, it cannot be reinstated.

If You Have Questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of

Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Manage Your COBRA Coverage

Log on to Benefits Direct (on Deltanet at https://deltanet.delta.com, or, if you don't have a valid Delta Passport password, directly at www.benefitsweb.com/delta.html) to:

- Elect COBRA continuation coverage
- Add/drop dependents
- Update your address (certain participants only)
- View coverage documents and print forms
- View the status of your account
- Look up payment dates and amounts
- Change payment methods and make one-time direct debit payments

Or, call the ESC at 1-800 MY DELTA (1-800-693-3582).

Plan Contact Information

Qualified Life Events (for example the addition of a child or spouse)

Delta Air Lines, Inc.
Employee Service Center
P.O. Box 52045
Phoenix, AZ 85072
1-800 MY DELTA (1-800-693-3582)

COBRA Administration

For correspondence only:
Delta Employee Service Center P.O. Box 52045
Phoenix, AZ 85072

For COBRA Premium payments only:
Conduent HR Services LLC for Delta Air Lines
P.O. Box 382119
Pittsburgh, PA 15251-8119

APPENDIX B

2012 RMA ALLOCATIONS

2012 RMA Option: Based on participant's age as of December 31, 2012

Applicable Age	Total One-Time RMA Allocation
Under 55 years	$120,000
55 years	$120,000
56 years	$111,000
57 years	$102,000
58 years	$93,000
59 years	$84,000
60 years	$75,000
61 years	$66,000
62 years	$57,000
63 years	$48,000
64 years	$39,000
65 years or older	$30,000

2012 Pilot RMA Option: Based on participant's age as of 6/30/2012:

Applicable Age	**One Time Allocation**
Under 55 years	$120,000
55 years	$120,000
56 years	$111,000
57 years	$102,000
58 years	$93,000
59 years	$84,000
60 years	$75,000
61 years	$66,000
62 years	$57,000
63 years	$48,000
64 years	$39,000
65 years or older	$30,000