

PPO Option B

This option is only available to eligible pre-merger Northwest IAM and AFA covered employees as well as pre-merger Northwest pilots on inactive or disabled status on October 30, 2008 who have not returned to active status.

The chart below shows coverage details and plan provisions. Covered services are detailed in the *Northwest Health Care Plans Summary Plan Description*. For 2010, the plan is administered by UHC. You and your covered dependents may use the voluntary UHC programs described in this guide and in Delta's *Healthcare Benefit Handbook* (such as URN, Centers of Excellence and Healthy Pregnancy).

IAM covered employee premiums are increasing by 8% over what you paid in 2009 for the Northwest Medical Plan. AFA covered employee premiums are increasing by 7% over what you paid in 2009 for the Northwest Medical Plan. This is the maximum increase allowable according to the terms of your respective contracts. The premiums are calculated based on the claims experience of covered individuals enrolled in this option and the Northwest Medical Plan (which covers pre-merger Northwest retirees).

2010 PPO Option B			
Benefit	Coverage Levels	Network Benefit	Non-Network Benefit
Annual Deductible <i>(Network and non-network expenses combined)</i>	Employee Family		\$350 \$700
Annual Out-of-Pocket Maximum (Max) <i>(Network and non-network expenses combined)</i>	Employee Family		\$2,000 \$4,000 Annual OOP max does not include mental health, chemical dependency or prescription drug copays/coinsurance
Mental Health/ Chemical Dependency OOP Max <i>(Network and non-network expenses combined)</i>	Employee Family		\$2,000 \$4,000 Mental Health/Chemical Dependency OOP max is separate from and does not include medical or prescription drug copays/coinsurance
Coinsurance		80% after deductible has been met	70% of R&C* after deductible has been met
		Network Retail Pharmacy	Network Mail Order Pharmacy
Pharmacy OOP Max	Employee/Family	\$1,000 per covered individual	
Network Pharmacy	Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs Lifestyle Drugs	\$15 copay \$30 copay \$45 copay 50% (\$30 minimum)	\$37.50 copay \$75 copay \$112.50 copay 50% (\$75 minimum)
Out-of-Network Pharmacy	Participant must pay the full retail price of the prescription at the time it is filled, then send a claim for reimbursement. Prescription will be reimbursed at the in-network retail cost of the drug less the applicable retail copay.		
Lifetime Maximum Benefit		No Limit	

*Reasonable and customary. Expenses for services charged by a doctor or supplier over and above R&C do not apply to an individual's deductible or coinsurance maximum and are not paid by the Plan. These charges can result in much higher costs than anticipated.

2010 PPO Option B: Key Covered Medical Expenses

To be covered by the plan, medical care, treatment, services and supplies must be for the diagnosis or treatment of an "illness" or "injury" (except for certain in-network covered preventive/wellness care).

Benefit	Network Benefit	Non-Network Benefit
Alcohol/Chemical Dependency - Facility-based treatment - Outpatient care treatment (<i>prior authorization required beyond 20 visits</i>)	80% No day limits* No day limits	70% No day limits* No day limits
Acupuncture <i>Limited to 15 combined network and non-network treatments per calendar year per episode</i>	80%	70%
Ambulance	80%	70%
Behavioral/Mental Health - Facility-based treatment - Outpatient care treatment (<i>prior authorization required beyond 20 visits</i>)	80% No day limits* No day limits	70% No day limits* No day limits
Cancer Treatment at URN Facility* <i>\$10,000 travel and lodging expenses are covered</i>	100%	N/A
Chiropractic Care Office Visit <i>Prior authorization is required for all visits beyond 20 visits per calendar year</i>	100% for first \$600 of expenses, then 80% after the deductible	70%
Dental Care – Accidental Injury* <i>Limited to what is covered by medical; dental care benefit may cover other services</i>	80%	70%
Disposable/Consumable Medical Supplies - Diabetic supplies – external diabetic pumps - Ostomy supplies - Dialysis/tracheal and enteral feeding supplies - Wigs – with limits - Eyeglasses – post-operative cataract treatment - Custom made orthotics - Compression hose	80% Covered Covered Covered Covered Covered Covered Covered	70% Covered Covered Covered Covered Covered Covered Covered
Durable Medical Equipment* <i>Examples include crutches, hospital beds, wheelchairs, inhalators, oxygen tents and hearing aids</i>	80%	70%
Emergency Room Visit <i>If a true emergency, copay applies for facility and doctor charges</i>	\$50 copay	\$50 copay
Home Healthcare*	80%	70%
Hospice*	100%	100% after deductible is met
Hospital Care – Inpatient* and Outpatient - Medical and surgical charges	80%	70%

* The covered participant or his or her doctor/provider must notify and get pre-approval from UHC's Customer Service – Health Advocate Team before these services are rendered or procedures performed. If UHC is not notified and pre-approval is not obtained, expenses will be paid at the plan's normal benefit level after a \$500 in-network hospital penalty or \$1,000 out-of-network hospital penalty.

2010 PPO Option B: Key Covered Medical Expenses

To be covered by the plan, medical care, treatment, services and supplies must be for the diagnosis or treatment of an "illness" or "injury" (except for certain in-network covered preventive/wellness care).

Benefit	Network Benefit	Non-Network Benefit
Infertility Treatment <i>Only covers those diagnostic steps and procedures that establish the cause of, or reason for, infertility and surgical treatment to correct bodily defects</i>	80%	70%
Lab Services – Diagnostic	80%	70%
Mammograms – Diagnostic	80%	70%
Maternity* <i>Medical, surgical and hospital care</i>	80%	70%
Office Visits <i>Primary care physicians and specialists</i>	80%	70%
Organ Transplants* at URN Facility <i>\$10,000 travel and lodging expenses are covered</i>	100%	N/A
Organ Transplants* <i>Combined travel and lodging maximum lifetime benefit of \$5,000 per person</i>	80%	70%
Preventive Care - Routine physicals - Annual GYN exams - Mammograms - Well child visits - Immunizations - Preventive lab work and testing - Eye and hearing exam	90% covered, Not subject to the deductible The 10% coinsurance that participant pays does not count toward reaching the annual deductible	Not covered
Private Duty Nursing*	80%	70%
Skilled Nursing Facility*	80%	70%
Surgeon Services	80%	70%
Assistant Surgeon Services	20%	20%
Multiple Surgical Procedures		
- 1 st procedure	80%	70%
- 2 nd procedure and subsequent procedures	50%	50%
Therapy – Physical, Occupational and Speech <i>Prior authorization is required for more than 20 outpatient visits</i>	80%	70%
Weight Loss Treatment* - Dietician/nutritional counseling – 6 sessions - Bariatric surgery at Centers of Excellence	80% Covered Covered with limitations	70% Covered Covered with limitations
X-Rays – Diagnostic and Therapeutic Procedures	80%	70%

* The covered participant or his or her doctor/provider must notify and get pre-approval from UHC's Customer Service – Health Advocate Team before these services are rendered or procedures performed. If UHC is not notified and pre-approval is not obtained, expenses will be paid at the plan's normal benefit level after a \$500 in-network hospital penalty or \$1,000 out-of-network hospital penalty.