GROUP INSURANCE CERTIFICATE

Highmark Life Insurance Company

P.O. BOX 1840, HARTFORD, CONNECTICUT 06144-1840
1-800-443-3221

Highmark Life Insurance Company certifies that eligible Members of the Participating Employer will be insured under the Group Policy during the time, in the manner, and for the amounts described in the Group Policy and this Employer's Participation Certificate issued to the Participating Employer.

Dennis M. Kulucz

President

NAME OF PARTICIPATING EMPLOYER	Delta Air Lines, Inc.
PARTICIPATING EMPLOYER NUMBER	991000-31
TYPE OF COVERAGE	Vision Care Expense Insurance
EFFECTIVE DATE	January 1, 2002
GROUP POLICY DELIVERED IN	District of Columbia and governed by the laws of that government.

IMPORTANT: PLEASE READ THIS

A Group Policy has been issued to the Trustee of the Highmark Vision Insurance Trust. The Participating Employer has applied for and been accepted as a Participating Employer in the Trust. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, we will provide the Participating Employer with a revised Certificate or other notice to be given to you. This document also serves as your Summary Plan Description for the Delta Vision Plan; however, please reference the Delta Benefits Handbook Administration Section for a statement of ERISA protections, information regarding Health Insurance Issuers including Davis Vision and Highmark Life and other important information about the Delta Vision Plan.

PLEASE READ THIS CERTIFICATE CAREFULLY. This Certificate of Insurance has a Table of Contents to help you find specific provisions. "You" and "your" refer to the insured Member. "We", "us", and "our" refer to **Highmark Life Insurance Company**. Other defined terms are printed with an initial capital letter.

TABLE OF CONTENTS

INDEX OF DEFINED TERMS

Part 1. BECOMING INSURED

To become insured you must meet each of the requirements of A through D.

A. DEFINITION OF MEMBER

You must be a Member. You are a **MEMBER** if you have enrolled in the plan, pay all required premiums, and you are:

1. An active regular full-time or regular part-time United States, expatriate, or Puerto Rico employee of the Employer, regularly scheduled to work at least 30 hours per week; or

2. A retired U.S. or Puerto Rico employee of the Employer

   under the Employer's retirement plan.

3. An inactive U.S., expatriate, or Puerto Rico employee of the employer or COBRA participant (provided the employee does not elect no coverage while inactive or on COBRA).

4. A survivor of a United States employee of the Employer provided you are eligible under the Employer's Disability and Survivorship Plan.

B. ELIGIBILITY FOR INSURANCE

You are eligible for Insurance on the later of the following dates if you are a Member on that date:

1. The effective date of the Employer's Participation Certificate or the first day of the calendar year following an annual enrollment.

2. For a midyear enrollment, the first day of the pay period following your enrollment deadline.

C. APPLICATION FOR INSURANCE

Your Insurance is Voluntary. If you wish to become insured, you must agree to make the required contributions to the Policyholder by enrolling in the Vision option through the Employer's enrollment process.

D. EFFECTIVE DATE OF INSURANCE AND CHANGES IN INSURANCE

1. Initial effective date of your Insurance:

   If you meet the requirements of Parts 1A through 1C, your Insurance will become effective on:

   a. The first day of the pay period following your enrollment deadline if newly eligible.

   b. The first day of the calendar year if you enroll during the annual enrollment period.

2. Effective date of status changes: Changes in your Insurance become effective on the later of the first day of the pay period following the event or the timely receipt of notification by the Employer.

Your Insurance will not become effective prior to the effective date of the Employer's Participation Certificate.

Part 2. INSURING YOUR DEPENDENTS

To insure your Dependents for Insurance, you must meet each of the following requirements:

1. You must be a Member who is insured for Insurance.

2. You must enroll your eligible Dependents in Insurance through the Employer's enrollment process.

A. DEFINITION OF DEPENDENT

DEPENDENT means a person who is:

1. Your legal spouse.

2. Your same sex domestic partner who has been reported to the Employer, has an Affidavit of Domestic Partner Relationship on file and meets all other requirements. Retirees or inactive non-pilots with event dates before October 5, 2000 are not eligible for domestic partners. Retirees or inactive pilots with event dates prior to January 1, 2002 are not eligible for domestic partner coverage.

3. The ex-spouse of a retired/disabled pilot in certain circumstances*.

4. Your natural born or legally adopted children from birth to their 19th birthday provided:

   a. they have never been married (even if that marriage was later annulled);
   b. they are not employed on a full-time basis and reside permanently in your household; or
   c. if they reside outside your household, you must provide more than 50% support.

5. Your natural born or legally adopted children from age 19 to their 23rd birthday if they are a full-time student or involved in qualified missionary service, and they meet all the criteria above for children under 19.

6. Stepchildren must meet the criteria for natural born children listed above and must establish permanent residency by permanently residing in the employee's household for at least 30 full and continuous days (other than time spent living at school) before being eligible. This same criteria must be met by the natural born or legally adopted children of your eligible domestic partner in order to be eligible for coverage.

7. Children who are physically or mentally incapacitated (provided the incapacitation by the Employer existed before the maximum age limits described above were met) and who have been approved. Application for incapacitated status should be made to the Employer before the child becomes ineligible due to age.

8. Children for whom you have been appointed legal guardian (this includes a grandchild, niece or nephew for whom you have assumed primary care) and who satisfy all the criteria for natural born children, and who live permanently in your home (other than time spent living at school.)

9. Children who are alternate recipients under a Qualified Medical Child Support Order (QMCSO) who have been approved by the Employer.

   All Life Events and status changes must be reported to and received by the Employer on the appropriate form within 30 days of the event.

* If you divorce the spouse you were married to at the time you became disabled or at the time of your retirement and you both are Insured, your spouse will remain eligible, even if he or she later remarries. The ex-spouse will pay any applicable premiums for this coverage. This coverage will end upon your death.

B. ELIGIBLE DEPENDENTS

Your Dependents are eligible for Insurance, except as follows:

1. You may not insure your Dependents for Insurance unless you are insured for Insurance.

2. You may not insure your Dependent for Insurance if your Dependent is a full time member of the armed forces of any country.

C. APPLICATION FOR INSURANCE ON YOUR DEPENDENTS

You must enroll your Dependents and agree to make the required contributions, if any, to your Employer.

D. EFFECTIVE DATE OF DEPENDENT INSURANCE

Your Dependents are eligible for Insurance on:

1. The date your Insurance becomes effective.

2. The date you first acquire a Dependent through birth or legal adoption. Otherwise, the effective date of coverage will be the later of the first day of the pay period following the event or the timely receipt of notification by the Employer.

You must enroll your newly acquired Dependents in the Insurance within 30 days of the event. Retirees must be enrolled to add new dependents to coverage.

We will not refuse:

1. To insure a child under the Employer's Participation Certificate on the grounds that the child was born out of wedlock, the child is not claimed as a Dependent on the parent's federal tax return, or the child does not reside with the parent or in our service area.

2. To insure an otherwise eligible child under the Employer's Participation Certificate if the child is presumed to be the natural child of the insured.

Your Dependents will not be insured before the day your Insurance begins.

E. MEDICAL CHILD SUPPORT ORDERS

You may request a copy of the Plan's procedures for processing Qualified Medical Child Support Orders at no charge by contacting the Delta Employee Service Center at 1-800-MYDELTA or Delta Air Lines, Inc., Employee Service Center, P.O. Box 20706, Atlanta, Georgia 30320-6001. Davis Vision, Inc. will be receiving eligibility from Delta. Delta will process all medical child support orders.

Part 3. SCHEDULE OF BENEFITS

Subject to all the terms of the Employer's Participation Certificate, we will pay for Covered Expenses incurred by a Covered Person as shown below.

You and your Covered Dependents may use either a Participating (In-Network) or Non-Participating (Out-of-Network) Provider for Covered Expenses. Except as shown below, Participating Providers will not charge you or your Covered Dependents for any balance over the applicable Copayment for in-network benefits. However, professional providers that do not have a contract with us through Davis Vision (Out-of-Network Providers) may bill you for any balances between the allowances shown below and the provider's actual charge for the eye examination and materials. Copayments, if any, only apply to Participating (In-Network) Providers. If you have any questions regarding network providers or need additional information regarding covered benefits, contact Davis Vision Member Services at 1-800-947-9955.

A. FREQUENCY OF USE

Routine Eye Examination*	Once every calendar year.
Materials	One pair of spectacle lenses, every calendar year
	Or
	One pair of standard, soft, dailywear lenses, or an initial supply of disposable**/planned replacement contact lenses (in lieu of spectacle lenses), every calendar year.
	One frame every other calendar year.

* Does not include professional services related to contact lenses.

** New (to the provider, or for the first time) contact lens wearers will receive an initial supply (2 multi-packs) of lenses, along with all necessary visits for proper fitting and recommended follow-up care. Existing contact lens wearers will receive 4 multi-packs of lenses.

B. IN-NETWORK BENEFITS

	Copayment *
Routine Eye Examination	$10.00 **
Materials	
Spectacle Lenses	$15.00
Frame	None ***
Contact Lenses ****	
Davis Vision Formulary	$0
Other Types	Allowance Based

* Does not apply to Covered Expenses received from an Out-of-Network Provider. Any Optional item purchased is in addition to the basic copayments listed.

** Eye examination copayment does not cover any applicable fees for professional services for contact lens evaluation.

*** Any Frame, other than a Davis Vision Tower Collection Frame, will have a maximum of a $120.00 allowance applied to the purchase price. The balance, if any, is the Covered Person's responsibility. If the Covered Person chooses a frame from the Premier Collection there is an additional co-payment; see "Optional In-Network Items" below. Please note that when obtaining services from a major participating retail chain (such as Sears, Pearle, etc.) you will be entitled to receive a frame with the retail allowance ($120) applied to the purchase price, as these locations do not have the Davis Vision Tower Collection.

**** Contact lenses other than the Davis Vision Formulary contact lenses, will be paid up to a maximum allowance of $105.00. The balance, if any, is the Covered Person's responsibility. Please note that the Davis Vision Formulary covers many popular brands of standard, soft, daily-wear, disposable, and planned replacement contact lenses. You will also receive a 15% discount off a network provider's professional services associated with the purchase of all prescription contact lenses. Your provider will give you specific information for the type of lenses you require.

Medically necessary contact lenses are covered in full (prior approval is required). Contact lenses may be selected in lieu of spectacle lenses.

Please note that when obtaining services from a major participating retail chain (such as Sears, Pearle, etc.) you will be entitled to receive the $105.00 allowance towards the retail cost. The Contact Lens Formulary benefit is not available at these locations; however, you will have the locations' full assortment of contact lenses to choose from.

Where applicable, State provider regulations may require you to pay out of pocket for the evaluation fee and apply the full $105.00 allowance towards the contact lenses.

Plan Level

Designer Plan — Eyewear from Davis Vision's Designer Collection; Most In-Network Providers will have a complete tower of Davis Vision's frame collection (see *** above for Retail frame benefits). In addition, you and your Covered Dependents may also select any of the Optional In-Network Items shown below, including frames from the Premier Collection. All Optional In-Network Items are subject to the applicable Copayment in addition to any basic copayment.

Optional Items	Copayment
Premier Frames	$20.00
Progressive Addition Lenses	
Standard	$50.00
Premium	$90.00
Photogrey Extra Lenses	$20.00
Scratch-Resistant Coating	$20.00
Anti-Reflective Coating (ARC)	
Standard	$35.00
Premium	$48.00
Blended Segment Lenses	$20.00
Ultra Violet Coating	$12.00
Polycarbonate Lenses	$30.00 *
High Index Lenses	$55.00
Transition Lenses	$65.00
Polarized Lenses	$75.00

* no copayment for children up to age 19 or monocular patients.

C. OUT-OF-NETWORK BENEFITS

	Allowance *
Eye Examination	$30.00
Materials	
Frames	$30.00
Lenses:	
Single Vision	$25.00
Bifocal	$35.00
Trifocal	$45.00
Lenticular	$60.00
Contact Lenses	$75.00

* The "Allowance" is the maximum amount payable under the Employer's Participation Certificate for eye examinations, the fitting of eyeglasses or Materials received and/or purchased by a Covered Person

from an Out-of-Network Provider. The Covered person is responsible for any charges in excess of the Allowance.

D. ADDITIONAL DISCOUNTS*

1. Discounts off additional pairs of spectacles – features a discount of 20% off usual and customary retail cost of additional pairs of spectacles purchased at a participating facility, or you may utilize the Value Advantage Program (a discounted fee schedule for additional eyewear purchases from the "Tower Collection").

2. You and your Dependent(s) may receive Laser Vision Correction Services at significant discounts through a network of surgeons. You and your Dependent(s) shall be entitled to a savings of up to 25% off usual and customary fees, or receive an additional 5% discount on any advertised specials, whichever is lower (please note that some providers have flat fees equivalent to these discounts.

* Discounted vision services, supplies and treatment are not underwritten by Highmark Life Insurance Company.

Part 4. COVERED EXPENSES

Subject to the exclusions and limitations in Part 5, Covered Expenses include charges made by a Provider for the following vision care services while you or your Dependents, if any, are insured for these benefits. The benefits payable under the Employer's Participation Certificate vary depending upon which Provider rendered the services.

A. EYE EXAMINATION

Covered Expenses for an eye examination include the following procedures:

1. Refractive care - distance and near.

2. Prescribing of eyeglasses.

3. Case history including eye and vision history and medical history.

4. Distance and near acuities: habitual and/or uncorrected.

5. External ocular examination.

6. Internal ocular examination.

7. Tonometry for a Covered Person when professionally indicated.

8. Binocular coordination evaluation - distance and near.

9. Color vision testing as appropriate.

10. Advise a Covered Person on matters pertaining to vision care.

Eye examinations from an In-Network Provider are subject to the Copayment shown in Part 3. This does not include professional services related to the dispensing of contact lenses. Benefits under the Employer's Participation Certificate for eye examinations from an Out-of-Network Provider are payable up to the Allowance shown in Part 3 or the actual charge for the eye examination, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance.

B. FITTING OF EYEGLASSES

If vision correction is recommended by a Provider, Covered Expenses will include the fitting of eyeglasses and follow-up adjustments.

C. MATERIALS

Designer Collection frames and the following lenses as provided through Davis Vision:

1. Glass or plastic lenses, in single vision, bifocal or trifocal prescriptions. The following types of lenses are also included:

   a. Prescription sunglasses with grey glass #3 lenses.
   b. Oversized lenses.
   c. Fashion and gradient tinting of plastic lenses.
   d. Cataract lenses.
   e. Contact lenses - many types of soft standard daily wear or an initial supply of disposable/planned replacement contact lenses, as described in Part 3.

   The above materials are subject to the Copayment for In-Network Benefits shown in Part 3.

2. Optional In-Network Items. Charges for the following items, subject to the Copayment for Optional In-Network Items shown in Part 3, are:

   a. Premier Frames - A frame from the Davis Vision Premier Collection is available with the Designer Collection package at the option of the Covered Person, where the collection is displayed.
   b. Progressive Addition Lenses - e.g. invisible bifocals.
   c. Photogrey Extra Lenses - Single vision or multifocal.
   d. Scratch-Resistant Coating - Single vision or multifocal.
   e. Anti-Reflective Coating (ARC).
   f. Blended Segment Lenses.
   g. Ultra Violet Coating.
   h. Polycarbonate Lenses (covered in full for children up to age 19 and monocular individuals).
   i. High index lenses.
   j. Transitions - Single vision or multifocal.
   k. Polarized lenses.

3. Frames and lenses provided by an Out-of-Network Provider or from an In-Network Providers' own collection. Benefits under the Employer's Participation Certificate are payable for frames and lenses from an Out-of-Network Provider or from an In-Network Providers' own collection are payable up to the Allowance shown in Part 3 for Out-of-Network Materials or the actual charge for the frames and lenses, whichever is less. A Covered Person is responsible for any amount in excess of that Allowance. You and your dependent(s) shall also be entitled to a discount of 20% off usual and customary retail cost of additional pairs of spectacles purchased at a participating facility.

Part 5. EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for and the term "Covered Expenses" will not include charges:

1. For services or supplies not recommended by a Provider.

2. For periodic vision examinations, except as provided for in Part 3.

3. For eye examinations required by an Employer as a condition of employment.

4. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.

5. For lenses which do not provide vision correction, except as provided in Part 3.

6. For charges for the replacement of lost or stolen lenses or frames within 24 months of service.

7. For sickness or injury covered by a workers' compensation act or other similar legislation.

8. Incurred as a direct or indirect result of war (declared or undeclared).

9. Incurred as a result of an intentionally self-inflicted injury; or from injury sustained while committing a crime.

10. For services or supplies furnished to a Covered Person before the effective date of the Employer's Participation Certificate or after the date a Covered Person's Insurance ends.

11. For services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.

12. For any medical treatment rendered outside the United States.

13. For services rendered by practitioners who do not meet the definition of Provider.

14. For expenses covered by:

    a. Any other group insurance.

    b. A health maintenance organization or hospital or medical services prepayment plan available through an Employer, union or association.

15. For any expenses covered by any union welfare plan or governmental program or a plan required by law.

Part 6. OTHER VISION CARE INSURANCE PROVISIONS

A. FREE CHOICE OF PROVIDER

You have the exclusive right to select the Provider of your choice to provide you with vision care services and materials. We are not responsible for the quality of care you receive from the Provider you select. We cannot be held liable for any injuries you suffer while receiving the vision services or materials.

B. INCURRED DATE

The incurred date of charge for a vision care examination, refractive and/or post refractive services or materials, as evidenced by a proper receipt, is:

1. The date a service or procedure is performed; or

2. The date a purchase is made.

C. COORDINATION OF BENEFITS PROVISION

1. General

This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Person has vision coverage under more than one plan. "Plan" and "This Plan" are defined below. If this COB

provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan: (i) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but (ii) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in 4, "Effect on the Benefits of This Plan."

2. Definitions

a. "Plan" means any of the following which provides benefits or services for, or because of, medical or vision care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

(3) "Plan" does not include school accident-type coverage, individual contracts of coverage, or some supplemental sickness and accident policies. Each contract or other arrangement for coverage under (1) or (2) is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.

b. "This Plan" includes the Employer's Participation Certificate that provides benefits for vision care expenses.

c. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.

d. "Allowable Expense" means a necessary, reasonable and customary item of expense for vision care when the item of expense is covered by This Plan. However, This Plan is not required to pay for a service, supply, or treatment which is not covered by the Employer's Participation Certificate. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and benefit paid.

3. Order of Benefit Determination Rules

a. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan whose benefits are determined after those of the other plan, unless:

(1) the other plan has rules coordinating its benefits with those of This Plan; and

(2) both those rules and This Plan's rules, in subsection below, require that This Plan's benefits be determined before those of the other plan.

b. This Plan determines its order of benefits using the first of the following rules which applies:

(1) The benefits of the plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) secondary to the plan covering the person as a Dependent; and

(b) primary to the plan covering the person as other than a Dependent (e.g. a retired employee).

(2) Benefits for a Dependent child whose parents are not separated or divorced will be determined as follows:

(a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which has covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Benefits for a Dependent child whose parents are divorced or separated will be determined as follows. To the extent the plan has been notified by receiving a copy of the court decree:

(a) If the specific terms of the court decree state that one of the parents is responsible for the vision care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent will be the Secondary Plan.

(b) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the vision care expenses of the child, the plans covering the child will be subject to the order of benefit determination contained in subdivision (B)(2) of this section.

If neither subdivision (a) nor (b) applies, the order of benefits will be determined in the following order:

(i) the plan of the parent with custody of the child;

(ii) the plan of the spouse of the parent with the custody of the child;

(iii) the plan of the parent not having custody of the child; and

(iv) the plan of the spouse of the parent not having custody of the child.

(4) The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before the benefits of a plan which covers that person as a laid off or retired employee (or as that employee's

Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.

(5) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another plan, the benefits of the plan covering the person as employee, member or subscriber (or that person's Dependent) will be determined before the benefits under the continuation coverage.

(6) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of This Plan

a. This section applies when, in accordance with 3, "Order of Benefit Determines Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. The other plan or plans are referred to as "the other plans" in "b" below.

b. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:

(1) The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses.

5. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

6. Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:

a. the persons it has paid or for whom it has paid;

b. another plan; or

c. the provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Part 7. WHEN A MEMBER'S INSURANCE ENDS

Your Insurance under the Employer's Participation Certificate will end automatically on the earliest of the following dates:

1. The date you cease to be a Member for any reason as defined in Part 1A.

2. The date the Employer's Participation Certificate terminates.

3. On the last day of the last period for which you make the required contribution for your Insurance, if you contribute toward the cost of your Insurance.

4. The elective date of your no coverage election.

5. The end of COBRA continuation coverage for any reason.

See the Employer's Benefit Handbook (Life Events Section) for a statement of COBRA rights.

Part 8. WHEN A DEPENDENT'S INSURANCE ENDS

Insurance on your Dependents will end automatically on the earliest of the following dates:

1. The date your Insurance ends for any reason.

2. The date the person ceases to be your Dependent, as defined in Part 2A.

3. On the last day of the last period for which you made the required contribution for Insurance on your Dependents, if you contribute toward the cost of the Insurance on your Dependents.

4. When you elect not to cover a dependent under this Insurance or elect no coverage under this Insurance.

5. The end of COBRA continuation coverage for any reason.

6. When the dependent is disenrolled from coverage.

See the Employer's Benefit Handbook (Life Events Section) for a statement of COBRA rights.

Part 9. PAYMENT OF CLAIMS

A. PAPERLESS SYSTEM

The Covered Person must contact an In-Network Provider to schedule an appointment. The In-Network Provider will verify that person's eligibility for Covered Expenses with Davis Vision before the date of the appointment. The Provider will submit the Covered Person's claim directly to Davis Vision.

B. PAYMENT OF BENEFITS

All out-of-network benefits will be paid to you and all in-network benefits will be paid directly to the Provider. Any covered expense unpaid at the time of your death will either be paid to your beneficiary or to your estate. If any benefits are payable to your estate, or to a person who is a minor or otherwise not competent to give a valid release, we may pay the indemnity, to an amount not exceeding $1,000, to any of

your relatives by blood or marriage who we deem to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment.

C. NOTICE OF CLAIM

Written notice of a claim should be given to us within one year after the incurred date of the Covered Expense or as soon thereafter as reasonably possible. Notice given to Davis Vision by or on behalf of a Covered Person or to us at P.O. Box 535601, Pittsburgh, PA 15253-0061, with information sufficient to identify the Covered Person, will be deemed notice to us.

If an In-network Provider is used, notice of claim will be given to Davis Vision directly by that Provider on behalf of the Covered Person.

D. CLAIM FORMS

Claims for in-network benefits will be submitted directly to Davis Vision by the Provider.

All claims for out-of-network benefits should be submitted on Davis Vision's forms. You or the Provider should obtain claim forms from Davis Vision. If Davis Vision fails to provide you with claim forms within 10 days of your request, you:

1. May submit your claim in a letter stating the medical expense for which the claim is made.

2. Will be deemed to have complied with the requirements of the Employer's Participation Certificate as to proof of loss upon submitting, within the time fixed in the Employer's Participation Certificate for submitting proof of loss, written proof covering the occurrence for which a claim is made, and the character and the extent of loss for which a claim is made.

E. PROOF OF LOSS

Proof of each of the following elements of proof of loss must be provided to Davis Vision at your expense. No benefits for such charges will be paid until Davis Vision receives satisfactory written proof:

1. That a Covered Person has incurred Covered Expenses.

2. That the charges for which benefits are claimed are not subject to any exclusion.

3. That a Covered Person's Insurance under the Employer's Participation Certificate was in effect on the date that the charge was incurred.

Or such additional information as we reasonably require in connection with the claim for benefits.

Any claim for benefits submitted by an In-Network Provider through the Paperless System (see A, PAPERLESS SYSTEM above) will satisfy this requirement.

F. TIME PAYMENT OF CLAIMS

Benefits payable under this Employer's Participation Certificate for any loss other than loss for which the Employer's Participation Certificate provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. If we do not pay the benefits under the Policy upon receipt of such proof we will, within 15 working days, mail you a letter or notice which:

1. States the reason or reasons we did not pay the claim, either in whole or in part.

2. Requests any additional information we require to process claim, or any portion of the claim which we did not pay.

Upon receipt of all the information needed to process the claim we will either pay or deny the claim in whole or in part. If we deny the claim or any portion of the claim we will give you the reason or reasons for such denial in writing. If we fail to pay the claim or any portion of the claim within this time period interest

will accrue at the rate of 18% per year starting with the day following the day such 15 working day period ends until such claim is finally settled or adjudicated.

G. INDEPENDENT EXAMINATION

We have the right to have a Provider of our choice examine you or your insured Dependent to evaluate and confirm the services and supplies for which benefits are claimed. Any such examination will be conducted at our expense. We have the right to defer payment of benefits if the Provider or you or your insured Dependent fail to permit or cooperate with a review by the Provider of our choice.

H. RIGHT TO RECOVER BENEFITS PAID BY MISTAKE

If we mistakenly make a payment to you or to a Provider on your behalf for benefits, and you are not eligible for all or a part of that payment, then we have the right to recover the payment from you or the Provider who received the payment. Our right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future benefits.

I. NOTICE OF DECISION ON CLAIM

Following our receipt of your claim you will receive an initial decision on the claim within:

1. 72 hours for urgent care claims;

2. 15 days for pre-service claims;

3. 30 days for post-service claims.

If you do not follow Davis Vision's procedures for filing a claim, Davis Vision will notify you as soon as possible but not later than 5 days (24 hours for urgent care claims) following Davis Vision's receipt of the claim.

Davis Vision may extend the initial period for pre-service claims and post-service claims by 15 days if circumstances beyond Davis Vision's control require an extension. Any notice of an extension will be in writing and issued prior to the end of the initial 15-day period for pre-service claims, or the initial 30-day period for post service claims.

If such an extension is necessary due to the failure to submit the information necessary to decide the pre-service or post-service claim, you have 45 days from receipt of that notice to provide Davis Vision with the information specified in that notice (48 hours to provide information for urgent care claims).

In any event, however, Davis Vision will make a decision on your claim within 15 days for pre-service claims and 30 days for post-service claims from the date notification of an extension is mailed unless the extension is necessary due to the failure of the claimant to submit the necessary information to file the claim.

If the extension is necessary due to your failure of the claimant to submit the necessary information to file the claim, Davis Vision will make a decision on your claim within 15 days for pre-service claims, and 30 days for post-service claims from the date Davis Vision receives all information necessary to process the claim; or following the end of the 45 day period from the date you received the request for additional information, if later.

"Post-service claim" means any claim for a benefit under the Plan that is not an Urgent Care Claim or a Pre-service Claim as defined.

"Pre-service claim" means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining care or treatment.

"Urgent care claim" means any claim with respect to which the application of the time periods for making non-urgent care determinations (1) could, in the opinion of a prudent person with an average knowledge of health or medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If we deny all or any part of your claim, you will be advised of the following in writing:

1. The reason for the denial.

2. The reference to the specific provisions of the Plan on which the denial was based.

3. Any additional material or information necessary for further review of the claim and explanation of why such information is necessary.

4. A description of the expedited review process applicable to denial of an urgent care claim, if applicable.

5. Notice of your right to appeal the denial.

6. An explanation of the Plan's review procedure.

7. If applicable, notice of your right to a civil action under ERISA section 502(a).

Concurrent Care Decisions

If you request an extension for an ongoing course of treatment, or number of treatments, you will be notified of Davis Vision's decision as soon as possible but not later than 5 days (24 hours for urgent care claims taking into account medical exigencies) following the request. If the request for an extension is denied, you have an immediate right to appeal.

If an approved ongoing course of treatment, or a number of treatments, is reduced or terminated by Davis Vision (other than by amendment to or termination of the Plan) before the end of such period of time, or number of treatments, you have an immediate right to appeal. You will be notified of such reduction or termination by Davis Vision as soon as possible so that you have time to appeal before the date of such reduction or termination.

J. REVIEW PROCEDURE

To obtain a review, you must submit a request for review to Davis Vision within 180 days after you receive notice of the denial. No special form is required. A request for review of an urgent care claim may be made over the phone. Any request for review of a pre-service claim or post-service claim must be in writing.

In connection with the review, you have the right to: (a) see the Plan and other papers affecting the claim; (b) argue against the denial in writing; (c) have a representative act on your behalf in the appeal.

The person conducting the review will: (a) not be, or subordinate to, the person who originally reviewed the claim; and (b) have medical expertise relevant to the claim, if the denial was based on medical judgement.

We will review your claim promptly after receiving your request for review. You will receive written notice of our decision for:

1. Urgent care claims as soon as reasonably possible taking into account medical exigencies but not later than 72 hours after Davis Vision receives your request for review of an adverse benefit determination.

2. Pre-service claims within a reasonable period of time appropriate to the medical circumstances but not later than 30 days after Davis Vision receives your request for review of an adverse benefit determination.

3. Post-service claims within a reasonable period of time but not later than 60 days after Davis Vision receives your request for review of an adverse benefit determination.

Davis Vision may extend the initial period for review of a post-service claim by 60 days prior to the end of the initial 60 day period if special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim.

Any notice of extension will be in writing, explain the special circumstances that may dictate an extension of the time period needed to review your appeal and give the date by which we expect to make our decision. In any event, however, you will receive written notice of Davis Vision's decision no later than 60 days after your request for review is received (120 days if there are special circumstances that require an extension for processing of the claim and notice was given). The written decision you receive will include:

1. The reasons for the decision.

2. A reference to any applicable standards or guidelines Davis Vision used to make the determination.

3. A reference to the provisions of the Plan on which the decision is based.

4. Notice of your right to a copy of and access to any guidelines, rules, and protocols Davis Vision relied upon in making the adverse determination.

5. Notice of your right to access of all documents, records and other information relevant to the benefit determination, without regard to whether Davis Vision relied on the material in making the adverse determination.

6. The names of medical professionals, if any, consulted as part of the claims process.

7. If applicable, notice of your right to a civil action under ERISA section 502(a).

Other voluntary alternative dispute resolution options, such as mediation, may be available.

One way to find out what may be available is to contact the local U.S. Department of Labor Office and the state insurance regulatory agency.

K. CHILD SUPPORT ORDERS

We will not refuse to accept and honor an otherwise valid claim for benefits which is filed by either parent of a covered child, by the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order. If we cover the child of a noncustodial parent or a parent sharing custody or temporary control of the child we will:

1. Provide such information to either parent sharing custody or temporary control of the child as may be necessary for the child to obtain benefits;

2. Permit either the parent sharing custody or temporary control of the child or the Provider with either parent's approval, to submit claims for Covered Expenses without the approval of the other parent; and

3. Make payments on claims directly to the parent who paid for the services, the Provider, the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order.

L. LEGAL ACTIONS

Except as provided for under ERISA section 502(a), no action at law or in equity may be brought to recover under the Employer's Participation Certificate until after the Review Procedure has been exhausted. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Part 10. INCONTESTABLE CLAUSE

A. INCONTESTABLE CLAUSE FOR YOUR INSURANCE

Any statement you make to obtain Insurance is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your Insurance unless all of the following are true:

1. Your Insurance would not have been approved if the truth had been known.

2. Your misrepresentation is contained in a written instrument signed by you.

3. You have been given a copy of the written instrument containing your misrepresentation.

After your Insurance has been in effect for three years, we will not use a misrepresentation by you to reduce or deny your claim or to deny the validity of your Insurance unless it was a fraudulent misrepresentation made with actual intent to deceive. However, we have the right at any time to assert as a defense to a claim that you were not eligible to become insured because you did not meet the requirements of Part 1, including, but not limited to, the requirements that you (1) be a Member and (2) submit and have approved an enrollment form.

B. INCONTESTABLE CLAUSE FOR EMPLOYER'S PARTICIPATION CERTIFICATE

Any statement made by the Policyholder to obtain the Employer's Participation Certificate is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Employer's Participation Certificate unless all of the following are true:

1. The Employer's Participation Certificate would not have been issued by us if the truth had been known.

2. The misrepresentation is contained in a written instrument signed by the Policyholder.

3. A copy of the written instrument has been given to the Policyholder.

The validity of the Employer's Participation Certificate will not be contested after it has been in effect for three years, except for nonpayment of premiums or a fraudulent misrepresentation made with actual intent to deceive.

Part 11. CLERICAL ERROR

Clerical error by the Employer will not:

1. Cause you to become insured.

2. Invalidate Insurance otherwise validly in force.

3. Continue Insurance otherwise validly terminated.

Part 12. ALLOCATION OF AUTHORITY

Except for those functions which the Employer's Participation Certificate specifically reserves to the Employer, we have the full and exclusive authority and discretion to administer claims and to interpret the Employer's Participation Certificate and resolve all questions arising in the administration, interpretation, and application of the Employer's Participation Certificate. Our authority includes, but is not limited to, the following:

1. The right to resolve all matters when a review has been requested.

2. The right to establish and enforce rules and procedures for the administration of the Employer's Participation Certificate and any claim under it.

3. The right to (a) verify your eligibility for Insurance, (b) determine your entitlement to benefits, and (c) determine the amount of the benefits payable to you.

4. Reservation of Rights to Amend or Terminate – As with all Employer benefits, Employer reserves the right at any time to amend, modify, or terminate all or any part of its benefit plans at its sole discretion, including the benefits described in this document. Any such amendment, modification, or termination, may apply to active employees, their dependents and survivors, as well as former employees, inactive employees, retirees, disabled employees, and employees on a leave of absence and each of their dependents and survivors. To the extent that the benefits described in this document apply to COBRA participants, such amendment, modification, or termination may apply to COBRA participants and their dependents as well. 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.

Part 13. GENERAL DEFINITIONS

AFFADAVIT OF DOMESTIC PARTNERSHIP means a certified statement to the Employer on the form provided for such purpose by the Employer that establishes the eligibility of the Member's named domestic partner for all benefits available through the Employer's Participation Certificate.

ALTERNATE RECIPIENT This term means any child of a participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Employer's Participation Certificate as the participant's eligible Dependent. For purposes of the benefits provided under the Employer's Participation Certificate, an Alternate Recipient will be treated as a Dependent.

ALLOWANCE The flat dollar amount payable under the Employer's Participation Certificate for eye examinations, the fitting of eyeglasses or Materials received and/or purchased by a Covered Person.

CALENDAR YEAR means the twelve month period beginning on January 1st and ending on December 31st.

COPAYMENT The amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments, if applicable, are shown in Part 3.

COVERED DEPENDENT means a Member's eligible, enrolled Dependent as determined by the Employer's eligibility guidelines insured under the Employer's Participation Certificate.

COVERED EXPENSE An expense for eye examinations, the fitting of eyeglasses or Materials, incurred by a Covered Person, for which benefits are payable under the Employer's Participation Certificate.

COVERED PERSON means a Member insured under the Employer's Participation Certificate or a Member's Dependent insured under the Employer's Participation Certificate.

EFFECTIVE DATE The date shown on the cover page. This is the date on which the Employer's Participation Certificate becomes effective.

EMPLOYER means Delta Air Lines, Inc.

ENROLLMENT means a request for enrollment in the Plan by an eligible person via Employer's enrollment methods.

EMPLOYER'S PARTICIPATION CERTIFICATE means our Employer's Participation Certificate number 991000-31 issued to the Policyholder.

IN-NETWORK PARTICIPATING PROVIDER Providers who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of Davis Vision's Provider Network.

INSURANCE The group vision care insurance provided to you and your Dependents, if any, under the Employer's Participation Certificate. This term does not include any discounted services, supplies or treatment.

LIFE EVENT OR STATUS CHANGE means events such as the following as outlined in the Employer's Benefit Handbook : (1) your marriage or divorce; (2) the death of your spouse; (3) the birth or adoption of your child; (4) the death of your child; (5) a change in the employment status of your spouse; or (6) a change in your employment status.

MATERIALS Frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Employer's Participation Certificate.

OPTIONAL IN-NETWORK ITEMS Materials provided under the Employer's Participation Certificate that can be selected at the Covered Person's option, subject to a Copayment, if any, shown in Part 3.

OUT-OF-NETWORK NON-PARTICIPATING PROVIDER Providers of optometric services who have not entered into a contract with Davis Vision to provide vision care services.

PLAN means the Employer's Participation Certificate and any discounted vision services, supplies or treatment made available to a Covered Person through Davis Vision. All discounted vision services, supplies and treatments described in the Employer's Participation Certificate and Certificate are provided by providers and suppliers that participate in one of Davis Vision's discount networks, and, are not underwritten by us.

POLICYHOLDER The legal entity to whom the Employer's Participation Certificate is issued.

PRE-SERVICE CLAIM means any claim for a benefit under the Employer's Participation Certificate or discount arrangement with respect to which the terms of the Employer's Participation Certificate or discount arrangement condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining care or treatment.

POST-SERVICE CLAIM means any claim for a benefit under the Employer's Participation Certificate or discount arrangement that is not an Urgent Care Claim or a Pre-service Claim as defined.

PROVIDER A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, an optometrist or an optician recognized as such in accordance with the laws of the state in which the services are provided. The Employer's Participation Certificate recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER This term means a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is entitled under the Employer's Participation Certificate. All determinations concerning whether a medical child support order is a qualified medical child support order shall be made by the Employer.

RIDER/ENDORSEMENT A formal document, signed by one of our authorized officers and attached to the Employer's Participation Certificate or a Certificate of Insurance issued under the Employer's Participation

Certificate, that amends the Employer's Participation Certificate to provide additional benefits, or to remove exclusions and/or limitations.

SCHEDULED FEE The amount negotiated between an In-Network Provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and Materials received or purchased by a Covered Person.

URGENT CARE CLAIM means any claim with respect to which the application of the time periods for making non-urgent care determinations (1) could, in the opinion of a prudent person with an average knowledge of health or medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

USUAL AND CUSTOMARY CHARGE That portion of a charge, as determined by us, made by a Provider for eye examinations, the fitting of eyeglasses or Materials which does not exceed the lesser of:

1. The customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or

2. The usual charge the provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

VOLUNTARY means you elect and pay the entire cost of your Insurance. The Insurance on your Dependents is Voluntary if you elect and pay the entire cost of the Insurance on your Dependents. You must enroll for both your Insurance and your Dependent's Voluntary Insurance.

WE, US, OUR OR THE COMPANY With respect to group vision insurance benefits, the insurance company identified on the cover page.