



**The NEW 65 and Over “Delta Affiliated” Plan
For Non-Pilot and Pilot Retirees of Delta Air Lines**

DENTAL BENEFITS

Cigna

PPO Plan - 2 pages
HMO Plan - 1 page
Preventative Plan - 1 page

VISION BENEFITS

Superior Vision

Plan Summary - 1 page

NOTE:

The Dental and Vision programs DO NOT qualify
for the subsidy.

DALRC Retiree Dental PPO Plan Effective January 1, 2007

Monthly Cost	
Retiree	\$29.72
Retiree + Spouse	\$59.79
Retiree + Child(ren)	\$66.44
Retiree + Family	\$96.44

Benefit Summary

Benefits	CIGNA Dental PPO	
	In-network	Out-of-network
Class I – preventive and diagnostic services <ul style="list-style-type: none"> Oral exams (2 per calendar year) Cleanings (2 per calendar year) Full mouth X-rays (1 complete set every 3 calendar years) Bitewing X-ray (2 per calendar year) Panoramic X-ray (1 every 3 calendar years) Fluoride application (1 per calendar year for participants under 19 years old) Sealants (limited to posterior teeth for participants under 14 years old; 1 treatment per tooth every 3 calendar years) Space maintainers (limited to non-orthodontic treatment) Emergency care to relieve pain 	100% no deductible	100% after deductible <i>Emergency services are paid at in-network levels.</i>
Class II – basic restorative services Fillings, root canal therapy, osseous surgery, periodontal scaling and root planing, denture adjustments and repairs, extractions, anesthetics, oral surgery	70% after deductible	70% after deductible
Class III – major restorative services Crowns, dentures, bridges	50% after deductible	50% after deductible
Optional services Class IV –Orthodontia <ul style="list-style-type: none"> Deductible Lifetime maximum 	50% after deductible Plan deductible applies. \$2,500 Lifetime Max	50% after deductible Plan deductible applies. \$2,500 Lifetime Max
Calendar year maximum¹ (Class I, II, III expenses)	\$1,500 per person	\$1,500 per person
Calendar year deductible¹ <ul style="list-style-type: none"> Individual Aggregate family maximum 	\$60 per person \$240 per family	\$60 per person \$240 per family

¹ All deductibles, plan maximums and service specific maximums (dollar and occurrence) cross accumulate in- and out-of-network.

Benefit exclusions (by way of example, but not limited to):

- *Services performed solely for cosmetic reasons.*
- *Replacement of a lost or stolen appliance.*
- *Replacement of a bridge or denture within five years following the date of its original installation.*
- *Replacement of a bridge or denture which can be made useable according to accepted dental standards.*
- *Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of T.M.J, stabilize periodontally involved teeth, or restore occlusion.*
- *Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second, and third molars.*
- *Bite registrations; precision or semi-precision attachments; splinting.*
- *Surgical implant of any type.*
- *Instruction for plaque control, oral hygiene and diet.*
- *Dental services that do not meet common dental standards.*
- *Services that are deemed to be medical services.*
- *Services and supplies received from a hospital.*
- *Charges which the person is not legally required to pay.*
- *Charges made by a hospital which performs services for the U.S. government if the charges are directly related to a condition connected to a military service.*
- *Experimental or investigational procedures and treatments.*
- *Any injury resulting from, or in the course of, any employment for wage or profit.*
- *Any sickness covered under any workers' compensation or similar law.*
- *Charges in excess of the reasonable and customary allowances.*
- *Reasonable and customary other than the 90th percentile.*

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company.

DALRC Retiree Dental HMO Plan effective January 1, 2007

Monthly Cost	
Retiree	\$18.32
Retiree + Spouse	\$36.37
Retiree + Child(ren)	\$48.88
Retiree + Family	\$57.03

Benefit Summary

Benefits	CIGNA Dental HMO In-network Only
Class I – preventive and diagnostic services <ul style="list-style-type: none"> • Oral exams (2 per calendar year) • Cleanings (2 per calendar year) • Full mouth X-rays (1 complete set every 3 calendar years) • Bitewing X-ray (2 per calendar year) • Panoramic X-ray (1 every 3 calendar years) • Fluoride application (1 per calendar year for participants under 19 years old) • Sealants (limited to posterior teeth for participants under 14 years old; 1 treatment per tooth every 3 calendar years) • Space maintainers (limited to non-orthodontic treatment) • Emergency care to relieve pain 	<p>Most preventive services are covered with no copay</p> <p>See patient charge schedule for details</p>
Class II – basic restorative services Fillings, root canal therapy, osseous surgery, periodontal scaling and root planing, denture adjustments and repairs, extractions, anesthetics, oral surgery	<p>amalgam fillings are covered with no copay</p> <p>Other services may have copays, please see Patient charge schedule for details</p>
Class III – major restorative services Crowns, dentures, bridges	<p>Most services have copays, please see patient charge schedule for details</p>
Optional services Class IV –Orthodontia <ul style="list-style-type: none"> • Deductible • Lifetime maximum 	<p>See Patient Charge Schedule</p> <p>None</p> <p>24 months of treatment</p>
Calendar year maximum¹ (Class I, II, III expenses)	<p>No Maximum Benefit</p>
Calendar year deductible¹ <ul style="list-style-type: none"> • Individual • Aggregate family maximum 	<p>no deductible</p>

DALRC Retiree Dental Preventive Plan Effective January 1, 2007

Monthly Cost	
Retiree	\$11.51
Retiree + Spouse	\$22.83
Retiree + Child(ren)	\$31.71
Retiree + Family	\$43.09

Benefit Summary

Benefits	CIGNA Preventive Plan	
	In-network	Out-of-network
Class I – preventive and diagnostic services <ul style="list-style-type: none"> • Oral exams (2 per calendar year) • Cleanings (2 per calendar year) • Full mouth X-rays (1 complete set every 3 calendar years) • Bitewing X-ray (2 per calendar year) • Panoramic X-ray (1 every 3 calendar years) • Fluoride application (1 per calendar year for participants under 19 years old) • Sealants (limited to posterior teeth for participants under 14 years old; 1 treatment per tooth every 3 calendar years) • Space maintainers (limited to non-orthodontic treatment) • Emergency care to relieve pain 	100% no deductible	100% no deductible
Calendar year maximum¹ (Class I expenses)	\$200 per person	\$200 per person

¹ All deductibles, plan maximums and service specific maximums (dollar and occurrence) cross accumulate in- and out-of-network.

Benefit exclusions (by way of example, but not limited to):

- Services performed solely for cosmetic reasons.
- Replacement of a lost or stolen appliance.
- Replacement of a bridge or denture within five years following the date of its original installation.
- Replacement of a bridge or denture which can be made useable according to accepted dental standards.
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion.
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second, and third molars.
- Bite registrations; precision or semi-precision attachments; splinting.
- Surgical implant of any type.
- Instruction for plaque control, oral hygiene and diet.
- Dental services that do not meet common dental standards.
- Services that are deemed to be medical services.
- Services and supplies received from a hospital.
- Charges which the person is not legally required to pay.
- Charges made by a hospital which performs services for the U.S. government if the charges are directly related to a condition connected to a military service.
- Experimental or investigational procedures and treatments.
- Any injury resulting from, or in the course of, any employment for wage or profit.
- Any sickness covered under any workers' compensation or similar law.
- Charges in excess of the reasonable and customary allowances.
- Reasonable and customary other than the 90th percentile.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company.



Superior Vision®

Our Members. Our Mission.

Presented by DALRC Retiree Vision Plan

Outline of Benefits - Effective 1/1/07

Vision Plan-Preferred Provider (PPO)/Indemnity

Monthly Rates:

Employee Only	\$6.20
Employee and Spouse	\$11.45
Employee and Child(ren)	\$11.60
Employee and Family	\$17.30

Copayment:	\$10.00 Exam
	\$15.00 Materials
	\$25.00 Contact Lens Fitting Exam Fee

In-network copayments are paid directly to the provider.
Out-of-network copayments will be deducted from the out-of-network reimbursement.

Gold Plus Preferred Plan Services/Frequency

Comprehensive Exam	12 months
Lenses	12 months
Frames	24 months
Contact Lenses	12 months

Benefits	In-Network	Out-of-Network
Comprehensive Exam Ophthalmologist (MD)	Covered in Full	Up to \$42.00
Comprehensive Exam Optometrist (OD)	Covered in Full	Up to \$37.00
Standard Lenses (Per Pair):		
Single Vision	Covered in Full	Up to \$32.00
Bifocal	Covered in Full	Up to \$46.00
Trifocal	Covered in Full	Up to \$61.00
Lenticular	Covered in Full	Up to \$84.00
Contact Lenses (Per Pair):*		
Medically Necessary	Covered in Full	Up to \$210.00
Elective**	Up to \$120.00	Up to \$100.00
Standard Contact Lens Fitting Exam Fee***	Covered in Full	Not Covered
Specialty Contact Lens Fitting Exam Fee***	Up to \$50.00	Not Covered
Frames-Standard**	Up to \$125.00	Up to \$68.00

* Contact lenses are in lieu of eyeglass lenses and frames benefit.

** The insured is responsible for paying any charges in excess of this allowance.

***Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50.

How to Use the Plan

Procedure when using a Superior Vision Plan in-network provider:

1. Identify yourself to the in-network provider as a member of the Superior Vision Plan. You can use your I.D. card for this purpose or simply give the provider your name, employer name, and your unique identification number. The provider will call the Superior Vision Customer Service Department to verify your eligibility and obtain an authorization number. The I.D. card provided to you can be used for all covered family members.
2. After eligibility is established and an authorization number is received by the provider, services will be rendered. There is nothing else that you need to do except pay the provider directly for any appropriate copayments or charges above the covered benefits. The in-network provider handles all claims and paperwork.

Procedure when using an out-of-network provider:

1. To receive services from an out-of-network provider, it is important that you first call the Superior Vision Customer Service Department at 800-507-3800 to receive your own authorization number. By doing so, you may be assured of your eligibility and reimbursement for money spent.
2. After receiving services and paying in-full for the examination and/or materials (you do not pay a copayment to the out-of-network provider), submit your original itemized billing or receipt received from the provider, along with your authorization number, to the Superior Vision Claims Administration office.
3. You will be reimbursed according to the schedule of allowances for out-of-network services, less any required copayments.

Refractive Surgery Discounts

Superior Vision Services has contracted a network of over 600 refractive surgeons nationwide who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy (PRK) and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blepharoplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

Discounts on Additional Purchases

- ◆ Prescription eyeglass lenses 30% off retail prices
- ◆ Add-on charges to basic lenses 20% off retail prices
- ◆ Contact lenses, standard hard or soft 20% off retail prices
- ◆ All other prescription materials 20% off retail prices

- ◆ Eyeframes 30% off retail prices
- ◆ Everyday "frame and lens package pricing" 20% off retail prices
- ◆ Disposable contact lenses 10% off retail prices

Discount SVP8-20

- ◆ Frames 20% off the difference between the covered frame allowance and the retail price of the selected frame.

Note: Discounts do not apply when prohibited by the manufacturer.

Add-on charges to the covered pair of lenses

- ◆ Factory Scratch Coat
- ◆ Ultraviolet Coat
- ◆ Standard Anti-Reflective Coat*
- ◆ High Index 1.6*
- ◆ Polycarbonate
- ◆ Standard Photochromic
- ◆ Glass coloring
- ◆ Plastic Tints solid or gradient
- ◆ Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism
- ◆ Cosmetic Finishing, Beveling, Edging & Mounting
- ◆ Miscellaneous Options

Member pays 20% off retail, up to:

- \$13 (Single Vision & Standard Lined Multifocal Lenses)
- \$15 (Single Vision & Standard Lined Multifocal Lenses)
- \$50 (Single Vision & Standard Lined Multifocal Lenses)
- \$55 (Single Vision Lenses Only)
- \$40 (Single Vision Lenses Only)
- \$80 (Single Vision Lenses Only)
- \$35 (Any Type Lenses)
- \$25 (Any Type Lenses)

Member pays:

- 20% discount off retail prices (Any Type Lenses)
- 20% discount off retail prices (Any Type Lenses)
- 20% discount off retail prices (Any Type Lenses)

* Higher end or brand name lens upgrades are at an additional expense to the member. Apply maximum out of pocket expense toward upgraded lens retail cost and the member is responsible for the difference less 20%.

Discounts are available only from participating providers who are identified with a DP or a DP8-20 in their provider listings as a service provided at their location.