NORTHWEST
AIRLINES

Tentative Agreement between Northwest Airlines, Inc. and Aircraft Technical Support Association

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COVERING: Training Representatives, Production Planners, Line Maintenance Planners, Technical Writers, Reliability Analysts and Technical Analysts

Duration: 2004-2011

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AGREEMENT

between

NORTHWEST AIRLINES, INC.

and

AIRCRAFT TECHNICAL SUPPORT ASSOCIATION

covering

Training Representatives, Production Planners,
Line Maintenance Planners, Technical Writers,
Reliability Analysts and Technical Analysts

PREAMBLE

The purpose of this Agreement is, in the mutual interest of the Company and personnel as specified herein, to provide for the operation of the services of the Company under methods which will further, to the fullest extent possible, the safety of air transportation, the efficiency of operation and the continuity of employment under conditions of reasonable hours, proper compensation and reasonable working conditions. For the advancement of this purpose the Company and the Union agree to cooperate fully, both individually and collectively.

ARTICLE 1: SCOPE AND STATUS

A. This Agreement is entered into this ____ day of November, **2005**, in accordance with the provisions of the Railway Labor Act, as amended, by and between Northwest Airlines, Inc. (hereinafter referred to as the "Company"), and the Aircraft Technical Support Association (hereinafter referred to as the "Union") and shall apply to and cover personnel in the classifications of:

Training Representative
Production Planner
Line Maintenance Planner
Technical Writer
Reliability Analyst
Technical Analyst

wherever employed for whom the Union was certified as exclusive bargaining agent by the National Mediation Board on February 9, 1971, in NMB Case R-4193 and NMB Case R-6289, dated August 9, 1994.

B. It is expressly understood and agreed by the Company and the Union that this Agreement shall supersede and supplant any and all Agreements previously executed between the Company and any bargaining agent or individual affecting the classifications referred to in Paragraph (A) above or any individual employee covered by this Agreement, and that all provisions of this Agreement shall be binding upon any successor or assign of the Company.

C. The Company and the Union agree that employees in the classifications covered by this Agreement will perform the work generally recognized as falling within the scope of the job descriptions defined in Article 2 of this Agreement for Training Representative, Production Planner, Line Maintenance Planner, Technical Writer, Reliability Analyst and Technical Analyst as certified by the National Mediation Board on February 9, 1971, NMB Case R-4193 and NMB Case R-6289, dated August 9, 1994, and which is performed in and about the Company facilities. Nothing herein shall be construed to limit or restrict the right of persons such as supervisory or clerical personnel not covered by this Agreement from the performance of their work which is necessary for the accomplishment of the work covered by these classifications, nor shall it be construed as preventing other persons from the performance of occasional assignments of an assisting nature to the Company, and provided further that such work done by others does not result in any employees in these classifications covered by this Agreement being displaced. Nothing herein shall be construed to limit or restrict employees covered by this Agreement from performing work at contract or vendor maintenance

facilities as determined appropriate or necessary by the Company. Further, nothing herein shall be construed to prevent consolidation or transfer of jobs within these six classifications whenever there is not sufficient work to justify retention of a full-time position. Nothing herein shall be construed as obligating the Company to maintain or to establish any number of positions in these classifications. The Union agrees that all employees covered by this Agreement shall be governed by Company rules, regulations and orders not in conflict with provisions or rules contained herein.

D. It is understood and agreed that the Addendum attached hereto covering Company operations outside the limits of the United States is a part and parcel of this Agreement, and that if during the life of this Agreement Company operations are extended to include additional foreign routes and bases, representatives of the Company and the Union will prior to the opening of the operation meet in negotiation for proper wage rates and other conditions to govern additional foreign-based employees.

E. Whenever the term "technician" or "employee" is used herein, it shall refer to and mean personnel in the job classifications covered by this Agreement.

F. In the event of the introduction of new or different equipment or technology to the employee, and such new equipment or technology requires training, the Company shall provide the training and tools for the employee to become qualified with the new or different equipment or technology.

G. It is understood and agreed that all provisions of this Agreement shall be binding upon **any** successor or assign of the Company **that is engaged in the operation of an air carrier, which acquires ownership and/or control of all or substantially all of the equity securities of the company or all or substantially all of the value of the assets of the Company**. In the case of a sale, consolidation, merger, liquidation, reorganization, bankruptcy or trusteeship, representatives of the Company and the Union will meet without delay and negotiate for proper provisions for the protection of employee's seniority **in accordance with Sections 2, 3, and 13 of the Allegheny-Mohawk Labor Protective Provisions.**

NOTE: The provisions of paragraph G above shall not apply in the event that the Successor is a present or future member of the Sky Team Alliance.

H. The Company will meet and agree with ATSA representatives to discuss concerns or issues related to subcontracting and where practical, the Company will notify ATSA in advance of financially significant subcontracting of work regularly performed by ATSA-represented employees.

ARTICLE 2: JOB DESCRIPTION

A. Training Representative. The Training Representative provides technical assistance to various divisions as required in an advisory capacity regarding aircraft maintenance and operational problems, new procedures and procedural changes. Duties also include technical training of Company flight and ground personnel as assigned, development and construction of course outlines, training aids and instructional materials in conjunction with other company personnel, administration of mechanic exams and other duties within the classification as assigned by the Company.

Positions within the Training Representative classification will be grouped according to the following principal duties:

1. Avionics and Electrical Systems
2. Powerplant Systems
3. Airframe Systems
4. SCEPTRE
5. Structural Repair
6. Aircraft Component Support Shops
7. Quality Assurance

Training Representatives shall have a minimum of six years work experience in the principal duties of the position so as to assure a thorough knowledge of subject matter, strong communication skills, fluent written and oral English skills, basic computer skills an understanding of applied mathematics and physical sciences, ability to impart knowledge clearly, ability to lead and control the discipline of a group, a high degree of independent judgment , and a thorough knowledge of maintenance operations policy and practices.

B. Production Planner: The Production Planners are responsible for the planning, forecasting and scheduling as required by Company approved procedures, work to be performed including routine and non-routine maintenance, modifications, etc. on flight and related equipment and accomplish other duties within the classification as assigned by the Company.

This work will be performed in the direct support of the aircraft maintenance effort and includes the major maintenance hangars, engine, component and accessory shop work planning and support.

Production Planners shall have a minimum of six years of diversified mechanical and/or inspection experience or equivalent thereof in the maintenance or overhaul of aircraft and/or a college degree or equivalent in mechanical or industrial engineering or related field with a demonstrated proficiency in analytical thinking, statistical analysis and creative problem solving.

C. Line Maintenance Planner: The Line Maintenance Planners are responsible for the planning, forecasting and scheduling as required by Company approved procedures, work to be performed including routine and non-routine maintenance, modifications, etc. on flight equipment and other duties within the classification as assigned by the Company.

This work will be performed in direct support of the line maintenance effort and includes maintenance station overnight work planning and support. The Line Maintenance Planners shall have a minimum of six years of diversified mechanical and/or inspection experience or equivalent thereof in the maintenance or overhaul of aircraft or shall possess a college degree or equivalent in mechanical or industrial engineering or related field.

D. Technical Writer: The Technical Writers are responsible for development and ongoing maintenance of aircraft maintenance data, tasks, manuals and related Company publications primarily associated with maintenance and inspection functions to meet the needs of both Company and governmental regulatory authorities. Technical Writers shall also perform other duties within the classification as assigned by the Company.

Technical Writers shall also be responsible for the coordination with other Company operating divisions and governmental agencies, of the proposed changes in maintenance tasks, manuals and related Company publications.

Technical Writers shall have a minimum of six years diversified mechanical and/or inspection experience so as to assure a thorough knowledge of subject matter, strong communication skills, basic computer skills, fluent written and oral English skills, an understanding of applied mathematics and physical sciences, a high degree of independent judgement and a thorough knowledge of maintenance operations policy and practices.

E. Reliability Analyst: The Reliability Analyst is responsible for performing the review, analysis, development and presentation of data and associated reports regarding aircraft/engine performance, including factors, such as, but not restricted to, components, flight delays/cancellations, operating trends, pilot reports, Regulatory Authority required data and/or reports, for use by NWA personnel and others as

designated. Analysis will be accomplished using the latest reliability techniques and methods including, but not limited to, probable cause and solutions, mortality analysis, MSG-3, FMEA analysis. The Analyst will make use of all available sources of maintenance/reliability data and must maintain a high level of accuracy and timeliness in the preparation of required data and reports. The Analyst will provide special investigations and analysis as required for the support of other programs, ensure accuracy of computerized data by continuous monitoring and verification of data. The analyst will review for compliance purposes, the policy, procedures, and requirements contained in the NWA Reliability Program and accomplish other duties within the classification as assigned by the Company.

Reliability Analysts shall have a working knowledge of aircraft systems, engines and structures, be familiar with P.C. and mainframe applications, possess statistical and analytical skills and strong written and verbal skills.

F. Technical Analyst: The Technical Analyst provides support for controlled maintenance documents and technical training materials. This includes word processing, graphics creation, page layout and control of document files. Duties also include the production of reports based on data base queries, audits of Company documents and the document distribution system, support of other ATSA classifications, and other duties within the classification as assigned by the Company. In addition, duties of the Technical Analyst may include contact with vendors, management or other individuals in a non technical support role, to assist in the accomplishment of work as assigned.

Technical Analysts shall have minimum of two years work experience in maintenance documentation, strong written and verbal skills and a very high degree of computer skills on mainframe, PC, and workstation computers using industry standard software as well as customized applications.

G. When open positions occur in the classifications listed in Paragraphs A-F above, the Company may require employees who apply for such positions to possess an Airframe and Powerplant License and/or an FCC License. Such requirement may vary within each classification, depending on the specific job function of the open position.

ARTICLE 3: HOURS OF SERVICE

A. Eight consecutive hours of service, exclusive of a 30 minute minimum meal period, will constitute a standard work shift. Such 30 minute minimum meal period shall be regularly scheduled within the fourth and fifth hours of the work shift or as mutually agreed to between the employee and his manager.

B. The normal workweek will consist of five eight hour workdays and two consecutive fixed days off within each workweek, which shall be defined as 12:01 a.m. Saturday to midnight the following Friday; however, it is understood that where Friday and Saturday are scheduled as consecutive days off, it will not be considered a violation of this rule.

The Company will make reasonable efforts to schedule most employees with fixed days off of either Friday/Saturday, Saturday/Sunday or Sunday/Monday; however, it is understood that other fixed day-off patterns may be used where required by the needs of the service.

C. It is recognized that the Company may establish rotating days off. However, at each station or location in instances where a majority of employees in a classification on a shift:

1. On fixed days off request rotating days off; or

2. On rotating days off request fixed days off; or

3. On rotating days off request a different type of rotation (i.e., fast or slow),

such request will be granted unless it can be shown that such change would cause impairment of the service or undue costs.

D. Regular shift starting times will be between the hours of 0600 and 0830, or between 1400 and 1630 or between 2000 and 0030. An additional shift starting time may be established outside these hours when the needs of the service require. Such requests will be granted unless it can be shown that such change would cause impairment of the service or undue costs.

E. Except as otherwise required by the needs of the service, assignment of work shifts and days off will be done on the basis of an employee's preference and his ATSA classification seniority.

F. Employees regularly in the service of the Company will be required to report for their scheduled work assignments, unless notified by the Company that there will be no work because of an Act of God, strike or other circumstances over which the

Company has no control, before the close of the employee's last shift worked or at least 16 hours before the start of their next regular scheduled work assignment, whichever period is shorter. Any employee not notified by the Company and as a result reports for work when there is temporarily no work because of an Act of God, strike or other circumstances over which the Company has no control shall receive a minimum of four hours pay at his regular hourly rate.

G. The workweek may be modified to meet employee preferences, subject to operational needs and management approval. As an example, such modification may consist of four 10-hour work days and three consecutive days off within the workweek.

H. Employees on a voluntary basis and subject to the approval of their manager may make up leave of absence time during the pay period at their straight time rate of pay.

I. Training Representatives will be allowed a reasonable amount of time before and/or after class for usual Training Representative activities as outlined in this Agreement.

J. If the governor of the state proclaims a state of extreme weather emergency advising people not to travel, employees employed within the affected area who are unable to report to work will be permitted a choice of authorized leave make-up time within the pay period or to use vacation time to receive pay for the scheduled work missed during the time of such emergency.

ARTICLE 4: OVERTIME AND HOLIDAYS

A. Employees will be paid at the overtime rate of time and one-half for all authorized time worked, including approved leave, sick leave, occupational injury or vacation time, during any two week pay period in excess of 80 hours up to and including 120 hours, and for all authorized time worked on either or both of the first two of their four rest days. These employees shall be paid at the overtime rate of double time for all authorized time worked during any two week pay period in excess of 120 hours and for all authorized time worked on the third and/or fourth day of their four rest days in a two week period, provided that they have worked on both of the first two days.

B. When an employee is required to report for work, training or a Company meeting on a scheduled day off, he shall be paid for the actual hours spent at work, in training or in attendance at a Company meeting with a minimum of two hours.

C. Employees covered by this Agreement will observe the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, **and** Christmas Day. Any employee required to work on any of these **7** holidays shall be compensated at a rate of two and one-half times his regular straight time rate for all time worked. Employees not scheduled to work and employees scheduled to work but not required to work on the above mentioned holidays shall be paid for eight hours at their regular rate for the holiday.

1. Employees may convert up to three fixed holidays to floating Personal Days Off (PDOs). Such PDOs may be used on any day during the current calendar year mutually agreed upon between the employee and his immediate supervisor.

D. There shall be no pyramiding of the overtime rates provided for in this Agreement, and no employee shall receive more than double the straight time rates for any hours worked except as provided for in Article 4.C.

E. Employees held in continuous service for more than two hours before and/or after their regular working hours will be permitted a paid meal period of 30 minutes after two hours of overtime work and thereafter at each interval of five hours of additional overtime work. If, at Company request or approval, the employee does not take such 30 minute lunch period, he will receive 30 minutes pay in lieu thereof at the applicable overtime rate for each such lunch period missed. The applicable overtime rate for a missed lunch period is the rate in effect at the time the entitlement to the paid lunch arose.

F. By mutual agreement between the employee and his/her manager, compensatory time off in lieu of overtime may be allowed.

ARTICLE 5: FIELD WORK/TEMPORARY VACANCIES

A. Employees required to leave their assigned base station to go to another point for training or to perform field service or to fill a temporary vacancy in the interest of the Company shall be paid not less than their established rate and, in addition, shall be reimbursed for all actual and necessary expenses in accordance with established Company policy.

B. Any employee temporarily assigned to a higher rated position covered by this Agreement shall receive the higher rate for the day or days so assigned.

C. Any employee temporarily assigned to a lower rated position will not have his rate reduced.

D. Employees engaging in field service or filling temporary vacancies away from their base stations shall be credited for pay purposes at the straight time rate for the first 8 hours and the time and one-half rate for hours in excess of 8 for all time spent in traveling or waiting and it is not their regular day off or a holiday. All time spent in traveling, waiting or working at Company request on scheduled days off, holidays and in excess of eight hours on scheduled workdays when work is required will be credited for payment under the applicable overtime provisions of the Agreement.

E. No travel or waiting time in excess of regular scheduled hours will be credited for travel to Company meetings or on special assignment (i.e., other than field service or temporary vacancy) on Company business or to attend training classes, except that:

1. When the Company directs an employee covered by this Agreement to travel on his regular scheduled day or days off, or on a holiday on which he is not scheduled to work, for the purpose of attending Company meetings, training classes or to fulfill other special assignments pertaining to his work, not constituting field service or the filling of temporary vacancies, he shall receive compensation for the actual time spent in traveling and/or waiting on his regular scheduled day or days off or on a holiday, not to exceed eight hours per calendar day (12 hours for international flights) at his regular straight time pay.

2. If such special assignment involves travel without an eight hour break in service prior to or after completion of the assignment or of the regular work for the day, the employee shall receive compensation at his regular straight time rate for the actual time spent in traveling and/or waiting, not to exceed eight hours (12 hours for international flights).

It is understood that for the purpose of this paragraph, none of the overtime pay provisions of this Agreement will apply to such travel time.

F. Employees required to attend training classes or Company meetings at locations other than their assigned base station will be paid eight hours per day for each day of such assignment.

G. Expense reports will be submitted according to the Company's corporate policy. The Company will allow adequate time during normal working hours for the preparation of expense reports relating to Company approved travel.

H. Where practical, employees who are required to leave their assigned base station for training or to perform field service shall not be scheduled to exceed two consecutive workweeks away from their permanently assigned base.

ARTICLE 6: SENIORITY

A.

1. "ATSA Seniority" means a length of time established, accrued and retained in a classification in accordance with the provisions of this Agreement, plus the ability to perform the work in a satisfactory manner.

2. ATSA Seniority shall apply in filling of open positions, assignment of vacation periods, working shifts and days off, reduction in force and recall.

3. For purposes of bidding in accordance with Article 7, Company seniority and then age will be used as a tie breaker in the event ATSA seniority is equal.

B. Establishment of Seniority

1. Seniority for Company employees who are selected (by bid or otherwise) to fill a position of greater than 180 calendar days duration in one of the classifications covered by this Agreement shall begin on the day following the final date of the job bulletin. Seniority for persons hired from outside the Company who enter one of these classifications by selection to unfilled bulletined positions shall begin from the date of permanent assignment to such positions.

2. Employees temporarily assigned to unbulletined positions do not establish seniority because of such assignment.

C. Probationary Period and Qualification Period

1. New employees shall be on probation during the first six months commencing effective the day following the close of the bid for the permanent position in a classification covered by this Agreement. The Company shall be the sole judge of an employee's performance during this probationary period, and the employee may be disciplined or discharged without recourse to the grievance and System Board of Adjustment provisions of this Agreement. If retained in service after the probationary period, the employee shall then be placed on the seniority list for his respective classification.

2. An employee who has established seniority in a classification under this Agreement and who has been selected (by bid or otherwise) for a position in another classification in which he/she had not previously established seniority or has been selected (by bid or otherwise) for a position in a different area of principal duties within the Training Representative

classification will be subject to a 90 day qualification period in the new classification, or new area of principal duties. Such qualification period will commence effective the date of assignment to the new classification. During such qualification period, the Company shall be the sole judge of the employee's performance and such employee may be disqualified at any time without recourse to the grievance and System Board of Adjustment provisions of the Agreement. An employee who is so disqualified will be allowed to exercise seniority to his former classification in accordance with Paragraph G below.

3. In the event an employee commences a probationary period in any classification covered by this Agreement, and such employee successfully completes his probationary period in a separate classification covered by this Agreement, such employee shall be placed on the seniority list applicable to both classifications, provided he successfully completed 90 days in the initial classification and successfully completed his probationary period in a subsequent classification.

D. Loss of Seniority

1. An employee who has established seniority in a classification shall continue to retain and accrue such seniority except that an employee shall lose his seniority and his name shall be removed from all seniority lists if:

   a. He quits, resigns, is discharged or retires.

   b. He is off payroll on layoff for 60 consecutive months.

   c. He fails to comply with the provisions of Article 6.G.5.

2. An employee transferred to a permanent position outside this agreement will retain and accrue seniority for a period of 12 months from the date of transfer to such permanent position. At the conclusion of the 12 month period, such employee shall retain seniority accrued without further accrual.

3. An employee who voluntarily transfers from a position covered by this Agreement to another classification covered by this agreement will retain and accrue seniority for a period of 12 months from the date of transfer to such permanent position. At the conclusion of the 12 month period, such employee shall retain seniority accrued without further accrual.

E. Assignment to Foreign Stations

Any employee covered by this Agreement accepting an assignment to a foreign station in a position equal to or higher than the position from which he transfers will continue to accrue seniority in the classification(s) under this Agreement in which he held seniority at the time of transfer. Employees transferred from the United States to permanent positions outside the limits of the United States shall not be permitted to bid for positions under this Agreement while on such foreign assignment. Upon completion of their terms of service at foreign stations, these employees will be privileged, after taking all accrued vacation, to exercise seniority to any classification on the domestic system in which they hold seniority and are qualified.

F. Seniority List

A seniority roster of all employees covered by this Agreement showing name, title, location and seniority date will be distributed in January of each year to all stations where there are employees covered by this Agreement. Any protest of seniority dates must be filed within 30 days after the initial appearance on the seniority roster, except reasonable extension of this time will be allowed for an employee who may be temporarily absent from his station.

G. Reduction in Force and Recall

1. When it becomes necessary to reduce the working force at any location, at least 10 workdays advance notice, or pay in lieu thereof for all workdays less than such advance notice, will be given to employees who are to be laid off. In the event of strikes by employees of the Company which curtail flight operations by 50% or more system-wide or in the event of an Act of God or other circumstances over which the Company has no control, such 10 days notice or pay in lieu thereof will not be required.

2. A list of employees laid off shall be provided promptly to ATSA's President.

3. Each employee issued a layoff notice or displaced by a senior employee in an exercise of seniority must make known within five calendar days thereafter his intention to exercise his seniority to displace the most junior employee at his station who holds a comparable or lesser rated job in which he holds seniority and for which he is qualified. An employee who does not exercise seniority within such five day time limit shall lose his right to exercise seniority, and will be placed on layoff status on the date specified in his layoff notice or the date of his last shift worked following his displacement.

4. An employee whose seniority is insufficient to allow him to exercise seniority at his station to a classification in which he holds seniority will be permitted

to exercise his seniority in any classification in which he holds seniority to displace the most junior employee in such classification at the station of his choice, provided he is qualified to perform the work of the employee displaced. Such transfer will be at the employee's expense except that tourist class passes with service charge waived will be furnished to the employee and his family.

5. Employees who are laid off shall file their names and addresses in writing with the Human Resources Department of the Company and the Secretary/Treasurer at time of layoff, and shall keep said parties informed in writing of any change of address. Failure to do so or to return to work within 10 days of notice to return will cause forfeiture of his seniority rights under this Agreement, unless authority in writing is secured from both the proper officer of the Company and the Secretary/Treasurer granting extension of time limit within which to return to service.

6. In the event of a reduction in force in either the Line Planner or Production Planner classification, although otherwise prohibited by this Agreement, an affected employee in either classification will be allowed to exercise his/her seniority to the other classification, provided such employee is deemed by the manager to be qualified to perform the essential functions of the job in the other classification as of the date of the exercise of seniority.

H. Any disputes as to reasonableness of action taken by the Company relating to seniority are to be handled in accordance with the grievance procedure outlined in Article 8, with the exception that any employee claiming that the Company's determination in matters involving promotions under this Article is unreasonable may have his claim reviewed in accordance with the grievance procedure up to and including the departmental executive vice president.

ARTICLE 7: FILLING OF POSITIONS

A. Any position established and anticipated to continue six months or more, or where established as temporary and then continuing for more than six months from date of establishment, shall be considered as a permanent position and bid in accordance with paragraph E of this article. The Company will notify the ATSA Secretary / Treasurer when temporary positions are to be established.

B. When positions are to be bulletined, the bulletin will show the principal duties, duration if the position is temporary, hourly pay rates in accordance with the ATSA Agreement, location, hours of assignment and days off. Bulletins will be posted on the Company's approved electronic system and a copy of each bulletin will be furnished to the ATSA Secretary/Treasurer.

C. All applications for bulletined positions must be made in writing to the official who issues the bulletin and must be received in his office within 10 calendar days of the date the bulletin is posted. An employee who has been disqualified from a classification pursuant to Article 6(C)2. will be ineligible to file an application for a bulletined position in such classification for two years from the date of disqualification.

D. All bulletined positions will be awarded within fourteen calendar days after the close of the bulletin. A position bulletined as temporary which later becomes permanent will be rebulletined as a permanent position. An employee who has been awarded a position in accordance with the bulletin shall receive pay in the classification in accordance with the award, no later than 10 calendar days following the date of the award.

E. Open bulletined positions shall be awarded to eligible bidders in the following order:

1. The Company will provide general notice of open positions to be filled through local realignment to other employees in the classification at the station, and awarded in seniority order from among the bids of employees who hold seniority and are working in the classification of the open position.

2. If not filled under 1. above, in seniority order from among bids received from employees who hold seniority and are working in the classification of the open position in another location.

3. If not filled under 2. above, in seniority order from among bids received from employees on layoff who hold seniority in the classification of the open position.

4. If not filled under 3. above, the position will be filled from bids of eligible employees in seniority order from among bids received from employees who hold seniority in the classification of the open position, and are working under this Agreement in a classification other than the one of the open position.

5. If not filled under 4. above, the position will be filled from bids of eligible employees who hold seniority in a classification other than the open position and are working under this agreement in a classification other than the one of the open position. The most qualified employee who in the judgment of the proper Company official is qualified for the position will be selected. However, if two or more persons are found to have substantially equal and adequate qualifications, then such position shall be awarded to the employee with the longest service under this Agreement.

6. If not filled under 5. above, the position will be filled from bids filed by laid off employees who hold seniority in a classification other than the one of the open position. The most qualified employee who in the judgment of the proper Company official is qualified for the position will be selected. However, if two or more persons are found to have substantially equal and adequate qualifications, then such position shall be awarded to the employee with the longest service under this Agreement.

7. If not filled under 6. above, the position will be filled from bids of employees outside of this Agreement who hold seniority in the open classification. The most qualified employee who in the judgment of the proper Company official is qualified for the position will be selected. However, if two or more persons are found to have substantially equal and adequate qualifications, then such position shall be awarded to the employee with the longest service under this Agreement.

8. If not filled under 7. above, the position will be filled from bids of employees outside of this Agreement who hold seniority in a classification other than the one of the open position. The most qualified employee who in the judgment of the proper Company official is qualified for the position will be selected. However, if two or more persons are found to have substantially equal and adequate qualifications, then such position shall be awarded to the employee with the longest service under this Agreement.

9. If not filled under 8. above, then the position may be filled by Company selection of any qualified employee from another agreement or by new hire.

F. An employee covered by this Agreement who is promoted to a temporary bulletined position, or to a temporary assignment to a management position, will, upon completion of the temporary assignment, be returned to his former job and status.

G. In the event of the geographical relocation of the work performed by employees covered by this Agreement in whole or in part, that will affect the employee's position, the employee affected will be offered transfer to the new location at Company expense.

H. Employees who have given long and faithful service and who, because of their age or physical condition, have become unable to handle their normal assignments under this Agreement will be given consideration for any available work which they are able to handle and will receive the rate for that work established by the Company pending retirement under the applicable pension plan.

I. No employee will be compelled to accept a transfer against his wishes, it being understood this does not apply to temporary assignments.

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ARTICLE 8: GRIEVANCES

A. The Company will not discriminate against any employee designated as a committeeman to represent employees covered by this Agreement and will, upon request, grant such committeeman free space available transportation over the Company's system to represent such employees.

B. Any employee, other than a probationary employee, who believes that he has been unjustly disciplined or discharged, or that any provision of this Agreement has been violated, shall so advise his immediate supervisor within 30 calendar days after the date on which the employee knew, or reasonably should have known, of the cause giving rise to the complaint. The supervisor and employee shall meet and discuss the complaint in a good faith, informal attempt to arrive at a satisfactory adjustment. The supervisor will issue a written reply within 10 calendar days.

C. If the employee is not satisfied with the supervisor's reply, the employee or his authorized Union representative may file a written grievance. Such written grievance must be filed within 45 calendar days after the date on which the aggrieved employee knew, or reasonably should have known, of the cause giving rise to the complaint. The grievance shall be filed with the next higher official of the Company designated by the Company to handle such matters. The employee's supervisor will tell him who that official is.

D. The hearing officer designated by Paragraph C above will hold a Step One hearing within 10 calendar days after the date on which he receives the grievance. The purpose of such hearing will be to afford the employee and/or his authorized Union representative the opportunity to fully present the employee's position and endeavor to reach a satisfactory settlement. Within seven calendar days after final discussion and closure of the hearing, the Company hearing officer will issue his written decision to the employee and his representative, with a copy to Labor Relations. In the event the Company Step One hearing officer makes no attempt within the required time limit to schedule a grievance hearing and the grievance is later the subject of a System Board of Adjustment Arbitration, the Company shall pay the Union's share of the arbitrator's fees and expenses.

E. The decision of the Step One hearing officer may be appealed, provided the employee or his authorized representative files a written request for review with the employee's department head within 15 calendar days after the date of issuance of the decision of the Step One hearing officer. The employee's department head, or his designee, shall then act as Step Two hearing officer and will hold a hearing on the grievance within 15 calendar days after receipt of the appeal. Within 10 calendar days after final discussion and closure of this hearing,

the Company's Step Two hearing officer will issue a written decision to the employee with a copy to the Union and to NWA Labor Relations.

F. The decision of the Step Two hearing officer may be appealed and the dispute submitted to the System Board of Adjustment by filing an appeal and submission with the System Board by the employee or his Union representative within 30 calendar days after the date of issuance of the Step Two hearing officer's decision

G. An employee will not be disciplined or discharged without being issued notification in writing by the Company of the reason(s) for such action within 15 calendar days after the date that the employee's immediate manager had knowledge of the offense. An employee who is held out of service pending the completion of the Company's investigation will be paid at his regular straight time rate of pay for scheduled hours of service lost.

H. If it is found that an employee has been unjustly withheld from service, disciplined or discharged, he will be reinstated with his seniority rights unimpaired, his personnel records corrected and compensatory relief and company benefits, if any, granted in accordance with the decision of the hearing officer.

I. If a Company hearing officer fails to issue a decision within the time limits set forth herein, the grievance will be deemed denied on the deadline date and will be subject to appeal accordingly. Any grievance not filed or appealed by the employee within the time periods set forth herein will be deemed invalid and will not be entitled to any further processing under Articles 8 and 21.

J. Grievances involving wage claims will not be valid and collectible for a period earlier than 30 calendar days prior to the date of the filing of the grievance.

K. All hearings and investigations will be conducted during regular working hours insofar as possible, and committee members and necessary witnesses shall not suffer loss of pay while handling grievances or attending Company investigations.

L. It is understood and agreed that the Company will not lock out any employee covered hereby, and the Union will not authorize or take part in any strike or picketing of Company premises during the life of this Agreement until procedures for settling disputes as provided herein and as provided by the Railway Labor Act have been exhausted.

M. The Company (minimum V.P. Labor Relations - Ground and V.P. Technical Operations) and ATSA agree to meet monthly, or as necessary, to address and resolve contractual and non-contractual issues.

ARTICLE 9: LEAVES OF ABSENCE

A. When the requirements of the service will permit, any employee hereunder shall, upon proper written application and approval by the appropriate manager, be granted a leave of absence in writing for a period not in excess of one year. Such leave may, upon proper written application, be extended by the Company for additional periods of not to exceed 90 calendar days and not to exceed a total duration of 60 consecutive months. Under such leaves and/or extensions, the employee shall continue to accrue seniority. Copies of the approval of such leaves and/or extensions shall be forwarded to the Secretary/Treasurer.

B. Any employee on special assignment in the interest of the Company or the Union shall be granted an indefinite leave of absence by the Company for the period so employed and shall have all employee benefits that can reasonably be continued in effect during his leave of absence. Under such leaves the employee shall continue to accrue seniority.

C. Any employee hereunder returning from an authorized leave of absence or extension thereof will be returned to the job held when the leave was granted. If the job no longer exists, he may exercise his seniority.

D. Any employee hereunder on leave of absence, engaging in gainful employment not provided for in Paragraph B above without prior written permission from both the Company and the Union, shall forfeit his seniority rights, and his name will be stricken from the seniority roster.

E. Employees on military leaves of absence shall retain seniority rights unimpaired. The rights of employees returning from military leaves of absence shall be in accordance with applicable United States law.

F. Maternity/Family Medical Leave Act (FMLA) leaves of absence will be granted to employees in accordance with Company policy.

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ARTICLE 10: SAFETY AND HEALTH

A. Employees entering the service of the Company may be subject to a physical examination. The cost of any such examination will be paid by the Company.

B. Personnel taken sick or injured while at work shall be given medical attention at the earliest possible moment and will be permitted to return to work without signing any release of liability pending the disposition or settlement of any claims for damage or compensation.

C. The Company agrees to maintain safe, sanitary and healthful conditions at all stations or locations and to provide reasonable protection to employees working with hazardous chemicals.

D. Employees should promptly report tools and equipment which are inoperative or which they believe are unsafe so that repairs or corrections can be expedited. Employees shall not be required to use tools or equipment that have been so reported until a determination is made by appropriate Company officials that the tool or piece of equipment in question is safe to use.

E. A representative from ATSA shall take part in all Joint Safety Committee meetings held by the Company and other employees outside this agreement.

1

ARTICLE 11: VACATIONS

A.

1. Employees working in a position covered by this Agreement on date of signing of this Agreement shall accrue vacation credit in accordance with completed years of service with the Company at the following rates for each month of service thereafter:

Completed Years of Service	Rate of Accrual Per Month of Service Thereafter
Less than 4	6.67 hours
4 but less than 9	10 hours
9 but less than 16	13.34 hours

B. Vacation credit shall continue to accrue to an employee while in a nonpay status for the first 30 calendar days of authorized absence and periods of suspension in any anniversary year, but shall not accrue beyond the first 30 days.

C. Each employee will be provided an opportunity to schedule vacation days equal to his/her annual rate of accrual. All annual rate of accrual vacation days may be taken as DAT (day-at-time) vacation days and may be taken in hourly increments, both are subject to supervisory approval. Vacation will be awarded on a first-come, first-serve basis based on ATSA seniority within the classification and operational needs. Excess vacation, i.e., accrued vacation days in excess of the annual rate of accrual, may also be taken as DAT days, or alternatively, requested in writing as a lump sum payoff. All requests for scheduled vacation are subject to the operational needs of the Company.

D. An employee whose scheduled vacation has been canceled by written Company directive may:

1. Bid for any vacation period open during the remainder of the calendar year, or

2. Receive lump sum payment for the days of canceled vacation within 30 calendar days of the request, or

3. Rebid such canceled vacation for use during the next calendar year. Such rebid will be handled separate and apart from the bidding of normal vacation and will be in addition to regular vacation allowance. Such rebid vacations will not be subject to cancellation.

Such employee will have 10 workdays from the date of his receipt of notice of cancellation to advise his supervisor in writing as to which of the above options he desires and failing to do so will be deemed to have elected to receive a lump sum payment.

E. An employee who changes cost center area after vacation periods have been awarded may:

1. Bid for any vacation period open during the remainder of the calendar year, or

2. Receive lump sum payment for the days of vacation affected within 30 calendar days of request, or

3. Accept any vacation period assigned by the Company.

NOTE: Such employee will have 10 workdays from the date of his assignment to the new vacation bid area to advise his supervisor, in writing, as to which of the above options he desires and failing to do so will be deemed to have elected to receive a lump sum payment.

F. An employee who resigns from the service of the Company and has given the Company two weeks advance written notice of his intention to resign shall be entitled to his accumulated vacation credit to the date of termination.

G. An employee who is laid off as a result of reduction in force or who is placed on leave of absence of greater than 30 calendar days anticipated duration shall be paid all of his accumulated vacation credit, provided he has had one year without a break in service with the Company, unless he advises the Payroll Division - HDQ in writing within 14 calendar days of the effective date of his leave or layoff that he desires to retain his accrued vacation intact.

H. The pay for such vacation shall be the pay which the employee would normally have received at his straight time rate for regular time had he worked during his vacation.

I. Employees covered by this Agreement will not be combined with employees covered under other agreements for vacation scheduling.

J. If recognized holidays fall within an employee's vacation period, the employee may elect to extend said vacation period (on either end) by an additional regular workday or to take the day on a DAT basis as provided in C above.

K. Employees with accrued vacation credit of 10 days or more will be given their vacation pay prior to taking vacation if the request is submitted in writing to the Director Payroll—HDQ at least two calendar weeks prior to starting vacation, but in no case will advance payment be made for less than a full vacation period of 10 days.

1

ARTICLE 12: SICK LEAVE

A. All employees covered by this Agreement shall earn **3.33** ~~eight~~ hours of sick leave for each month of service in the employ of the Company. If sickness does not require their use as earned, these days shall accrue to a total credit of **520** hours. **Sick leave will be paid at 75% of the composite hourly pay rate.**

B. Sick leave credit shall not accrue to an employee while in nonpay status when the duration of such nonpay status in any anniversary year aggregates 30 scheduled workdays or more, except that during approved leaves of absence employees shall accrue sick leave credit during the first 30 days of such absence.

C. Any employee transferred, promoted or demoted without a break in service from one station, department, branch or section to another shall at the time of his transfer be credited with accrued sick leave.

D. Employees who are laid off, because of reduction in force and unable to exercise seniority in obtaining hourly rated employment, shall retain intact sick leave credit for a period not to exceed 60 months from date of layoff. If such employees return to the service of the Company within that period, the sick leave credit which they will then begin to earn shall be added to such previously accrued sick leave credit. If such employees do not return to the service of the Company within the 60 month period, the accrued sick leave credit shall be canceled, and if they return subsequently their sick leave credit shall begin to accrue as of the date of their return. Employees on extended leaves of absence shall retain all accrued sick leave credit.

E. Sick leave taken on workdays shall be deducted from the accrued sick leave earned by an employee. An employee will be permitted to use sick leave in hourly increments on days on which he also performs work.

F. Occupational Injury Leave

1. If an employee incurs a physical injury while at work and in the course of performance of his duties for the Company, he will be eligible to receive occupational injury pay as provided herein.

2. Each employee shall be credited with eight hours of occupational injury leave for each month of service under this Agreement. Employees who have transferred to this Agreement from the NWA/IAM Mechanics and Related Personnel Agreement will be credited with their accrued occupational injury leave under the Mechanics and Related Agreement as of the date of their transfer to this Agreement. All unused occupational injury time shall accrue to a total credit of 800 hours of occupational injury

time. This maximum accrual limitation shall not apply to occupational injury leave hours earned for months of service after July 31, 1993. Occupational injury leave compensation shall be paid by the Company at the employee's base rate for each workday for which occupational injury leave is approved.

An employee will be permitted to use occupational injury leave in hourly increments on days on which he also performs work.

3. An employee shall not be permitted to use any of his occupational injury leave credit for sick leave. After an employee has exhausted his occupational injury leave credit, however, he may use accrued sick leave credit for occupational injury leave. Under such circumstances, for each day that an employee receives sick leave pay, he shall pay to the Company any amount received for that day from Workers' Compensation benefits due him.

G. A doctor's certificate may be required prior to approval of pay for any sick leave or occupational injury leave taken, or to justify an employee's absence due to claimed sickness or occupational injury. Such request must be made in advance of the time the employee notifies the Company of the intent to utilize sick leave or occupational injury leave or must be requested during the course of illness. All expenses incurred in connection with obtaining such doctor's certificate shall be borne by the employee.

ARTICLE 13: SHIFT PREMIUMS

A. For the purpose of this Agreement it is understood and agreed that for any employees covered by this Agreement, any work shift with a starting time of 1200 or later and before 1800 shall be considered an afternoon shift, and any work shift with a starting time of 1800 or later and before 0600 shall be considered a night shift.

B. Shift differential pay shall be included in the computation of overtime rates.

C. The following shift premiums will be in effect during the term of this Agreement:

Afternoon:	51¢ per hour
Night:	58¢ per hour

D. A relief employee who is scheduled to rotate between two or more types of work shifts (i.e., day, afternoon, night) or an employee who is scheduled for two or more starting times that are three or more hours apart during a work week will be paid 61 cents per hour additional compensation over the rate paid on the day shift for all hours worked during any workweek in which he works such schedule.

1

ARTICLE 14: TEST FLIGHTS AND COMPANY BUSINESS TRAVEL

A. All employees covered by this Agreement required to participate in test flights shall be paid at the rate of one and one-half times their ground rate for all time thus engaged with a minimum of one hour, and shall be covered by a standard aviation accident insurance policy with a death benefit of not less than $100,000.00 paid for by the Company.

The Company will encourage ATSA employees who are Certified Airmen, to ride the jump seat in order to interface with Flight Operations personnel, and to gain a better understanding of the inter-working relationship of all systems on the aircraft in an effort to enhance the employee's value to the Company.

B. The Company will provide employees covered by this Agreement while they are on active payroll, Company-paid business travel accident coverage in the amount of $100,000.

C. The maximum amount payable under this Article in the event of an employee's death is $100,000.00.

1

ARTICLE 15: UNIFORMS

The Company agrees that uniforms will not be required during the duration of this Agreement. In the event it is determined to be necessary, appropriate protective clothing will be provided to employees under this Agreement.

1

ARTICLE 16: REDUCED RATE TRANSPORTATION

Free and reduced rate transportation shall be made available to all personnel covered herein in accordance with Company policy and applicable laws and regulations.

1

ARTICLE 17: SEVERANCE PAY

A. Any employee who is laid off and who has no seniority under any other agreement, or who does not have sufficient seniority to be able to exercise his rights under any agreement in which he has seniority or who is not provided other employment with the Company shall be paid severance pay as provided in Paragraph B below, but he shall receive no severance pay if any of the following conditions exist:

1. He exercises his seniority in order to remain in the employ of the Company.

2. He accepts any other employment with the Company or refuses to accept a job in his own or comparable work classification under this Agreement.

3. He fails to exercise his seniority at any station which would enable him to remain in the employ of the Company.

4. The layoff is caused by an Act of God, a war emergency, revocation of the Company's operating certificate or certificates or grounding of a substantial number of Company aircraft.

5. The layoff is caused by a strike or picketing of the Company's premises or any work stoppage or other action which would interrupt or interfere with any operations of the Company.

6. He is dismissed for cause, resigns or retires.

7. There is a temporary cessation of work because of circumstances beyond the Company's control.

B. The amount of severance pay due under this Article shall be based on the length of actual straight time compensated service with the Company under this Agreement in addition to straight time compensated service under an NWA/IAM Agreement, and shall be computed on the basis of the employee's regular straight time basic hourly rate at the time of layoff as follows:

If Employee Has Completed	Severance Allowance
Less than 1 year of service	None
1 year but less than 3 years of service	80 hours
3 years but less than 4 years of service	120 hours

If Employee Has Completed	Severance Allowance
4 years but less than 5 years of service	160 hours
5 years but less than 6 years of service	200 hours
6 years but less than 7 years of service	240 hours
7 years but less than 8 years of service	280 hours
8 years but less than 9 years of service	320 hours
9 years but less than 10 years of service	360 hours
10 or more years of service	400 hours

C. An employee shall receive his severance pay at the time of layoff, and such severance pay shall be at regular pay periods and continue until all such pay credit is used. In no event shall severance pay be due after the recall of any such employee by the Company or if he accepts other employment with the Company.

D. An employee returning to the service of the Company or transferring to a position not covered by this Agreement who is thereafter laid off prior to expiration of two years from his last layoff under this Agreement shall be entitled to the greater of (1) any severance pay applicable to the position then held by him or (2) the severance pay to which his compensated service under this Agreement would entitle him.

E. An employee who has returned to the service of the Company who is again laid off under conditions entitling him to severance allowance shall be entitled to an amount computed on his years of compensated service with the Company after the date of such return to the Company's service. If for any reason an employee did not use all of the severance allowance to which he may have been entitled, and who is again laid off under conditions entitling him to severance allowance, he shall be entitled to an amount computed on his years of compensated service with the Company after the date of such return to the Company's service plus any previously unused severance allowance, if any.

ARTICLE 18: GENERAL AND MISCELLANEOUS

A. Any employee leaving the service of the Company will, on written request to the Personnel Department, be furnished with a letter setting forth the facts as to his employment and length of service with the Company.

B. An employee shall be expected to familiarize himself as soon as reasonably possible with new equipment put into service by the Company where knowledge of such equipment is an integral part of his work assignment. The Company will cooperate to the fullest extent possible without a change of classification or rate to the person affected.

C. All orders or notices to employees under this Agreement involving a change in station assignment, promotion, demotion, off payroll status, layoff and leave of absence shall be given in writing.

D. No employee shall be required to perform any manual work except**:** in an emergency or as may be necessary to instruct or train others or to make minor adjustments during the course of experimental or research work. Manual work related to any labor dispute will not be considered to be an emergency.

E. Employees hereunder who must be absent from their work while serving as jurors shall, upon proper evidence that they were called and actually served such jury duty, be paid their regular rate of compensation less the fee received for jury services.

F.

1. When it is necessary for an employee to be absent from duty because of death in his immediate family (spouse, child, dependent stepchild, mother, father, sister, brother, mother-in-law or father-in-law), such employee will be granted absence with pay for any three consecutive scheduled workdays, one of which shall be the date of death or the date of the funeral. If the death of an immediate family member occurs while the employee is on vacation, bereavement leave may be taken in lieu of vacation days. Such days will not be charged against an employees' vacation accrual. NOTE: An employee's stepparent(s) or legal guardian(s) may be substituted for his mother and father upon approval of the Managing Director of Labor Relations-Ground or his designee(s).

a. In conjunction with bereavement leave, employees will be permitted to use additional vacation time off as needed to round off the work week. When an employee uses additional vacation time off, such time off will be deducted from his vacation accrual but will not reduce the number of DAT's intended to be used throughout that calendar year. An employee who chooses to use this vacation time should notify his manager at the time bereavement leave is requested.

2. When it is necessary for an employee to be absent from duty because of the death of a grandparent or other individual (maximum of two other individuals), such employee will be permitted to use vacation time for any three consecutive scheduled workdays, one of which shall be the date of death or the date of the funeral. Such time off will be deducted from the employee's vacation accrual but will not reduce the number of DAT's intended to be used throughout that calendar year.

G. During the first year of this Agreement the Company will establish a 401(K) Plan for employees hereunder.

H. The material contained in service or personnel records that are maintained for all employees by the Company in the Human Resources Department will, after written request has been made by the employee, be made available to him and, upon his authorization, to his Union representative. Information contained in an employee's local file maintained by local management that has been used as a basis for disciplinary action that has been taken against an employee will, after written request has been made by the employee, be made available to him and, upon his authorization, to his Union representative.

I. Wherever in the Agreement employees are referred to in the male gender, it is recognized as referring to both male and female employees.

J. There shall be no discrimination against employees covered by this Agreement because of race, color, religion, age, sex or national origin.

K.

1. Unequal application and/or administration of any disciplinary action occasioned, in whole or in part, because of the race or color of an employee who is the subject of the same, shall not be allowed or condoned.

2. Harassment of any employee based in whole or in part on race or color shall not be condoned or permitted to continue once discovered.

3. No promotion, transfer, overtime or other compensation opportunity or other term or condition of employment shall be denied based in whole or in part, on race or color; provided, however, that any consideration of race or color in achieving the affirmative action goal and other legal obligations of NWA shall not be a violation of this provision of the Agreement. It is further provided that actions taken by NWA in achieving its affirmative action goals or other legal obligations shall not be inconsistent with or override any of the other terms of this Agreement.

L. Positions for Disabled Employee

Notwithstanding any provision to this Agreement to the contrary, the Company may create a special job assignment or restructure any existing job assignment(s) for a disabled employee in an effort to reasonably accommodate such employee's disability to enable the employee to perform essential functions of the employee's position.

M. Written notice of formal discipline shall become inactive and shall, upon the employee's request, be removed from his files after 18 months from the date of issuance, provided that there has been no subsequent formal discipline issued to the employee in the same category within such 18 months.

N. Within 60 days, or as soon thereafter as reasonably practicable, the Company shall provide each employee covered by this Agreement with a pocket-size copy of this Agreement. The Company will provide a pocket-size copy of this Agreement to new employees covered by this Agreement within 30 days of their date of assignment in a classification covered herein.

O. The Company will make reasonable efforts to allow for ATSA orientation of new hire employees.

P. The Company will meet and confer with ATSA representatives to review circumstances relating to, or providing for, electronic commuting where such proposal will allow for mutual advantage to the Company and to employees represented by ATSA.

Q. Should there be any change during the life of this Agreement in federal or state license requirements, all employees affected shall be given a reasonable length of time from the date of change to obtain such license without change in status or pay.

ARTICLE 19: INSURANCE BENEFITS

See attached exhibit.

ARTICLE 20: WAGE RULES

A. The rates of pay set forth in Schedule "A", attached hereto and made a part of this Agreement, shall be the minimum rates paid effective on the first day of the pay period commencing on or before the agreed date of pay increases set forth on such Schedule "A". Any employee who, as a working member of any one of the classifications covered herein, is designated and required by the Company in addition to his usual duties to be regularly responsible for supervising, directing and approving the work of other employees in his or other classifications covered by this Agreement, shall be deemed to be in a lead position, and for that reason and while so assigned shall have 89¢ added to his regular hourly rate of pay.

B. No employee shall suffer any reduction in his rate of pay as a result of making this Agreement effective, and nothing in this Agreement shall be considered to prevent increases in individual rates or classifications over and above the minimums specified.

C. Regular pay days shall be established for each station on the basis of biweekly payment of compensation, except as it may be changed to a more frequent method to comply with a state law.

D. Should the regular payday fall on a holiday or on a day when the shop or facility is closed down, every reasonable effort will be made to pay employees on the preceding day.

E. In the event of a pay discrepancy equal to eight hours or more in the pay of an employee, a special check will be issued to cover the shortage within five working days of notification to Payroll of the shortage; provided, however, that when a regular paycheck is due the employee within such five day period, Payroll may include the shortage in the regular paycheck.

F. Employees leaving the service of the Company will be furnished with a paycheck covering all time due upon request at the earliest possible time after separation and in compliance with state laws.

G. Employees returning to the jobs covered by this Agreement, either through bidding or from a layoff status, shall be returned to the position their seniority entitled them to and paid a rate determined by all time spent in the classification, plus all time spent in subsequent equal or higher classifications.

H. In computing an employee's time elements for automatic progression under the wage scales, the following shall be observed:

Authorized initial leaves of absence shall be included in length of service, but days absent beyond the authorized time shall not be so included unless a renewal has been approved by the management and the Union.

Absence on sick leave and absence due to injury or accident occurring off the job (up to and including a total of 90 days for injury or accident suffered off the job whether or not covered by sick leave) shall be included, and also time spent by employees away from their regular jobs when they are loaned by the Company to other employers.

I. In the event of an overpayment to an employee which is to be recouped by the Company, not more than 25 percent of an employee's gross pay will be deducted from any one paycheck. This 25 percent limitation will not apply to recoupment deductions taken by the Company with respect to advanced vacation or Worker's Compensation offset payments.

J. Employees classified as Training Representatives, Production Planners, Line Maintenance Planners, Technical Writers and Reliability Analysts who hold and continue to hold a valid FAA mechanic certificate with an airframe or powerplant rating (each rating considered as one license) or a valid FCC General Radio-telephone Operator License will be paid for each of two licenses held at these rates per hour:

1st license	$0.80
2nd license	$0.80
Maximum	$1.60

To be eligible to receive payment for a license, an employee must submit to Payroll Data Maintenance - HDQ, Department A4715, the license listing form showing license number, type(s) and date of issuance which form shall be confirmed by his supervisor.

Unlicensed employees in the above classifications who successfully obtain either a FAA mechanic certificate with an airframe or powerplant rating or a FCC General Radio-telephone Operator License will be reimbursed on a one-time basis for actual expenses, capped at $500.00, for classes and/or programs directly related to obtaining such license.

ARTICLE 21: SYSTEM BOARD OF ADJUSTMENT

A. Any dispute which may arise under the terms of this Agreement and any dispute between the Company and the Union or its members employed by the Company as to the meaning and application of this Agreement, except as limited in Paragraph H of Article 6, shall first be considered in the manner provided in Article 8 of this Agreement.

B. In the event any dispute arising under the terms of this Agreement or any dispute connected herewith, except as limited in Article 6, Paragraph (H), shall not have been satisfactorily settled, the Company and the Union shall each promptly select one member of a System Board of Adjustment. The Company and Union will then select a third member of the System Board of Adjustment who shall act as chairman.

C. Such System Board of Adjustment shall hear and determine the grievance or dispute and, within a period agreed upon by the majority of the members of the Board, shall issue its findings, award and decision in writing. The decision of a majority of the System Board of Adjustment shall be final and binding and conclusive upon the parties hereto. Such decision shall be within the scope and terms of this Agreement but shall not change any of its terms or conditions.

D. The jurisdiction of the System Board of Adjustment shall not extend to proposed changes in hours of work, employment, basic rates of compensation or working conditions covered by this Agreement or any amendments thereof.

E. Each of the parties hereto shall assume the compensation, traveling expense and other expenses of its System Board member and witnesses called or summoned by it, and each of the parties shall assume one-half of the expenses and compensation of the third member. So far as space is available, witnesses who are employees of the Company shall receive free space available transportation over the lines of the Company from point of duty or assignment to the point at which they must appear as witnesses before the System Board and return, to the extent permitted by law.

F. It is understood and agreed that each and every participant in the System Board of Adjustment proceeding who is an employee of the Company shall be free to discharge his duty in an independent manner, without fear that his individual relations with the Company or with the employee may be affected in any manner by any action or by testimony given by him in good faith**.**

G. Nothing herein shall be construed to limit, restrict or abridge the rights or privileges accorded either to the employees, or to the Company or to their duly accredited representatives under the provisions of the Railway Labor Act, as amended.

Article 22: SAVING CLAUSE

Should any part or provision of this Agreement be rendered invalid by reason of any existing or subsequently enacted legislation, such invalidation of any part or provision of this Agreement shall not invalidate the remaining portions thereof and they shall remain in full force and effect.

ARTICLE 23: EFFECTIVE DATE AND DURATION

This Agreement constitutes full and complete settlement between the parties of rates of pay, rules and working conditions for the period **November 2, 2004 until December 31 of the full fourth calendar year after emergence from Bankruptcy.**

Except as otherwise specifically stated herein, this Agreement shall become effective on its date of signing, shall continue in full force and effect through _____**,** and shall renew itself without change through each succeeding _____ thereafter, unless written notice of intended change is served in accordance with Section 6, Title I, of the Railway Labor Act, as amended, by either party hereto at least 30 calendar days but not more than 60 calendar days prior to _____ or _____ in any year thereafter.

IN WITNESS WHEREOF, the parties hereto have signed this _____ **November, 2005.**

For AIRCRAFT TECHNICAL SUPPORT ASSOCIATION	NORTHWEST AIRLINES, INC.
/s/_____	/s/_____
/s/_____	/s/_____
/s/_____	/s/_____
/s/_____	/s/_____
	/s/_____

1

SCHEDULE "A" RATES OF PAY

(The time periods referenced below apply to the period of time the employee is in a position in the classification.)

	Date of Signing
Training Representatives	
1st 6 months	**$21.31**
2nd 6 months	**$21.81**
2nd year	**$22.32**
3rd year	**$23.29**
4th year	**$24.27**
5th year	**$25.25**
6th year	**$26.22**
7th year	**$27.22**
Technical Writers, Line Maintenance Planners, Production Planners, and Reliability Analysts	
1st 6 months	**$20.91**
2nd 6 months	**$21.42**
2nd year	**$21.90**
3rd year	**$22.87**
4th year	**$23.85**
5th year	**$24.82**
6th year	**$25.80**
7th year	**$26.80**

SCHEDULE "A" RATES OF PAY

(The time periods referenced below apply to the period of time the employee is in a position in the classification.)

	Date of Signing
Technical Analyst	
1st year	**$10.88**
2nd year	**$12.59**
3rd year	**$13.26**
4th year	**$14.15**
5th year	**$15.14**
6th year	**$16.21**
7th year	**$19.30**

October 22, 1998

Mr. Allan D. Goldstein
Executive Committee Chairman, ATSA
P.O. Box 11617
St. Paul, MN 55111-0617

Re: **Temporary Positions**

Dear Mr. Goldstein:

This letter will serve to clarify the Company's intent regarding the use of temporary positions as outlined in Article 7.A of the Agreement. Temporary positions provide the Company the flexibility necessary to meet operational requirements. Temporary positions are not intended to circumvent the employment of permanent employees in positions with an anticipated duration of more than six months.

Yours very truly,

NORTHWEST AIRLINES, INC.

Gary L. Soma

Gary L. Soma
Director, Labor Relations

July 20, 1993

Mr. Rich D'Loss, Chairman
Aircraft Technical Support Association
P.O. Box 11617
St. Paul, MN 55111-0617

Dear Mr. D'Loss:

This will confirm our commitment made during negotiations that time clocks will not be required for ATSA-represented employees, unless such employees are currently utilizing time clocks, until such time as programming of the PACE system is implemented for ATSA-represented employees. At that time, time clocks may be used where appropriate.

Please confirm the above by signing below and returning a copy of this agreement to my office.

Sincerely,

P. Douglas McKeen

P. Douglas McKeen
Managing Director, Labor Relations, Ground

ACCEPTED AND APPROVED:

Rich D'Loss
Rich D'Loss
Chairman, ATSA

Date: *20 Jul 93*

P. Douglas McKeen
Northwest Airlines, Inc.
Labor Relations, Dept. A1170
5101 Northwest Drive
St. Paul, MN 55111-3034

September 21, 1994

Dear Mr. McKeen,

Per our conversation of September 19, I am outlining the proposed additional usage of Office Vision by ATSA. Currently, it is understood that ATSA may use OV on any matters concerning union/company relations, such as contract interpretations, grievance correspondence, any correspondence with company personnel, etc. We are proposing that in addition to these matters, ATSA be allowed to the use of OV for the following internal union matters:

1. Announcing open positions in the union hierarchy, and all correspondence relating to such.

2. Addressing union bylaws issues, including announcing proposed revisions, debate on proposed revisions, and balloting on proposed revisions.

3. Announcing union meetings.

4. Routing, non-sensitive correspondence among officers and committee members, i.e., committee reports, committee assignments and scheduling, meeting minutes, etc.

We recognize the right of the Company to monitor all Office Vision usage, and any proposed use of Office Vision would be in compliance with the Company Code of Conduct.

Sincerely,

Richard D'Loss

Richard D'Loss
President, ATSA

RETIREMENT PLAN AGREEMENT
FOR
RETIREMENT PLAN FOR UNION-REPRESENTATED EMPLOYEES

THIS AGREEMENT, entered into this _____ day of _____, 2005, by and between NORTHWEST AIRLINES, INC., a Minnesota corporation (hereinafter sometimes called the "Employer"), and the AIRCRAFT TECHNICAL SUPPORT ASSOCIATION (hereinafter sometimes called the "Union");

WITNESSETH THAT

WHEREAS, Certain employees in the service of the Employer are represented by the Union under a collective bargaining agreement covering Training Representatives, Production Planners, Line Maintenance Planners, Technical Writers, Reliability Analysts and Technical Analysts (hereinafter individually an "Employee" and collectively the "Employees");

WHEREAS, The Employer and the Union previously adopted the tax qualified defined benefit pension plan presently known as the "Northwest Airlines Pension Plan for Contract Employees" and fourteen (14) amendments thereto for the purpose of providing pension benefits to eligible Participants (such plan and fourteen amendments being hereinafter collectively referred to as the "Pension Plan");

WHEREAS, The Employer and the Union have agreed to further amend the Pension Plan by adoption of the "Fifteenth Amendment of Northwest Airlines Pension Plan for Contract Employees";

WHEREAS, The Employer and the Union have agreed to cease the further accrual of benefits under the Pension Plan at the time hereinafter specified;

WHEREAS, The Employer previously adopted the tax qualified defined contribution plan presently known as the "Northwest Airlines Retirement Savings Plan for Contract Employees" and ten (10) amendments for the purpose of providing retirement and other benefits to eligible Participants (such plan and ten amendments being hereinafter collectively referred to as the "RSP");

WHEREAS, the Employer and the Union have agreed that the Employer shall make a contribution in accordance with the terms of the RSP commencing at the time hereinafter specified;

NOW, THEREFORE, The parties agree as follows:

1. **AMENDMENT ADOPTED**. The Employer and the Union agree that the document attached hereto as Exhibit A and entitled "Fifteenth Amendment of Northwest Airlines Pension Plan for Contract Employees" is adopted.

RETIREMENT PLAN AGREEMENT
FOR
RETIREMENT PLAN FOR UNION-REPRESENTATED EMPLOYEES

2. **ACCRUAL CESSATION**. The Employer and the Union further agree that the accrual of benefits under the Pension Plan for employees represented for collective bargaining purposes by the Union shall cease as of the last day of the first calendar month in which the following conditions are first satisfied:

(a) As determined by the Vice President Compensation and Benefits, the plan administrator has made a good faith effort to deliver the notice required by section 204(h) of ERISA to the Participants and alternate payees who are entitled to such notice and the applicable advance notice period (e.g., 45 days) has been completed.

(b) As determined by the Vice President Compensation and Benefits, all requirements to give prior notice to the IRS, DOL, PBGC or any other governmental agency has been given and all required waiting periods, approvals and permissions have been obtained (e.g., Code §412(f)).

3. **RSP CONTRIBUTION**. Effective upon the first day of the first month following emergence from bankruptcy but no sooner than the first day of the calendar month following the date that accruals cease under the Pension Plan pursuant to paragraph 2 above and in accordance with the RSP, the Employer's contribution rate shall be five percent (5%) of eligible pay.

4. **PERMANENCE**. The Employer and the Union agree that the Pension Plan as amended through the Fifteenth Amendment and this Agreement shall continue in effect without change for the benefit of employees represented by such Union for the periods covered by the collective bargaining agreement relating to such employees and as such collective bargaining agreement may be renewed from time to time thereafter provided that written notice of intended change in the Pension Plan or this Agreement may be served in accordance with Section 6, Title I, of the Railway Labor Act, as amended, by either party hereto, and in accordance with the applicable provisions of the collective bargaining agreements relating to such employees.

5. **IRS QUALIFICATION**. It is the intent of the Employer and the Union that the Pension Plan as amended through the Fifteenth Amendment and the RSP shall comply with the pertinent provisions of the Internal Revenue Code and, in particular, Section 401(a) thereof so as to entitle the Employer to deduct from its gross income subject to federal income tax, contributions for the support of the Pension Plan and RSP, subject to the provisions of Section 404(a) of the Internal Revenue Code. The Employer agrees promptly to submit this Agreement, the Pension Plan as amended through the Fifteenth Amendment and the RSP to the

RETIREMENT PLAN AGREEMENT
FOR
RETIREMENT PLAN FOR UNION-REPRESENTATED EMPLOYEES

Internal Revenue Service for ruling and approval. The Employer and the Union agree to negotiate any amendments to this Agreement, the Pension Plan and the RSP as may be necessary to obtain and retain such approval. In the event the Employer is unable to obtain such approval, or, if after obtaining such approval, such approval is withdrawn for any reason, then this Agreement shall be null and void and the Employer and the Union will meet to determine the disposition of funds which would otherwise be paid into the trust funds established pursuant to the Pension Plan and the RSP.

IN WITNESS WHEREOF, NORTHWEST AIRLINES, INC. and the Union have caused this Retirement Plan Agreement to be executed as of the day and first above written.

NORTHWEST AIRLINES, INC.

By _____
Julie Hagen Showers
Vice President Labor Relations

And _____
Timothy J. Meginnes
Vice President Compensation and Benefits

AIRCRAFT TECHNICAL SUPPORT ASSOCIATION

By _____
Its _____

By _____

By _____

Exhibit A

FIFTEENTH AMENDMENT
OF
NORTHWEST AIRLINES
PENSION PLAN FOR CONTRACT EMPLOYEES

The "NORTHWEST AIRLINES PENSION PLAN FOR CONTRACT EMPLOYEES" heretofore adopted by NORTHWEST AIRLINES, INC., a Minnesota corporation, and heretofore amended by fourteen amendments (hereinafter collectively referred to as the "Plan Statement"), is hereby further amended in the following respects:

1. GENERAL STATEMENT OF PURPOSE. The purpose of this Amendment is to implement the cessation of the accrual of benefits under the Plan as of the Accrual Cessation Date.

(a) This Amendment shall not cause the termination of the Plan Statement in the sense contemplated by ERISA §4041, et seq.

(b) Absent some further action by this corporation, the benefits due under the Plan Statement shall continue to be held and paid under the terms of the Plan Statement as if there had been no cessation of accruals.

(c) The Participants in this Plan are employed in multiple bargaining units represented by multiple unions. The cessation of accruals may be effective for the employees in the several bargaining units as of more than one date. If that occurs, there will be multiple Accrual Cessation Dates.

(d) The Plan Statement and this Amendment shall be construed and administered on a basis consistent with this general statement of purpose. In giving effect to this general statement of purpose, no significance shall attach to the placement of the following rules in the Plan Statement or to the repetition of some but not other of the following rules.

2. ACCRUAL CESSATION DATE DEFINED. Effective as of September 13, 2005, Section 1.2 of the Plan Statement is amended by adding thereto the following new Section 1.2.1 (and all subsequent sections and cross references thereto shall be renumbered accordingly).

1.2.1. **Accrual Cessation Date** — the date specified in a Retirement Plan Agreement by and between the Employer and the union representing a classification of Participants (or in writing by the Employer for a

classification of Participants) as the date the accrual of benefits under this Plan shall cease for that classification.

3. ACCRUED BENEFIT FROZEN. Effective as of the Accrual Cessation Date, Section 1.2.2 (formerly Section 1.2.1) of the Plan Statement is amended by adding thereto the following new Section 1.2.2(g):

(g) **Accrual Cessation**. Notwithstanding the forgoing, a Participant's Accrued Benefit determined as of the Accrual Cessation Date shall not thereafter change.

4. BENEFIT SERVICE FROZEN. Effective as of the Accrual Cessation Date, Section 1.2.7 (formerly Section 1.2.6) of the Plan Statement is amended by adding thereto the following new Section 1.2.7(h).

(h) **Accrual Cessation**. Notwithstanding the foregoing, no service performed after the Accrual Cessation Date, shall be considered in determining Benefit Service for any purpose under this Plan. A Participant's Benefit Service determined as of the Accrual Cessation Date shall not thereafter change.

5. DISABILITIES NOT RECOGNIZED. Effective as of the Accrual Cessation Date, Section 1.2.9 (formerly Section 1.2.8) of the Plan Statement is amended by adding thereto the following new Section 1.2.13(c).

(c) **No New Disabilities Recognized**. No condition shall be considered a Disability unless a substantially completed application for a Disability Retirement Pension premised on that condition was filed prior to the Accrual Cessation Date.

6. EARLY RETIREMENT ELIGIBILITY NOT FROZEN. Effective as of the Accrual Cessation Date, Section 1.2.11 (formerly Section 1.2.10) of the Plan Statement is amended by adding thereto the following sentence.

Notwithstanding the cessation of the accrual of additional benefits as of the Accrual Cessation Date, as required by section 411(d)(6) of the Code a Participant may attain Earliest Retirement Date after the Accrual Cessation Date (i.e., age attained prior to Termination of Employment and Vesting Service earned after the Accrual Cessation Date shall be recognized in determining a Participant's Earliest Retirement Date).

7. ELIGIBILITY SERVICE FROZEN. Effective as of the Accrual Cessation Date, Section 1.2.13 (formerly Section 1.2.12) of the Plan Statement is amended by adding thereto the following new Section 1.2.13(e).

(e) **Accrual Cessation**. Notwithstanding the foregoing, no service performed after the Accrual Cessation Date, shall be considered in determining

Eligibility Service for any purpose under this Plan. A Participant's Eligibility Service determined as of the Accrual Cessation Date shall not thereafter change.

8. VESTING SERVICE NOT FROZEN. Effective as of the Accrual Cessation Date, Section 1.2.31 (formerly Section 1.2.30) of the Plan Statement is amended by adding thereto the following new Section 1.2.31(g).

(g) **Accrual Cessation**. Notwithstanding the cessation of the accrual of additional benefits effective as of the Accrual Cessation Date, as required by section 411(d)(6) of the Code a Participant's employment (whether in or out of Recognized Employment) after the Accrual Cessation Date shall be taken into account in determining the Participant's Vesting Service (i.e., Vesting Service determined as of the Accrual Cessation Date may thereafter increase).

9. USERRA RIGHTS FROZEN. Effective as of the Accrual Cessation Date, Section 1.4 of the Plan Statement is amended by adding thereto the following sentence.

Notwithstanding the foregoing, a Participant shall not be credited with any Benefit Service and shall not be deemed to have earned any earnings or other remuneration on account of any uniformed service after the Accrual Cessation Date.

10. PARTICIPATION CLOSED. Effective as of the Accrual Cessation Date, Section 2.1 of the Plan Statement is amended by adding thereto the following sentence.

No individual who has not become a Participant before the Accrual Cessation Date shall thereafter become a Participant in this Plan.

11. PARTICIPATION CLOSED. Effective as of the Accrual Cessation Date, Section 2.2 of the Plan Statement is amended by adding thereto the following sentence.

No individual who returns to employment with the Employer after the Accrual Cessation Date shall become a Participant pursuant to the previous sentence.

12. DISABILITIES NOT RECOGNIZED. Effective as of the Accrual Cessation Date, Section 3.3.1 of the Plan Statement is amended by adding thereto the following sentence.

Notwithstanding the forgoing, no Participant shall receive a Disability Retirement Pension unless a substantially completed application for a Disability Retirement Pension was filed prior to the Accrual Cessation Date.

13. SAVINGS CLAUSE. Save and except as hereinabove expressly amended, the Plan Statement shall continue in full force and effect.

14. ACCRUAL CESSATION. With respect to classifications of employees in the service of the Employer as Meteorologists represented by the Northwest Airlines Meteorologists Association, the accrual of benefits under the Pension Plan shall cease as of the last day of the first calendar month in which the following conditions are first satisfied:

(a) As determined by the Vice President Compensation and Benefits, the plan administrator has made a good faith effort to deliver the notice required by section 204(h) of ERISA to the Participants and alternate payees who are entitled to such notice and the applicable advance notice period (e.g., 45 days) has been completed.

(b) As determined by the Vice President Compensation and Benefits, all requirements to give prior notice to the IRS, DOL, PBGC or any other governmental agency has been given and all required waiting periods, approvals and permissions have been obtained (e.g., Code §412(f)).

IN WITNESS WHEREOF, NORTHWEST AIRLINES, INC. has caused this Amendment to be executed as of _____, 2005.

NORTHWEST AIRLINES, INC.

By

_____

Julie Hagen Showers, Vice President Labor Relations

AIRCRAFT TECHNICAL SUPPORT ASSOCIATION

By

_____

Its

_____

And

_____

Timothy J. Meginnes, Vice President
Compensation and Benefits

ADDENDUM TO AGREEMENT

between

NORTHWEST AIRLINES, INC.

and

AIRCRAFT TECHNICAL SUPPORT ASSOCIATION

Covering Personnel In The Classifications Of:

Training Representative
Production Planner
Technical Writer
Reliability Analyst

OPERATIONS OUTSIDE OF THE UNITED STATES

Pursuant to the provisions of Article 1, Paragraph (D), of the current Agreement between Northwest Airlines, Inc., and the **Aircraft Technical Support Association**, this Addendum, providing conditions of employment and proper wage rates for employees assigned as a result of bidding or transferred outside the limits of the United States, is made and entered into this **2nd day of November, 1998.**

SECTION 1

(A) Classes and crafts covered by this Addendum shall include all employees of the Company working in the crafts or classes for which the Union was recognized as the bargaining agent (as defined in Article 1 of the Agreement) who are assigned as a result of bidding or transferred from the United States to foreign bases and stations in Canada and other foreign bases and stations outside the limits of the United States.

(B) All terms and provisions of existing Agreements between the Company and Union not in conflict with or modified by the provisions of this Addendum shall remain in full force and effect until changed by mutual agreement.

(C) Wherever "the Agreement" is referred to herein, it shall mean the current Agreement between the Company and Union and all amendments thereto.

(D) Wherever used herein, all references to foreign or overseas operations and foreign or overseas bases or stations shall mean outside the limits of the United States, and any references to the United States shall mean the limits of the United States unless otherwise specified.

SECTION 2

NEW JOBS AND VACANCIES

(A) All jobs determined by the Company to be filled from the United States in the classifications covered by the Agreement of more than ninety (90) days anticipated duration will be bulletined in accordance with Article 7 of the Agreement.

(B) Employees assigned as a result of bidding or transferred from stations within the limits of the United States will retain all seniority rights on the system unimpaired, except as limited hereafter or in Paragraph (F) of Article 6 of the Agreement.

(C) The minimum terms of service for employees assigned as a result of bidding or transferred from the United States shall be for the term specified, but not more than two (2) years.

(D) Employees assigned as a result of bidding or transferred from the United States shall not be displaced by employees from the United States through exercise of seniority rights, and the employees assigned shall have no bidding privileges on the system during their periods of assignment or renewal thereof, except as hereinafter provided.

(E) Employees permanently returned to the United States by the Company prior to the expiration of the minimum term of service for which assigned, as set forth above, shall be privileged to exercise their seniority on the domestic system.

(F) Employees assigned as a result of bidding or transferred from the United States requesting return to the United States and returned by the Company prior to the expiration of the minimum term of service will only be privileged to exercise their seniority in filling vacancies that may occur in their work classifications or in obtaining employment on the system through exercise of their job bidding privileges under the Agreement.

(G) Employees assigned as a result of bidding or transferred from the United States to permanent positions outside the limits of the United States shall not be permitted to bid for any other position on the system during the term of employment in foreign operations, except for new jobs or vacancies in higher classifications covered by the Agreement at the station to which assigned or in higher classifications at other

foreign stations when it becomes necessary to bulletin jobs on a system basis in order to obtain qualified personnel.

(H) Employees, upon completion of their terms of service in foreign stations, will be privileged, after arrival in the United States and taking of all accrued vacation, to exercise their station seniority on the domestic system.

(I) The Company agrees it will pay all reasonable and necessary moving expenses in accordance with the travel and transfer regulations hereinafter provided for any successful bidder or employee assigned from the United States to stations outside the limits of the United States, subsequently transferred from one station to another in operations outside the United States or returned to the United States under this Addendum or the Agreement.

SECTION 3

HOURS OF SERVICE AND OVERTIME

Provisions for hours of service and overtime shall be the same as those provided in Articles 3 and 4 of the Agreement dated **November 2, 1998,** and amendments thereto.

SECTION 4

HOLIDAYS

The holidays designated in Article 4 of the Agreement or a day or days determined locally to be of greater significance shall be observed, but in no event shall a total of more holidays be recognized than called for by Article 4 of the Agreement.

SECTION 5

Provisions for:

Travel and Transfer Regulations

Lodging, Food and Station Allowance

Leaves of Absence (Emergency)

Sick Leave and Medical Benefits

Vacations

Missing, Internment and Prisoner of War Benefits

Wage Rules and Bonuses and Other Employee Benefits

shall be the same as those which are applicable to the employees under the Mechanics and Related Personnel Agreement who have been transferred from the United States.

SECTION 6

EFFECTIVE DATE AND DURATION

This Addendum to Agreement shall become effective the same date as the Agreement signed concurrently herewith and shall be subject to renewal, termination or modification in accordance with the terms of Article **23** of said Agreement.

IN WITNESS WHEREOF, the parties hereto have signed this Addendum to Agreement this **2nd day of November, 1998.**

WITNESSED:

Allan Goldstein

Gary L. Soma

For NORTHWEST AIRLINES, INC.

P. Douglas McKeen

For **AIRCRAFT TECHNICAL SUPPORT ASSOCIATION**

Alkiviades C. Dimassis

July 29, 1993

Mr. Richard D'Loss, Chairman
Aircraft Technical Support Association (ATSA)
P. O. Box 11617
St. Paul, MN 55111-0617

Dear Mr. D'Loss:

This will confirm our agreement reached during negotiations that the Company may, at its discretion, implement a SLIP program from time to time in the future.

I have attached a copy of the essential elements of our last SLIP program, together with a list of administrative procedures. Any SLIP program implemented by the Company will incorporate the essential elements and administrative procedures attached, unless modified by agreement between the Company and the ATSA.

Sincerely,

P. Douglas McKeen

P. Douglas McKeen
Managing Director
Labor Relations-Ground

Agreed to for the ATSA by:

Richard D'Loss
Richard D'Loss, Chairman

SPECIAL LEAVE INCENTIVE PROGRAM "SLIP"

- ELIGIBILITY: All union-represented employees at (Location/Point) in (Department) are eligible to be granted a SLIP leave if they are:

  - On active payroll status at (Location/Point) in a full-time permanent position.
  - Able to be released from active payroll without adversely affecting operational needs.
  - Willing to go on unpaid leave for a minimum of seven days (maximum of 90 days) with the understanding that any leave with a duration longer than seven days may be canceled short of its intended duration if required by operational needs.

- INCENTIVES: SLIP leaves will be treated as normal unpaid personal leaves of absence in all respects except:

  - Company-paid medical, dental and life insurance coverages in effect at the time leave is granted will be continued as if the participant had remained on active payroll.
  - Participants will remain eligible for unlimited pass travel on Northwest Airlines. Travel will not be permitted on the Northwest Airlink carriers or other airlines. The Employee Easy-Write Pass Policy may be used, and service charges will be payroll deducted upon the employee's return to work.
  - Time spent on SLIP leave will be treated as active payroll time for purposes of a participant's seniority date, longevity for pay purposes, automatic pay date or sick/injury/vacation date and for pension credit (both vesting service and benefit accrual service).
  - For purposes of unemployment compensation, a participant will be reported to the applicable state unemployment office as being on "voluntary leave of absence in lieu of layoff of junior employee," and the Company will not contest any award of unemployment compensation made to the participant by the State.

- MISCELLANEOUS

  - SLIP leaves should be granted in seniority order unless prohibited by operational needs (e.g., loss of critical skills or training burden).
  - Temporary and part-time employees are not eligible for SLIP leaves.
  - Long-Term Disability (LTD) coverage will not be continued during SLIP leave.
  - Participants will accrue sick days, occupational injury days and vacation days to their accounts during SLIP leave.

SPECIAL LEAVE INCENTIVE PROGRAM "SLIP"

Employees are not eligible for SLIP leaves during any period of time they are scheduled to be on vacation. Such vacation should be taken as scheduled.

EXCEPTION: Union and management representatives may, by local agreement, allow an employee who has vacation scheduled during a proposed SLIP leave period to reschedule it during any vacation period remaining open on the (year) vacation bid calendar.

- ATSA-represented employees who are placed on a SLIP leave of 30 days or more will not be paid their accumulated vacation credit unless they advise Payroll within 14 days of the commencement of their leave that they desire to be paid such accrual.
- In preparing the Personnel Action Notice (PAN) for a participant, the manager must both note "SLIP leave" in the remarks section of the PAN and attach a copy of the signed SLIP Leave Request form to the PAN.
- At the conclusion of their SLIP leave, participants will return to work in accordance with applicable provisions of their collective bargaining agreement.

I hereby request a voluntary unpaid personal leave of absence pursuant to the Company's Special Leave Incentive Program for the period of _____ through _____ (minimum of seven days).

I understand that this request and any future extension requests are subject to the conditions set forth above and written approval of an authorized management representative.

REQUEST APPROVED BY:

Name (please print) Authorized Signature

Signature Name

Date: Title

Employee No.: Date:

Address:

Telephone No.:

Original to personnel file with PAN

SPECIAL LEAVE INCENTIVE PROGRAM "SLIP"

1 Copy to local file
2 Copy to employee

SPECIAL LEAVE INCENTIVE PROGRAM "SLIP"

ADMINISTRATIVE PROCEDURES

Outlined below are commonly asked questions and answers regarding the SLIP Leave Program for ground employees:

1. Q: Which employees are eligible for SLIP leave?

   A. (Fill in Description)

2. Q: Why are SLIP leaves not offered to all employees?

   A: The offering of SLIP leaves is based on operational needs. If you believe your department would benefit from the SLIP Leave Program, you should contact your immediate supervisor/manager and, through the chain of command, the program should be reviewed. If your department head decides the SLIP Leave Program is appropriate for your department, he/she should contact Labor Relations to coordinate a SLIP Leave Program.

3. Q: Are part-time employees eligible for the SLIP Leave Program?

   A: No.

4. Q: Are employees occupying temporary positions eligible for the SLIP Leave Program?

   A: No.

5. Q: Are managers eligible for the SLIP Leave Program?

   A: The inclusion of other managers in the SLIP Leave Program is the decision of the department head.

6. Q: When an employee's SLIP leave ends, how does the employee return to work?

   A: ATSA employees return to work pursuant to Article 9(D).

7. Q: Can an employee who has received a layoff notice take a SLIP leave?

   A: Yes. The employee may opt to take a SLIP leave any time prior to the effective date of his/her layoff and any exercise of seniority.

SPECIAL LEAVE INCENTIVE PROGRAM "SLIP"

8. Q: Is a SLIP leave available to someone who has been displaced (bumped by another employee)?

A: Yes. An employee may opt for a SLIP leave prior to the effective date of his/her displacement and any exercise of seniority.

9. Q: Does an employee who has been laid off or displaced and who opts for a SLIP leave have the right to exercise seniority at the conclusion of his/her SLIP leave?

A: Yes. At the conclusion of the SLIP leave, the employee is placed on layoff. The employee has a right to exercise seniority in accordance with Article 6(G).

10. Q: While an employee is on a SLIP leave, are they protected from being displaced or laid off?

A: An employee on a SLIP leave is in a "bubble"; i.e., he/she cannot be displaced. An employee can be issued a layoff notice; however, the effective date of any layoff for an employee on a SLIP leave may not be earlier than the expiration of the SLIP leave.

11. Q: How will an employee on a SLIP leave be notified that he/she will be laid off at the conclusion of their SLIP leave?

A: The manager will send the employee a layoff notice as required by the applicable Collective Bargaining Agreement. The employee will be eligible to exercise his/her seniority as specified under the applicable agreement, but only at the conclusion of the SLIP leave. The effective date of such layoff will be the last day of the employee's SLIP leave. NOTE: It is the employee's responsibility to notify Employee Records and his/her manager of any change in his/her address and/or phone number.

12. Q: Can a SLIP leave be extended once an employee has been given a layoff notice?

A: Yes. Once an employee has been given a layoff notice, their SLIP leave can be extended under the terms of the applicable Collective Bargaining Agreement. The employee must give his/her manager written notice requesting a SLIP leave extension at least five days prior to the conclusion of his/her original SLIP leave.

SPECIAL LEAVE INCENTIVE PROGRAM "SLIP"

13. Q: Can an employee end a SLIP leave voluntarily?

A: Employees requesting to end SLIP leaves earlier than anticipated will be reviewed on a case-by-case basis. In general, employees are expected to remain out on a SLIP leave for the period of time they have requested. Exceptions will be made for hardship cases.

14. Q: What if a vacation is scheduled during the SLIP leave?

A: The handling of scheduled vacations will be determined on a department-by-department basis.

Q: How will HMO payments be deducted while an employee is on a SLIP leave?

A: The employee will be sent a letter from the Employee Insurance area outlining required monthly payments and will be required to send in such payments.

16. Q: If the employee takes more than one SLIP leave, can the cumulative total of all SLIP leaves exceed 90 days?

A: Yes.

17. Q: If an employee takes a SLIP leave after the first of the month, are they still covered for that month for the purpose of medical insurance, dental insurance, long-term disability insurance and life insurance?

A: Yes. As long as the employee is on active payroll on the first of the month, he/she will be covered for that month; however, if the SLIP leave extends beyond that month, the employee will not be covered for the purposes of long-term disability.

18. Q: Does time spent on a SLIP leave count toward the completion of the waiting periods for long-term disability coverage?

A: Yes. Time on a SLIP leave counts for the completion of the benefit waiting period and the eligibility waiting period.

19. Q: Am I eligible for unemployment if I take a SLIP leave?

A: The decision of whether an employee is eligible for unemployment compensation is determined by each state. Labor Relations is in the

SPECIAL LEAVE INCENTIVE PROGRAM "SLIP"

process of contacting the various state unemployment offices to determine whether the state feels NWA employees are eligible to receive unemployment. Once that information is available, it will be distributed.

20. Q: Can an employee take a leave for less than seven days?

A: Yes. An employee may take a personal leave of absence for less than seven days; however, if he/she does take a leave for less than seven days, he/she is not covered by the SLIP Leave Program.

21. Q: Do Frick unemployment forms need to be completed for employees on SLIP leave?

A. Yes. Frick unemployment forms should be completed by the manager for employees on SLIP leave.

22. Q: Can an employee work while on a SLIP leave?

A: Yes. The employee may work for other employers provided there is no conflict of interest. If you are unsure whether there is a conflict of interest, contact the Labor Relations Department.

23. Q: While on a SLIP leave, is an employee eligible for holiday pay?

A: No. An employee must be on active payroll status in order to receive holiday pay.

LETTER OF AGREEMENT
Between
NORTHWEST AIRLINES, INC.
and
TRAINING REPRESENTATIVES, PRODUCTION PLANNERS,
LINE MAINTENANCE PLANNERS, TECHNICAL WRITERS,
RELIABILITY ANALYSTS AND TECHNICAL ANALYSTS
in the service of
NORTHWEST AIRLINES, INC.
as represented by
AIRCRAFT TECHNICAL SUPPORT ASSICIATION

THIS LETTER OF AGREEMENT is made and entered into in accordance with the provisions of Title II of the Railway Labor Act, as amended, by and between Northwest Airlines, Inc. (the "Company") and the training representatives, production planners, line maintenance planners, technical writers, reliability analysts and technical analysts in the service of the Company (the "employees") as represented by the Aircraft Technical Support Association ("ATSA").

Notwithstanding the execution and delivery of this Agreement by Northwest or any other provision or condition set forth in this Agreement, (a) Northwest, as debtor in possession, is not assuming any liabilities or obligations under any prior agreement or any claims which otherwise may be alleged to have arisen against Northwest at any time prior to the execution of this Agreement; (b) any obligations of Northwest under this Agreement shall not constitute costs and expense of its pending Chapter 11 case and are limited by the terms of the order with respect to wages and benefits entered by the Bankruptcy Court having jurisdiction of Northwest's pending chapter 11 case on September 15, 2005; and (c) Northwest continues to have all of its rights to seek rejection and modification of the terms and conditions of this Agreement under sections 1113 and 1114 of the Bankruptcy Code or otherwise on the same basis as if this Agreement had been executed and delivered by the parties prior to the commencement of Northwest's chapter 11 case on September 14, 2005.

Signed on this ___ day of November, 2005.

For the Company:

_____
Julie Hagen Showers
Vice President Labor Relations
For the Aircraft Technical Support Association:

_____

Allan Goldstein
President

00-0410-3-0040

ATSA Article 19

Full Text Addendum

October 27, 2005

Contents

Section A – NWA Medical Plan, Prescription Drug Program & Dental Plan – General

The NWA medical plan is a managed care plan that features a "preferred provider organization" (PPO). A PPO is simply a "network" of doctors, Hospitals and other preferred providers. The NWA dental plan also is a managed care plan that features a network of dentists. Both cover most common expenses. Prescription drug coverage is provided by the prescription drug program. If you enroll in the NWA medical plan, you will be enrolled automatically in the prescription drug program.

With the medical and dental plans, each time you need medical or dental care, you decide whether to use a provider who is part of the plan's network (an "in-network provider") or an out-of-network provider. While you and your covered dependents can use any doctor or dentist, Hospital or other medical or dental care provider or facility, whenever you use in-network providers, benefits are higher and out-of-pocket expenses are lower. When you use other providers, the plans' "out-of-network" benefits apply.

Words that have special meaning are either in quotations (and defined immediately in the text) or capitalized (and defined in "Definitions").

Eligible Employees
You are eligible to participate in the NWA medical plan, prescription drug program and the NWA dental plan if you are:

- An active employee of Northwest Airlines, Inc. or an affiliated company covered by a labor agreement between the Aircraft Technical Support Association (ATSA); or
- An inactive or terminated employee who has chosen to continue coverage under COBRA;

There is no waiting period for newly hired or rehired employees – you can participate immediately.

Eligible Dependents
If you participate in the plans, your "eligible dependents" who can participate are:

- Your spouse of the opposite sex, as recognized in your state of residence as long as your spouse does not have coverage available through his or her employer . A spouse does not include a person from whom you are legally separated or divorced or a person of the same gender. In the case of a common law marriage, proof is required – contact the NWA Benefits Department for details;
- Your eligible "Domestic Partner" who is the same gender as you as long as your Domestic Partner does not have coverage available through his or her employer. Before you can enroll a Domestic Partner, you first must register him or her online through NROL & More. Detailed information about Domestic Partner health care coverage, including possible tax consequences for you, is available on RADAR (nwapeople.nwa.com).
- Your unmarried "children" up to age 19;

- Your unmarried "children" from age 19 up to age 26 who are full-time students (as defined by the school) and primarily dependent on you for support.
- Your unmarried "children" over the maximum age who are "totally" disabled, either physically or mentally, as long as the child:
  - Became disabled on or before reaching age 19 (on or before reaching age 26, if the child is a full-time student);
  - Was covered by the plans when he/she became disabled;
  - Is incapable of earning his/her own living.

  You must call the claims administrator and provide proof of the child's disability within 30 days of the child reaching age 19 (or age 26 if a full-time student). If a covered child first becomes disabled between age 19 and 26, you must call and provide proof to the claims administrator within 30 days of the child becoming disabled. "Totally" disabled will be determined by the claims administrator.
- Eligible children of your eligible Domestic Partner who live with you and are dependent on you for support (this includes your Domestic Partner's natural children), provided your Domestic Partner also is enrolled.

"Children" include:

- Natural children;
- Adopted children who are placed in your home and for whom you are legally obligated to provide total or partial support;
- Stepchildren who live with you in a parent/child relationship (e.g., go to school from your home);
- Children for whom a court awards you legal guardianship, who live with you and are primarily dependent upon you for their support.
- Foster children who live with you in a parent-child relationship, are primarily dependent on you for support, and for whom you receive no government reimbursement for maintenance and support;
- Grandchildren, as long as their mother is covered by the plan(s) as your dependent child, the mother lives in your home with the grandchildren and the grandchildren are primarily dependent on you for support; and
- Children covered under the terms of a QMCSO (see below).

Qualified Medical Child Support Order QMCSO
A QMCSO may require you to provide medical coverage for a dependent child after it otherwise would have ended. These plans have specific rules and procedures that a QMCSO must meet.

Enrolling
You have a limited period of time in which to enroll in the plans. This is called the "allowable time frame." The allowable time frame is 30 days plus an additional 30-day grace period (60

days total). Enrolling is easy using NWA's "NROL & More" enrollment Web site. If you do not enroll for coverage during the allowable timeframe you will have no medical and/or dental coverage and only will be allowed to enroll in the plan during the next open enrollment period (with coverage effective on the following January 1st) unless you experience a Qualified Family Status Change.

Active and inactive employees can access NROL & More through RADAR (nwapeople.nwa.com). If you are a terminated employee or former dependent with coverage under your own name (such as COBRA), go to nwa.wwwhrt.com to enroll.

If Both You & Your Spouse/Domestic Partner Are NWA Employees
If you and your spouse are both NWA employees, each of you may enroll as an employee or one of you may enroll the other as a dependent. Only one of you may enroll your children. If you and your Domestic Partner are both NWA employees, each of you may enroll as an employee and you each may enroll your own eligible dependent children, but not the other's dependent children.

Important -- When you enroll a dependent, you will have to provide proof that your dependent meets all of the eligibility rules, for example, a copy of a birth certificate, marriage certificate, etc. Details about acceptable proof can be found on RADAR. Failure to provide adequate proof will result in your dependent being dropped from coverage.

Who Pays for the Plans
The cost for medical coverage under the NWA medical plan is shared by Northwest Airlines, Inc. and employees who are enrolled in the plan. Your share of the cost for medical coverage also provides for your coverage in the NWA prescription drug program. Your monthly cost (premium) depends on the type of coverage you are enrolled in – single, employee and spouse, employee and children or family coverage.

NWA Medical Plan
Full-Time Employees – Your monthly share of the cost is 25% of the projected cost of the plan. The projected cost of the plan will be equal to the projected COBRA cost of the plan excluding the 2% administrative fee. Employees who use tobacco, or whose spouse uses tobacco, either currently or within the last 6 months, will pay an additional 25% of the employee share of the premium (for a total employee share of the premium of 31.25%). For employees on active payroll status, premium contributions (and alternative standard program costs – see below) will be made on a semi-monthly basis by payroll deduction on a pre-tax basis.

Special note for tobacco users: For an employee and/or spouse who does not meet the non-tobacco user standard, a reasonable alternative standard will be offered through a bona fide wellness program -- a tobacco cessation program. Any fees or cost associated with participation in the alternative standard will be paid by the employee through payroll deduction. The alternative standard will be available once an employee (or spouse) submits a completed physician's statement indicating he/she is unable to satisfy the non-tobacco user criteria because of a medical condition. Upon completion of the wellness program the tobacco user surcharge will be waived beginning the first of the month

following the completion of the bona fide wellness program. The tobacco surcharge will be waived for the remainder of the calendar year following completion of the bona fide wellness program.

The bona fide wellness program for the cessation of tobacco use also will be made available to tobacco users who do not submit a completed physician's statement.

Individuals Continuing Coverage under COBRA – You pay the full cost for coverage. Your monthly cost (premium) depends on the type of coverage you are enrolled in – single, employee and spouse, employee and children or family coverage.

NWA Dental Plan

The cost for dental coverage under the NWA dental plan is shared by Northwest Airlines, Inc. and employees who are enrolled in the plan. Your monthly cost (premium) depends on the type of coverage you are enrolled in – single, employee and spouse, employee and children or family coverage.

Full-Time Employees – your share of the cost is 20% of the projected cost of the plan. The projected cost of the plan will be equal to the projected COBRA cost of the plan excluding the 2% administrative fee.

Individuals Continuing Coverage under COBRA – You pay the full cost for coverage. Your monthly cost (premium) depends on the type of coverage you are enrolled in – single, employee and spouse, employee and children or family coverage

You'll find the latest medical and dental premiums (the amount you may be required to pay) in RADAR – nwapeople.nwa.com.

Subject to its collective bargaining obligations, the Company may change cost-sharing arrangements and the amount of premiums in the future.

Identification Cards

After you enroll in the plans, you will receive medical, dental and prescription drug ID cards. Your ID cards contain important personalized information and phone numbers. Always carry them with you and be prepared to present them whenever you or a covered dependent receives medical or dental care or needs a prescription filled.

Section B – NWA Medical Plan

The NWA medical plan covers most common medical expenses and pays benefits that are a percentage of allowed expenses. The NWA medical plan is a managed medical plan that features a "preferred provider organization" (PPO).

In-Network vs. Out-of-Network – How the Plan Works

With the NWA medical plan, you receive the plan's higher "in-network" benefits whenever you use Doctors, Hospitals and other medical providers who are part of the PPO network. Otherwise, the plan's "out-of-network" benefits apply. The decision to use an in-network provider or an out-of-network provider is always yours…each time medical care is needed.

In-Network Benefits

In-network benefits mean that covered medical services are paid at a higher percentage (generally 80%) after the annual in-network deductible. Another advantage to using in-network providers is that they usually handle calling for approval when it's needed – see pages 8-11. (Still, you are responsible for seeing that the call is made to avoid benefits being reduced.)

Some services only are covered by the plan if provided by in-network providers, such as preventive care.

Out-of-Network Benefits
When you use Doctors, Hospitals and other medical providers who are not part of the PPO Network, out-of-network benefits apply. Out-of-network benefits pay a lower percentage (generally 70%) after you meet an annual out-of-network deductible. You are responsible for filing claims or seeing that claims have been filed by your provider. You also are responsible for calling for pre-approval of certain outpatient services and hospital pre-approval and continued stay approval when needed to avoid benefits being reduced – see pages 8-11.

Allowed Amount

In-Network PPO Providers
In-network providers have agreed to accept certain pre-determined discounted fees as payment in full. This is known as the "allowed amount." More specifically, the allowed amount is defined as the negotiated amount of payment that an in-network provider has agreed to accept as payment in full for a covered service at the time your claim is processed. In-network benefit payments are based on the claims administrator's allowed amount for medical expenses. When you use in-network PPO providers, you only have to pay your in-network deductible and any copayment or coinsurance amounts. With in-network providers, you are not responsible for any charges over the allowed amount.

Out-of-Network Providers
For out-of-network providers, the allowed amount is 140% of the published rates allowed by Medicare for the same or similar service. Benefit payments to providers who are not part of the PPO network are based on this allowed amount for a medical expense.

Amounts over the allowed amount for services received out-of-network are not covered expenses under the plan and will not count toward the plan's deductibles or "out-of-pocket maximums" – see below through page 7.

No Pre-existing Condition Limitation
Generally, a pre-existing condition is a physical or mental condition that you or an eligible dependent received treatment for, or was diagnosed with, before coverage under a plan begins. The NWA medical plan covers eligible expenses for a pre-existing condition the same as for any other medical condition.

Deductibles
A deductible is an amount you, your covered dependent or your family has to pay each calendar year before a plan will start to pay benefits. You, your covered dependent or your family has to meet a deductible each calendar year – starting January 1st and ending December 31st. There are separate deductibles for in-network and out-of-network benefits. The deductibles under the NWA medical plan for 2006 are shown next:

Calendar Year Deductibles		
	In Network	Out-of Network
Individual	$350	$700
Family	$700	$1,400

In determining when the family deductible has been met, amounts used to meet the individual deductibles for covered family members are combined. However, no one person can contribute more than the individual deductible amount toward the family deductible, as shown in the example that follows:

Covered Individual	Covered Expenses	Amount Applied to Family Deductible
You	380	350
Spouse	220	220
Child	80	80
Child	340	50
	$1,020	$700

Once the family deductible has been met, the plan will start to pay benefits for every covered member of your family for the rest of that calendar year.

Special Note – Beginning January 1, 2007, the plan's deductibles are indexed (adjusted) annually, using the same cost trend factors used to determine the plan's COBRA premiums each year. (COBRA premiums are the estimated total cost of the plan for the upcoming year.) This means, generally, that the deductibles will go up each year on January 1.

The following expenses do not count in determining when the individual or family deductibles have been met:

- Emergency Room copayment;
- Expenses that are not "covered" by the plan;
- Expenses that are not medically necessary;
- Prescription drug coinsurance, including minimum and maximum copayments;
- The portion of any charge that is above the plan's "allowed amount";
- Any amount you or your covered dependent has to pay because you did not follow the plan's preadmission certification or continued stay review requirements.

Out-of-Pocket Maximums
The plan's "out-of-pocket maximum" feature helps protect you and your family from the financial burden of large medical expenses. Separate out-of-pocket maximums apply to in-network and out-of-network benefits. Here's how these maximums work:

When out-of-pocket expenses reach one of the individual maximum amounts shown in the chart that follows for you or a covered dependent in a calendar year, the plan will pay 100% of applicable covered expenses (either in-network or out-of-network) for that person for the rest of that calendar year.

This also applies to families. When the out-of-pocket expenses for all of your covered family members combined reach one of the family out-of-pocket maximums in a calendar year, the plan will pay 100% of applicable covered expenses for all of your covered family members for the rest of that year. However, no individual can contribute more than the individual maximum toward the family maximum.

The plan's 2006 out-of-pocket maximums are shown next. Keep in mind that the out-of-pocket maximums do not apply to mental health expenses or prescription drug expenses.

Out-of-Pocket Maximums (Does not include deductibles, mental health or prescription drug copays/coinsurance or emergency room copays)		
	In-Network	Out-of-Network
Individual	$2,750	$5,000
Family	$5,500	$11,000

Special Note – The plan's out-of-pocket maximums are indexed (adjusted) annually, using the same cost trend factors used to determine the plan's COBRA premiums each year. (COBRA premiums are the estimated total cost of the plan for the upcoming year.) This means, generally, that the out-of-pocket maximums will go up each year on January 1 and provide you with consistent protection.

In-Network, Out-of-Pocket Expenses
In-network, out-of-pocket expenses include your in-network coinsurance. In-network, out-of-pocket expenses do not include:

- In-network deductible;
- Coinsurance for mental health care;
- Emergency room copayment;
- Prescription drug coinsurance;
- All out-of-network expenses, including;
  - Out-of-network deductibles;
  - Amounts you must pay for out-of-network services or supplies once the plan has paid its benefits (your out-of-network coinsurance amounts);
  - The portion of any charge by an out-of-network provider that is above the plan's "allowed amount;"
  - Any amount you or your covered dependent has to pay because you did not follow the plan's preadmission certification or continued stay review requirements;
- Expenses that are not "covered" by the plan;
- Expenses that are not medically necessary.

Out-of-Network, Out-of-Pocket Expenses
Out-of-network, out-of-pocket expenses include the amount you pay of the out-of-network covered expenses (your out-of-network coinsurance) once the plan has paid its benefits. Out-of-network, out-of-pocket expenses do not include:

- Out-of-network deductible;
- Out-of-network preventive care;
- Out-of-network family planning services;
- Coinsurance for mental health care;
- Emergency room copayment;
- Prescription drug coinsurance;
- All in-network expenses, including in-network coinsurance;
- In-network deductibles;
- Expenses that are not "covered" by the plan;
- Expenses that are not medically necessary;
- The portion of any charge by a provider that is above the plan's "allowed amount;"
- Any amount you or your covered dependent has to pay because you did not follow the plan's preadmission certification or continued stay review requirements.

Effect of Reaching Out-of-Pocket Maximums on Mental Health Benefits
The plan's out-of-pocket maximums do not apply to mental health care expenses. Mental health care expenses will not be paid at 100% after you reach the plan's in-network or out-of-network, out-of-pocket maximum. Instead regular plan benefits will continue to apply to mental health care expenses.

No Maximum Lifetime Benefit for In-Network Services
Some plans limit the amount of benefits a plan will pay over a person's lifetime. This is called a maximum lifetime benefit limit. With the NWA medical plan, there is no overall plan limit imposed on the amount of medical benefits payable over a covered individual's lifetime when they are received from an in-network provider. However, benefits received from out-of-network providers are limited to $1 million per covered individual's lifetime. In addition, as explained below certain covered expenses may have a lifetime or other limit.

Other Maximum Benefits
For certain covered expenses, the plan has maximum annual benefits each calendar year:

- Chiropractic care is limited to 20 visits in a calendar year combined for in- and out-of-network services unless authorized in advance by the claims administrator as medically necessary;
- Physical, occupational & speech therapy is limited to 20 visits each in a calendar year for both in-and out-of-network combined, unless authorized by the claims administrator as medically necessary;

- Home health care, generally, is limited to 40 visits in a calendar year for both in and out-of-network combined, unless authorized in advance by the claims administrator;
- Weight-loss management is limited to four physician office visits and six dietician visits per calendar year for both in- and out-of-network combined for treatment of obesity.

For more information, see “Covered Medical Expenses.”

When You Must Call for Approval

Health-Threatening Conditions Do Not Require a Call
If you need emergency treatment for a “health-threatening condition,” you do not have to call for pre-approval. You should seek needed medical care. For complete information about “health-threatening conditions,” see “Emergency Services.” If you subsequently are admitted to a Hospital, you should follow the notification procedures on pages 10-11.

Specific Expenses (Whether In-Network or Out-of-Network)
Certain expenses are not always medically necessary and, when not medically necessary, are not covered by the plan. To ensure that the following are covered before you incur an expense, you should call for pre-approval (or you should make sure your Doctor calls) before you or a covered dependent:

- Receives an organ or bone marrow transplant or incurs travel or lodging expenses related to an organ or bone marrow transplant;
- Receives certain dental services, such as oral surgery (including orthognathic surgery) or hospitalization for dental care;
- Receives certain maternity services, such as ultrasounds;
- Receives home health care;
- Receives inpatient or outpatient treatment for weight loss;
- Receives an MRI;
- Receives a sleep study;
- Receives services for TMJ;
- Transfers by ambulance from one Hospital to another;
- Purchases Durable Medical Equipment over $1,000;
- Uses midwife services;
- Receives outpatient private duty nursing;
- Receives Hospice care;
- Will be receiving more than 20 visits for:
  - Alcohol and chemical dependency treatment;
  - Chiropractic care;
  - Outpatient mental health, and

- Physical, occupational, speech or vision therapy.

Call the number on your medical ID card. If the preceding expenses are determined not to be medically necessary, no benefits are payable. In addition, medical supervision is needed for transfers by ambulance from one Hospital to another.

By law, health care plans must complete pre-service reviews like the preceding, no later than 72 hours after you call concerning an urgent care claim (if all information is complete) and within 15 days after you call concerning other pre-service claims (with one 15-day extension available to decide other pre-service claims). If you do not receive notification of a decision within these time frames, you should check with the pre-admission program. If a pre-service review results in a denial, you can appeal it – see pages 57-61 for the claim review and appeal procedures. In addition, if the plan decides to reduce or end a previously approved course of treatment (or number of treatments), it will notify you sufficiently in advance to allow you the opportunity to appeal the decision.

Admissions

Pre-approval & Continued Stay Approval

"Pre-approval" and "continued stay approval" are programs that apply to both in-network and out-of-network admissions. Pre-approval requires you to call at least seven days in advance to get approval for a non-emergency admission. You also must call within 24 hours of any emergency admission. This includes admission to:

- A Hospital;
- A Skilled Nursing Facility;
- Any facility for inpatient hospice care;
- Any facility for inpatient mental health care;
- Any facility for inpatient treatment of alcohol or chemical dependency; and
- Any facility for inpatient therapy (physical, occupational, speech or vision).

Continued stay approval requires you to call if your length of stay needs to be extended beyond the number of days originally approved by the pre-admission certification program.

Steps to Take for Pre-approval & Continued Stay Approval

At least seven days before a non-emergency inpatient stay or within 24 hours of an emergency admission, call for pre-approval. Call the number on your medical ID card. Be prepared to provide the following information:

- Employee's Social Security Number;
- Employee's name and address;
- Patient's name and address;
- Doctor's name, telephone number, and address;

- Hospital's name and address;
- Date of proposed or emergency admission;
- The reason for the admission.

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

Once the call has been made, the pre-approval program will contact your Doctor to discuss symptoms, test results, the treatment plan and the length of stay. After your Doctor provides the necessary medical information, the pre-approval review will be completed in a matter of hours. In most cases, you can be admitted as planned. If the pre-approval review findings differ from your Doctor's recommended treatment, the pre-approval program will work with your Doctor to develop an appropriate treatment plan.

When the pre-approval review is complete, you may receive a phone call from the pre-approval program. You, your Doctor and the Hospital also will be notified by letter.

By law, health care plans must complete pre-service reviews, like the pre-approval program, no later than 72 hours after receipt of the initial urgent care claim (if it was complete) and within 15 days after receipt of other pre-service claims (with one 15-day extension available to decide other pre-service claims). If you do not receive notification of a decision within these time frames, you should check with the pre-approval program. If a pre-approval review results in a denial, you can appeal it – see pages 57-61 for the claim review and appeal procedures. In addition, if the plan decides to reduce or end a previously approved course of treatment (or number of treatments), it will notify you sufficiently in advance to allow you the opportunity to appeal the decision.

Once you are admitted, if your length of stay needs to be longer than the number of days originally approved, you must call (or see that your Doctor calls) for continued stay approval (approval of the additional days). You must call before your original length of stay ends. If your continued stay approval request is for urgent care, you must call at least 24 hours before your original length of stay ends and you will receive a decision within 24 hours of your call. If a continued stay approval request is denied, you can appeal it – see pages 57-61 for the claims review and appeal procedures.

<u>If You Have Medicare</u> -- If you have coverage under both Medicare and this plan and your Medicare coverage is primary – for example, if you are retired – pre-approval and continued stay approval are not required for you.

Special Note Concerning Childbirth Benefits
Under federal law, you do not have to get pre-approval for a maternity admission if your expected Hospital stay is 48 hours or less after a normal vaginal delivery or 96 hours or less after a cesarean section. Once you deliver, if you need to stay in the Hospital longer than that, you must call (or see that your Doctor calls) to get continued stay approval. This plan

may not, under federal law, require pre-approval for stays that fall within the preceding time frames nor may it restrict benefits to less than those time frames. This does not, however, prohibit a mother or child from being discharged sooner, if the discharge is voluntary on the part of the mother and attending Doctor.

Reduction of Benefits for Not Following Pre-approval
If you get pre-approval when required and follow the approved course of treatment, the plan will pay its usual benefits for your covered expenses. Benefits will be reduced if you:

- Do not get pre-approval and it is determined that your Hospital or other facility stay is not medically necessary. No benefits will be paid for expenses that are not medically necessary. Medically necessary expenses will be paid at the plan's normal benefit level after a $500 in-network hospital deductible or $1,000 out-of-network hospital deducible.
- Get pre-approval and it is determined that your Hospital or other facility stay is not medically necessary, but you proceed with the admission anyway. No benefits will be paid for expenses that are not medically necessary. Medically necessary expenses will be paid at 50% after the calendar year deductible.

Pre-approval is not required for emergency admissions. Expenses reduced or not paid because of these penalties will not be paid under any other part of this plan and will not count toward the plan's deductibles or out-of-pocket maximums.

Medical Management Services
The plan includes several medical management services – medical case management, disease management and transplant benefit management – that can help both the patient and family and provide added benefits for special, serious medical situations. These programs are voluntary.

Medical Case Management
The claims administrator will identify cases that may be appropriate for medical case management, based on its established standard criteria that consider the patient's condition and prognosis, the cost, duration and intensity of expected health care services for the condition and available alternatives.

In such cases, the claims administrator will provide an alternative benefit program that includes coverage for alternative health care services and supplies that would not otherwise be covered by the plan.

These alternative services and supplies will be designed by the claims administrator for the diagnosis and treatment of the patient's illness or injury and will be medically necessary, appropriate and cost-effective. The plan will pay for, and cover as plan benefits, the health care services and supplies contained in an alternative benefit program. The plan administrator has given the claims administrator the discretion and authority to develop and revise alternative benefit programs. If a patient or Doctor does not want to participate in medical case management, the claims administrator will not provide these services.

Disease Management

The claims administrator will identify cases that may be appropriate for a disease management program. These programs include, but are not limited to, diabetes, asthma, coronary artery disease, and congestive heart failure. The disease management program identifies participants based on its established standard criteria that consider the patient's condition. These programs respond to the growing need for better health information and ways to manage health for individuals with chronic conditions.

Transplant Benefit Management
The claims administrator has a list of certain transplant procedures that qualify for transplant benefit management. This list can change from time to time.

For covered individuals who are authorized to receive a qualified transplant procedure, the claims administrator will provide access to its network of transplant facilities, as well as corresponding discounts. If a transplant facility determines that a patient does not meet all of its acceptance criteria, the claims administrator will make a reasonable effort to locate an appropriate alternate facility.

Services and supplies from a transplant facility for qualified procedures include:

- Evaluation of the patient for the procedure;
- Hospital and physician fees;
- Organ acquisition and procurement;
- Transplant procedures;
- Follow-up care for a period of up to one year after the transplant;
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient.

The plan will pay for, and cover as plan benefits, the services and supplies provided for a medically necessary qualified procedure under this program. The plan administrator has given the claims administrator the discretion and authority to approve for payment those services and supplies provided to covered individuals under this program. If a covered individual chooses not to have care for a qualified transplant procedure under the terms of this program, the plan will pay its usual benefits for covered services and supplies that individual receives.

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). An illness means a non-work related sickness, disease or related condition of the body requiring medical treatment. An illness includes pregnancy, routine Hospital and pediatric care of a newborn before discharge from the Hospital and birth defects and related conditions. An injury means non-work related physical harm to the body requiring medical treatment. In addition, to be covered by the plan, medical care, treatment, services and supplies must be recommended or performed by a Doctor or other licensed provider and be "medically necessary."

Medically necessary means essential for the necessary care and treatment of the illness, injury or pregnancy, as determined by the claims administrator. Care is considered medically necessary if it:

- Is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Is based on recognized standards of the health care specialty involved;
- Represents the most appropriate level of care. That is, the frequency of service, the duration of services, and the site of services (such as in the Hospital or in the Doctor's office) are appropriate for the seriousness of the condition being treated; and
- Is not Experimental, investigative or unproven.

Remember, for in-network benefits to apply, covered services must be provided by in-network providers. In addition, not all services available through preferred providers are considered covered expenses under this plan. Out-of-network expenses are subject to the plan's allowed amount – see page 5.

Generally, plan benefits are paid at 80% after the deductible for in-network care and 70% after the deductible for out-of-network care. However, copays and other limits apply to certain benefits.

Key Covered Medical Expenses – At A Glance		
	In-Network	Out-of-Network
Acupuncture * Limited to 15 treatments per episode	80% after deductible*	70% after deductible*
Alcohol & chemical dependency treatment Inpatient treatment and Outpatient treatment	80% after deductible	70% after deductible
Ambulance Service	80% after deductible	70% after deductible
Chiropractic Care office visit Limited to 20 visits per calendar year	80% after deductible	70% after deductible
Doctor office visits Office or home visit Injections (including allergy injections) Diagnostic lab or X-ray	80% after deductible	70% after deductible
Durable medical equipment and consumable medical supplies Expenses over $1,000 require pre-approval	80% after deductible	70% after deductible
Emergency Room	$100 copay for facility, 80% after deductible for physician charges if true emergency. Otherwise, 80% after deductible for facility and physician charges	$100 copay for facility, 80% after deductible for physician charges if true emergency. Otherwise, 70% after deductible for facility and physician charges
Home health care	80% after deductible	70% after deductible
Hospital inpatient	80% after deductible	70% after deductible
Lab services	80% after deductible	70% after deductible
Maternity You must enroll in the plan's prenatal program. Otherwise, subject to pre-approval penalty upon hospitalization.	80% after deductible	70% after deductible
Mental health	80% after deductible	70% after deductible
Podiatry	80% after deductible	70% after deductible
Preventive care	90%; no deductible for covered services	Not covered
Surgeon services	80% after deductible	70% after deductible

Therapy, physical, occupational and speech Limits apply.	80% after deductible	70% after deductible
Weight loss treatment Limits apply. Use of centers of excellence required where available.	60% after deductible	Not covered
X-ray, diagnostic & therapeutic procedures	80% after deductible	70% after deductible

The following medical expenses are covered by the plan:

Abortion, Spontaneous & Legal Therapeutic – Covered the same as any other illness or injury – see "Maternity" for benefit details.

Acupuncture – Only when medically necessary for the treatment of chronic pain and specific diagnoses, as determined by the claims administrator. Limited to 15 treatments per episode of chronic pain (each episode must be separated by six months or more of no treatment).

Alcohol & Chemical Dependency – The plan covers both inpatient and outpatient treatment. For inpatient treatment, to receive in-network benefits, all services must be provided by an in-network provider and provided in an in-network Hospital, other in-network facility or an in-network residential treatment center. In addition, you must obtain an evaluation by an in-network provider before admission. You must get pre-approval before you are admitted to a facility for inpatient alcohol or chemical dependency treatment whether in or out-of-network.

The following inpatient services and supplies are covered by the plan:

- Detoxification;
- Semi-private room and board;
- Services of appropriate medical professionals, including a Doctor or Psychologist; and
- Other medically necessary services for the diagnosis and treatment of alcohol or chemical dependency, including lab work, X-rays and emergency room treatment.

For outpatient treatment, the following services are covered by the plan:

- Group therapy;
- Individual therapy; and
- Services of a Doctor or Psychologist.

You should get pre-approval for outpatient care beyond 20 visits. If your pre-approval request is approved, additional services may be covered.

Ambulance Services – Emergency ambulance service to the nearest medical facility capable of providing required "Emergency Services" (described on pages 19-20). Transfer from one

Hospital or facility to another Hospital or facility for subsequent covered treatment also is covered if medical supervision is required en route. To ensure that expenses will be covered by the plan, you (or your Doctor) should call for pre-approval before you are transferred from one Hospital to another by ambulance.

Blood & Blood Transfusions – Received as an outpatient.

Chemical Dependency – See "Alcohol & Chemical Dependency." Coverage is provided for diagnosable alcohol and chemical dependency conditions. You should get pre-approval for outpatient care beyond 20 visits. If your pre-approval request is approved, additional services may be covered.

Chiropractic Care – Short-term chiropractic care is covered. Covered services include:

- Services to treat muscular-skeletal injuries only;
- One set of diagnostic X-rays per condition.

Maintenance or palliative chiropractic care or chiropractic care other than for treatment of muscular-skeletal injuries is not covered. In- and out-of-network benefits are limited to 20 visits per covered person each calendar year unless additional visits are authorized by the claims administrator. You should get pre-approval for care beyond 20 visits. If your pre-approval request is approved, additional services may be covered.

The plan gives the claims administrator the right to deny benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Consumable Medical Supplies – See "Durable Medical Equipment & Consumable Medical Supplies" for benefit details.

Complications of Pregnancy – Includes complications from spontaneous and legal, therapeutic abortions. Covered the same as any other illness or injury – see "Maternity" for benefit details.

Cosmetic Surgery – Only reconstructive surgery that is determined by the claims administrator as necessary to repair a functional disorder as a result of illness, injury or congenital defect (e.g., cleft lip/cleft palate for a child, removal of "port wine" stain) or to repair bodily injury due to an accident, other medically necessary reconstructive surgery, breast reduction surgery if medically necessary and breast reconstruction after a mastectomy. See "Surgeon's Services & Assistants" and "Mastectomy & Post-Mastectomy Reconstruction" for benefit details.

Dental Services – The plan only covers the dental-related services listed here. If you or a dependent is enrolled in the NWA Dental Plan, see that section of this booklet for other dental care coverage. To receive in-network benefits, all services must be provided by in-network providers, except for an emergency situation. To ensure that expenses will be covered by the plan, you (or your Doctor) should call for pre-approval before receiving any of the dental services listed here, whether you are doing so in-network or out-of-network.

For accidental dental injury, the plan covers services to repair a tooth and supporting dental tissues to a functional level after the tooth and/or tissues have been accidentally injured by violent contact with an external object. This includes injury to a "sound natural tooth," as well as a tooth that was restored previously with a filling, crown or bridge. In the case of a previously restored tooth, the plan will cover services to repair the tooth to the same condition that existed before the accident. (Teeth that are cracked or broken while chewing are not covered.) A sound, natural tooth is one that has not been weakened by existing dental pathology, such as decay or periodontal disease. For dental implants, the plan covers charges for dental implants when it is the only viable, alternative procedure available for restoration. If no alternative procedure is available, payment is based upon the allowed amount for the implant(s).

For outpatient dental care, the plan covers dental services needed to treat an underlying medical condition. Examples are removing teeth to complete radiation therapy for cysts, lesions or cancer of the jaw.

For Hospital services for dental care, the plan covers Hospital facility and anesthesia charges for dental care directed by a Doctor for children through age five. For individuals over age five, Hospital facility and anesthesia charges for dental care are covered when directed by a Doctor and when medically necessary and needed because of an underlying medical condition. Generally, an oral surgeon's or dentist's charges are not covered. Medical conditions that may require you to be hospitalized for dental care include, but are not limited to:

- Hemophilia;
- Severe airway obstruction;
- Severe asthma.

Hospitalization for dental care due to the extent of the dental procedure is not covered. You must get pre-approval before you are hospitalized for dental care. The plan covers treatment directed by a Doctor for significant medical complications of non-covered dental care, such as complications affecting the head, neck or substructures. Generally the plan only covers oral surgery when directed by a Doctor to treat medical conditions. Included is:

- Treatment of fracture of the jaw;
- Treatment of non-dental cysts;
- Treatment of oral neoplasm;
- Treatment of trauma to the mouth and jaw; and
- Any other medically necessary (as determined by the claims administrator) oral surgery.

For orthognathic surgery, the plan covers charges directly related to the surgery for treatment of obstructive sleep apnea, for direct treatment of acute traumatic injury, tumor or cancer or other (as determined by the claims administrator), such as surgeon's fees, anesthesia and Hospital expenses. (Orthognathic surgery is the widening, lengthening or shortening of the bones in the jaw to correct severe skeletal facial deformities due to trauma, congenital or acquired conditions or disproportionate growth of the bones in the face or jaw.)

Orthodontia is limited to services related to oral surgery required for treatment of congenital abnormalities, such as cleft lip and palate, for eligible dependent children.

For temporomandibular joint dysfunction (TMJ), the plan covers diagnostic testing and treatment (including surgery) of TMJ when directed by a Doctor and medically necessary (as determined by the claims administrator). Subsequent dental treatment (e.g., crowns) is not considered an eligible medical expense for TMJ.

Doctor's Office Visits – Charges for visits to a Doctor's office for diagnosis, care and treatment of an illness or injury, including necessary diagnostic lab and X-ray work performed during a visit. Injections administered in a Doctor's office are covered, including allergy injections. For immunizations, see "Preventive Care."

Durable Medical Equipment & Consumable Medical Supplies – Short-term rental or purchase (as determined solely by the claims administrator) of medically necessary, durable medical equipment. You must get pre-approval for the purchase of durable medical equipment over $1,000. Examples of covered durable medical equipment include, but are not limited to:

- Crutches;
- Hospital beds;
- Inhalators;
- Intermittent positive-pressure breathing machines;
- Oxygen tents;
- Respirators;
- Suction machines;
- Walkers;
- Wheelchairs; and
- Other items as determined eligible by the claims administrator.

Hearing aids are covered under "Prosthetic Medical Appliances."

Also covered are certain consumable medical supplies. Examples of covered consumable medical supplies include, but are not limited to:

- Ostomy supplies (and certain other related supplies);
- Total Parenteral Nutrition (TPN) administered by an IV and enteral feedings and formula administered by stomach or nasal tube as a sole source of nutrition and calories to someone who cannot eat or digest food. Food supplements (for weight gain or loss) are not covered;
- Wigs, up to $500, but only when needed due to baldness from chemotherapy or radiation, alopecia, burns, acute traumatic scalp injury or other medical reasons determined by the claims administrator;

- Custom-made orthotics for the feet, but only if medically necessary as determined by the claims administrator (for example, if the covered individual has been diagnosed with diabetes);
- Eyeglasses/Lens – Only when prescribed as medically necessary for the post-operative treatment of cataracts or treatment of corneal tears, aphakia or keratoconus. In those cases, the initial evaluation, lenses and fitting are covered by the plan. To receive in-network benefits, lenses must be obtained from an in-network provider;
- Other items as determined eligible by the claims administrator.

Diabetic supplies (syringes, lancets, test strips and glucometers) are not covered. Diabetic supplies are, instead, covered under the prescription drug program.

In the case of wigs, the plan will cover replacement costs up to $500 only if needed due to normal body growth or normal wear and tear and if determined to be medically necessary by the claims administrator.

To be eligible for coverage, durable medical equipment must be:

- Prescribed by a Doctor,
- Durable enough to withstand repeated use,
- Primarily and customarily used for medical reasons,
- Not useful without the illness or injury, and
- Appropriate for use in the home.
- Pre-approved by the claims administrator if purchased and the price is over $1,000.

Emergency Services – The plan covers charges for an emergency room or urgent care facility and associated Doctor's services. To receive in-network benefits, services must be provided by an in-network provider or at an in-network Hospital or facility. Out-of-network services or charges are paid the same as in-network if the condition is "health threatening." Examples of health-threatening conditions include, but are not limited to:

- Allergic reactions to drugs;
- Accidental poisoning;
- Acute asthma with respiratory distress;
- Acute pancreatitis;
- Cardiac arrest;
- Convulsions/seizures;
- Diabetic coma;
- Excessive bleeding;
- Fractures;

- Head injuries;
- Heat stroke;
- Hypothermia;
- Insulin shock;
- Kidney stones;
- Loss of consciousness/coma;
- Motor vehicle accidents;
- Myocardial infarction;
- Open wounds, including lacerations;
- Respiratory arrest;
- Severe chest pain; and
- Shock.

For follow-up care, to receive in-network benefits, services must be provided by an in-network provider.

Family Planning Services –The following services and supplies are covered when provided by an in-network provider only:

- Intrauterine devices (IUDs) provided in an in-network Doctor's office;
- Information and counseling on contraception;
- Medical history;
- Medical services connected with surgical sterilization (vasectomy, tubal ligation and termination of pregnancy);
- Medical supervision in accordance with generally accepted medical practice;
- Physical examination;
- Related laboratory tests; and
- Sex education, including prevention of venereal disease and AIDS, after appropriate counseling.

The plan does not cover oral contraceptives and contraceptive patches. Oral contraceptives and contraceptive patches are covered, instead, under the prescription drug program.

Health-Threatening Conditions – See "Emergency Services."

Home Health Care – Home health care services and supplies are covered when they are part of a "home health care plan." A home health care plan is a written plan of care and treatment of a person in his or her home that is established and approved by a Doctor. Home health care

must be provided by or under the direction of a "Home Health Care Agency" and be for a condition or related condition for which you are/were being treated in a Hospital. Custodial Care, maintenance and respite care are not considered to be, or covered as, home health care. To ensure that expenses will be covered by the plan, you (or your Doctor) should call for pre-approval before you begin receiving home health care services.

Covered home health care includes:

- Charges made by a Home Health Care Agency for medical services and supplies provided under the terms of a home health care plan for the person named in that plan;
- Home "visits" by a Doctor, nurse (R.N., L.P.N. or L.V.N.) or "home health aide" that are needed for patient management and are monitored by progress reviews. When included as part of a home visit, the following also are covered expenses:
  - Nutritional counseling provided under the direction of a registered dietician; and
  - Physical, occupational, respiratory and speech therapy when rehabilitative.

Both in- and out-of-network benefits (combined) are limited to 40 visits per calendar year for each covered person. (Each four hours of care is considered one visit.) However, if your Doctor recertifies in writing that you would need to be confined in a Hospital or Skilled Nursing Facility without home health care, an additional 40 visits may be covered.

A home health aide is a person who reports to and is under the direct supervision of a Home Health Care Agency and who provides medical or therapeutic care.

Covered home health care does not include:

- Any period during which the patient is not under the continuing care of a Doctor;
- Care or treatment that is not stated in the home health care plan;
- Custodial Care;
- Respite care; and
- Services provided by a member of the patient's family or a dependent's family or by a person who normally lives in the patient's or a dependent's home.

Hospice Care – Hospice care is covered for a patient who, according to their Doctor's diagnosis, has a terminal illness and is not expected to live more than six months. Care must be provided under a "hospice care program," which is a coordinated, interdisciplinary program to meet the physical, psychological and social needs of terminally ill patients and their families and provides palliative and supportive medical, nursing and other health services during the illness. Hospice care services can be provided by a Hospital, Skilled Nursing Facility or similar institution, a home health agency, a "hospice facility" or any other licensed facility or agency under a hospice care program. If services are provided by a hospice facility, it must be accredited by the National Hospice Organization, provide care primarily for terminally ill patients and meet all licensing requirements of the state or locality in which it operates as well as the standards of this plan. You must get pre-approval before you are admitted to a facility for hospice care.

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

- Drugs, medicines and medical supplies for pain relief treatment provided by the hospice facility or home health care company, including existing and new drugs not otherwise excluded by the plan;
- Home health aid services and lab services to ease pain;
- Outpatient hospice services;
- Part-time or intermittent nursing care services by a Home Health Care Agency – see page 20;
- Professional services provided by a Doctor, Psychologist, Licensed Clinical Social Worker (L.C.S.W.), family counselor or ordained minister for individual and family counseling;
- Room and board, up to the facility's most common daily rate for a semi-private room, and "necessary services and supplies." Necessary services and supplies include only those medical services and supplies charged by the facility and actually used during a confinement. It does not include special nursing fees, dental or medical fees.

Covered hospice expenses do not include:

- Any curative or life-prolonging procedures;
- Any period during which the patient is not under the continuing care of a Doctor;
- Care or treatment that is not stated in the hospice care plan;
- Services or supplies that are primarily to aid in homemaking/daily living;
- Services provided by a member of the patient's family or a dependent's family or by a person who normally lives in the patient's or a dependent's home; and
- Services, supplies, care or treatment that is covered under other provisions of the plan.

Hospital Inpatient Expenses – The plan covers eligible medical or surgical services that are recommended by a Doctor for the treatment of acute illness, injury or pregnancy that requires the level of care only provided in an acute care facility. To receive in-network benefits, all services must be provided in an in-network Hospital or facility. You must get pre-approval before all Hospital admissions, except for certain maternity admissions – see pages 8-11.

Covered services while confined in a Hospital include:

- Anesthesia;
- Biologicals, fluids, blood and the administration of blood transfusions;
- Doctor, surgeon and anesthesiologist services and other medical professional services while in the Hospital;
- Dressings and casts;

- General nursing care;
- Intensive care facilities and newborn nursery facilities;
- Lab, X-ray and other diagnostic services, including MRIs;
- Oxygen;
- Prescription drugs and other medications administered in an inpatient setting, including existing and new drugs not otherwise excluded by the plan;
- Private room and board – Only if the claims administrator determines that a private room is medically necessary;
- Professional ambulance service to or from a Hospital, whether you are billed by the Hospital or ambulance service;
- Radiation therapy, chemotherapy and physical/occupational therapy;
- Semi-private room and board;
- Special diets;
- Surgery, including services and supplies;
- The use of operating rooms and maternity delivery rooms;
- Treatment of mental illness and functional nervous disorders (if billed by the Hospital); and
- Treatment of chemical dependency (if billed by the Hospital).

Services for items for personal convenience are not covered.

Infertility Services – The plan covers only those diagnostic steps and procedures that establish the cause of, or reason for, infertility (as approved by the claims administrator) and surgical treatment to correct bodily defects.

The plan does not cover injectable fertility drugs or oral fertility drugs (e.g., clomid) or infertility procedures (assisted reproduction), such as artificial insemination, in-vitro fertilization and other related services. In addition, expenses incurred for or in connection with a non-covered procedure are not covered.

Laboratory Services – Diagnostic laboratory services performed in a lab facility or performed in an office or clinic. Even if ordered by an in-network Doctor, to receive in-network benefits, lab services must be performed in an in-network facility.

Mastectomy & Post-Mastectomy Reconstruction – For complications of mastectomy, the plan's regular coinsurance amounts apply according to the service received – the same as for any other illness or injury. In addition to the plan's regular Hospital and surgical benefits for a mastectomy, the plan will cover prostheses and treatment for physical complications at all stages of a mastectomy, including swelling with the removal of the lymph nodes. In addition, the plan will cover two mastectomy bras each calendar year and external prosthetics, with such coverage limited to the lowest cost alternative that meets external prosthetic needs. If you or a

covered dependent chooses to have breast reconstruction after a mastectomy, the plan will cover the following:

- Reconstruction of the breast on which the mastectomy was performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

This plan is in compliance with the Women's Health and Cancer Rights Act of 1998.

Maternity – Pregnancy/maternity care is covered the same as any other illness or injury. Covered are medical, surgical and Hospital care during the term of the pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous and legal therapeutic abortions and complications of pregnancy.

You must enroll and participate in the plan's prenatal program. Otherwise, you will be subject to the plan's inpatient pre-approval penalty when you are hospitalized – see page 11.

Under the healthy baby program, trained nurses with experience in obstetrical and/or perinatal care work with expectant mothers and their doctors to detect and reduce risks that could prevent a healthy full-term delivery. Through assessment, education and support, nurse case managers ensure that you achieve optimal childbirth outcomes.

Mothers-to-be can initiate the program by calling the number on their NWA medical plan ID card and speaking to a trained registered nurse. To take full advantage of the program you should call within first twelve weeks of pregnancy.

When the program is initiated, the nurse assesses the expectant mother's potential pregnancy risk by obtaining a comprehensive health history and begins personalized one-on-one education and personal support.

To ensure that expenses will be covered by the plan, you (or your Doctor) should call for pre-approval before you use midwife services. In addition, midwife services must be provided by a practitioner recognized by the American College of Midwives.

The following maternity services only are covered if the claims administrator determines them as medically necessary. To ensure that expenses will be covered by the plan, you (or your Doctor) should call for pre-approval before you receive any of the following services:

- Amniocentesis (if more than one will be done);
- Chorionic villi sampling (to see if cells are healthy);
- Genetic testing (to determine if baby has inherited any disease);
- Home uterine monitoring (for pre-term labor);
- Obstetricians for global pregnancy services (the first office visit to confirm pregnancy will not be included in global charges);
- Tocolytic therapy (for pre-term labor);

- Ultrasounds; and
- Any other non-standard services.

For hospitalization for delivery, you do not have to get pre-approval for stays that are 48 hours or less after a vaginal delivery or 96 hours or less after a cesarean section – see page 11 for details.

Mental Health – The plan covers both inpatient and outpatient treatment. Mental health expenses do not count in determining when you have met the plan's out-of-pocket maximums – see pages 6-7.

For inpatient treatment, to receive in-network benefits, all services must be provided by an in-network provider and provided in an in-network Hospital, other in-network facility or an in-network Residential Treatment Center. In addition, you must obtain an evaluation by an in-network provider before admission. You must get pre-approval before you are admitted to a facility for inpatient mental health treatment.

The following inpatient services and supplies are covered by the plan:

- Crisis intervention;
- Semi-private room and board;
- Services of appropriate medical professionals, including a Doctor, Psychiatrist, Psychologist or Licensed Clinical Social Worker (L.C.S.W.); and
- Other medically necessary services.

The following outpatient services are covered by the plan if medically necessary:

- Group therapy;
- Individual therapy;
- Services of a Doctor, Psychiatrist, Psychologist or Licensed Clinical Social Worker (L.C.S.W.); and
- Testing and assessment.

Out-of-network, outpatient treatment also is covered for the preceding services when medically necessary, but services must be provided by a facility that is licensed to provide mental health services.

Coverage is provided for diagnosable mental health conditions, including autism and eating disorders. Treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a Doctor, psychiatrist, licensed psychologist, licensed alcohol and drug dependency counselor or a certified substance abuse assessor is considered medically necessary. Prior authorization for care beyond 20 visits is required for services to be covered under the plan.

NurseLine Services –The plan's free nurseline lets you speak to an R.N. (24 hours a day, seven days a week) to get information about self care for common symptoms, explanations of medical tests and risks and benefits of surgeries and diagnostic procedures. In addition, the plan's nurseline can answer your questions about appropriateness of care, prescription drugs and over-the-counter medications, medical conditions and more. Call the number on your wallet card.

Nutritional Counseling – The plan covers nutritional counseling services provided by a licensed dietician, but only for a medical condition that requires a special diet (such as diabetes). Nutritional counseling is limited to three visits per condition in a covered individual's lifetime. Nutritional Counseling as part of a weight management program is covered at 60% after the deductible and limited to six visits per calendar year.

Office Visits – See "Doctor's Office Visits."

Oral Surgery – See "Dental Services."

Organ & Bone Marrow Transplants –To ensure that expenses will be covered by the plan, you (or your Doctor) should call for pre-approval before you have an organ or bone marrow transplant, whether the procedure is in-network or out-of-network. Covered are expenses for or in connection with approved organ or bone marrow transplant services, including:

- Donor testing expenses for immediate family members only (spouse, children, parents and siblings);
- Immunosuppressive medication provided while an inpatient or in a Doctor's office, including existing and new drugs not otherwise excluded by the plan;
- Organ procurement costs, but only those costs directly related to procurement of an organ;
- The donor's medical expenses, but only those services and supplies directly related to the transplant itself.

This plan's benefits for donor medical expenses will be reduced by amounts payable from any other plan.

The plan does not cover immunosuppressive drugs purchased at a pharmacy. (Immunosuppressive drugs purchased at a pharmacy are covered, instead, under the prescription drug program.) In addition, the plan does not cover expenses for the donor related to complications from the transplant.

Certain transplants are not covered by the plan. For example, transplants that are considered to be Experimental or investigative, as determined by the claims administrator. Therefore, coverage for organ transplants, bone marrow transplants and bone marrow rescue services is reviewed periodically and modified by the claims administrator when new medical or scientific evidence and/or technology shows that a procedure is no longer investigative or if medical or scientific evidence shows that a procedure is no longer the standard and/or acceptable treatment for a specific condition.

Travel and lodging expenses (for yourself or a family member acting as a travel companion) related to organ transplants may be covered when care is provided in a facility that is more than a reasonable distance from your home. If air travel is necessary, you are required to use your NWA pass travel privileges when available. Benefits for lodging are limited to $50 per day. In addition, there is a combined travel and lodging maximum lifetime benefit of $5,000 per person. You (or your Doctor) must call and get pre-approval before you incur any travel and lodging expenses related to an organ/bone marrow transplant.

Special Note: The IRS classifies benefits paid for travel and lodging for an organ or bone marrow transplant as taxable income. You will receive a notice from the claims administrator identifying any such taxable amount in time to file your taxes.

Outpatient Services – The plan covers eligible medical and surgical services for the diagnosis or treatment of illness, injury or pregnancy that are performed on an outpatient basis.

Covered outpatient services include:

- Anesthesia;
- Biologicals, fluids, blood and the administration of blood transfusions;
- Doctor, surgeon, anesthesiologist services and other medical professional services while an outpatient;
- Dressings and casts;
- General nursing care;
- Lab, X-ray and other diagnostic services, including MRIs;
- Prescription drugs and other medications administered in an outpatient setting, including existing and new drugs not otherwise excluded by the plan;
- Radiation therapy and chemotherapy;
- Surgery, including services and supplies;
- The use of operating rooms and maternity delivery rooms; and
- The use of other outpatient facilities.

Podiatry – Only when medically necessary for the treatment of metabolic or peripheral vascular disease. Custom-made orthotics for the feet are covered as a consumable medical supply (see "Durable Medical Equipment & Consumable Medical Supplies" for benefit details) if medically necessary as determined by the claims administrator (for example, if the covered individual has been diagnosed with diabetes). Other routine foot care is not covered.

Prescription Drugs – The plan covers medically necessary prescription drugs administered while confined in a Hospital, Hospice, Skilled Nursing Facility or administered in an outpatient facility. Injections administered in a Doctor's office are covered. Depo-Provera is not covered under the medical plan – see the prescription drug program for coverage information. However, injection of Depo-Provera is covered when provided in an in-network Doctor's office. Other injectable

drugs also may be covered as part of the prescription drug program. Covered drugs and medications include existing and new drugs that are not otherwise excluded by the plan. All other prescription drugs are provided under the prescription drug program – see the "Prescription Drug Program" section for details.

Preventive Care (Wellness Benefits) – Available in-network only. Well-child care is available through age 18. Adult preventive care (well-adult care) is available after age 18.

Well-child care includes the following:

Exams and Office Visits:

- Six visits 0-12 months;
- Three visits 12-24 months;
- Annual visits from 24 months through age 18;
- Annual eye and hearing exam.

Immunizations:

- Meningococcal vaccine ;
- Two doses of hepatitis A;
- Three doses of hepatitis B;
- Six doses of diphtheria, tetanus, pertussis (DTP);
- Four doses of haemophilus influenza type B;
- Four doses of polio;
- Four doses of pneumococcal conjugate;
- Two doses of varicella;
- Two doses of measles, mumps, rubella;
    - One dose of influenza vaccine (flu shot) annually;
    - One dose of influenza vaccine (flu shot) annually; children age 8 or less who are receiving the influenza vaccine for the first time should receive two doses separated by at least 4 weeks.

Screenings:

- Lead level testing, one between ages 9 to 12 months and one at 24 months or after;
- Vision screening when done as part of well-child care office visit;
- Hearing screening when done as part of well-child care office visit;
- Pap smear and routine pelvic exam annually beginning at age 18 or the onset of sexual activity, whichever comes first.

Well-adult care includes:

Exams and Office Visits:

- Annual routine office visit and examination;
- Annual eye and hearing exam.

Immunizations:

- Tetanus/Diphtheria (TD) booster once every 10 years;
- Influenza vaccination (flu shot) once per plan year;
- Meningococcal vaccine;
- Pneumococcal vaccination (pneumovaz) one dose for persons 65 and over.

Screenings:

- Cholesterol screening including triglycerides, LDL, HDL, or lipid panel once every 5 years beginning at age 20;
- Mammogram annually starting at age 40;
- Pap Smear and routine pelvic exam once per plan year beginning at age 18;
- Bone density test for osteoporosis once for women age 65 and over;
- Colorectal cancer screenings:
  - Fecal occult blood test (FOBT) once per plan year and flexible sigmoidoscopy once every 5 years both beginning at age 50; or
  - Colonoscopy once every 10 years beginning at age 50; or
  - Double contrast barium enema once every 5 years beginning at age 50;
- Digital rectal examination (DRE) and prostate specific antigen (PSA) test once per plan year beginning at age 45.

Private Duty Nursing, Outpatient – Private duty nursing care given on an outpatient basis by a licensed nurse such as a register nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) only when medically necessary as determined by claims administrator.

Prosthetic Medical Appliances – To receive in-network benefits, all supplies must be provided and obtained from an in-network provider. The plan covers purchase, maintenance, and repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts. Specifically covered are:

- Artificial joints;
- Artificial heart valves;
- Cardiac pacemakers;
- Intraocular lenses;
- Other surgical materials, such as screw nails, sutures and wire mesh; and
- Other items as determined eligible by the claims administrator.

The plan also covers the purchase and fitting of certain external prosthetic devices that replace or substitute for a missing body part and are necessary to alleviate or correct an illness, injury or congenital defect. The plan covers the initial purchase and fitting of only the following external prosthetic devices:

- Artificial eyes;
- Artificial arms and legs;
- Hearing aids; and
- Terminal devices, such as a hand or hook.

For hearing aids, the plan also covers replacement and repairs. (Replacement of hearing aids is allowed every three years.) All plan benefits for hearing aids are limited to $1,000 per ear every three years.

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

Other items also may be covered as approved by the claims administrator.

Skilled Nursing Facility Care –You must get pre-approval before you are admitted to a Skilled Nursing Facility. Covered inpatient services in a Skilled Nursing Facility, include:

- Administration of drugs, medications, biologicals and fluids, including existing and new drugs not otherwise excluded by the plan;
- General and skilled nursing care (by an R.N., L.P.N. or L.V.N.);
- Medical supplies;
- Semi-private room and board; and
- Other services that a Skilled Nursing Facility commonly provides (except for Custodial Care). These services must be provided in lieu of Hospital care. The claims administrator

determines when care no longer meets criteria for coverage and becomes custodial in nature. Rehabilitation services are limited to services from which significant measurable progress is expected to occur within a reasonable period of time, as determined by the claims administrator.

Surgeon's Services & Assistants – Medical and surgical services provided on an inpatient or outpatient basis. Included are charges made by a Doctor, surgeon, registered graduate nurse, radiologist, and anesthesiologist, as well as other services billed separately from Hospital expenses if services are received in an in-network Hospital. Also covered are services by a Doctor in the appropriate surgical specialty, consultation and charges for X-rays, laboratory exams and minor surgical procedures that are routinely performed in a Doctor's office (such as incision and drainage of an abscess and excision of a benign lesion) – as long as the procedure or charge is not for a cosmetic or dental surgical procedure that is excluded by the plan.

Charges made by a Doctor for or in connection with surgery are subject to the maximum described below when two or more surgical procedures are performed at one time:

- The maximum amount payable will be the amount otherwise payable for the most expensive procedure and 50% of the amount otherwise payable for other surgical procedure(s).
- For out-of-network surgical assistants, a maximum applies. The maximum amount payable for an out-of-network surgical assistant (assistant surgeon, physician assistant or registered nurse) during surgery is 20% of the surgeon's fee (subject to the plan's allowable expense).

Temporomandibular Joint Dysfunction (TMJ) – see "Dental Services."

Therapy, Physical, Occupational, Speech & Vision – Rehabilitative physical, occupational, speech and vision therapy (only to correct the effects of illness or injury) are covered. Speech therapy due to developmental delay is not covered. In all cases, therapy must be medically necessary as determined by the plan. Further, in all cases, functional improvement and measurable progress, as determined by the claims administrator, must be made towards achieving functional goals, within a predictable period of time toward the person's maximum potential ability. Habilitative speech and other therapy (education and training of handicapped persons) is covered only in-network and only for conditions that have significantly limited the successful initiation of normal speech and motor development. You must get pre-approval before you are admitted to a Hospital or facility for inpatient therapy. Therapy is limited to 20 visits per type of therapy each calendar year for both in- and out-of-network care combined, unless the claims administrator authorizes more visits. You should get pre-approval for care beyond 20 visits. If your pre-approval request is approved, additional services may be covered.

Urgent Care – When medically necessary. Benefits depend on place of service – see "Doctors' Office Visits" and "Emergency Services" for benefit details.

Weight Loss Treatment – Requires pre-approval. Available only in-network and only when determined by the claims administrator as medically necessary. Includes gastric stapling and diversion and any other services for the purpose of weight reduction. To ensure that expenses will be covered by the plan, you (or your Doctor) should call for pre-approval before you begin receiving weight loss treatment, whether the treatment is in-network or out-of-network. The plan

covers up to four Doctor visits per year, six dietician visits per year and counseling. Weight loss medications are covered under Prescription Drugs. You must use the claims administrator's centers of excellence for care and surgery where available.

X-rays & Other Diagnostic and Therapeutic Procedures – Diagnostic or therapeutic radiology services and other diagnostic and therapeutic procedures. Even if ordered by an in-network Doctor, to receive in-network benefits, lab services must be performed in an in-network facility.

Covered X-ray and diagnostic services include:

- CAT scan;
- Electrocardiogram;
- Electroencephalogram;
- Mammogram;
- MRI;
- Radiation therapy; and
- Other diagnostic and therapeutic procedures.

The claims administrator reviews certain diagnostic (such as MRI and other selected services) and therapeutic procedures to verify that they are medically necessary and that the treatment provided is the proper level of care. You should get pre-approval before you receive selected services, so that you do not incur charges that the plan will not pay (if not considered medically necessary upon review). The most current list is available by calling the claims administrator.

Medical Expenses Not Covered
The plan will not pay benefits for expenses or charges for the following:

- Acupuncture – Except as described in "Covered Medical Expenses" on page 15. Limited to 15 treatments per episode of chronic pain (each episode must be separated by six months or more of no treatment).
- Alcohol & chemical dependency services – Except as described in "Covered Medical Expenses" on page 15.
- Ambulance, Hospital to Hospital transfers – If medical supervision is not required en route or if you do not get pre-approval in advance.
- Care:
  - That is not medically necessary as determined by the claims administrator, including services and supplies that are not medically necessary;
  - From providers who waive deductible and coinsurance payments from a covered person;
  - That is Custodial Care, maintenance care, non-therapeutic or non-rehabilitative or education or training;
  - Paid by another plan, under the plan's coordination of benefits provisions.

- Charges:
  - Above the allowed amount for treatment, care or a service or supply;
  - Above 20% of the surgeon's fee for charges by a surgical assistant during surgery (assistant surgeon, physician assistant or registered nurse);
  - For an expense that the plan is prohibited to pay under any law to which you or a covered dependent is subject to at the time the expense is incurred;
  - Made for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- Complications – Services and supplies for complications resulting from non-covered medical services or procedures as determined by the claims administrator.
- Chiropractic maintenance care or chiropractic therapy other than for treatment of an acute musculoskeletal condition.
- Contraceptives – Oral contraceptives, contraceptive patches and Depo-Provera are not covered under the medical plan – see the prescription drug program for coverage information. (However, injection of Depo-Provera is covered when provided in an in-network Doctor's office.) Intrauterine devices (IUDs) are covered only when provided in an in-network Doctor's office.
- Cosmetic or cosmetic surgical procedures – Except for reconstructive surgery that is determined by the claims administrator as necessary to repair a functional disorder as a result of illness, injury or congenital defect (e.g., cleft lip/cleft palate for a child, removal of "port wine" stain) or to repair bodily injury due to an accident, other medically necessary reconstructive surgery, breast reduction surgery if medically necessary and reconstructive surgery or prosthetic devices after a mastectomy (removal of all or part of the breast for medically necessary reasons).

  Specifically not covered is:

  - Surgical excision or reformation of any sagging skin on any part of the body including, but not limited to, the eyelids, face, neck, abdomen, arms, legs or buttocks;
  - Any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body including, but not limited to, the breasts, face, lips, jaw, chin, nose, ears or genitals;
    - Hair transplants;
    - Chemical face peels or abrasion of the skin;
    - Electrolysis depilation;
    - Any other surgical or non-surgical procedures that are primarily for cosmetic purposes.
- Counseling – Religious counseling, except as specifically described in "Covered Medical Expenses" on page 21, marital and or relationship counseling and sex therapy rendered in the absence of a significant mental disorder.
- Dental Care & Treatment – Except when needed as a result of accidental injury to teeth or for approved Hospital charges, described in detail on pages 16-17.

- Durable Medical Equipment (certain) & outpatient medical consumable supplies – Including, but not limited to:
  - Augmentative devices;
  - Breast pumps, unless medically necessary due to the cleft palate of the infant or other medically necessary reason approved by the claims administrator;
  - Consumable medical supplies, including but not limited to, bandages and other disposable supplies, skin preparations, test strips, except support stockings with a compression of 30mm or greater and wigs, unless approved by the claims administrator;
  - Food supplements, except for Total Parenteral Nutrition (TPN) and enteral feedings and formula, as specifically described in "Covered Medical Expenses" on page 18;
  - Deluxe (the most expensive or state-of-the-art) equipment, such as motor-driven wheelchairs and beds;
  - Deluxe models of prosthetic appliances such as biomechanical limbs;
  - Disposable supplies such as disposable sheaths, and disposable bags, (other than for a colostomy);
  - Doctor's equipment such as stethoscopes and sphygmomanometers;
  - Duplicate items;
  - Environmental control equipment, such as air purifiers, humidifiers and electronic machines;
  - Equipment used for athletic activities including, but not limited to, braces and splints;
  - Exercise and hygienic items or equipment such as an exercycle, Moore wheel, toilet seats and bathtub seats;
  - Institutional equipment, such as diathermy machines;
  - Items not primarily medical in nature or for the patient's comfort or convenience, such as bedboards, bathtub lifts, adjust-a-bed, telephone arms, air conditioners, bathtub chairs, stair gliders or elevators, over-the-bed tables, hot tubs, saunas or exercise equipment;
  - Items that are not generally accepted by the medical profession as being therapeutically effective, such as auto tilt chairs, paraffin bath units and whirlpool baths;
  - Long-term rental or purchase of otherwise covered durable medical equipment;
  - Orthotics for the feet that the claims administrator determines are not medically necessary, including off-the-shelf shoe inserts;
  - Penile implants/prostheses, unless medically necessary;
  - Self-help items or equipment (not primarily medical in nature), such as sauna baths and elevators.
- Expenses:
  - For care before your coverage or your dependent's coverage begins under the plan;

- For the treatment of military service disabilities that are treatable through governmental services if the covered person is legally entitled to such treatment and facilities are reasonably available;
- Incurred by a covered person to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law, uninsured motorist insurance law or any other automobile insurance;
- That are covered, and for which benefits are provided to a covered person, under government insurance (other than Medicaid or CHAMPUS), Workers' Compensation or similar type of insurance or coverage. A person eligible for Medicare is considered by this plan as being covered by Part A, Part B and Part D of Medicare even if he or she is not.;

- Experimental and Investigational Services or Unproven Services – Medical, surgical or other health care procedures determined to be "Experimental and Investigational Services or Unproven Services" by the claims administrator in accordance with accepted medical practice and including:
  - Experimental surgery and other Experimental health care procedures;
  - Expenses for or in connection with Experimental procedures or treatment methods not approved by the American Medical Association (AMA) or the appropriate medical specialty society.

  "Experimental and Investigational Services or Unproven Services" includes all procedures, technologies, treatments, facilities, equipment, drugs and devices that are considered investigative or otherwise not a clinically accepted medical service in the judgment of the claims administrator.

  This exclusion applies even if the Experimental and Investigational Services or Unproven Services are the only available treatment for your condition.
- Eyeglasses – Eyeglasses, lenses and contacts and the fitting of eyeglasses, lenses or contacts. However, intraocular lenses are covered (see pages 28-29) and the initial evaluation, lenses and fitting of eyeglasses are covered when prescribed as medically necessary for the post-operative treatment of cataracts or treatment of corneal tears, aphakia or keratoconus (see page 18).
- Foot care – Routine foot care, including the paring and removal of corns and calluses, or trimming of nails, unless such services are determined to be medically necessary by the claims administrator.
- Health conditions required by state or local laws to be treated in a public facility.
- Home delivery & midwife services – Medical services connected with the home delivery of a newborn and services of midwives, except to the extent that the claims administrator pre-approves midwife services by practitioners recognized by the American College of Midwives.
- Home Health Care – Charges for the following:
  - Care or treatment that is not stated in the home health care plan;

  - Services provided by a member of the patient's family or a dependent's family or by a person who normally lives in the patient's or a dependent's home;
  - Any period during which the patient is not under the continuing care of a Doctor;
  - Custodial, maintenance or respite care.
  - Homemaker, chore or similar services and health care services primarily for rest, custodial, domiciliary or convalescent care.
- Hospice care – Charges for the following:
  - Care or treatment that is not stated in the hospice care plan;
  - Services provided by a member of the patient's family or a dependent's family or by a person who normally lives in the patient's or a dependent's home;
  - Any period during which the patient is not under the continuing care of a Doctor;
  - Any curative or life-prolonging procedures;
  - Services, supplies, care or treatment that is covered under other provisions of the plan; and
  - Services or supplies that are primarily to aid in daily living.
- Immunizations & Injections – Except as described in "Covered Medical Expenses" on pages 17-18 and 27-28. All other immunizations are not covered.
- Infertility Services – Except as described in "Covered Medical Expenses" on page 23. All other infertility services are not covered. Specifically not covered is reversal of a voluntary sterilization procedure, all costs associated with surrogate parenting, artificial insemination, gamete intrafallopian transfer (GIFT), in-vitro fertilization or other similar procedures, and any costs associated with non-covered services such as collecting and storing sperm for artificial insemination (including donor fees).
- In-network services and supplies not provided by an in-network provider or authorized when required by the plan – except for covered emergency services described on pages 19-20.
- Laser eye surgery and all associated services and supplies.
- Naturopaths.
- Non-medical ancillary services – Such as vocational rehabilitation, employment counseling and psychological counseling and training or educational therapy for learning disabilities.
- Organ transplants – Except as described in "Covered Medical Expenses" on pages 25-26. All other organ transplant expenses are not covered. Specifically not covered are immunosuppressive drugs purchased at a pharmacy, expenses for the donor related to complications from the transplant and more than $50 per day in benefits for lodging or more than $5,000 in benefits per person in a lifetime for travel and lodging expenses (combined) related to a transplant.
- Orthognathic surgery – Except as described in "Covered Medical Expenses" on page 17.

- Out-of-network services and supplies for preventive/wellness care, family planning and weight-loss treatment and in-network preventive care except those expenses listed on pages 27-28. (Certain services are covered when provided in-network only.)
- Personal or comfort items – Such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary and guest meals, hair care, birth announcements and other related articles which are not for the specific treatment of an illness or injury.
- Physical fitness and exercise equipment and facility charges.
- Prescriptions – Except for those administered in an outpatient facility or while confined in a Hospital, Hospice or Skilled Nursing Facility and injections provided in a Doctor's office. Other prescription drugs are covered under the prescription drug program – see the "Prescription Drug Program" section for details. (Note: Depo-Provera is not covered under the medical plan. It is covered under the prescription drug program. However, injection of Depo-Provera is covered when provided in an in-network Doctor's office.)
- Private-duty nursing – Outpatient private-duty nursing unless medically necessary, as determined by the claims administrator. Private-duty nursing services provided in an inpatient setting.
- Private Hospital room – Unless medically necessary, as determined by the claims administrator, or unless this is the only type of room in the Hospital.
- Prosthetic medical appliances & services – Including, but not limited to:
  - Biomechanical prosthetic devices, dentures, corrective lenses, eyeglasses and contact lenses (except for intraocular lenses and eyeglasses/lenses prescribed as medically necessary for the post-operative treatment of cataracts or the treatment of corneal tears, aphakia or keratoconus);
  - Non-rigid appliances and supplies such as elastic stockings, garter belts, arch supports and corsets;
  - Items considered to be Experimental or research devices in the opinion of the claims administrator and in accordance with acceptable medical practice;
  - Devices designed exclusively to remedy sexual dysfunction except when authorized by the claims administrator to repair the physical functions of a body part as a result of a functional disorder or an accidental injury.

  A second opinion may be required, at the discretion of the claims administrator.
- Radial keratotomy and all associated services and supplies.
- Rehabilitation services – For physical, occupational, vision or speech therapy when such services cannot be expected to significantly improve a covered person's condition, as determined by the claims administrator.
- Reports, evaluations, or physical examinations not required for health reasons, including, but not limited to:
  - Employment;

  - Insurance or government licenses;
  - Court ordered, forensic or custodial evaluations; and
  - Evaluations for school.
- Services:
  - That are outside of the scope of practice or license of the individual or facility rendering the service;
  - For which a charge would not have been made in the absence of insurance or health plan coverage;
  - For which you or your family members are not required to pay;
  - That are not prescribed or approved by a Doctor;
  - That are not included in the list of "Covered Medical Expenses."
- Sex determination of a fetus – amniocentesis, ultrasound, or any other procedure requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder.
- Skilled nursing care – That can be delivered safely and effectively by a non-medical person, regardless of who actually performs or supervises the services.
- Social worker – Except as described in "Covered Medical Expenses" on page 21 and pages 24-25.
- Speech therapy – To treat developmental delay. Habilitative speech therapy (education and training of handicapped persons) may be covered under the plan's in-network benefits if certain guidelines are met – see "Therapy, Physical, Occupational, Speech & Vision."
- Teeth or periodontium – Expenses for the treatment of the teeth or periodontium, unless such expenses are:
  - Incurred for or in connection with dental work due to an injury that occurred while a person was covered by the plan;
  - Charges made by a Hospital for room and board or necessary services and supplies. Note that facility and anesthesia charges will be covered only if dental surgery in a Hospital is medically necessary based on the patient's medical condition and history as determined by the claims administrator;
  - Charges made by a Hospital or Free-Standing Surgical Facility in connection with outpatient surgery.
- Temporomandibular Joint Dysfunction (TMJ) – Except when medically necessary as determined by the claims administrator and as described in "Covered Medical Expenses" on page 17.
- Transportation or travel other than local ambulance service as described in "Covered Medical Expenses" on page 26.

- Transsexual surgery and related expenses, including medical or psychological counseling and hormonal therapy to prepare for or after any such surgery.
- Treatment of any injury or disease resulting from war or any act of war, declared or undeclared.
- Weight loss – Including gastric stapling or diversion or any other services (or drugs) for the purpose of weight reduction, unless determined by the claims administrator as medically necessary as described in "Covered Medical Expenses" on page 30 and received in network. Specifically not covered under any circumstance are food supplements for weight loss and personal trainers.

Definitions
When capitalized in the medical plan section, the following words have these meanings:

- Custodial Care means care provided mainly to help a person perform the activities of daily living, including personal hygiene, that can, by generally accepted medical standards, be safely and adequately provided by people who have no medical training.

  Examples of Custodial Care are training or help to get in and out of bed, bathe, dress, eat or walk and help with or supervision of taking drugs, medicines or other typically self-administered medication and exercise supervision done by someone other than a physical therapist. Custodial Care is marked by watching and protecting rather than seeking to cure. It is not primarily medical in nature and not medically necessary for the care and treatment of an illness or injury.
- Doctor means a person legally licensed to practice medicine who is operating within the scope of his or her license and who is licensed to prescribe and administer drugs and/or to perform surgery. The term Doctor includes, but is not limited to, a Doctor of medicine (M.D.), an osteopath (D.O.), a chiropractor and a podiatrist. For any dental work that is covered under the plan, a Doctor also includes a Doctor of dental surgery (D.D.S.) or dental medicine (D.M.D.).
- Experimental means procedures, technologies, treatments, facilities, equipment, drugs and devices that are investigative, or otherwise not clinically accepted medical services, as determined by the claims administrator.
- Free-Standing Surgical Facility means a legally licensed institution, operated in accordance with the laws that apply to such institutions, which has a medical staff of Doctors, registered nurses (R.N.) and licensed anesthesiologists and has agreements with Hospitals for immediate acceptance of patients requiring inpatient Hospital care. It also must maintain at least two operating rooms, one recovery room, a blood supply and facilities and equipment for lab work and X-rays, emergency care and medical record keeping.
- Home Health Care Agency means a Hospital, facility or non-profit or public agency that primarily provides skilled nursing service and other therapeutic services under the supervision of a Doctor or a registered graduate nurse (R.N.). It must be run according to rules established by a group of medical professionals, maintain clinical records on all patients and be legally licensed and operated in accordance with the laws that apply to such agencies. A Home Health Care Agency does not primarily provide Custodial Care or care and treatment of the mentally ill.

- Hospital means a legally licensed institution, operated in accordance with the laws that apply to Hospitals, that is supervised by a staff of Doctors and is primarily engaged in providing inpatient surgical and medical diagnosis, treatment and care to injured or ill patients. It also must maintain on its premises all needed facilities for the diagnosis, therapy and surgical treatment of any illness or injury and provide 24-hour nursing services by or under the supervision of registered nurses (R.N.).

  The term "Hospital" also includes the following, if accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals:

  - A psychiatric Hospital;
  - A tuberculosis Hospital; and
  - A facility that provides services under Medicare.
  - The term "Hospital" also includes:
    - A state-licensed facility (or otherwise licensed by the appropriate legally authorized agency) that specializes in the treatment of mental illness, alcoholism, chemical dependency or other related illness and which maintains a residential treatment program; and
    - A Free-Standing Surgical Facility.

  A Hospital is not, other than incidentally, a place for rest, the aged or a nursing or convalescent home.

- Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.
- Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended. Medicare covers health benefits for people who are age 65 or over or who are permanently disabled.
- Psychologist means an individual who is duly licensed or certified as a Psychologist in locations where statutory or non-statutory licensure or certification exists or, where neither exists, an individual who is duly qualified as a professional Psychologist by a recognized psychological association.

  The term Psychologist also includes certified marriage/family/child counselors (M.F.C.C.) and other counseling practitioners whose services are required to be covered by law in the locality where the plan operates, if such person is operating within the scope of his or her license, is performing a service for which benefits are otherwise provided under this plan when performed by a Psychologist and whose services are provided under the supervision of a Doctor.

- Skilled Nursing Facility means a licensed institution approved by Medicare as a Skilled Nursing Facility, specializing in and providing on an inpatient basis, physical rehabilitative and/or skilled nursing and medical care. Nursing services provided must be under the supervision of a Doctor. In addition, a Skilled Nursing Facility must maintain on its premises all facilities needed for medical treatment. A Skilled Nursing Facility is not, other than incidentally, a place for rest, the aged or a nursing or convalescent home.

Section C – Prescription Drug Program

When you enroll yourself and/or your eligible dependents in the NWA medical plan, you are enrolled automatically in the prescription drug program as well. The program is administered for NWA by the Rx Program Administrator.

Network Pharmacies

While you can use any pharmacy you want for prescriptions, you pay only a reasonable copay when you use "network" pharmacies and show your Prescription Drug ID card. With network pharmacies, there are no claim forms to fill out. The Rx Program Administrator's Rx network is a comprehensive, national pharmacy network. It includes most major pharmacy chains, such as Target, CVS, Walgreen's, Wal-Mart, K-Mart and Kroger Food and Drug. The Rx Program Administrator's Rx network also includes many local independent pharmacies.

Out-of-Network Pharmacies

You and your covered dependents are not limited to network pharmacies. However, when you use a pharmacy that is not part of the Rx Program Administrator's Rx network (an "out-of-network" pharmacy), you have to pay the full retail price of the prescription at the time it is filled. You then must send in a claim for reimbursement. You only will be reimbursed the in-network retail cost of the drug less the applicable copay.

Maintenance Medications

With the Rx Program's mail-order prescription service, when a doctor prescribes certain maintenance medications, you can get up to two fills at a retail pharmacy for the regular retail copay amount. After that, you should get refills through the mail-order service or you will pay a higher copay at the pharmacy. (You also can use the mail-order service right away and start saving money immediately.)

Mail-Order Prescriptions

Rather than using a network retail pharmacy, prescriptions can be filled through the mail. Using mail order to fill prescriptions is convenient and cost effective. It is also easy.

You can either mail in your prescription or have your doctor fax it in. You can download/print an order form and order envelopes at Rx Program Administrator.com. If you want your doctor to fax in your order, give your doctor your prescription drug ID card number and ask him/her to call 1-xxx-xxx-xxxx for instructions about how to use Rx Program Administrator's fax service.

> Note: Specialty drugs are extremely expensive, difficult to administer and usually have serious side effects. The Rx Program Administrator's Special Care Pharmacies are built to deliver specialized services and support to patients who use specialty medications. Organized into teams of pharmacists, nurses, and patient care representatives, dedicated professionals are extensively trained in condition-specific protocols and the unique needs of patients who use these complex and difficult-to-administer pharmaceuticals.

Formulary Drugs

The drug plan includes a "formulary" feature. A formulary is a list of specially selected generic, single source and multi-source brand name drugs. The formulary has been developed to

enhance the quality of care by encouraging the use of prescription medications that are demonstrated to be safe, effective and produce favorable patient outcomes, while providing opportunities for cost savings. You can save money by choosing a generic drug or a formulary brand name drug.

A single source formulary drug is a brand name drug for which there is no generic alternative. A multi-source formulary drug is a brand name drug for which there may be one or more brand names available, as well as a generic alternative.

Special Note about Proton Pump Inhibitors (PPI): You will be offered a generic and/or formulary PPI at the drugstore. If you still purchase a non-formulary PPI, you will have to pay the full cost of the drug.

Copays & Costs	
In-Network Pharmacy Copay **Up to a 30-day Supply.**	• Generic Drugs -- 30% of the retail cost (minimum of $10 and maximum of $50) • Formulary Brand Drugs* -- 30% of the retail cost (minimum of $20 and maximum of $75) • Non-Formulary Brand Drugs* -- 50% of the retail cost (minimum of $35; no maximum) • Lifestyle Drugs -- 50% of the retail cost. However, for multi-source drugs 50% of the retail cost plus cost difference between brand and generic. ($30 minimum; no maximum) Lifestyle drugs generally encompass two types of products: 1) Drugs used for "non-health" related purposes 2) Drugs used to treat illnesses resulting from lifestyle choices • Maintenance Medications -- 50% of the retail cost for maintenance medications after original and one refill (preceding minimums apply; no maximum) ***** Special Note: if you purchase a brand name medication when a generic equivalent is available, you will be required to pay the difference between the cost of the brand name and generic drug, plus your generic copayment. This provision applies even if your physician prescribes the brand name medication.

Mail-Order Copay **Up to a 90-day supply.**	• Generic Drugs -- 30% of the mail-order cost (minimum of $25 and maximum of $125) • Formulary Brand* Drugs -- 30% of the mail-order cost (minimum of $50 and maximum of $187.50) • Non-Formulary Brand* Drugs -- 50% of the mail-order cost (minimum of $87.50; no maximum) • Lifestyle Drugs -- 50% of the mail-order cost. However, for multi-source drugs, 50% of the retail plus cost difference between brand and generic. ($75 minimum; no maximum) Lifestyle drugs generally encompass two types of products: 1) drugs used for "non health" related purposes 2) drugs used to treat illnesses resulting from lifestyle choices ***** Special Note: if you purchase a brand name medication when a generic equivalent is available, you will be required to pay the difference between the cost of the brand name and generic drug, plus your generic copayment. This provision applies even if your physician prescribes the brand name medication.
Out-of-Network Pharmacy	• You pay the full cost and file a claim for reimbursement. • You'll be reimbursed the in-network price less copay.

Prior Authorization Program

Some medications must receive "prior authorization" before they will be dispensed. Certain drugs only require prior authorization if specific pre-set limits are exceeded. The entire review process typically takes two business days and both the patient and doctor will be notified when it is completed. By law, health care plans must complete pre-service reviews, like the prior authorization program, no later than 72 hours for urgent care claims and 15 calendar days for other pre-service claims, with one 15-day extension. If you do not receive notification of a decision within these time frames, you should check with Rx Program Administrator. If your medication is not approved for coverage, you will have to pay the full cost of the prescription. You also can appeal the decision – see pages 57-61 for the claim review and appeal procedures.

How the Prior Authorization Program Works

You can see if a drug needs prior authorization by reviewing the prior authorization list on RADAR (nwa.nwapeople.com) or on the Rx Program Administrator's website (www.Rx Program Administrator.com). If a drug is listed as needing prior authorization, you, your covered dependent, the pharmacist or your doctor must call Rx Program Administrator at the phone number on your ID card. The person calling will be provided with instructions. (If a prescription requiring prior authorization is submitted to a network pharmacist or the Rx program's mail-order service, the pharmacist will begin the prior authorization process automatically.)

If benefit coverage for a Prescription Drug requiring prior authorization is approved, the pharmacist will be notified and the prescription will be dispensed. If benefit coverage for a Prescription Drug requiring prior authorization is denied, the person who initiated the prior authorization process will be notified by telephone that coverage has been denied and the reason for denial. A denial letter will be sent to both the patient and doctor that will state the reason for the denial and include the steps to take to appeal the decision and the information needed for a review.

If you are using an out-of-network pharmacy for a Prescription Drug that requires prior authorization, it's up to you or your covered dependent to call to begin the prior authorization process.

Drug Utilization Review Program
Another feature of the prescription drug program is "drug utilization review." With this feature, drugs filled through an in-network pharmacy or the Rx program's mail-order service are examined for potential health and safety issues including drug interactions, appropriate dosing and duplication of therapy. Drug utilization review is especially important if you or a covered dependent takes many different medications or sees more than one doctor.

Covered Prescription Drugs
The prescription drug program covers an existing or new prescription drug as long as it meets all of the following rules:

It is:

- A federal Legend Drug approved by the Food and Drug Administration (FDA); and
- Medically necessary, as determined by the claims administrator, for treating an Illness or Injury; and
- Prescribed in writing by a doctor; and
- Dispensed by a licensed pharmacist; and
- Not available over-the-counter (OTC) or as an over-the-counter equivalent; and
- Not specifically excluded by the program, as described on page 43.

In addition, the prescription drug program covers the following:

- Compound medications where at least one ingredient is a federal Legend Drug;
- Depo-Provera;
- Diabetic supplies, including syringes and/or needles, glucose blood test strips, glucose, glucose monitoring machines, urine test strips, ketone tablets, ketone testing strips, lancets and lancet devices;
- Oral contraceptives, diaphragms and contraceptive patches are covered only when purchased at a network pharmacy (and you must use your Prescription Drug ID card at the time of purchase) or through the Rx Program's mail-order service;

- Prescription smoking cessation products that are prescribed by a doctor;
- Syringes and/or needles for other medically necessary purposes;
- Infertility medications, including those used for, and in conjunction with, assisted reproduction. For example, Clomiphene, Clomid, Serophene, Pergonal, HCG and Metrodin;
- Injectables, including insulin. Some injectables may be subject to prior authorization. For details, see the most recent list of drugs requiring prior authorization;
- Nutritional supplements for the treatment of PKU (phenylketonuria) only;
- Prescription vitamins; and
- Proton Pump Inhibitors (only generic or formulary PPIs).

Certain drugs are subject to limits on the quantity dispensed. If you purchase a quantity that is greater than the limit, you have to pay the full cost for the portion that's over the limit. For a list of drugs, see RADAR or Rx Program Administrator.com.

Drugs & Supplies Not Covered
The prescription drug program does not cover the following (even if they are prescribed by a doctor):

- Contraceptive devices. However, diaphragms and contraceptive patches are covered when purchased through an in-network pharmacy or the Rx Program's mail-order service;
- Drugs administered in and purchased through a doctor's office. However, these may be covered under the medical portion of the NWA medical plan.
- Durable or disposable medical supplies and devices, except those specifically described under "Covered Prescription Drugs" – see pages 42-43;
- Injectable contraceptives. However, Depo-Provera is covered;
- Injectables, except those described under "Covered Prescription Drugs" – see pages 42-43;
- Medications prescribed for cosmetic purposes. For example, Renova and Retin-A for aging, Rogaine or other hair growth products;
- Medications used for investigative purposes or experimental indications and/or dosage regimens determined to be experimental by the claims administrator;
- Medications with no approved FDA indications;
- Most appetite suppressants;
- Nutritional supplements. However, those used for the treatment of "PKU" (phenylketonuria) are covered;
- Oral contraceptives, diaphragms and contraceptive patches purchased from an out-of-network pharmacy or from a network pharmacy if you do not use your Prescription Drug ID card;
- Over-the-Counter (OTC) medications that do not require a doctor's prescription or any prescription medication that is available as an OTC medication;

- Prescription refills dispensed more than one year from the original date of dispensing;
- Non-formulary Proton Pump Inhibitors;
- Replacement prescriptions resulting from loss, theft or breakage;
- Substances restricted by law;
- Vitamins (for example, over-the-counter vitamins). However, prescription vitamins are covered.
- Growth hormones when used to treat idiopathic short stature.

Section D – NWA Dental Plan

The NWA dental plan covers most common dental expenses and pays benefits that are a percentage of allowed expenses. The plan is a managed care dental plan administered by a dental plan administrator and features a "preferred provider" network – the dental claims administrator's National Network of dentists. These dentists have been selected based on their history of consistently making high-quality treatment decisions, focus on the individual's unique oral health needs and ability to deliver the best long-term cost savings.

In-Network vs. Out-of-Network – How the Plan Works

With the NWA dental plan, you receive the plan's higher "in-network" benefits whenever you use Dentists and other dental providers who are part of the National Network of dentists. Otherwise, the plan's "out-of-network" benefits apply. The decision to use an in-network provider or an out-of-network provider is always yours…each time dental care is needed. In-network benefits mean that benefits for covered dental services are paid at a higher percentage than out-of-network.

Out-of-Network Benefits

When you use Dentists and other dental providers who are not part of the National Network, out-of-network benefits apply. Out-of-network benefits pay a lower percentage (generally 10% lower than in-network benefits) after you meet the plan's calendar year deductible for certain benefits. You are responsible for filing claims or seeing that claims have been filed by your Dentist.

Allowed Amount

In-Network Providers

Dentists in the National Network have agreed to accept certain pre-determined discounted fees as payment in full. This is known as the "allowed amount." More specifically, the allowed amount is defined as the negotiated amount of payment that an in-network provider has agreed to accept as payment in full for a covered service at the time your claim is processed. In-network benefit payments are based on the claims administrator's allowed amount for dental expenses. When you use Dentists in the National Network (in-network providers), you only have to pay the deductible and any coinsurance amounts. With in-network providers, you are not responsible for any charges over the allowed amount.

Out-of-Network Providers

Out-of-network benefit payments are based on the plan's payment obligation, which, for nonparticipating dentists, is the treating dentist's submitted charge or the "Table of Allowances" established solely by the claims administrator. The Table of Allowances is a schedule of fixed dollar maximums established by the claims administrator for services rendered by a licensed dentist who is a nonparticipating dentist.

Amounts over the Table of Allowances are not covered expenses under the plan and will not count toward the plan's deductible. The covered person is responsible for all treatment charges made by the nonparticipating dentist. When dental care, treatment services and supplies are obtained from a nonparticipating provider, any benefits payable under the plan are paid and sent directly to the employee.

How Much the Plan Pays
The plan classifies different dental procedures as Class I, Class II, Class III or Class IV. Exactly which procedures fall under each category can be found in "Covered Dental Expenses," on pages 47-52. The percentage of a covered expense that the plan will pay differs by its category. (After the plan pays its percentage, the remaining percentage that you must pay is called your "coinsurance.") You must satisfy the plan's "deductible" before benefits will be paid for Class II and Class III covered expenses, in- or out-of-network.

The benefit percentages the plan pays are shown below:

Service	In-Network percentage of covered expenses	Out-of-Network percentage of covered expenses
Class I	80%	70%
Class II	70%	60%
Class III	60%	50%
Class IV	50%	40%

Limited Benefits for Certain Services/Pre-existing Conditions
The dental plan does not cover services that were begun but not completed before coverage under this plan started, for example, crown work or dentures begun before coverage started. Otherwise, the plan covers eligible expenses for pre-existing conditions the same as for any other dental condition. This provision does not apply to employees who were enrolled in another Northwest Airlines, Inc. sponsored dental plan immediately prior to being covered by this plan or to orthodontia in progress when coverage begins.

Deductibles
For certain dental expenses, the plan has an annual "deductible." Deductibles are amounts you, your covered dependent or your family has to pay each calendar year before the plan will start to pay benefits. (The plan deductible amount applies to Class II and Class III covered expenses, whether received in- or out-of-network.)

You, your covered dependent or your family has to meet a new deductible each calendar year – starting January 1st and ending December 31st.

The 2006 deductibles for Class II and III services under the NWA dental plan are shown below:

Calendar Year Deductibles (Class II & III Covered Expenses Only -- Applies to In- and Out-Of-Network Expenses)	
Individual	$75
Family	$225

In determining when the family deductible has been met, amounts used to meet the individual deductibles for covered family members are combined. However, no one person can contribute more than the individual deductible amount toward the family deductible, as shown in the example below:

Covered Individual	Covered Expenses	Amount Applied to Family Deductible
You	$125	$75
Spouse	60	$60
Child	100	75
Child	75	15
	$260	$225

Once the family deductible has been met, the plan will start to pay benefits for every covered member of your family for the rest of that calendar year.

The following expenses do not count in determining when the individual or family deductibles have been met:

- Expenses that are not "covered" by the plan; and
- The portion of any out-of-network charge that is above the amount specified in the claims administrator's Table of Allowances.

  Special Note: Beginning January 1, 2007, the plan's deductibles will be indexed (adjusted) annually, using the same cost trend factors used to determine the plan's COBRA premiums each year. (COBRA premiums are the estimated total cost of the plan for the upcoming year.) This means, generally, that the deductibles will go up each year on January 1.

Maximum Benefits

Calendar Year Maximum
For each covered person, the plan has a maximum annual dental benefit of $2,000 for Class I, II and III covered expenses -- in- and out-of-network combined.

Lifetime Orthodontia & Dental Implant Maximum
For Class IV covered expenses there is no maximum annual benefit. However, the plan will pay no more than $2,000 in a covered person's lifetime for covered expenses (in- and out-of-network combined) for orthodontia and dental implants (Class IV). Amounts applied to a covered person's orthodontia and dental implant maximum do not apply in determining when that person has met his or her calendar year maximum.

Maximum Benefits (In- and Out-of-Network Combined)

Calendar Year (Class I, II and III)	$2,000/person
Orthodontia and Dental Implants (Class IV)	$2,000/person (lifetime)

Pretreatment Estimate
Getting a pretreatment estimate lets you and the Dentist know ahead of time what the plan covers and how much it will pay for certain dental services.

You should get a pretreatment estimate if you or your covered dependent needs dental services that will cost $200 or more. Here's how it works:

Before beginning dental treatment costing $200 or more, ask the Dentist to send in a claim form, describing the dental treatment or services and charges, to the dental claims administrator. The dental claims administrator will determine how much the plan will pay, certify what's payable and write to you and the Dentist. This way you can discuss the results of the pretreatment estimate with the Dentist before dental treatment or services begin. In deciding how much the plan will pay, the dental claims administrator will consider alternate procedures, services or courses of treatment (based on accepted dental standards) that could provide the same or similar results, as well as the plan's contractual limitations. Benefits payable by the plan will be only for the least costly, most commonly performed course of treatment and any remaining balance will be your responsibility to pay. This review does not determine whether the services are necessary for you. It only provides you with information about the coverage for the services submitted to the dental claims administrator.

If you or your covered dependent does not get a pretreatment estimate, you may find that you have to pay more out of your own pocket than you expected. Keep in mind, you are always responsible for payment of any treatment costs not covered by the plan.

By law, health care plans must complete pre-service reviews like the preceding, no later than 72 hours after receipt of an urgent care claim (if all information is complete) and within 15 days after receipt of other pre-service claims (with one 15-day extension available to decide other pre-service claims). If you do not receive notification of a decision within these time frames, you should check with the dental claims administrator. If a pre-service review results in a denial, you can appeal it – see pages 57-61 for the claim review and appeal procedures. In addition, if the plan decides to reduce or end a previously approved course of treatment (or number of treatments), it will notify you sufficiently in advance to allow you the opportunity to appeal the decision.

Covered Dental Expenses
To be covered by the plan, dental care, treatment, services and supplies must be essential for the necessary care of the teeth and provided by or under the direction of a Dentist.

Alternate Benefit
Many dental conditions can be treated effectively in more than one way. However, some treatment methods may be more expensive than is necessary for good dental care. The NWA dental plan will pay benefits for the least expensive method (called the "alternate benefit") if more than one method will provide professionally satisfactory results. If you or

your Dentist decides to use a more expensive procedure or material, you must pay any additional cost. For example, resin (white) fillings are not covered for posterior (back) teeth. If you choose to have a resin filling in a posterior tooth, you must pay the difference between the cost of the resin filling and a regular amalgam (silver) filling. Getting a pretreatment estimate will let you know in advance if an alternate benefit will apply – see earlier on this page.

Temporary Treatment
A temporary dental procedure will be considered an integral part of the final dental procedure rather than a separate procedure and will not be paid separately. For example, a temporary crown is considered an integral part of the charge for the permanent crown.

Time Limitations
Some services are subject to time limitations. For example, prophylaxis (cleaning) is limited to two per calendar year. If you and your Dentist decide that you will require services beyond a specific plan limit, you must pay any additional cost.

Class I – Diagnostic & Preventive Services (No Deductible Applies)

- **Fluoride Treatments** – Limited to individuals under 19 years of age. Up to two each calendar year;
- **Oral Exams, Routine** – Up to two each calendar year;
- **Palliative Treatment**;
- **Prophylaxis (cleanings) or Periodontal Prophylaxis** – Up to two each calendar year;
- **Space Maintainers** – Limited to individuals under 17 years of age to replace missing posterior teeth. Unilateral and bilateral, fixed and removable;
- **Tests & Lab Exams;**
- **Caries susceptibility tests;**
- **Pulp vitality tests;**
- **X-rays:**
  - Panoramic or full-mouth series – No more than one in any 36-month period;
  - Periapical;
  - Bitewing – Up to two series each calendar year;
  - Single occlusal film.

Class II – Basic Restorative, Endodontics, Periodontics, Prosthetic Repairs & Adjustments & Oral Surgery (Calendar Year Deductible Applies)

- **Analgesia** – Limited to individuals under 17 years of age. Includes nitrous oxide;

- **Anesthesia, General** – Only when medically necessary and provided by a dentist, used with oral or dental surgery and only if the anesthetic agent produces a state of unconsciousness with absence of pain sensation over the entire body;
- **Antibiotic Drugs, Injection of** – Therapeutic;
- **Sedation, Intravenous** – Only when medically necessary, as determined by the claims administrator, and used with oral surgery.

Basic Restorative

- **Recementing Inlays, Onlays and Crowns;**
- **Restorations (Fillings):**
  - Amalgam (silver fillings);
  - Acrylic or plastic composite acrylic resin (white fillings) – Covered for anterior (front) teeth only. For posterior (back) teeth, covered as described below;

    Special Note about Restorations (Fillings) for Posterior Teeth: The plan pays alternate benefits for restorations for posterior (back) teeth based on the cost of amalgam (silver) restorations. If you or your Dentist chooses acrylic or plastic composite acrylic resin restorations (white fillings) for posterior teeth, you will be responsible for the difference in cost;
- **Recement cast or prefab post and core**;
- **Sealants** – Limited to individuals under 14 years of age and only to posterior teeth. No more than one treatment per eligible tooth in any 36-consecutive month period;
- **Occlusal Adjustments** – Limited and complete. Only when no restoration is involved.

Endodontics

- **Apicoectomy;**
- **Pulp Capping** – Direct and indirect;
- **Pulpotomy, vital** – Generally, this is included in the cost of a root canal. However, if a root canal is not performed, this procedure is covered only for the primary teeth of children under age 19;
- **Root Canal Therapy** – Any treatment plan, clinical procedure or follow-up care for root canal therapy. No coverage for re-treatment.

Periodontics to Retain Natural Teeth

If more than one periodontal surgical service is performed per quadrant only the most inclusive surgical service performed will be considered a covered dental service. Benefits are provided to save and preserve natural teeth only.

- **Periodontal Surgery** – limited to 1 every 36 months;
- **Crown Lengthening;**

- **Gingival Curettage & Root Planing;**
- **Gingivectomy or Gingivoplasty;**
- **Osseous Surgery & Osseous Graft** – Includes flap entry and closure. Coverage for osseous grafts includes single and multiple sites;
- **Periodontal Scaling & Root Planing** (Non-surgical procedure).

Prosthetic Repairs, Relines & Adjustments

Adjustments and repairs to dentures only are covered if six months or more has passed since the initial installation.

- **Additions to Partial Dentures** – To replace extracted teeth. Includes clasps;
- **Adjustment to Dentures** – Complete or partial dentures;
- **Recement Bridge**;
- **Relining Dentures** – Office or laboratory. Includes complete or partial dentures, upper and/or lower;
- **Repair Broken Dentures** – Whether or not there is damage to teeth. Includes replacement of broken teeth;
- **Repair Fixed Bridge**;
- **Replace or Reattach Damaged Clasps on Dentures;**
- **Tissue Conditioning** – As a part of adjustment or repair of dentures.

Oral Surgery

Routine post-operative care is part of each covered service described below.

- **Biopsy of Oral Tissue** – Hard or soft;
- **Simple Extractions**;
- **Surgical Extractions** – Of erupted teeth and impacted teeth, including in soft tissue or bone (partially or completely);
- **Surgical Preparation of Ridge for Dentures** – Whether or not in conjunction with extractions.

Class III – Major Restorative & Prosthetics (Calendar Year Deductible Applies)

Major Restorative

Special restorative procedures (crowns, veneers, inlays and onlays) to restore lost tooth structure as a result of decay or fracture. Coverage also is allowed for crowns, inlays or onlays when the amount of lost tooth structure does not allow placement of a filling material.

- **Crown Buildup, Cast Post & Core** – In addition to crown;

- **Crowns** – Plastic (acrylic) both prefabricated and not prefabricated, plastic with gold, porcelain, porcelain with gold, cast gold (full and ¾), titanium, stainless steel (up to age 20);
- **Gold Foil Restorations** – The plan pays benefits for all gold foil restorations based on the cost of metallic restorations;
- **Inlays** – The plan pays benefits for resin-based composite or porcelain ceramic inlays for anterior (front) teeth only. For posterior (back) teeth, covered as described next;

  Special Note about Inlays for Posterior Teeth: The plan pays alternate benefits for inlays for posterior (back) teeth based on the cost of metallic (but not gold) inlays. If you or your Dentist chooses resin-based composite, porcelain ceramic or gold foil inlays for posterior teeth, you will be responsible for the difference in cost;
- **Onlays;**
- **Veneers.**

No coverage is provided for crowns, veneers or onlays:

- When done for cosmetic or aesthetic purposes, such as covering healthy teeth that are discolored, stained or unusually shaped or formed;
- If used for diastema closure (closing a gap between teeth); or
- If used to alter tooth position of healthy teeth that are tipped, hyper-erupted or rotated.

Prosthetics (Bridges & Dentures)
Prosthetics are bridges, partial dentures or full dentures that replace fully extracted permanent teeth. Benefits are limited to the most commonly held dental standards of functional acceptability.

Replacement of an existing prosthetic appliance only is covered if it is not and cannot be made satisfactory and it has been five or more years since the plan last paid benefits for any appliance in the arch. This limitation applies unless the replacement is made necessary by additional extraction of natural teeth. The plan does not cover replacement of misplaced, lost or stolen prosthetic appliances.

Services to make a prosthetic satisfactory are covered.

Class IV – Orthodontia & Dental Implants (Calendar Year Deductible Does Not Apply)

Orthodontia

The plan will cover:

- **Comprehensive Full Banded Orthodontic Treatment:**
  - Preliminary study, including cephalometric X-rays, diagnostic casts and treatment plan;
  - Active treatment;
  - Retention & observation treatment;

- **Other Orthodontic Treatment:**
  - Appliances for tooth guidance – Removable, fixed or cemented. Limited to one per covered individual;
  - Appliances to control harmful habits – Removable or fixed. Limited to one per covered individual;
  - Orthodontic retention appliances – Removable, fixed or cemented. Limited to one per covered individual. Also covered is a cephalometric X-ray, examination, treatment and adjustment of the appliance.

  Orthodontia benefit payments are made in three installments spread out over the entire banding period.

  Since each treatment for orthodontia is considered a separate dental service, any orthodontia treatment received while an individual is not covered by the plan is not considered a covered expense and is not payable by the plan.

Implants

Implants are performed in a three-step process and certain limitations apply:

- **Surgical placement of the implant body;**
- **Abutment placement** – This may include the removal of a temporary healing cap and placement of the abutment;
- **Prosthetic placement** – For example, placement of crowns, bridges, partial dentures or dentures. Coverage for the prosthetic is provided under Class III – Major Restorative & Prosthetics and, therefore, the plan's deductible and calendar year maximum apply.

The plan will pay benefits for replacement of an implant body only after a seven-year period starting on the date the placement procedure occurred. Coverage for replacement of the prosthetic appliance is subject to any applicable time limitation for a crown, bridge, partial denture or dentures.

Surgical removal of an implant also is covered.

Dental Expenses Not Covered

The plan will not pay benefits for expenses or charges for the following (or, where noted, will limit benefits):

- Adjunctive diagnostic tests.
- Anesthesiologist charges are not covered under the dental plan – see your medical plan booklet.
- Any service or expense not included in the list of "Covered Dental Expenses" and/or that does not have a current CDT (Common Dental Terminology) code as defined by the American Dental Association.

- Athletic mouthguards.
- Bite registrations.
- Care that is:
  - Provided by a Dentist who is a family member;
  - Performed by someone other than a licensed Dentist or his or her employees or agents (under the direction of the Dentist).
- Charges above the Table of Allowances for treatment, care or a service or supply.
- Charges for or in connection with custodial care, education or training.
- Consultations or office visits.
- Cosmetic Procedures – Services performed solely for cosmetic reasons.
- Crowns, veneers or onlays when done for cosmetic or aesthetic purposes, such as covering healthy teeth that are discolored, stained or unusually shaped or formed or if used for diastema closure (closing a gap between teeth) or to alter tooth position of healthy teeth that are tipped, hyper-erupted or rotated.
- Decalcification procedure.
- Dental procedures, appliances or restorations that are necessary to alter, restore or maintain occulusion, including, but not limited to:
  - Increasing vertical dimension;
  - Realignment of teeth;
  - Periodontal splinting; and
  - Gnathologic recordings.
- Direct and indirect immunofluorenscence.
- Electron microscopy.
- Expenses:
  - For care or treatment that began before your coverage or your dependent's coverage begins under the plan (except for orthodontia that is in progress when coverage begins);
  - For which payment under the plan is prohibited by any law to which you or a covered dependent is subject to any time expenses are incurred;
  - For the treatment of an injury or disease that results from military service or war, or any act of war, whether declared or undeclared;
  - For the treatment of temporomandibular joint dysfunction (TMJ) – Except for the diagnostic X-ray described in "Covered Dental Expenses." See the "NWA Medical Plan" section for coverage details about the treatment of TMJ;

  - Incurred for a dental service completed more than three months after coverage ends. (However, in the case of orthodontia, the plan will not pay for any services received after coverage ends.);
  - Paid or payable by a Company-sponsored group medical plan (benefits payable by this plan will be reduced by such amounts) or any other group dental plan with which this plan coordinates benefits (to the extent benefits are paid or payable from the other plan).
- Experimental services and supplies, as determined by the claims administrator.
- Genetic tests.
- Gold foil restorations and inlays – Will be paid at (limited to) the allowance level for metallic.
- Hospitalization for dental care or accidental injury to teeth – See the "NWA Medical Plan" section for coverage details.
- Instructions or products for plaque control or oral hygiene.
- Intentionally self-inflicted injuries.
- Nitrous oxide (analgesia) for individuals over age 16.
- Oral surgery to remove tumors or cysts or to cut or drain abscesses or cysts – See the "NWA Medical Plan" section for coverage details.
- Porcelain inlays for posterior (back) teeth – Will be paid at the alternate benefit or (limited to) the allowance level for metallic.
- Precision or semi-precision attachments.
- Prescription drugs – See the "Prescription Drug Program" section for coverage details.
- Interim partial/complete dentures (flippers).
- Replacement of a prosthetic appliance (bridge or denture):
  - If it can be made satisfactory; or
  - If it has not yet been five years since the plan last paid benefits for the appliance or, in the case of a bridge, for any of the individual units, such as a crown or cast restoration;
  - That is lost or stolen.
- Resin-based composite (white) inlays for posterior (back) teeth – Will be paid at the alternate benefit or (limited to) the allowance level for metallic.
- Re-treatment or additional treatment to correct or relieve the results of previous treatment.
- Services and supplies:
  - That are covered by "no-fault" or any other automobile insurance;
  - For which you or a covered dependent has filed a claim more than 18 months after the expense was incurred;
  - For which you or a covered dependent is not legally required to pay;

- For which you or a covered dependent is charged, but for which no charge would have been made if you or your dependent did not have dental coverage;
- Covered by any public or government-sponsored program, including Workers' Compensation or Medicare. A person eligible for Medicare is considered by this plan as being covered by Part A, Part B and Part D of Medicare even if he or she is not.

- Splinting.
- Stains.
- Temporary procedures.
- Viral Cultures.
- Work-related (on-the-job/occupational) accidents.

Dental Work in Progress
In some instances, dental work may have begun, but was not finished when your coverage or a dependent's coverage ends (for example, crowns or bridges). In such a case, the plan will pay its usual benefits for work completed within three months of the day coverage ends. It will not pay benefits after three months, even if the work is not completed by then. In the case of orthodontia, the plan will not pay benefits for any services received after coverage ends.

Definitions
When capitalized in this dental plan section, the following words have these meanings:

- Dentist means a person legally licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his or her license. This includes, but is not limited to, a doctor of dental medicine (D.M.D.) and a doctor of dental surgery (D.D.S.). Also included is a doctor of medicine (M.D.) who performs a covered dental service and who is operating within the scope of his or her license.

Section E – How to File a Claim or Appeal

When used in this section, an urgent care claim is one in which a delay could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your medical condition, could cause severe pain. A pre-service claim is one in which benefits must be approved before you receive medical care or advance approval for certain specific services or prescriptions, unless the claim involves urgent care. A concurrent care claim is one in which the claims administrator has approved treatment for a specific period of time and (a) determines the period of time for treatment should be reduced or terminated, or (b) you request an extension of time for the treatment. A post-service claim is any other kind of claim, but specifically, claims filed after you receive medical care or a prescription.

If the nature of a claim changes as it goes through the claims process, the claim type may change. For example, an urgent care claim may change to a pre-service claim if the urgency subsides.

In-Network Medical & Dental Providers, Network Pharmacies

When you use an in-network medical or dental provider or a network pharmacy (and present your ID card), the provider or pharmacy will file claims for you automatically and payment will be made directly to the provider.

Out-of-Network Providers
When you use out-of-network providers, you must file a claim. Claims under the NWA medical plan are processed by the medical claims administrator, claims under the NWA dental plan are processed by the dental claims administrator and prescription drug claims are processed by Rx Program Administrator. Claim forms are available by calling the claims administrator's customer service number. For active and inactive employees, claim forms also are available on RADAR – nwapeople.nwa.com.

To file a claim, follow these steps:

1. Send original, itemized bills, attached to a completed claim form, to the claims administrator at the following address:

   Medical Claims:
   Claims Administrator - TBD
   P.O. Box xxxx
   City, ST xxxxx-xxxx

   Dental Claims:
   Claims Administrator - TBD
   P.O. Box xxxx
   City, ST xxxxx-xxxx

   Prescription Drug Claims:
   Claims Administrator - TBD
   P.O. Box xxxx
   City, ST xxxxx-xxxx

   Make sure your name, the member number shown on your ID card (for the applicable plan or program) are on all documents, including bills and receipts. Keep a copy of all completed claims and attachments for your records.

2. Urgent care medical claims may be submitted to the medical claims administrator by calling 1-xxx-xxx-xxxx . Urgent care prescription drug claims may be submitted to Rx Program Administrator by calling 1-xxx-xxx-xxxx. Pre-service and concurrent claims are considered filed when they are received by the claims administrator. Post-service claims must be filed within 90 days after the date of service unless:

   - It was not reasonably possible to file the claim within that time frame, and
   - The claim is filed as soon as possible, but in no event later than 18 months from the date of service.

3. If a pre-service claim is filed incorrectly, the claims administrator will notify you within five days of receipt of the claim. For incorrectly-filed urgent care claims, the claims administrator

will notify you no later than 24 hours after receipt of the claim. The notice will tell you what information is missing.

4. If you currently participate in the Health Care *FlexSaver* Account, you may be able to be reimbursed from that account for your share of medical, dental and prescription drug expenses, once the plan has paid its benefits – see your *FlexSaver* Summary Plan Description for details and claim filing instructions.

Orthodontia Claims
Orthodontia benefit payments are made in three installments spread out over the entire banding period. This applies even if you pay for orthodontia services in advance. While you may receive a discount from your Dentist for paying "up front," you still will be reimbursed by the claims administrator over the banding period as services are actually received.

International Medical Claims
Claim filing procedures pending.

Time Frames for Deciding Claims
The claims administrator will decide urgent care claims as soon as possible but no later than 72 hours after receipt of the claim. Pre-service claims will be decided no later than 15 days after receipt of the claim. If a claim is a request to extend a concurrent care decision involving urgent care and the claim is made at least 24 hours before the end of the approved period of time or treatments, the claims administrator will decide the claim within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the same time frames as any other pre-service, urgent care or post-service claim. Reduction or termination of an approved course of treatment is an adverse benefit determination that you may appeal under the claims appeal procedures described in this section. A decision will be made in advance of the termination or reduction to allow you to appeal before the reduction or termination occurs. Post-service claims will be decided no later than 30 days after receipt of the claim.

Other Important Information about Claims
If you have a question about the status of a claim, call the appropriate claims administrator's customer service number or visit its website. The claims administrator, at its own expense, has the right to examine, as often as reasonably necessary, any person for whom a claim has been filed. The claims administrator also can perform an autopsy when a person dies, except where it is illegal. If your claim for benefits is denied, see the information that follows.

Claim Review & Appeal Procedures
If all or part of a post-service claim for benefits is denied, the claims administrator will notify you in writing or electronically. In the case of an urgent care or pre-service claim (such as a pre-approval request or continued stay approval request), the pre-approval program administrator or claims administrator will notify you and your doctor or Dentist by phone, followed by a letter or electronic notification. (For information about the time frames within which you can expect to receive notification, see page 56.) If a claim is denied, the written or electronic denial letter from the pre-approval program administrator will include:

- The specific reasons for the denial;
- References to the specific plan provisions on which the denial is based;

- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the claim review procedure, including the time limits, and a statement of your right to bring an action under section 502(a) of ERISA.

If you disagree with the determination on a pre-service request or a post-service claim denial, you must follow the review and appeal procedures described here. If you do not, you may give up legal rights. You may, at your own expense, have an attorney or other person act on your behalf during an appeal or review request, but the claims administrator, the pre-approval program administrator and the Northwest Airlines, Inc. Benefits Appeal Committee reserve the right to require a written authorization from you.

Pre-Service Appeals & Requests for Initial Review of Post-Service Claims
If you properly followed the procedures for a pre-service request, but your request is denied, you can file an appeal, as described here. These also are the steps to follow to request a review if you – or a provider on your behalf – filed a claim after you received services (a post-service claim) and all or part of that claim was denied.

For medical pre-service appeals (such as the medical plan's pre-approval and continued stay approval programs), the plan administrator has delegated to the claims administrator the exclusive right to interpret and administer the provisions of the plan. For prescription drug and dental pre-service appeals (such as the prior authorization program), the plan administrator has delegated to the claims administrator the exclusive right to interpret and administer the provisions of the plan. The steps that follow are the only level of appeal for those claims and the pre-approval program administrator's decisions (for medical claims) and the claims administrator's decisions (for prescription drug and dental claims) are conclusive and binding.

For post-service claims, if the following initial review results in continued denial of your claim, you may appeal it further.

How to File a Pre-Service Appeal or Request for Initial Review of a Post-Service Claim
Submitting – Generally, all appeals and review requests must be in writing. Send written pre-service medical appeals to the pre-approval program administrator. Send written post-service medical claim review requests to the claims administrator. Send written pre-service prescription drug and dental appeals and post-service prescription drug and dental claim review requests to the appropriate claims administrator. The requirement of a written request does not apply to an urgent care pre-service appeal. For an urgent care pre-service appeal, you or your doctor or Dentist should call for pre-approval as soon as possible and request a review, indicating that you are appealing an urgent care pre-service decision. You or your doctor or Dentist also may wish to send a letter to the medical plan's pre-approval program administrator or to the prescription drug program's or dental plan's claims administrator to document your appeal request.

Timing – In all cases, an appeal or review request must be received by the pre-approval program administrator or the appropriate claims administrator, whichever applies, within 180

days of the date you received the original decision denying a pre-service request, or for post-service claims, within 180 days of the date you received the original claim denial.

What to include – Include all of the facts and arguments that you want considered. Specifically:

- The patient's name and identification number from the ID card;
- For pre-service appeals – the date an original pre-service request was made, the date of the proposed service or hospital admission or the dates of the ongoing inpatient stay and the nature of the proposed service, admission or prescription;
- For post-service claim review requests – the date the medical or dental service or prescription was received and the nature of the service or prescription;
- The doctor's, dentist's and/or hospital's name;
- For pre-service appeals – the reason you believe the care or prescription requiring pre-service approval should be approved or authorized. For post-service claim review requests – the reason you believe the claim should be paid;
- All documentation and other information you would like considered in support of your appeal.

Access to information – On request, you are entitled to receive, free of charge, reasonable access to and copies of documents, records and information relevant to your claim, any internal rule, guideline, protocol or other similar criterion that was relied on in making the initial benefit determination or appeal determination and an explanation of the scientific or clinical judgment for the determination applied to the medical or dental circumstances at issue in the claim if the denial was based on medical or dental necessity, experimental treatment or a similar exclusion or limitation.

About the appeal or review process – An individual or individuals who were not involved in the original decision and who are not subordinates of the initial decision maker will decide the appeal or review. The appeal or review process will take into account all information regarding the pre-service request or the denied claim (whether or not presented or available when the original decision was made) and the original decision will not be given any weight.

If your appeal or review is related to clinical matters, it will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. If medical, dental or vocational experts are retained in the process, those experts will be identified upon request, regardless of whether their advice is relied upon in deciding the appeal or claim review. In the case of an urgent care claim, you may request that all necessary information (including the decision) between you and the claims administrator or the pre-approval program administrator, whichever applies, be transmitted by telephone or fax instead of by written or electronic means.

Response – Following receipt of your appeal or request for review, you will be provided with a written or electronic notice of the decision within:

- 72 hours for an urgent care claim appeal;
- 30 days for a pre-service or post-service claim appeal;
- For a concurrent claim appeal, (a) before the proposed reduction or termination of approved treatment takes place, or (b) in the case of a request to extend a concurrent care decision, the same appeal time frames used for pre-service, urgent care appeals or post-service claim appeals apply.

If your pre-service appeal or post-service claim review is denied – If the result of your pre-service appeal or post-service claim review request is that your appeal or claim is denied, the claims administrator or the pre-approval program administrator, whichever applies, will provide a written or electronic denial letter that includes:

- The specific reasons for the denial;
- References to the specific plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon, either the specific rule, guideline or protocol or a statement that it will be provided free of charge upon request;
- If the denial was based on medical or dental necessity or experimental treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination applied to the medical or dental circumstances at issue in the claim, or a statement that such explanation will be provided upon request; and
- A statement of your right to bring an action under section 502(a) of ERISA.

If the result of a post-service request for review is that your claim still is denied, you can file an appeal – see below.

Review of Post-Service Claim Appeals
If the result of a post-service medical or dental request for review is that your claim still is denied, you can file an appeal with the Northwest Airlines, Inc. Benefits Appeal Committee within 60 days of receiving the response from the claims administrator. For post-service prescription drug requests for review, you can file an appeal within 60 days with the organization indicated in the appeal instructions included in the claim review letter you received.

How to File a Post-Service Claim Appeal for Review by the Committee
Submitting – For medical and dental appeals, get an "Application for Appeal" by calling or visiting the NWA Benefits Department. For prescription drug appeals, put your appeal request in writing. In both cases, include all of the facts and arguments that you want considered. Specifically:

- The patient's name and identification number from the ID card;

- The date the medical or dental service or prescription was received;
- The nature of the service or prescription received;
- The doctor's, dentist's and/or hospital's name;
- The reason you believe the claim should be paid;
- All documentation and other information you would like considered in support of your appeal.

For medical and dental appeals, hand deliver or mail your completed application to:

Northwest Airlines, Inc.
Benefits Appeal Committee A1430
2700 Lone Oak Parkway
Eagan, MN 55121-1534
Phone Numbers: (612) 726-3774 or 1-800-NWA-BENS

For prescription drug appeals, mail your appeal to the organization indicated in the appeal instructions included in the claim review letter you received.

Timing – Your appeal must be received within 60 days of the date you received the denial notice indicating that your post-service claim review resulted in a continued denial of your claim.

Response – Following receipt of your appeal, you will be provided with a written or electronic notice of a decision within 30 days.

If your post-service claim appeal is denied – If your appeal is denied, the written or electronic denial letter will include:

- The specific reasons for the denial;
- References to the specific plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon, either the specific rule, guideline, or protocol or a statement that it will be provided free of charge upon request;
- If the denial was based on medical or dental necessity or experimental treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination applied to the medical circumstances at issue in the claim, or a statement that such explanation will be provided upon request; and
- A statement of your right to bring an action under section 502(a) of ERISA.

Other Important Information about Reviews & Appeals

The plan uses the claims review and appeal procedures outlined in this section to ensure that the plan's provisions are correctly and consistently applied.

- Authority – For medical and dental claims and appeals, the Northwest Airlines, Inc. Benefits Appeal Committee has the sole discretion, authority and responsibility to decide all factual and legal questions under the plan, but may delegate its discretion, authority, and responsibility from time to time. The Committee's authority includes interpreting and construing the plan and any ambiguous or unclear terms, and determining whether a claimant is eligible for benefits and the amount of the benefits, if any, a claimant is entitled to receive. The Committee may hold hearings and may rely on any applicable statute of limitations as a basis to deny a claim. The Committee's decisions are conclusive and binding on all parties.
- Limitations Period – If you file your claim within the required time, complete the entire claims and appeals procedure and your claim is still denied, you may sue over your claim (unless you have executed a release on your claim). You must, however, begin that suit within 30 months after you knew or reasonably should have known of the facts behind your claim or – if earlier – within 6 months after the claims procedure is completed.
- Exhaustion of Administrative Remedies – Before starting legal action to recover benefits, or to enforce or clarify rights, you must completely exhaust the plan's claims and appeals procedures.
- Grievances (for contract employees) – After following the preceding claims review and appeal procedures, if your claim still is denied in whole or in part, you maybe able to file a grievance under the terms of your labor agreement.

Section F – Coordination of Benefits (COB)

If you or your covered dependent is eligible to receive benefits under the NWA medical or dental plan or the prescription drug program ("our plan" or "our program") and another group plan, our plan or program will coordinate benefits with the other plan. Under coordination of benefits, one plan pays first (is "primary") and one plan pays second (is "secondary"). When the NWA plan is secondary, it coordinates benefits using a "non-duplication of benefits" method. With non-duplication of benefits, the total payments from all plans will not be more than what this plan would have paid if it were the only plan paying benefits.

An "allowable expense" is any necessary item of expense that is covered in full or in part by any one of the plans involved.

The NWA plan will coordinate benefits with any of the following:

- Group, blanket or franchise insurance coverage;
- Service plan contracts, group or individual practice or other prepayment plans;
- Coverage under any labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans; and
- Medicare.

When the NWA plan is primary (the plan that pays first), it will pay its benefits without regard to any other plans. When the other plan is primary, the NWA plan (which is secondary) will subtract the primary plan's benefits before the NWA plan pays benefits. This means that when the NWA plan is secondary:

- It will not pay any additional benefits if the primary plan pays an amount equal to or greater than the amount the NWA plan would have paid if it were primary;
- If the primary plan pays less than the amount payable by the NWA plan, the NWA plan will pay the difference between the benefit it would have paid if it were primary and the amount paid by the other plan.

The claims administrator of our plan will determine which plan pays first and which pays second according to the following rules:

- If another plan does not have coordination of benefit provisions, that plan pays first;
- The plan that covers an individual as an employee pays first and the plan that covers an individual as a dependent, laid-off or former employee pays second;
- When both spouses cover their dependent children under two different group plans, the plan of the parent whose birthday falls earlier in the calendar year pays the children's expenses first. This is known as the "birthday rule." If the other plan has not adopted the birthday rule, the other plan's coordination of benefits rules apply to the children's expenses instead;
- When parents are separated or divorced, the birthday rule does not apply. Instead the following rules determine which plan pays the children's expenses first:
    - If there is a court order placing financial responsibility on one parent for a child's health care expenses, that parent's plan pays first. Otherwise, the plan of the parent with legal custody pays first;
    - The plan of the spouse of the parent with legal custody pays second;
    - The plan of the parent who does not have legal custody pays last;
- If none of the preceding rules apply, the plan that has covered an individual longest pays first.

In the case of out-of-network expenses, you should file claims with the plan that is primary first. Then, once you receive an Explanation of Benefits (EOB) from the primary plan, you would submit a claim to the secondary plan and include a copy of the EOB from the primary plan.

The claims administrator of our plan has the right to exchange information about benefit payments by our plan with other insurance companies, organizations or individuals in order to coordinate benefits. In addition, the claims administrator of our plan has the right to request from you or your covered dependent information about other plans in which your dependent may participate. If you or your covered dependent does not provide requested information within 90 days, your dependent's claim will be denied. To avoid a delay, error or even denial of benefit payments, completely fill out all information about other plan coverage that's asked for on claim forms.

Effect of Eligibility for Medicare
If you become eligible for Medicare, our plans will be primary for you, as long as you continue to be an active employee of the Company. If your covered spouse or child becomes eligible for Medicare while you are an active employee of the Company, our plans will be primary for your spouse or child.

If you are a terminated or retired employee covered by our medical or dental plans and you become eligible for Medicare, to get full coverage under our medical plan, dental plan and prescription drug program, you must sign up for Part A, Part B and Part D of Medicare as soon as you are entitled. When coordinating benefits, the NWA plans will pay benefits as if you were covered by Part A, Part B and Part D of Medicare even if you are not.

Recovery of Excess Payment
If for any reason a benefit is paid by the NWA medical plan, NWA dental plan or the prescription drug program that is larger than the amount allowed, the claims administrator has the right to recover the excess amount from the person or agency that received it.

Section G – Right to Third Party Payment (Subrogation)

With the NWA medical plan, NWA dental plan and the prescription drug program, if you or one of your covered dependents receives benefits for covered medical, dental or prescription drug expenses and has a claim for damages against a third party personally or under a liability, casualty, self-insurance or other insurance program that is based, in whole or in part, on those covered expenses, the NWA medical plan, NWA dental plan and the prescription drug program have the right of subrogation and reimbursement with respect to any recovery you or your dependent receives on that claim. This includes recovery from claims against an automobile insurance policy maintained by you, your covered dependent, or any other person. This right can be exercised in the sole discretion of the plan administrator. In addition, the NWA medical plan, NWA dental plan and the prescription drug program will have a lien on any amounts payable by a third party or under an insurance policy or program to the extent covered expenses are paid by the NWA medical plan, NWA dental plan or the prescription drug program.

As a condition of receiving benefits under the NWA medical plan, NWA dental plan and the prescription drug program, you or your covered dependent must:

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

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

The NWA medical plan, NWA dental plan and the prescription drug program are not responsible for paying any expenses you or your covered dependent incurs while pursuing a claim, including legal fees and costs, unless the claims administrator has agreed, in writing, and in advance, to pay those expenses.

Section H – Other Important Plan Information

Northwest Airlines, Inc. reserves the unilateral right to:

- Select the claims administrator(s);
- Offer an alternative plan;
- Administer and interpret the plan; and
- Comply with legally required changes in the administration of the plan, including but not limited to ERISA claim and appeal procedures, COBRA, and HIPAA.

Section I – Retirees

Eligible Retirees

An employee who retires and meets the criteria for an Disability or Early or Normal Retirement under the Northwest Airlines, Inc. Pension Plan for Contract Employees and who is enrolled in the Company's Medical, Prescription Drug Program and Dental Plans on his/her Retirement Date may continue as a participant in such plans, providing the employee is not eligible for group medical or dental coverage in other employment. A spouse may continue coverage provided such spouse does not have medical and/or dental coverage available through his/her employer (this provision does not apply to a spouse employed by the Company). Eligible children will be eligible for continued coverage for as long as either the retiree or spouse remains a participant under the plans.

Each Employee who meets the criteria for a Disability, Early or Normal Retirement under the Northwest Airlines, Inc. Pension Plan for Contract Employees, and who is not eligible for Medicare shall be eligible to be a participant in the Company's Medical, Prescription Drug Program and Dental Plan, until such time as the Employee becomes eligible for Medicare. Each such retiree's dependent spouse, who is not eligible for Medicare, shall be eligible for participation in said plans, even if the retiree is no longer eligible, until such time as such spouse becomes eligible for Medicare. Eligible children will be eligible for continued coverage for as long as either the retiree or spouse remains a participant under the plans. Participation in the Company’s Medical and Dental Plans ceases at the age of Medicare eligibility (age 65) and cannot be continued.

The premium cost for each such covered person will be paid 100% by that covered person.

Exception: The premium contribution for medical coverage will be equal to 50% of the projected retiree medical cost of the plan up to the age of initial Medicare eligibility for Employees retiring and who meet the criteria of an Early or Normal Retirement under the Northwest Airlines, Inc. Pension Plan for Contract Employees, providing such an Employee's retirement occurs after his/her attainment of age 55 and completion of at least twenty three (23) years of Benefit Accrual Service as defined in the Plan.

Exception: The premium contribution for medical coverage will be equal to 50% of the projected retiree medical cost up to the age of initial Medicare eligibility, were the employee not disabled, who meet the criteria for a Disability Retirement pension as defined under the Northwest Airlines, Inc. Pension Plan for Contract Employees after his/her completion of at least ten (10) years of Benefit Accrual Service.

Note: For retirees (and or their spouse) who have used tobacco products within the six months prior to enrollment there will be a tobacco surcharge equal to 6.25% of the retiree premium. For a retiree and/or spouse who does not meet the non-tobacco user standard, a reasonable alternative standard will be offered through a bona fide wellness program - a tobacco cessation program (see special note on page 5 for additional information).

For purposes of this section, Benefit Accrual Service means “Benefit Service” as defined in the Northwest Airlines, Inc. Pension Plan for Contract Employees (Pension Plan), including all Benefit Service actually accrued prior to the date of a plan freeze and all service thereafter which would have constituted Benefit Service under the Pension Plan had the accrual of Benefit Service not been frozen.

Retirees who have elected dependent coverage but who no longer have dependents (including a spouse) eligible for such coverage shall promptly remove coverage from such dependent(s) within thirty (30) days of such event. If the retiree does not remove coverage within such thirty (30) day period, the retiree will be responsible to repay the full cost of any claims paid out on that dependent’s behalf after coverage should have ended.

The Company will provide Company-subsidized medical coverage for eligible surviving family members of a deceased retired employee under the same terms, conditions and duration that are applicable to the Family Security Benefit.

Eligible Dependents
If you participate in the plans, your “eligible dependents” who can participate are:

- Your spouse of the opposite sex, as recognized in your state of residence as long as your spouse does not have coverage available through his or her employer . A spouse does not include a person from whom you are legally separated or divorced or a person of the same gender. In the case of a common law marriage, proof is required – contact the NWA Benefits Department for details;
- Your eligible “Domestic Partner” who is the same gender as you as long as your Domestic Partner does not have coverage available through his or her employer.

Retirees may not enroll a Domestic Partner. However, if you retired on or after January 1, 2001, you may continue coverage for your Domestic Partner after you retire, as long as he or she was covered by the plan at the time you retired and your Domestic Partner does not have coverage available through his or her employer. If you continue coverage for your Domestic Partner after retirement, you also may continue to cover your Domestic Partner's children, including children born to or acquired by your Domestic Partner after you retire. Important -- Your own coverage and your Domestic Partner's coverage after you retire must remain continuous. If you drop coverage for yourself or for your Domestic Partner at any time after retirement, you cannot ever again add your Domestic Partner and his or her children;

- Your unmarried "children" up to age 19;
- Your unmarried "children" from age 19 up to age 26 who are full-time students (as defined by the school) and primarily dependent on you for support.
- Your unmarried "children" over the maximum age who are "totally" disabled, either physically or mentally, as long as the child:
  - Became disabled on or before reaching age 19 (on or before reaching age 26, if the child is a full-time student);
  - Was covered by the plans when he/she became disabled;
  - Is incapable of earning his/her own living.

  You must call the claims administrator and provide proof of the child's disability within 30 days of the child reaching age 19 (or age 26 if a full-time student). If a covered child first becomes disabled between age 19 and 26, you must call and provide proof to the claims administrator within 30 days of the child becoming disabled. "Totally" disabled will be determined by the claims administrator.
- Eligible children of your eligible Domestic Partner who live with you and are dependent on you for support (this includes your Domestic Partner's natural children), provided your Domestic Partner also is enrolled. If you are a retiree, you only may enroll your Domestic Partner's children if you retired on or after January 1, 2001.

"Children" include:

- Natural children;
- Adopted children who are placed in your home and for whom you are legally obligated to provide total or partial support;
- Stepchildren who live with you in a parent/child relationship (e.g., go to school from your home);
- Children for whom a court awards you legal guardianship, who live with you and are primarily dependent upon you for their support.
- Foster children who live with you in a parent-child relationship, are primarily dependent on you for support, and for whom you receive no government reimbursement for maintenance and support;

- Grandchildren, as long as their mother is covered by the plan(s) as your dependent child, the mother lives in your home with the grandchildren and the grandchildren are primarily dependent on you for support; and
- Children covered under the terms of a QMCSO – see page 2.

Enrolling
You have a limited period of time in which to enroll in the plans. This is called the "allowable time frame." The allowable time frame is 30 days plus an additional 30-day grace period (60 days total). Enrolling is easy using NWA's "NROL & More" enrollment Web site. If you do not enroll for coverage during the allowable timeframe you will have no medical and/or dental coverage and only will be allowed to re-enroll in the plan if you have had coverage through another employer.

Retirees can access NROL & More at nwapeople.nwa.com. A spouse of a retiree who has coverage under his/her own name can access NROL & More at nwa.wwwhrt.com.

If Both You & Your Spouse/Domestic Partner Are NWA Retirees
If you and your spouse are both NWA retirees, each of you may enroll as a retiree or one of you may enroll the other as a dependent. Only one of you may enroll your children. If you and your Domestic Partner are both NWA retirees, each of you may enroll as a retiree and you each may enroll your own eligible dependent children, but not the other's dependent children.

Important: When you enroll a dependent, you will have to provide proof that your dependent meets all of the eligibility rules, for example, a copy of a birth certificate, marriage certificate, etc. Details about acceptable proof can be found on RADAR. Failure to provide adequate proof will result in your dependent being dropped from coverage. Retirees who have elected dependent coverage but who no longer have dependents (including a spouse) eligible for such coverage shall promptly remove coverage from such dependent(s) within sixty (60) days of such event. If the retiree does not remove coverage within such sixty (60) day period, the retiree will be responsible to repay the full cost of any claims paid out on that dependent's behalf after coverage should have ended.

NWA Medical Plan, Prescription Drug Program and NWA Dental Plan
Retirees will have the same coverage as active employees (for medical coverage, see pages 4-39; for prescription drug coverage, see pages 39-43; for dental coverage, see pages 44-54).

Section J – Family Security Benefits
The Family Security Benefits are listed below.

General rule: In the event of an active employee's death, benefits under the NWA Medical Plan and NWA Dental Plan will be continued for his family members covered on that date, with advance payment of the monthly contribution without payment of premiums, until the earliest of the following dates:

- Remarriage of the surviving spouse, in which case the coverage for the family members terminates;

- The date a family member becomes eligible for Medicare (there is no continuation for a family member who is already eligible for Medicare at the time of the employee's death);
- The date a family member ceases to qualify as a family member for any reason other than lack of primary support by the employee;
- Two (2) years from the date of the employee's death.

The coverage which is continued for family members will be the coverage in force for family members of employees on active payroll. The coverage which is continued in force for family member children because of the employee's death will not be affected if the surviving spouse dies during the two (2) year (maximum) continuation of coverage.

When coverage under the Family Security Benefit ends, the employee's eligible family members may continue their coverage under the NWA Medical Plan and NWA Dental Plan by the monthly advance payment of the premium to the Company until the earlier of the dates below (subject to a maximum of thirty-six (36) months from the employee's date of death):

- The date of remarriage of the surviving spouse, or
- The date coverage would otherwise have terminated if the employee had lived.

In the event an inactive employee's death, benefits under the NWA Medical Plan and NWA Dental Plan may be continued for his/her family members covered on that date, with advance payment of the full monthly premiums for up to three years from the date of death.

Section K – Flexible Spending Account

The Company shall maintain a Flexible Spending Account (FSA) Plan for employees covered by this Agreement. The FSA Plan shall be designed and administered by the Company and may be modified from time- to-time at the Company's discretion, provided however, that the maximum amount an employee may contribute to his/her health care expense account and dependent care expense account shall not be modified without the consent of the Union. The Company shall prepare and make available to employees a Summary Plan Description (SPD) booklet for the FSA Plan.

The FSA Plan shall consist of two (2) individualized accounts, one for payment of a employee's health care expenses and the other for payment of the employee's dependent care expenses. The maximum amount a employee may contribute to the health care expense account per year shall be limited to five thousand dollars ($5,000.00), and the maximum amount a employee may contribute to the dependent care expense account per year shall be limited to five thousand dollars ($5,000.00). Employees shall be permitted to contribute a portion of their compensation through payroll deduction into one or both accounts on a pre-tax basis.

As employees submit claims for eligible expenses throughout the plan year, they shall be reimbursed from their account(s).

Money contributed by an employee to his/her account during a plan year that is not used by the following March 31, for reimbursement of eligible expenses incurred during such plan year shall be used to reduce expenses incurred by the Company in the ongoing administration of the plan.

Section L – Group Life Insurance and Other Coverage

Company Paid Life Insurance - the Company shall provide to an employee covered by this Agreement while he/she is on active payroll status, Company-paid Group Term Life Insurance (Group Term Life I) coverage in the amount of fifteen thousand dollars ($15,000.00) and Group Term Life Insurance (Group Term Life II) in the amount of twenty thousand dollars ($20,000.00).

Upon the insurance company's determination of a covered employee's disability, the employee shall receive the face value of the Group Term II policy in a lump sum. A disabled employee who receives the face value of his/her Group Term II policy shall be excluded from coverage under such policy if he/she is returned to duty with the Company.

Group Term I Life insurance shall include an accelerated death benefit.

For employees who retired after November 2, 1998 and who meet the definition of a Normal, Early or Disability Retiree as defined in the Northwest Airlines, Inc. Pension Plan for Contract Employees shall be provided ten thousand dollars ($10,000.00) of Company-paid Group Term I life Insurance. Upon retirement the employee's Company-paid Group Term Life I coverage will be reduced from fifteen thousand dollars ($15,000.00) to ten thousand dollars ($10,000.00).

Employee Paid Life Insurance - the Company shall continue to provide administrative services, including payroll deduction, for optional Term Life Insurance under the Group Term Life I and II coverages which are wholly employee-paid. Employees may elect to purchase additional Group Term I coverage in increments of five thousand dollars ($5,000.00) to a maximum of eighty-five thousand dollars ($85,000.00) and Group Term II coverage in increments of ten thousand dollars ($10,000.00) to a maximum of eighty thousand dollars ($80,000.00).

Employee Paid Dependent Life Insurance - the Company shall provide administrative services, including payroll deduction, for optional Dependent Life Insurance, provided by an insurer selected by the Company. Premiums for such insurance shall be wholly employee-paid.

Business Travel Accident Insurance - the Company shall continue in effect the existing Business Travel Accident Insurance in the amount of one hundred thousand dollars ($100,000.00) while they are on active payroll and on Company-paid business travel.

Group Long Term Disability Coverage - the Company shall provide administrative services, including payroll deduction, for a Group Long Term Disability Plan provided by an insurer selected by the Company. Premiums for such coverage shall be shared equally between the employee and the Company.

Eligibility, employee contribution, benefit amount & payment, definitions and general limitations shall be defined in the Long-Term Disability (LTD) Insurance Summary Plan Description for ATSA employees.

Section M – Continuation of Coverage

Employees who are off payroll may continue their NWA Medical Plan and/or NWA Dental Plan coverage as specified in the booklet entitled Group Benefit Plans Booklet for Union Employees, as revised to comply with the requirements of federal law, provided:

- Employees who are on a leave of absence (other than a medical leave or military leave) or layoff may, by the monthly advance payment of the premium to the Company, continue their coverage until the next premium due date following eighteen (18) months from the effective date of the employee's leave of absence or layoff.

- Employees who are on a medical leave may by monthly advance payment of premium to the Company, continue their coverage for the duration of the leave subject to a minimum continuation period of eighteen (18) months from the date the employee's medical leave begins.
- Employees who are transferred from active payroll status to military leave status and are covered under the NWA Medical Plan and/or NWA Dental Plan will continue to have Company-subsidized coverage, provided he/she elects to continue such coverage, during their first two months of military leave of absence. In addition, the Company-paid Group I and II basic life insurance coverage will be continued at no cost to the employee during their first two months of military leave of absence.

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- Continuation of coverage for an employee's former spouse and other dependents, after a employee's divorce or legal separation, shall comply with the requirements of federal law.

Additional Provisions of Tentative Agreement Specified With Initials

Company Proposal
9/27/2005 2:08 PM

ATSA Temporary Bankruptcy Pay Cut

- Implement an incremental, temporary, five percent (5%) pay cut for all ATSA-represented employees.
- Incremental pay cut to remain in place until Company emerges from bankruptcy.

ATSA Job Security/LPP/Scope/Successor Provisions

Job Security Covenants

- Status Quo: (None).

Labor Protective Provisions

- Amend to delete in entirety the following "labor protective provisions" from the Collective Bargaining Agreement: Article 1.B. and 1.G.; provide for successor transactions to be binding only on a successor that is engaged in the operation of an air carrier, and only where a transaction involves transfer to the Successor of all or substantially all of the equity securities of the Company or all or substantially all of the value of the assets of the Company ("Successor Transaction").
- Provide seniority integration rights provided in Sections 2, 3 and 13 of the Allegheny-Mohawk LPPs.
- Amend to provide for certain exceptions to this Successor Transaction provision in the event of Sky Team partner ownership.

No Strike and Related Provisions

- Amend to enhance all "no strike" provisions contained in the CBA. (e.g.; Article 8.L.)

ATSA Pension

- Freeze existing defined benefit plan for ATSA-represented employees.
- Negotiate a follow on defined contribution plan for same.

Retiree Medical

- Medical benefits for current and future retirees are under review, and the Company reserves the right to propose changes in these areas.

ATSA Profit Sharing Plan

Implement a Profit Sharing Plan in consideration for restructuring labor costs.

- Eligibility: All employees on payroll as of December 31 of Plan year (contingent upon participation in labor cost restructuring efforts);
- Payout: Ten percent (10%) of all pre-tax income (excluding extraordinary items) in excess of $1 million (no cap);
- Payout to be made annually in cash by April 15 following end of fiscal year;
- Distribution to be calculated as a uniform percentage of all W-2 wages, excluding paid SIK/OJI benefits.

T.A
10/27

T.A. 11/27 8:51 pm

Company Proposal 10-27-05
Northwest Airlines, Inc. / ATSA

2004 - 2011

ARTICLE 1: SCOPE AND STATUS

A. This Agreement is entered into this 2nd day of November, 1998, in accordance with the provisions of the Railway Labor Act, as amended, by and between Northwest Airlines, Inc. (hereinafter referred to as the "Company"), and the Aircraft Technical Support Association (hereinafter referred to as the "Union") and shall apply to and cover personnel in the classifications of:

Training Representative
Production Planner
Line Maintenance Planner
Technical Writer
Reliability Analyst
Technical Analyst

wherever employed for whom the Union was certified as exclusive bargaining agent by the National Mediation Board on February 9, 1971, in NMB Case R-4193 and NMB Case R-6289, dated August 9, 1994.

B. It is expressly understood and agreed by the Company and the Union that this Agreement shall supersede and supplant any and all Agreements previously executed between the Company and any bargaining agent or individual affecting the classifications referred to in Paragraph (A) above or any individual employee covered by this Agreement, and that all provisions of this Agreement shall be binding upon any successor or assign of the Company.

C. The Company and the Union agree that employees in the classifications covered by this Agreement will perform the work generally recognized as falling within the scope of the job descriptions defined in Article 2 of this Agreement for Training Representative, Production Planner, Line Maintenance Planner, Technical Writer, Reliability Analyst and Technical Analyst as certified by the National Mediation Board on February 9, 1971, NMB Case R-4193 and NMB Case R-6289, dated August 9, 1994, and which is performed in and about the Company facilities. Nothing herein shall be construed to limit or restrict the right of persons such as supervisory or clerical personnel not covered by this Agreement from the performance of their work which is necessary for the accomplishment of the work covered by these classifications, nor shall it be construed as preventing other persons from the performance of occasional assignments of an assisting nature to the Company, and provided further that such work done by others does not result in any employees in these classifications covered by this Agreement being displaced. Nothing herein shall be construed to limit or restrict employees covered by this Agreement from performing work at contract or vendor maintenance facilities as determined appropriate or necessary by the Company. Further, nothing herein shall be construed to prevent consolidation or transfer of jobs within

these six classifications whenever there is not sufficient work to justify retention of a full-time position. Nothing herein shall be construed as obligating the Company to maintain or to establish any number of positions in these classifications. The Union agrees that all employees covered by this Agreement shall be governed by Company rules, regulations and orders not in conflict with provisions or rules contained herein.

D. It is understood and agreed that the Addendum attached hereto covering Company operations outside the limits of the United States is a part and parcel of this Agreement, and that if during the life of this Agreement Company operations are extended to include additional foreign routes and bases, representatives of the Company and the Union will prior to the opening of the operation meet in negotiation for proper wage rates and other conditions to govern additional foreign-based employees.

E. Whenever the term "technician" or "employee" is used herein, it shall refer to and mean personnel in the job classifications covered by this Agreement.

F. In the event of the introduction of new or different equipment or technology to the employee, and such new equipment or technology requires training, the Company shall provide the training and tools for the employee to become qualified with the new or different equipment or technology.

G. It is understood and agreed that all provisions of this Agreement shall be binding upon **any** successor or assign of the Company **that is engaged in the operation of an air carrier, which acquires ownership and/or control of all or substantially all of the equity securities of the Company or all or substantially all of the value of the assets of the Company**. In the case of a sale, consolidation, merger, liquidation, reorganization, bankruptcy or trusteeship, representatives of the Company and the Union will meet without delay and negotiate for proper provisions for the protection of employee's seniority **in accordance with Sections 2, 3, and 13 of the Allegheny-Mohawk Labor Protective Provisions.**

NOTE: The provisions of paragraph G above shall not apply in the event that the Successor is a present or future member of the Sky Team Alliance.

H. The Company will meet and agree with ATSA representatives to discuss concerns or issues related to subcontracting and where practical, the Company will notify ATSA in advance of financially significant subcontracting of work regularly performed by ATSA-represented employees.

10/27 9.56 pm

Supplemental Company Proposals

Duration of Agreement

Agreement will be effective until December 31 of the fourth full calendar year after emergence from bankruptcy.

Pension Benefit

1. Current DB plans to be frozen.
2. Preservation of the frozen defined benefit plans is contingent upon legislation being enacted to reduce pension funding costs to acceptable levels. In order for this legislation to have the effect of preserving the frozen pension plans, Northwest must also realize a competitive cost structure and have the ability to attract new financing to successfully exit bankruptcy. If this relief does not materialize, arrives too late, is insufficient, or Northwest suffers adverse economic circumstances on other fronts, Northwest may seek to terminate its pension plans.
3. Should termination of the defined benefit plans occur, ATSA agrees that such termination does not represent a violation of its collective bargaining agreement, but reserves the right to contest that termination.
4. Defined benefit plans to be replaced with a defined contribution plan at 5% of wages or a similar plan of equivalent cost to Northwest, effective on the company's emergence from bankruptcy. The deferral of the onset of contributions to the defined contribution plans will be in lieu of the temporary 5% supplemental pay cut during the bankruptcy period.

Retiree Medical Benefits

1. Current Retirees
   a. Pre-Age 65: Retiree will be eligible to participate in the company's medical coverage plan for active employees. Retiree will be responsible for paying 50% of the cost of the benefit (to be determined based on the average cost of health benefits to the company for all retirees).
   b. Post-Age 65: Retiree medical coverage will be eliminated.
2. Active Employees
   a. Pre-Age 65 Retirees:
      i. Retiree will be eligible to participate in the company's medical coverage plan for active employees. Retiree will be responsible for paying 50% of the cost of the benefit (to be determined based on the average cost of health benefits to the company for all retirees).
   b. Post-Age 65 Retirees: Retiree medical coverage will continue to be unavailable.

Effective Date of Agreement

This Agreement shall become effective on its date of signing which shall be no later than the implementation of labor cost reductions achieved either through consensual agreement or pursuant to 1113(e) or (c) of the bankruptcy code with any other Northwest union, whichever is earlier.

TENTATIVE AGREEMENT

Area	Proposal	Year 1 Steady State Value ($ Millions)		
		Independent	Interaction	Net of Interaction
Base Pay	Reduce base rates by 9.9%	$1.34	$0.00	$1.34
Sick	Cap sick bank hours at 520 hrs, accrue 5 sick days/yr and pay sick at 75% if used	$0.09	($0.01)	$0.08
Vacation	4 weeks max annual vacation accrual	$0.17	($0.02)	$0.15
Holidays	Eliminate 3 Holidays (President's Day, Birthday and Personal Day)	$0.10	($0.01)	$0.09
Benefits	Modify group medical and traditional dental plans	$0.61	($0.01)	$0.60
Total Estimated Value				**$2.25**

10/27 8:49 pm

Company Proposal
10/27/2005 8:24 PM

Dist to ATSA
10/27 8:43 pm

ATSA Letters of Agreement

- Eliminate A.4. Integration of Administrators of Applications
- Eliminate A.7 Retirement Plan Agreement
- Eliminate A.8. Retirement Plan Agreement
- Eliminate A.20. 3.5% Cash Lump Sum Payment
- Eliminate A.21. Job Security Covenants
- All other Letters of Agreement remain in effect.

T A d

10/27 8:57 pm

Once a new Company Group Medical Plan is implemented, ATSA-represented employees will participate in that plan on the same terms (contribution levels and plan design features) as other collective bargaining unit employees. The Company's current intention is to implement a single plan that is consistent with the summary plan description provided to ATSA on September 27, 2005. The credit toward ATSA's labor cost reduction target has been valued based on that plan design and structure. Should any other group plan be agreed to by the Company and another bargaining unit, ATSA will be given the opportunity to participate in that plan provided that any reduction in savings associated with an improved plan is offset by a corresponding reduction in base rates of pay as calculated by the Company.

Dist to ATSA
10/27 3:20pm

NORTHWEST AIRLINES, INC.
SEPTEMBER 2005

Medical	NWA Group Medical (TODAY)	New NWA Group Medical Plan Proposal (PROPOSAL)
Bargained	Yes	Yes
Contribution Amount	20% ALPA & Salaried	25% all employee groups
Tobacco Surcharge	Yes AMFA 1/1/06	Yes
How the plan works	Services rec'd from participating providers, provider files claims and benefits paid based on allowable charge, otherwise patient responsible for filing claims and benefits paid based on R&C	IN – if services rec'd from in-network provider, provider files claims and benefits paid based on allowable charge OUT – if services rec'd from out-of-network provider, patient responsible for filing claims and benefits paid based on R&C
Deductible	$200/$500 ALPA $200/$475 Exception – $100/$300 IAM/AMFA OOA	In - $350/$700 Out - $700/$1,400 Index for inflation
Out-of-Pocket Maximum – excludes Rx and MH	$1,600/$4,000	In – $2,750/$5,500 Out – $5,500/$11,000 Index for inflation
Maximum Lifetime Benefit	Unlimited	In – Unlimited Out – $1,000,000
Preadmission Certification	Patient responsible	In – Provider will call Out – Patient responsible
Eligible Expenses	No preventive care (except AMFA), payment based on R&C	In – Most preventive care covered (based on age/gender) Out – no preventive care, payment based on R&C
Nurseline	Available through claims administrator	Available through claims administrator
Office Visits	20% after deductible	In – 20% after deductible Out – 30% after deductible
Preventive Care	Not covered (except AMFA)	In – Most care covered, 10% no deductible (based on age/gender Out – Not covered
Laboratory Services	20% after deductible	In – 20% after deductible Out – 30% after deductible
Diagnostic Procedures & X-rays	20% after deductible	In – 20% after deductible Out – 30% after deductible
Facility Charges – Outpatient	20% after deductible	In – 20% after deductible Out – 30% after deductible
Emergency Room	20% after deductible	In – $100 copay Out – $100 copay Only if true emergency, otherwise 20% In or 30% Out
Hospital – Inpatient	0% of first $4,000, then 20% ($5,000/PFAA, AMFA, $7,500/ALPA)	In – 20% after deductible Out – 30% after deductible

Physician Hospital/ Professional Services	20% after deductible	In – 20% after deductible Out – 30% after deductible
Prescription Drugs	Covered under Rx Plan	Covered under Rx
Durable Medical Equipment & Consumable Medical Supplies	20% after deductible	In – 20% after deductible Out – 30% after deductible Prior auth required on purchases over $1,000
Mental Health/Chemical Dependency	Inpatient combined w/hospital inpatient Outpatient – MH 20% up to certain $ limit, then 50% after deductible, CD 20% after deductible limited to 130 hours/yr	In – 20% after deductible Out – 30% after deductible
Maternity	20% after deductible	In – 20% after deductible for prenatal office visits, 20% after deductible for post-natal, labor, delivery, newborn hosp care Out – 30% after deductible All moms-to be automatically registered in prenatal program, otherwise subject to precert penalty on IP hosp
Physical, Occupational & Speech Therapy	20% after deductible	In – 20% after deductible Out – 30% after deductible Limited to 20 visits/yr IN and OON combined unless add'l authorized by plan
Chiropractic Care	20% after deductible (IAM 0% up to $600/yr including maintenance care)	In – 20% after deductible Out – 30% after deductible Limited to 20 visits/yr IN and OON combined, unless add'l authorized by plan
Weight Management/ Bariatric Surgery	20% after deductible for physician + hospital inpatient	In – 40% after deductible – covers 4 physician visits/yr for treatment of obesity, 6 dietician visits/yr plus counseling (also cover 2 weight-loss drugs), prior auth required – centers of excellence required where available
Home Health Care	20% after deductible, limited to 40 visits/yr	In – 20% after deductible Out – 30% after deductible
Hospice Care	0% with plan approval	In and Out – 0% with plan approval
Health Threatening Emergencies	N/A	Covered as in-network (initial care only, follow-up care paid at IN or OON level)
Coordination of Benefits (COB)	Full COB (except salaried – MOB)	Maintenance of Benefits (MOB)– if NWA is secondary, total payment on claim will be no more than what NWA would have paid as primary plan
Working Spouse Exclusion	No	Yes, if spouse has coverage available through own employer, not eligible for coverage through NWA

Assumptions:

- Continue Disease Management programs

Prescription Drugs	NWA Rx	New NWA Rx Proposal
Deductible	None	None
Maximum Lifetime Benefits	Unlimited	Unlimited
In-Network Pharmacy Benefits	Varies by labor group $7/8/14/generic $10/12/18/20brand 50% for maintenance meds after two fills for ALPA and Salaried Up to a 34-day supply	Generic 30% - $10/min, $50/max Formulary 30% + difference in brand/generic - $20/min, $75/max Non-Formulary – 50% + difference in brand/generic - $35/min, no max Lifestyle drugs 50% + difference in brand/generic - $30/min, no max 50% for maintenance meds after two fills (min above apply, no max) Up to a 30-day supply
Medco By Mail	Varies by labor group $14/16/35/generic $20/24/36/50/brand Up to a 90-day supply	Generic 30% - $25/min, $125/max Formulary 30% + difference in brand/generic - $50/min, $187.50/max Non-Formulary 50% + difference in brand/generic - $87.50/min, no max Lifestyle drugs 50% + difference in brand/generic - $75/min, no max Up to a 90-day supply
Out-of-Network Coverage	Reimbursed difference between retail price and in-network price, less copay	Reimbursed difference between retail price and in-network price, less copay
Formulary	Open	Preferred* Formulary First Coverage Review**
Prior Authorization	Traditional and Smart Auth Programs	Traditional and Smart Auth Programs
Drugs Not Covered	OTC and prescribed medications with OTC equivalents Appetite suppressants (except if approved via prior authorization) Cosmetic medications Contraceptives and contraceptive devices (however, oral contraceptives and contraceptive patches covered in-network and through Medco by Mail) Experimental or investigational medications Replacement prescriptions resulting from loss, theft or breakage Vitamins, except for prescription vitamins	OTC and prescribed medications with OTC equivalents Appetite suppressants (except if approved via prior authorization) Cosmetic medications Contraceptives and contraceptive devices (however, oral contraceptives and contraceptive patches covered in-network and through Medco by Mail) Experimental or investigational medications Replacement prescriptions resulting from loss, theft or breakage Vitamins, except for prescription vitamins

* Preferred Formulary – includes both single source and multi-source brand drugs. Additions are made to the formulary four times a year; deletions are made two times a year.

** Formulary First Coverage Review – for Proton Pump Inhibitors (PPI). For non-formulary prescriptions of PPIs, stopped at point of sale. Patient offered generic. If doesn't want generic, offered formulary brand. If patient purchases non-formulary PPI, no coverage under Rx plan, patient pays full cost of drug.

Dental	Traditional Dental Plan	New Dental Plan Proposal
Bargained	Yes	Yes
Contribution Amount	20% ALPA and Salaried	20% all employee groups
How the plan works	If participating dentist used, no claim forms to file and benefits paid based on allowed charge – no balance bill If non-par dentist used, must file claim form and benefits paid based on R&C	IN- if services rec'd from in-network* provider, provider files claims and benefits paid based on allowable charge (no balance billing for amounts over R&C). OUT – if services rec'd from out-of-network provider, patient responsible for filing claims and benefits paid based on R&C. Eliminated in 2008.
Deductible	$50/$125 for Class II and III services	$75 /$225 for Class II and III services. Indexed for inflation
Plan Dollar Maximums	Varies by labor group Class I, II & III/person/year $2,250 – IAM & AMFA $2,000 – ALPA, PFAA, TWU & Salaried Class IV/lifetime/person $2,500 – IAM & AMFA $2,000 – ALPA, PFAA, TWU & Salaried	Class I, II & III/person/year $2,000 Class IV/lifetime/person $2,000
Plan Covers	Class I – Preventive – 90% Class II – Minor Restorations – 80% after deductible Class III – Major Restorations – 60% after deductible Class IV – Orthodontia – 50% Coverage for dental implants varies by labor group Class III – ALPA, PFAA, TWU & Salaried Class IV – IAM and AMFA	Class I – Preventive – 80% in/ 70% out Class II – Minor Restorations – 70% in/ 60% out (after deductible) Class III – Major Restorations – 60% in/ 50% out (after deductible) Class IV – Orthodontia & Dental Implants – 50% in/ 40% out
Coordination of Benefits	Full COB (except salaried employees – MOB)	Maintenance of Benefits – if NWA is secondary, total payment on claim will be no more than what NWA would have paid as primary plan
Working Spouse Exclusion	No	Yes, if spouse has coverage available through own employer, not eligible for coverage through NWA

* Participating dentists are included in the network based on selective contracting by DeCare.