DELTA PILOTS MUTUAL AID, INC.

PLAN

As Amended and Restated Effective January 1, 2026

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ARTICLE I

PURPOSE AND DEFINITIONS

Section 1. Formation and Purpose

The Delta Pilots Mutual Aid Voluntary Employees' Beneficiary Plan (hereinafter "the Plan" or "Plan") was formed effective January 1, 1996, and was originally documented as part of DPMA's operational By-Laws ("By-Laws").

The purpose of the Plan, subject to the limitations and conditions set forth in this document, is to afford financial aid to its Members in the event of a loss of earning power through death, sickness, or disability (mental or physical) of a Member while employed by Delta Air Lines, Inc. (hereinafter referred to as "Delta.")

On January 1, 2009, DPMA was expanded to cover former pilot employees of Northwest Airlines, Inc. (hereinafter referred to as "NWA") who became pilot employees of Delta as a result of the merger of NWA with and into Delta on the Date of Corporate Closing ("DCC"). The provisions of DPMA benefits to the former NWA pilots are outlined throughout this Plan, and are designated as the Delta Pilots Mutual Aid/Former Northwest Airline Pilots ("DPMA/FNWAP").

On May 1, 2025, the Plan is amended so that the Plan may be funded, and at the Board's discretion, may eventually provide benefits to all Members without distinguishing between Members who are or are not Former Northwest Airlines Pilots.

Section 2. Definitions

(a) "Account" means one or more custodial accounts established pursuant to a trust or custodial instrument approved by the Board.

(b) "Active Payroll Status" means the status of a pilot who is actively receiving flight pay from Delta.

(c) "Appeals Committee" means the committee appointed by the Chairman pursuant to the By-Laws to review claims for benefits that are initially denied by the Claims Committee and for which the claimant requests a full and fair review pursuant to Article X.

(d) "Board of Trustees" or "Board" means the Board of Directors of Delta Pilots Mutual Aid, Inc. For purposes of the Plan and the By-Laws of the DPMA, the word "Board" shall refer synonymously to the Board of Directors and the Board of Trustees.

(e) "Chairman" means the Chairman of the Board.

(f) "Claims Committee" means the Claims Committee as defined in the By-Laws. Such Committee shall review claims for benefits that are submitted by Members pursuant to Article X, Section 2.

(g) "Code" means the Internal Revenue Code of 1986, as amended.

(h) “Composite Hourly Rate” or “CHR” means the current pay rate for the equipment/seat/years of service the Member was assigned on the Member’s SLOA date.

(i) “DCC” means the Date of Corporate Closing of the merger transaction of Delta Air Lines, Inc. and Northwest Airlines, Inc., which was October 30, 2008.

(j) “Delta” means Delta Air Lines, Inc.

(k) “Delta Pilot” means a Delta employee who is classified as a pilot on the Delta Pilots System Seniority list (the “List”).

(l) “Delta Pilots Mutual Aid, Inc.” or “DPMA®” means the entity formed to establish, maintain, and administer the Plan. “DPMA®”, “Pilots Helping Pilots” and the DPMA logo are registered trademarks.

(m) “Delta’s D & S Plan” or “D & S Plan” means the Delta Pilots Disability and Survivorship Plan.

(n) “DPMA Account” means the portion of the funds in the VEBA Trust associated with DPMA benefits. Pre-May 1, 2025 Amounts held in the DPMA Account are subject to the Exclusivity Rule. Post-April 30, 2025 Amounts are not subject to the Exclusivity Rule.

(o) “DPMA Claim Forms” means “DPMA Disability Claim Form” or “DCF” for disability claims and “DPMA Claimant Statement” for survivor benefit claims, or such successor forms as may be adopted by DPMA for claims purposes.

(p) “DPMA Disability Benefit” means the optional supplemental disability benefit payable by DPMA to an eligible DPMA participant, also referred to herein as the DPMA Benefit Payout.

(q) “DPMA/FNWAP Account” means the portion of the funds in the VEBA Trust associated with DPMA/FNWAP benefits. Pre-May 1, 2025 Amounts held in the DPMA Account are subject to the Exclusivity Rule. Post-April 30, 2025 Amounts held in the DPMA Account are not subject to the Exclusivity Rule.

(r) “Enhanced Disability Benefit (EDB)” means the additional disability benefit payable to a pilot with hours in their enhanced disability account administered by Delta.

(s) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

(t) “Exclusivity Rule” refers to the requirement that all Pre-May 1, 2025 Amounts held in either the DPMA Account or the DPMA/FNWAP Account be used exclusively to pay for benefits and administrative costs of Members of the pilot group associated with each Account (i.e., Pre-May 1, 2025 Amounts held in the DPMA Account must be used exclusively to pay for benefits and administrative costs for Members who are not FNWA Pilots and Pre-May 1, 2025 Amounts held the DPMA/FNWAP Account must be used exclusively to pay for benefits and

administrative costs for Members who are FNWA Pilots). Post-April 30, 2025 Amounts are not subject to the Exclusivity Rule and may be used (subject to the requirements under Article III, Section 2 to exhaust all Pre-May 1, 2025 Amounts before Post-April 30, 2025 Amounts may be used to pay benefits) at the Board's discretion to pay for benefits of any Member without regard to whether the Member is or is not a FNWA Pilot.

(u) "Event Date" means the date that a pilot is disabled under the terms of the Delta D&S Plan. This date is provided to DPMA by Delta.

(v) "Final Average Earnings" or "FAE" means the monthly average of a Member's highest 12 consecutive months of Normal Earnings out of the 36 months while on Active Payroll Status (including accident leave, sick leave and vacation) immediately preceding the Member's Disability (the "36-Month Period"). However, if the 36-Month Period contains a month during which the Employee was on inactive status for more than 15 days, then the Normal Earnings for the month following such month will be excluded from the determination of the FAE. In lieu of such excluded month, the 36-Month Period will be deemed to include the month immediately preceding the previously determined 36-Month Period and the Normal Earnings for such month (if they are part of the highest 12 consecutive months of normal earnings) shall be included in the determination of the FAE.

(w) "Former Northwest Airline Pilot" or "FNWA Pilot" means a pilot who was employed by NWA and became employed by Delta as a result of the merger between Delta and NWA in 2008.

(x) "Fund" means the Voluntary Employees' Beneficiary Association (VEBA) Trust maintained by DPMA for purposes of holding Plan assets and is made up of the DPMA Account and DPMA/FNWAP Account until such time as the Accounts may be merged into a single account. The merger of the DPMA Account and DPMA/FNWAP Account will not occur earlier than the date that both Accounts have exhausted all Pre-May 1, 2025 Amounts and will only happen, if ever, at the Board's sole discretion.

(y) "Inactive Payroll Status" means the status of a pilot who is furloughed, receiving benefits under the D&S Plan, military leave that exceeds 60 consecutive days, medical leave, personal leave, FMLA leave, maternity leave, or a pilot on a disciplinary suspension.

(z) "Medically Released for Flight Duty" means a Member has a valid FAA medical certificate to fly and Delta has notified DPMA of return to active status.

(aa) "Member" means:

(1) A Delta Pilot who has become a participant in the Plan pursuant to the provisions of Article II, and for so long as such membership has not terminated pursuant to the provisions of Article II; and

(2) A FNWA Pilot who has become a participant in the DPMA/FNWAP portion of the Plan pursuant to the provisions of Article II, and for so long as such membership has not terminated pursuant to the provisions of Article II.

(bb) "Normal Earnings" means the sum of Flight Pay, Flight Advance, Profit Sharing, and Shared Rewards.

(cc) "Northwest Airlines, Inc." or "NWA" means Northwest Airlines, Inc. as it existed prior to its merger with and into Delta as of the DCC.

(dd) "Officers of the Board" or "Officers" shall mean the Officers of the Board, as elected by the Board pursuant to Article III, Section 5 (b) and Article IV of the By-Laws.

(ee) "Pilot Resource Team" or "PRT" means the volunteer pilot members designated to assist the Board as subject matter experts (SMEs) in pilot disability matters, as provided in the By-Laws.

(ff) "Pilot Working Agreement" or "PWA" means the agreement between Delta pilots and Delta regarding compensation, benefits and work rules.

(gg) "Plan Year" means the calendar year.

(hh) "Plan Administrator" means the Board.

(ii) "Pre-May 1, 2025 Amounts" mean all amounts held in the DPMA Account or DPMA/FNWAP Account due to contributions received by the Fund prior to May 1, 2025, adjusted for investment earnings, expenses paid, and benefits paid.

(jj) "Post-April 30, 2025 Amounts" mean all amounts held in the DPMA Account or DPMA/FNWAP Account due to contributions received by the Fund after April 30, 2025 adjusted for investment earnings, expenses paid, and benefits paid.

(kk) "7-Day Waiting Period" means the first seven calendar days after the Event Date of a disability in which there are no Delta D&S benefits paid.

(ll) "Sick Leave of Absence" or "SLOA" means and is the first date on which a Member qualifies for DPMA disability benefits hereunder.

(mm) "Temporary Disability" or "TD" is a period of 26 weeks from the time a pilot calls in sick and runs concurrently with sick leave.

(nn) "Top-Up Benefit" or "Top-Up" means a benefit to a FNWA Pilot who remains disabled after having reached the benefit duration limits under the DPMA/FNWAP disability coverage (12-month single disability benefit limit or the lifetime 24-month limit) and whose number of hours remaining in the FNWA Pilot's NWA sick leave bank, as adjusted in the PWA is greater than zero.

(oo) "Trustee" means a Trustee under the VEBA Trust established to hold Plan assets and a member of the Board, as established under the By-Laws.

ARTICLE II

MEMBERSHIP

Section 1. Eligible Employees

(a) Delta Pilots. All Delta Pilots are eligible to participate as Members of the DPMA portion of the Plan, subject to the terms and conditions set forth herein.

(b) FNWA Pilots.

(1) All FNWA Pilots who were active on the DCC are eligible to participate as Members of the DPMA/FNWAP portion of the Plan, as a result of the PWA, subject to the terms and conditions set forth herein.

(2) Any FNWA Pilot who was employed by NWA on the DCC and was inactive on the DCC but who returns to active status thereafter shall be eligible to participate as a Member of the DPMA/FNWAP portion of the Plan pursuant to the terms of Section 2 below.

Section 2. Independent, Voluntary Membership

(a) The decision of a Delta Pilot to participate in the DPMA portion of the Plan is voluntary. Plan participants are free to terminate membership in the Plan at any time.

(b) The decision of a FNWA Pilot to participate in the DPMA/FNWAP portion of the Plan is voluntary. Plan participants are free to terminate membership in the Plan at any time.

(c) An individual will become eligible to participate in the Plan as follows:

(1) When an individual becomes a Delta Pilot;

(2) On the DCC, for FNWA Pilots who were active on the DCC; or

(3) On the day a FNWA Pilot returns to active status, for FNWA Pilots who were employed by NWA but were inactive on the DCC.

(d) Within a reasonable time after the date outlined in Subparagraph (c) above, DPMA shall provide such Delta Pilot or FNWA Pilot with: (1) notice of eligibility for Plan membership; (2) such information and forms as are appropriate to enable the pilot to ascertain whether membership in the Plan would be beneficial to such pilot; (3) such information and forms as are appropriate to enable the individual pilot to then elect or decline membership in the Plan; and (4) such information as is required by ERISA.

(e) Failure by a Delta Pilot or FNWA Pilot to exercise membership privileges within forty-five (45) days of receipt of notice of eligibility and enroll in the Plan shall result in permanent forfeiture of the privilege of membership in the Plan. Such forty-five (45) day period may be extended by the Officers if the Delta Pilot or FNWA Pilot at issue can demonstrate good reason for such extension, such as reasonable evidence that the

notices under subparagraph (d) above were not timely received by the Delta Pilot or FNWA Pilot.

Section 3. Voluntary Termination

Any Member may terminate membership at any time by giving thirty (30) days written notice to DPMA on such form of resignation as specified by DPMA. Benefit coverage will cease effective as of the pay period following the receipt by DPMA of such notice, but no more than thirty (30) days after the receipt by DPMA. Any pilot who voluntarily terminates membership in the Plan shall forever forfeit the privilege of again becoming a Member.

Section 4. Membership Following Termination of Employment

(a) Any Member whose employment with Delta is terminated shall cease to be a Member effective on the operative date of such termination of employment.

(b) Any Member whose employment with Delta was terminated shall be reinstated in the Plan as of the first day of their return to employment as a pilot with Delta provided such former Member is otherwise qualified for Plan membership under the provisions of the Plan.

Section 5. Inactive Membership Due to Leave of Absence, Disability, or Furlough

(a) Any pilot who is no longer contributing to DPMA because of SLOA, TD/LTD (Temporary Disability/Long Term Disability), LOA (Leave of Absence), MLOA (Military Leave of Absence), or furlough, and was otherwise a Member in good standing at the time of the status change, will be considered an inactive Member. (Exception: dues will be extracted from MLOA pilots' Profit Sharing payments.) Such pilot will remain an inactive Member of DPMA until return to active flight status, resignation from DPMA, retirement from Delta, attainment of FAA mandatory retirement age for commercial pilots, or other termination of employment with Delta.

(b) A Member who has been furloughed will be considered an inactive Member and is not eligible to receive DPMA benefits unless such pilot was receiving DPMA benefits at the time of furlough.

(c) Any Member receiving DPMA disability benefits at the time of furlough shall remain eligible for DPMA disability benefits under this Plan. Furloughees receiving DPMA benefits at the time of furlough will not be eligible for DPMA benefits during furlough pay. Upon cessation of furlough pay, DPMA benefits will resume, provided the Member is still disabled and will continue until return to active flight status, resignation from DPMA, retirement from Delta, attainment of FAA mandatory retirement age for commercial pilots, or other termination of employment with Delta, whichever is sooner.

(d) Any inactive Member shall be returned to active membership status as of the first day eligible to receive flight pay, provided such Member is otherwise qualified for DPMA membership under the provisions of this Plan.

Section 6. Termination for Nonpayment of Contributions/Excess Benefits

The Officers shall terminate the membership of any Member who fails to pay assessed contributions or otherwise fails to follow a payment schedule approved by the Officers for payment of assessed contributions. It is a Member's obligation to ensure that amounts for payment of DPMA contributions are being removed from a member's paycheck. If it is discovered (either by the Member or by DPMA) that such amounts were not removed from a Member's payroll in error, the Board shall offer the Member a reasonable method of payment of the contributions in arrears over a period of time. If a Member does not agree to such repayment, or if the Member does not advise the Board of the failure to have such amounts removed from their paycheck for a period exceeding a year, the Member will be deemed to have elected not to be a Member of DPMA.

The Officers shall terminate the membership of any Member who fails to repay any excess benefits received, and as determined by the Claims Committee.

Section 7. Termination Upon Retirement

Any Member who voluntarily retires from Delta shall, as of the effective date of such retirement, cease to be a Member and shall not be entitled to receive any disability or survivor benefits under the Plan on or after the actual date of retirement, except as otherwise provided.

Section 8. Termination Upon Attainment of FAA Mandatory Retirement Age for Commercial Pilots

Any Member who attains FAA mandatory retirement age for commercial pilots shall, as of the date of attainment of such age, cease to be a Member and shall not be entitled to receive any disability or survivor benefits under the Plan on or after such date.

Section 9. Termination of DPMA/FNWAP Based on the PWA

Participation by FNWA Pilots in the DPMA/FNWAP portion of the Plan is conditional, based on the provision of this benefit in the PWA. To the extent that such participation is no longer a provision of the PWA, the participation of FNWA Pilots in this program may be terminated, as determined by the Board.

ARTICLE III

FUNDING

Section 1. Member Contributions.

The source of funding to operate the Plan (including the payment of all benefits and expenses) is the monthly contributions of the Membership. Such contributions shall be paid at a rate determined to be sufficient to meet Plan obligations. The Board shall set the required monthly Member contributions as it deems necessary to meet current and anticipated commitments. The Board shall review the required monthly Member contributions at least annually to determine whether an adjustment is appropriate. DPMA has arranged with Delta for Member contributions to be made through payroll deductions and shall notify Members at once if they are required to pay their Plan contributions in any other manner.

Section 2. DPMA Funds

(a) DPMA Account. Contributions by or on behalf of all Members who are not FNWA Pilots shall be held in the DPMA Fund or DPMA Account. These funds shall be invested as directed by the Board or the Officers and disbursed by the DPMA office staff to meet operating expenses and to pay benefits under the terms of any DPMA trust or custodial agreement, the Plan, and applicable state and federal laws, including, without limitation, ERISA. Pre-May 1, 2025 Amounts held in the DPMA Fund or DPMA Account are subject to the Exclusivity Rule and, therefore, may only be used to pay for benefits and expenses related to Members who are not FNWA Pilots. All Pre-May 1, 2025 Amounts held in the DPMA Fund or DPMA Account shall be exhausted before any Post-April 30, 2025 Amounts held in the DPMA Fund or DPMA Account may be used to pay benefits. Post-April 30, 2025 Amounts are not subject to the Exclusivity Rule and may be used to pay for benefits and administrative costs of all Members without regard to FNWA Pilot status.

All returns on investments and expenses paid by the DPMA Fund or DPMA Account prior to May 1, 2025, shall be allocable solely to the Pre-May 1, 2025 Amounts. Thereafter, the Board shall apportion investment returns on and expenses paid by the DPMA Fund or DPMA Account between the Pre-May 1, 2025 and Post-April 30, 2025 Amounts. Apportionment shall occur on the last day of each Plan Year and on any other day determined at the sole discretion of the Board. The Board, in its sole discretion, may use any method of apportionment so long as the method employed allocates investment returns and expenses between the Pre-May 1, 2025 and Post-April 30, 2025 Amounts in a reasonable manner.

(b) DPMA/FNWAP Account. Contributions by all Members who are FNWA Pilots shall be held in a separate DPMA Fund referred to herein as the DPMA/FNWAP Fund or the DPMA/FNWAP Account. These funds shall be invested as directed by the Board or the Officers and disbursed by the DPMA office staff to meet operating expenses and to pay benefits under the terms of any DPMA trust or custodial agreement, the Plan, and applicable state and federal laws, including, without limitation, ERISA. Pre-May 1, 2025 Amounts held in the DPMA/FNWAP Fund or DPMA/FNWAP Account are subject to the Exclusivity Rule and, therefore, may only be used to pay for benefits

and administrative costs for Members who are FNWA Pilots. All Pre-May 1, 2025 Amounts held in the DPMA/FNWAP Fund or DPMA/FNWAP Account shall be exhausted before any Post-April 30, 2025 Amounts in the DPMA/FNWAP Fund or DPMA/FNWAP Account may be used to pay benefits. Post-April 30, 2025 Amounts are not subject to the Exclusivity Rule and may be used, subject to paragraph (c) below, to pay for benefits and administrative costs of all Members without regard to FNWA Pilot status.

All returns on investments and expenses paid by the DPMA/FNWAP Fund or DPMA/FNWAP Account prior to May 1, 2025, shall be allocable solely to the Pre-May 1, 2025 Amounts. Thereafter, the Board shall apportion investment returns on and expenses paid by the DPMA/FNWAP Fund or DPMA/FNWAP Account between the Pre-May 1, 2025 and Post-April 30, 2025 Amounts. Apportionment shall occur on the last day of each Plan Year and on any other day determined at the sole discretion of the Board. The Board, in its sole discretion, may use any method of apportionment so long as the method employed allocates investment returns and expenses between the Pre-May 1, 2025 and Post-April 30, 2025 Amounts in a reasonable manner.

(c) Merged Account. On or after the date that all Pre-May 1, 2025 Amounts have been exhausted from both the DPMA Fund or Account and the DPMA/FNWAP Fund or Account, the Board, in its sole discretion, may elect to merge the DPMA and DPMA/FNWAP Funds or Accounts into a single account from which all benefits and expenses under the Plan will be paid without distinction between any Member's FNWA Pilot status.

Section 3. Work Stoppage or Strike

Neither disability benefits nor survivor benefits will be paid from the Plan during a partial or total work stoppage, except to the extent specific funds are allocated or paid to provide disability benefits or to pay survivor benefits prior to or during a partial or total work stoppage. At the sole discretion of the Board, disability benefits or survivor benefits may be continued during a partial or total work stoppage for a period not to exceed sixty (60) days.

ARTICLE IV

BOARD OF DIRECTORS

The Board of Directors shall be the governing body of DPMA, the Plan, and the Trust. The "Board of Directors" and "Board of Trustees" shall be referred to synonymously herein as the "Board." The Board shall act as Trustee of any Plan Funds and shall also be responsible for the administration of the Plan. The Board may appoint such committees as it deems necessary and proper to administer the Plan and its Funds and may delegate responsibilities to such committees subject to the Board's supervision. Furthermore, the Board may delegate authority and responsibilities to administer the Plan and its Funds to the Officers and Operations Manager for the DPMA, subject to the Board's supervision.

ARTICLE V

RESERVED

ARTICLE VI

DUTIES OF THE PLAN ADMINISTRATOR

Section 1. Duties of the Board as Plan Administrator

(a) The Plan Administrator shall from time to time establish rules, not contrary to the provisions of the By-Laws and the Plan, for the administration of the Plan and the transaction of its business. All elections and designations to be made under the Plan by a Member or beneficiary shall be made on forms prescribed by the Plan Administrator.

(b) The Board shall have discretionary authority to construe the terms of the Plan and shall determine all questions arising in the administration, interpretation, and application of the Plan, including, but not limited to, those concerning eligibility for benefits, and it shall not act so as to discriminate in favor of any person. All determinations of the Board shall be conclusive and binding on all Delta Pilots, Members, and beneficiaries, subject to the provisions of the Plan and subject to applicable law.

(c) The Plan Administrator shall furnish Members and beneficiaries with all disclosures now or hereafter required by ERISA or the Code. The Plan Administrator shall file the various reports and disclosures concerning the Plan and its operations as required by ERISA and by the Code, and shall be responsible for establishing and maintaining all records of the Plan.

(d) The statement of specific duties for a Plan Administrator in this Section is not in derogation of any other duties that the Plan Administrator have under the provisions of the By-laws, the Plan, or under applicable law.

(e) The Board may delegate duties as Plan Administrator to the Officers, the Claims Committee, the Appeals Committee, the Operations Manager for the DPMA, or such other individuals or committees that it, in its discretion, forms for such purpose.

ARTICLE VII

DISABILITY BENEFITS

Section 1. Covered Disabilities

(a) Covered Disabilities. Subject to the exclusions provided in Article VIII and the other limitations provided herein, when a Member becomes disabled, either mentally or physically, while employed by Delta and is therefore unable to perform their duties as a pilot for Delta and is deprived of income, they shall be paid certain disability benefits.

(b) Initial Qualification for Benefits. To qualify for benefits, the Member must follow the claims procedure discussed in Article X.

(c) Notice of Disability Continuing. A DPMA Disability Claim Form (DCF) certifying a disability covered by the Plan must be submitted to the DPMA office. The DCF required under this Section is valid through the date indicated by the physician in the section “anticipated return to work date or length of disability.” If no date is indicated, DPMA will certify the member’s claim in accordance with the Disability Continuing Certification Table. The phrase, “medically released for flight duty” means the first day Delta considers the pilot eligible to begin receiving flight pay. Should the pilot elect not to return to flight duty at the time Delta considers or would consider the member eligible for flight pay, the pilot shall no longer qualify for DPMA benefits until such time as the pilot returns to flight duty and is eligible to receive flight pay from Delta.

Section 2. Term of Disability Benefits

Disability benefit payments for any disability period shall begin upon the expiration date of a Member's earned Delta sick leave or, if a pilot elects to file for Delta Disability benefits, the expiration of a Member’s enhanced disability benefit, whichever is later, and shall continue until the earliest of:

(a) The Member’s medical release for return to flight duty;

(b) The expiration of a period of 365 days of continuous disability beginning with the termination of earned Delta sick leave; or

(c) The date the member reaches FAA mandatory retirement age for commercial pilots, retires, or is terminated.

In all cases, the lifetime Plan benefits paid to any Member (including when a FNWA Pilot is eligible for Top-Up Benefits) for all disabilities arising during the duration of membership shall not exceed a total of 730 days of payments from any DPMA Fund or Account.

Section 3. Incapacity of Claimants

If DPMA shall find that any person to whom a benefit is payable is unable to care for their affairs because of any disability or infirmity, any payment due (unless a prior claim therefore shall have been made by a duly appointed representative of the claimant) may be paid to a spouse, child, parent, brother or sister, or to any person deemed by DPMA to have incurred

expenses for or on behalf of the disabled Member for such period. Any such payment so made shall completely discharge all liabilities owed by the Plan for the payment of disability benefits to such Member.

Section 4. Guardian

In the event a guardian of any Member receiving or claiming benefits shall be appointed by a court of competent jurisdiction, benefit payments may be made to such guardian, provided that proper proof of appointment and continuing guardianship is furnished in a form and manner acceptable to DPMA. Any such payment so made shall be a complete discharge of any liability by DPMA for the payment of disability benefits to such Member.

Section 5. Further Benefits for New and Unrelated Disabilities

If, following a period of disability for which benefits have been paid, a Member is medically released to return to flight duty and subsequently becomes sick or disabled from a cause not directly related to the previous disability (ICD-10 code to the thousandth decimal), they shall be entitled to further benefits up to the additional disability maximum of 365 days as provided by Section 2 above in this Article, subject to all other provisions of the Plan.

Section 6. Recurrence of Same Disability

If, following a period of disability for which benefits have been paid under the Plan, a Member is medically released to return to flight duty and does return to flight duty for a period of two (2) years or more, any subsequent disability resulting from the same condition (ICD-10 code to the thousandth decimal), will be regarded as a new disability for Plan purposes and Plan benefits will be paid without any reduction for those previously paid with respect to such disability. If said period following a disability should be less than two (2) years, disability for the same cause shall be regarded as one continuous disability, and the benefits paid on account of that disability shall be aggregated for purposes of applying the benefit maximum outlined in Section 2 above.

Section 7. Benefit Calculation

(a) Disability benefits for all members will be calculated in accordance with Appendix I.

(b) In situations where a member files for Delta D & S benefits, but no Delta Temporary Disability Plan or Delta Long-Term Disability Plan benefits are paid for disabilities, and the Plan specifically includes such disabilities, DPMA will pay, up to five (5) weeks, the benefit amount in accordance with Appendix I following the later of:

(1) Termination of Delta sick leave; or

(2) Termination of any Delta D&S Plan benefits.

After such five (5) week period, the DPMA disability benefits will be reduced to the amounts described in Appendix I.

Section 8. Prorating of Benefits

The Plan is a mutual aid plan and not an actuarially funded insurance plan. Therefore, Plan benefits may, of financial necessity, be prorated at the discretion of the Board.

Section 9. Repayment of Excess Benefits

If any Member is paid disability benefits in excess of those benefits provided by this Article:

(a) Upon becoming aware of such excess benefit payments, DPMA shall notify the Member in writing of the excess payment and the need of the Member to repay such excess;

(b) Within ninety (90) days after receipt of such notice from DPMA, the Member must either:

(1) Repay the excess; or

(2) Work with DPMA to establish a reasonable repayment plan acceptable to DPMA.

Section 10. Benefit Deductions

If a member has an outstanding dues or overpayment balance and subsequently files for additional benefits, that balance will be deducted from the member’s benefit payment.

ARTICLE VIII

DISABILITY BENEFIT EXCLUSIONS

Section 1. Exclusions

Benefits under any provision of the Plan are not available when payments for sickness or disability are caused by, contributed to, or related to:

(a) Injury, sickness, or death for which the Member knowingly and voluntarily does not seek proper and adequate medical care, absent sufficient justification that must be approved by the Claims Committee. Members shall follow recognized or accepted medical or surgical procedures as prescribed by a physician or surgeon who is duly licensed to prescribe and administer all drugs or to perform surgery. At the direction of the Officers, Members shall submit to examinations by doctors of the Officers' choosing. Failure to do so may result in a suspension or forfeiture of Plan benefits.

(b) War or Invasion while engaged in or taking part in military service or operations *except* military duties while actively employed by Delta and receiving salary from Delta. For Plan purposes, "War or Invasion" is defined as declared or undeclared armed aggression by one or more countries resisted by or on orders of any country, combination of countries, or international organization.

(c) Instances where Members are receiving benefits from Delta in excess of normal D&S Disability payments. (e.g., Delta paid Maternity Leave).

Section 2. Furlough or Leave of Absence

No DPMA disability benefits will be paid to a Member on furlough or leave of absence from Delta employment. However, a Member already receiving Plan benefits when a furlough begins shall nonetheless continue to be eligible for such benefits in accordance with the Plan terms.

Section 3. Retirement

Final benefits to an eligible and approved claimant may be made after the claimant has voluntarily retired from Delta but only for benefits accrued prior to the actual date of retirement. No benefit payments will be made for any disability for which a Member would have become eligible on or after, the day on which the member voluntarily retires from Delta.

Section 4. Attainment of FAA Mandatory Retirement Age for Commercial Pilots

Final benefits to an eligible and approved claimant may be made after the claimant has reached the FAA mandatory retirement age for commercial pilots but only for benefits accrued up to the FAA mandatory retirement age for commercial pilots. No benefit payments will be made for any disability for which a Member would have become eligible on or after the day on which the member attains the age of FAA mandatory retirement age for commercial pilots.

Section 5. Exclusions Applicable to Survivor Benefits

There are no exclusions for Survivor Benefits for eligible Members. During any period for which the Plan is providing survivor benefit coverage for Members as provided in Article IX, exclusions from coverage shall be determined by DPMA in accordance with the provisions of the Plan.

Section 6. Cessation of Membership

Final benefits to eligible and approved claimants will not be paid on or after, and no benefit payments will be made for any disability for which a Member would have become eligible on or after, the day on which the Member ceases to be a Member, except as noted in Article II, Section 5(c).

ARTICLE IX

SURVIVOR BENEFIT

Section 1. Coverage and Amount

(a) So long as it is economically prudent in the judgment of the Board, the Plan shall pay a survivor benefit to each Member's beneficiary or beneficiaries in the total amount of Thirty-Five Thousand Dollars ($35,000.00). The survivor benefit described in this Article shall be payable, consistent with the Plan, to the beneficiary, beneficiaries, trust, or estate of a Member who is on the Delta Pilots System Seniority List. DPMA shall assist the beneficiary or beneficiaries in submission of a claim to DPMA as soon as practical after receiving notification or otherwise becoming aware of a Member's death. Concurrently, DPMA will ascertain that the claim for the survivor benefit is proper and whether the benefit is payable under the provisions of the Plan.

(b) An active Member's beneficiary, beneficiaries, trust, or estate will be entitled to the survivor benefit, notwithstanding the Member's death after having previously exhausted all 730 days of disability benefits.

Section 2. Beneficiaries

Members shall be given the opportunity to designate a beneficiary for any survivor benefit. Such designation shall be made on a form provided by DPMA for such purpose. A Member's designation of a beneficiary is not effective until the Member provides such designation to DPMA; designations provided to DPMA after the Member's death shall be void and ineffective.

If a Member has not designated a beneficiary, DPMA shall name beneficiaries in the following order of priority to receive the benefits payable regarding the Plan survivor benefit:

(a) The Member's spouse;

(b) If the Member has no surviving spouse, the Member's children (including adopted children) or their descendants per stirpes;

(c) If the Member has no surviving spouse or lineal descendants, the Member's parents;

(d) If the Member has no surviving spouse, lineal descendants, or parents, the Member's siblings; and

(e) If the Member has no surviving spouse, lineal descendants, parents, or siblings, the Member's estate.

To the extent allowed under applicable State or Federal law, the priority of beneficiaries may be altered in consideration of physical, mental, or criminal circumstances of the Member's survivors at the sole discretion of the Officers.

Notwithstanding anything herein to the contrary, a Member's designation of their spouse as the Member's beneficiary made during the marriage shall become null and void if the marriage is subsequently legally dissolved. However, an affirmative designation by a

Member of a former spouse made subsequent to the legal dissolution of marriage, in absence of any other designation, shall be of full force and effect.

Section 3. Minors or Incompetent Beneficiaries

Whenever a Survivor benefit is to be paid to a minor or a person determined to be incompetent by qualified medical advice, the Plan Administrator need not require the appointment of a guardian or custodian, but will be authorized to pay the person having custody of such minor or incompetent for the benefit of the minor or incompetent beneficiary.

ARTICLE X

CLAIMS PROCEDURE

Section 1. Disputes

All disputes regarding matters not clearly addressed by the Plan and arising out of the operation of the Plan shall be resolved by a majority vote of the Board. Such vote shall be final and binding.

Section 2. Processing of Initial Claim

(a) Any Member or beneficiary (or a duly authorized representative of a Member or beneficiary) (a “Claimant”) may file a claim for a benefit to which the Claimant believes that they are entitled. Such claim must be in writing on the appropriate DPMA Disability Claim Form (DCF), and such DCF shall be executed by the Claimant acknowledging DPMA’s right of subrogation, reimbursement, and equitable liens, and delivered to the DPMA office, in person, by email or by mail, postage prepaid. The claim must be accompanied by evidence of the Member’s sickness or disability or death. No benefits provided under the Plan shall be paid unless a participant has first submitted the appropriate DCF for benefits to the DPMA office. The DCF shall be submitted to the DPMA office as soon as possible, but not later than 365 days after the commencement of the disability or the Member’s death.

(b) Submission of a DCF shall authorize DPMA to make a determination as to whether disability benefit payments should commence for the Member. Any member of the Claims Committee (or, if applicable, the Appeals Committee) may, at their discretion, request a letter of denial of an Airman Medical Certificate from the Federal Aviation Administration (hereinafter referred to as the "FAA") upon termination of payment of temporary or long term disability benefits under Delta’s D&S Plan before payment of additional Plan benefits. Members agree to authorize release of all personal, personnel, professional, or medical data pertinent to their disability and in accordance with federal law to DPMA as the Claims Committee or the Appeals Committee may request whenever DPMA finds it needs the information requested to satisfy its obligation to verify that a claim for benefits should be honored.

(c) Upon receipt of a properly documented claim and completion of any investigation described in subsection (b) above, DPMA may approve the disbursement of benefits provided under the Plan as soon as is administratively feasible unless the claim is denied. If the claim for benefits is denied, the procedures described in Section 3 of this Article will apply.

(d) Failure to Give Timely Notice. Failure of a Member or beneficiary to give notice of a claim within the time provided shall not invalidate a claim if it is established to the Claims Committee’s satisfaction that timely notice could not reasonably have been given.

(e) The Claims Committee may delegate review and approval of claims to an employee of DPMA.. Any claims recommended for denial will be submitted to the Claims

Committee for confirmation before such denial is communicated to the Member or beneficiary pursuant to Section 3 below.

Section 3. Procedure if Benefits are Denied

(a) Notice of Denial. If a Member or a beneficiary is denied a claim for benefits under the Plan, DPMA shall provide to the Claimant written notice of the denial within forty-five (45) days (ninety (90) days with respect to a denial of any claim for a survivor benefit) after DPMA receives the claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial forty-five (45)-day period. In no event shall the extension exceed a period of thirty (30) days (ninety (90) days with respect to a claim for survivor benefits) from the end of such initial period. With respect to a claim for disability benefits, an additional extension of up to thirty (30) days beyond the initial thirty (30)-day extension period may be required for processing the claim. In such event, written notice of the extension shall be furnished to the Claimant within the initial thirty (30) day extension period. Any extension notice shall indicate the special circumstances requiring the extension of time, the date by which DPMA expects to render the final decision, the standards on which entitlement to benefits are based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues.

(b) Contents of Notice of Denial. If a Member or beneficiary is denied a claim for benefits under the Plan, DPMA shall provide to such Claimant written notice of the denial which shall set forth:

(1) The specific reasons for the denial, including, if applicable, an explanation of the basis for disagreeing with or not following

(i) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; or

(ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

(iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

(2) Specific references to the pertinent provisions of the Plan on which the denial is based;

(3) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) An explanation of the Plan's claim review procedures, and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and notice that the Plan limits the time to bring a claim under the Sections to two years from the date of such adverse benefit determination, the requirement that any such civil action be brought in binding arbitration, and a conspicuous notice advising the Claimant that such arbitration is in lieu of their rights to litigate the claim in federal court;

(5) In the case of a claim for disability benefits, if an internal rule, guideline, protocol, standard, or other similar criterion ("Internal Criterion) is relied upon in making the adverse determination, either the specific Internal Criterion; or a statement that such Internal Criterion was relied upon in making the decision and that a copy of such Internal Criterion will be provided free of charge upon request; or, alternatively, a statement that such Internal Criterion does not exist; and

(6) In the case of a claim for disability benefits, if a denial of the claim is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, an explanation applying the terms of the Plan to the Claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request.

(c) Right to Review. After receiving written notice of the denial of a claim, a Claimant shall be entitled to:

(1) Receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(2) Submit written comments, documents, records, and other information relating to the denied claim to DPMA or the Appeals Committee, as applicable; and

(3) A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(d) Application for Review.

(1) If a Claimant wishes a review of the decision denying a claim to benefits under the Plan, other than a claim described in Subsection 2 below, the member must submit (in person or by mail, postage prepaid) a written application for review to the Appeals Committee at the DPMA office within one hundred eighty (180) days after receiving written notice of the denial. With respect to any such claim, in deciding an appeal of any denial based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental,

investigational, or not medically necessary or appropriate), the Appeals Committee shall:

(i) Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; and

(ii) Identify the medical and vocational experts whose advice was obtained on behalf of the Plan in connection with the denial without regard to whether the advice was relied upon in making the determination to deny the claim; and

(iii) Provide the Claimant, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan, insurer, or other person deciding the appeal. Such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on review is issued, so as to give the Claimant a reasonable opportunity to respond prior to that date.

Notwithstanding the foregoing, the health care professional consulted pursuant to this Subsection (1) shall be an individual who was not consulted with respect to the initial denial of the claim that is the subject of the appeal or a subordinate of such individual.

(2) If the Claimant wishes a review of the decision denying a claim for survivor benefits under the Plan, a written application to the Appeals Committee must be submitted at the DPMA office within sixty (60) days after receiving written notice of the denial.

(e) Hearing. Upon receiving such written application for review, the Appeals Committee may schedule a hearing for purposes of reviewing the Claimant's claim, which hearing shall take place not more than thirty (30) days from the date on which the Appeals Committee received such written application for review.

(f) Counsel. All Claimants requesting a review of the decision denying their claim for benefits may employ counsel for purposes of the hearing.

(g) Decision on Review. No later than forty-five (45) days (sixty (60) days with respect to a claim for survivor benefits) following the receipt of the written application for review, the Appeals Committee shall submit its decision on the review in writing to the Claimant involved and to their representative, if any, unless the Appeals Committee determines that special circumstances (such as the need to hold a hearing) require an extension of time, to a day no later than ninety (90) days (one hundred twenty (120) days with respect to a claim for survivor benefits) after the date of receipt of the written application for review. If the Appeals Committee determines that the extension of time is required, the Appeals Committee shall furnish to the Claimant written notice of the extension before the expiration of the initial forty-five (45) day (sixty (60) days with respect to a claim for survivor benefits) period. The extension notice shall

indicate the special circumstances requiring an extension of time and the date by which the Appeals Committee expects to render its decision on review. In the case of a decision adverse to the Claimant, the Appeals Committee shall provide to the Claimant written notice of the denial which shall include:

(1) The specific reasons for the denial, including, if applicable, an explanation of the basis for disagreeing with or not following

(i) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; or

(ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

(iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

(2) Specific references to the pertinent provisions of the Plan on which the decision is based;

(3) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(4) An explanation of the Plan's claim review procedures, and the time limits applicable to such procedures, including a statement of the Claimant's right to bring an action under Section 502(a) of ERISA following the denial of the claim upon review;

(5) In the case of a claim for disability benefits, if an Internal Criterion is relied upon in making the adverse determination, either the specific Internal Criterion; or a statement that such Internal Criterion was relied upon in making the decision and that a copy of such Internal Criterion will be provided free of charge upon request; or, alternatively, a statement that such Internal Criterion does not exist;

(6) In the case of a claim for disability benefits, if a denial of the claim is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, an explanation applying the terms of the Plan to the Claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request; and

(7) In the case of a claim for disability benefits, a statement regarding the availability of other voluntary alternative dispute resolution options.

Within forty-five (45) days after the receipt of such request for review, DPMA shall send to the Claimant, by mail, postage prepaid, notice of the grant or denial, in whole or part, of such appealed claim unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed sixty (60) days from the end of the initial forty-five (45) day period. If such extension is necessary, the Claimant shall be given a written notice to this effect before the expiration of the initial forty-five (45)-day period. DPMA shall have full discretion to deny or grant an appealed claim in whole or in part. If notice of the denial of an appealed claim is not furnished in accordance with this Section, the appealed claim shall be deemed denied.

(h) Statute of Limitations on Civil Action. No Claimant shall be permitted to commence any legal action to recover Plan benefits or to enforce or clarify rights under the Plan under ERISA Sections 502 or 510 or under any other provision of the law, whether or not statutory, unless such action is commenced before the expiration of two (2) years following the date of the last adjudication by the Appeals Committee.

(i) Arbitration. Any civil action by a Claimant under ERISA Sections 502 or 510 or under any other provision of the law, whether or not statutory, must be brought through binding arbitration pursuant to this Section.

(1) Any arbitration under this Section shall be brought according to the Commercial Arbitration Rules of the American Arbitration Association.

(2) The Claimant must file with the Board a notice that it intends to arbitrate the claim within the Statute of Limitations identified in Subparagraph (h) above.

(3) Upon receipt of such notice, a good faith attempt shall be made by the Board and the Claimant to choose a mutually acceptable arbitrator. If this cannot be accomplished within sixty (60) days of the date of the notice of arbitration by the Claimant under Subparagraph (h) above, the Board will provide notice to the Claimant of this failure, and will notify the Claimant of the alternate procedure under subsection (D) below. The deadline to select a mutually acceptable arbitrator may be extended by the Board in its sole discretion beyond the sixty (60) day period if the Board reasonably concludes that such process will be successful with additional time.

(4) In the absence of the selection of a mutually acceptable arbitrator by the Claimant and the Board, the matter will be adjudicated by a three-person arbitration panel, as follows: one arbitrator shall be chosen by the Board, one chosen by the Claimant, and one chosen by the other two selected arbitrators. If any party does not select an arbitrator within the thirty (30) day period following the provision of notice by the Board to the Claimant of the need for such a selection under Subparagraph (3) above, the failure will constitute a waiver of the right to select an arbitrator and the arbitrator selected by the other party will arbitrate the matter.

(5) The arbitrator or arbitration panel, as applicable, shall provide a written statement of its decisions, as well as the reasons upon which the decisions were made.

(6) The costs of arbitration (including, but not limited to, the fees charged by the arbitrator and any fees related to the arbitration process, but not including the costs of attorneys' fees for either the Plan or the Claimant) shall be shared equally between the Plan and the Claimant unless the arbitrator (or arbitration panel) finds that there was a breach of fiduciary duty by the Board, in which case the Plan shall pay for such costs.

(j) Deemed Exhaustion.

(1) In the case of a claim for disability benefits, if the Plan fails to strictly adhere to all the requirements of 29 CFR 2560.503-1 with respect to a claim, the Claimant is deemed to have exhausted the administrative remedies available under the Plan and is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(2) The administrative remedies available under the Plan with respect to claims for disability benefits will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. If the Claimant requests a written explanation of the violation, the Plan will provide such explanation within 10 days, including the basis for asserting that the violation should not cause the administrative remedies to be deemed exhausted.

(k) Rules for Non-English Notices. If the Plan determines that a Claimant resides in a United States county in which ten percent or more of the residential population is literate in only the same non-English language, the Plan will provide the following services and communications in the applicable non-English language:

(1) Oral language services, including answering questions and assisting with filing claims and appeals;

(2) A notice, provided upon request;

(3) Any notification of a denial of the claim or decision on review; and

(4) A statement on all English versions of notices indicating how to access the language services provided by the Plan.

ARTICLE XI

SUBROGATION, REIMBURSEMENT, AND OFFSET

Section 1. General Provisions and Definitions

The Plan has a right to Subrogation and Reimbursement. For purposes of this Article, the definitions provided below will apply. Capitalized terms used in this Article not defined below have the same definitions as used in the Plan generally.

(a) "Recovery," "Recovered," "Recover," and "Recoveries" mean all amounts paid or payable by a Third Party to the Member or Related Party due to an Injury or Illness. Such amounts include, but are not limited to, proceeds from insurance (including, but not limited to, medical insurance, underinsured or uninsured motorist protection, no-fault or traditional automobile insurance, homeowners' insurance), payments from a third-party administrator, workers' compensation coverage (whether or not insured), damages awarded by any court or arbitrator, settlements, judgments, and payments from Third Parties.

(b) "Related Party" means a Member's beneficiary, heir, estate, and representative.

(c) "Cause" means any affirmative act or omission by a Third Party.

(d) "Injury" or "Illness" means an injury or illness or multiple injuries or illnesses that are: (i) suffered by a Member; (ii) Caused or allegedly Caused by a Third Party or for which a Third Party is or may be responsible; (iii) which results or may result in payments from the Plan to the Member or a Related Party.

(e) "Subrogation" means that the Plan is substituted to and will succeed to any and all legal and equitable claims that a Member and Related Party may be entitled to pursue against any Third Party for an Injury or Illness. The Plan has a right to Subrogation when the Plan has paid or may pay benefits related to an Injury or Illness.

(f) "Reimbursement" means the Plan's right to be reimbursed by the Member or Related Party where the Member or Related Party obtains a Recovery. The Plan has a right to Reimbursement when the Plan has paid or may pay benefits related to an Injury or Illness. Members and Related Parties must use Recoveries to fully return to the Plan 100% of any benefits paid by the Plan related to an Injury or Illness. The right of Reimbursement will apply to Recoveries at all times until the Plan's rights are extinguished, resolved, or waived in writing by the Plan.

(g) "Third Party" or "Third Parties" mean the following:

(1) Any person or entity that Caused or is alleged to have Caused the Injury or Illness.

(2) Any person or entity legally responsible for the Injury or Illness.

(3) Any insurer or other indemnifier of any person or entity who Caused or is alleged to have Caused the Injury or Illness.

(4) The Member's employer in a Workers' Compensation case or other matter alleging liability due to an Injury or Illness.

(5) Any person or entity who is or may be obligated to provide benefits, compensation, payments, or any award to the Member or a Related Party due to an Injury or Illness.

(6) Any person or entity against whom the Member may have any claim for professional and/or legal malpractice arising out of or connected to an Injury or Illness.

(7) Any person or entity that is liable for payment to the Member or Related Party related to an Injury or Illness on any equitable or legal liability theory.

(8) Any agent or representative of any person or entity that is a Third Party.

Section 2. The Member's Obligations

(a) Cooperation Required. The Member and Related Parties will cooperate with the Plan in protecting the Plan's Subrogation and Reimbursement rights in a timely manner. Cooperation shall include, but is not limited to:

(1) Notifying the Plan, in writing, of any potential claim(s) the Member and Related Parties have against any Third Party for an Injury or Illness.

(2) Providing any information requested by the Plan that is related to an Injury or Illness or that the Plan deems to be potentially related to an Injury or Illness.

(3) Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the Plan's Subrogation and Reimbursement rights. For example, the Member or Related Party shall execute, upon demand by the Plan, written directions to a Third Party to pay directly to the Plan any amount that would otherwise constitute Recovery if paid to the Member or Related Party.

(4) Responding to requests for information about any accident or injuries.

(5) Making court appearances.

(6) Obtaining the Plan's written consent or the Plan's agents' written consent before releasing any Third Party from liability or payment of medical expenses.

(7) Complying with the terms of this Article.

(b) Failure to Cooperate. The Member's or a Related Party's failure to cooperate with the Plan constitutes a breach of contract. Where a Member or Related Party fails to cooperate with the Plan (as provided for under Section 2(a) of this Article), the Plan has the right, at the Plan's sole discretion, to terminate or deny future benefits, take legal action against the Member or Related Party, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Injury or Illness to the extent not recovered by the Plan. If the Plan incurs attorneys' fees and costs to collect any Recovery held by the Member or Related Party, the Plan has the right to recover its fees and costs from the Member or Related Party. The Member or Related Party will also be required to pay interest on any Recovery the Member or Related Party holds that should have been returned to the Plan; interest shall accrue beginning on the 15th calendar day following receipt of Recovery by the Member or Related Party (or upon demand from the Plan, if sooner). Interest shall accrue at the rate of seven percent per annum.

(c) The Member agrees that the Plan has an equitable lien on any amounts that may be Recovered or that are Recovered. Any Recovery that comes into possession of the Member or a Related Party is immediately subject to a constructive trust, the terms of which require the Member and/or Related Party to hold the Recovered funds in a separate bank account created for the sole purpose of holding the Recovered funds until such time as the funds are distributed to the Plan in satisfaction of the Plan's right to Reimbursement. The Recovered funds held in the constructive trust shall not be used for any purpose other than payment to the Plan until such time as the Plan has been completely reimbursed for benefits it paid stemming from the Injury or Illness. The Member or Related Party shall not deposit any amounts into the bank account that are not Recovered amounts.

(d) By participating in the Plan, the Member agrees on their own behalf and on behalf of any Related Party that:

(1) Any Recovery constitutes Plan assets to the extent the amounts Recovered do not exceed the Plan benefits paid or payable to the Member or Related Party;

(2) The Member and Related Party will be fiduciaries of the Plan (within the meaning of ERISA) with respect to any Recovery; and

(3) The Member and Related Party will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) incurred by the Plan to enforce its Reimbursement rights.

(e) Upon the Plan's request, the Member and Related Party will assign to the Plan all rights of recovery against Third Parties to the extent that the Plan has paid or may pay benefits for an Injury or Illness.

(f) The Member and Related Party are prohibited from accepting any settlement that does not fully reimburse the Plan, without the Plan's prior express written approval.

(g) No allocation of damages, settlement funds, or any other Recovery related to an Injury or Illness will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

Section 3. The Plan's Rights

(a) First Priority Right to Receive Payment. The Plan has first priority right to receive payment on any claim or potential claim against a Third Party before the Member or any Related Party receives payment from that Third Party. Further, the Plan's first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or Recovered from an allegedly responsible Third Party and/or insurance carrier.

(b) The Plan's Subrogation and Reimbursement rights apply to full and partial settlements, judgments, or other Recoveries paid or payable to the Member or Related Party no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages.

(c) The Plan is not required to help the Member (or Related Party) pursue the Member's claim (or Related Party's claims) for damages or personal injuries and no amount of associated costs, including attorneys' fees, will be deducted from the Plan's recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" or similar doctrine will apply.

(d) Regardless of whether the Member or Related Party has been fully compensated or made whole, the Plan may collect from the Member or Related Party the proceeds of any full or partial Recovery, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit the Plan's Subrogation and Reimbursement rights.

(e) The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under this Article, including, but not limited to: (1) providing or exchanging medical payment information with an insurer, the insurer's representative, or other Third Party; (2) filing an ERISA reimbursement lawsuit to recover from any Recovery the full amount of Plan benefits the Member receives for an Injury or Illness; and (3) filing suit in the Member's name or the names of one or more Related Parties, which does not obligate the Plan in any way to pay the Member or Related Party part of any award or settlement the Plan might obtain. The Plan may bring an ERISA reimbursement lawsuit stemming from a Member's or Related Party's refusal to refund Plan benefits as required under the terms of the Plan for a period of three years from the date that the Member or Related Party fails or refuses to refund the Plan benefits (or if later, from the date that the Plan initially learns that the Member or Related Party failed to or refused to refund the Plan benefits).

(f) The Plan may deem benefits paid by the Plan related to an Injury or Illness to be benefits advanced.

(g) Where the Member's or Related Party's own action(s) or failure(s) to act renders the Member or a Related Party unable to obtain a Recovery or where the Member or Related Party failed to provide the Plan with sufficient information about an Injury or Illness to enable the Plan to have adequate time to prepare for and bring a claim (i.e., to assert its Subrogation rights) against the Third Party that Caused (or allegedly Caused) the Injury or Illness, the Plan may demand and, upon demand, the Member or Related Party shall pay to the Plan an amount equal to the benefits paid by the Plan to the Member or Related Party as a result of the Injury or Illness. The Plan may demand such payment or bring legal action to obtain the payment for a period of three years beginning on the date that the Plan initially learns of the Member's or Related Party's action or failure to act or failure to provide sufficient information. For purposes of this paragraph, an adequate time to prepare for and bring a claim shall be deemed to be a period that is at least six months prior to the date that the Member or Related Party's right to assert a claim against the Third Party expires (i.e., the date that the statute of limitations expires).

(h) To the extent that the Recovery received in a settlement and release of claims approved by the Plan is less than the full amount of Plan benefits paid to the Member or a Related Party in relation to the Illness or Injury, the amount Recovered shall be fully available for Reimbursement and the Plan will not seek Reimbursement for any additional amount from the or the Related Party or Subrogate claims against the Third Party that settled the claim. However, if the Plan has not approved the settlement and release of claims entered into by the Member or Related Party, the Plan's claims for Reimbursement from the Member or the Related Party and right to Subrogate claims against the Third Party will not be affected by such settlement or release of claims.

(i) If any Third Party Causes or is alleged to have Caused the Member to suffer an Injury or Illness while the Member is covered under this Plan, the provisions of this Article continue to apply, even after the Member is no longer covered by the Plan.

(j) The Plan has authority and discretion to enforce the Plan's rights under this Section 3. The Plan has authority and discretion to take any actions against a Member or Related Party provided for under Section 2.

(k) Where the Plan Administrator determines that there is sufficient equitable, legal, or other considerations, the Plan Administrator has authority and discretion to waive, in whole or in part, the Plan's claims or rights under this Article. The Plan Administrator's waiver of a claim or right under this Article shall not constitute a waiver of any other claim or right that the Plan may have under this Article or the Plan, either in relation to the Member or Related Party for whose benefit the claim or right was waived or for any other Member or Related Party.

(l) The Plan Administrator (and its delegates in relation to this Article) have such powers and duties as are necessary to discharge its duties and functions, including authority and discretion to:

(1) construe and enforce the terms of this Article including the Plan's Subrogation and Reimbursement rights; and

(2) make determinations with respect to the Subrogation and Reimbursement amounts owed to the Plan.

Section 4. Restoration of Benefits

(a) The gross amount of the Plan benefit payments that are subsequently returned to the Plan pursuant to the Plan's rights under this Article will be used to restore to the Member's benefits. The gross amount returned to the Plan will be converted to days using the daily payout used to calculate the Member's benefit.

ARTICLE XII

GENERAL

Section 1. Interests Not Transferable

The interests of the Members and their beneficiaries under the Plan are not subject to the claims of their creditors and may not be voluntarily or involuntarily transferred, assigned, alienated, or encumbered without the written consent of the Officers.

Section 2. Gender and Number

Except when otherwise indicated by context, words in the masculine gender shall include feminine gender, plural shall include singular, and singular shall include plural.

Section 3. Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. DPMA shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided by Plan provisions.

Section 4. Headings

All Article and Section headings in the Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

Section 5. No Vested Interests

The Plan does not create vested interests for any individual. During active membership in the Plan, Members may be entitled to disability and or survivor benefits. However, upon termination of a Member’s membership, neither the former Member nor any Member of their family or other beneficiaries shall have any right or enforceable interest in the former Member's contributions hereunder, in the funds accumulated in any Account, or benefits that the former Member might have been eligible to receive under the terms of the Plan while a Member. DPMA reserves the right to change the amount of benefits due to any Member whether or not the member is currently receiving DPMA benefits. No Member has any vested, grandfathered, or expectant interest in the amount of benefits to be paid under Appendix I or any replacement and/or successor version of the Appendix.

Section 6. Waiver and Estoppel

No term, condition, or provision of the Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Member or beneficiary other than as named in the waiver shall be entitled to rely on the waiver for any purpose.

ARTICLE XIII

AMENDMENTS TO PLAN

Amendments to the Plan may be adopted by the affirmative vote of two-thirds (2/3) of the members of the Board then in office and shall become effective as of the date specified in the enabling resolution. The Officers may at any time, in their sole discretion, adjust, modify, or change the benefit provision presented in Appendix I of the Plan. Appendix I describes the current DPMA Benefit Payout. It is subject to change at any time based on the Officers' judgment as to what specific benefit structure should be in place, based on factors such as the number of Members currently receiving Plan benefits, the investment returns of the Trust, projected future benefit costs, and what benefit structure is consistent with the goals of and ability of the Plan to pay disability benefits at a level that does not financially impair DPMA or the Plan.

The Board shall have the right to amend the Plan in any and all respects at any time, without prior notice to any Member or beneficiary; provided, however, that no amendment shall divert Trust funds or assets (if any) from the exclusive purpose of paying obligations of the Plan, as provided by the Plan provisions.

DPMA shall notify all covered Members of any amendment modifying the substantive terms of the Plan as soon as is administratively feasible after its adoption, but in no event later than two hundred ten (210) days after the close of the Plan Year in which the amendment has been adopted (or at such other time as is prescribed by ERISA and any regulations thereto). Such notification shall be in the form of a Summary of Material Modifications, unless incorporated in an updated Summary Plan Description.

ARTICLE XIV

TERMINATION OR ADOPTION BY OTHER GROUPS

Section 1. Plan Termination

(a) The Plan may be terminated at any time by the affirmative vote of two-thirds (2/3) of the Board then in office. The Officers shall notify all Members and eligible dependents covered under the Plan of its termination as soon as is administratively feasible, but no more than sixty (60) days after the last effective date of the Plan provisions.

(b) The portion of the Plan developed for the FNWA Pilots hereunder may be terminated if said portion is no longer funded in accordance with the PWA.

Section 2. Adoption by Additional Organizations

(a) Any additional organization of pilots that joins Delta or a successor company may be permitted to adopt the Plan as a participating group if such adoption is approved by written resolution by at least two-thirds (2/3) of the Board. The Board, before proffering eligibility in the Plan to such participating group, has the sole and complete discretion to adopt any and all necessary benefit or funding policies that set forth the benefits of existing Members and the benefits that prospective new Members would receive following the inclusion of such group in the Plan.

(b) Because every contingency or issue cannot be anticipated, the Officers are hereby given broad and complete discretion to resolve any and all issues concerning benefit-related questions pertaining to, or following, adoption of the Plan by another participating group. This authority includes but is not limited to the establishment of terms, conditions, or prerequisites that must be satisfied or agreed to in writing by any other group wishing to adopt the Plan before such adoption is permitted. Such authority is subject to any formal agreement made between DPMA and Delta or such other entity that is representing the other participating group.

(c) Notwithstanding the foregoing, none of the Pre-May 1, 2025 Amounts in the DPMA Account shall be used for the provision of benefits to FNWA Pilots. For the avoidance of doubt, all Post-April 30, 2025 Amounts may be used under this Section for all Members without regard to FNWA Pilot status.

Section 3. Distribution of Assets on Termination

(a) In the event of the termination of the Plan, the Board shall act as agent for the Members in disposing of and distributing all assets in any DPMA Fund or Account. Distributions shall be made in the following order or priority:

(1) The payment of all accrued and outstanding liabilities for administrative expenses;

(2) The payment of pending survivor benefit claims;

(3) The payment of up to 90 days' disability benefits to all Members then receiving disability benefits; and

(4) The payment to all Members in good standing with DPMA of their pro rata share of any remaining assets.

For purposes of subparagraph (4) above, the pro rata share of each Member shall be determined by the percentage which such Member's contributions during the six (6)-month period immediately preceding the termination bears to the total contributions made by all Members during such six (6)-month period.

(b) The allocations performed in this Section shall be done separately for the DPMA Account and the DPMA Account with respect to Pre-May 1, 2025 Amounts . None of the Pre-May 1, 2025 Amounts in the DPMA Account shall be available to pay benefits to FNWA Pilots. For the avoidance of doubt, all Post-April 30, 2025 Amounts may be used under this Section for all Members without regard to FNWA Pilot status.

Christine F.L. Holliday
Chairman, DPMA

Appendix I

DPMA BENEFIT CALCULATIONS

The DPMA Disability Benefits will be reviewed and established annually by the Board. The disability benefits are defined as follows:

(a) **Normal Benefit**: A Member who transitions to SLOA following the 7-Day Waiting Period will receive a benefit equal to FAE x 25%.

(b) **Enhanced Benefit**: A Member who transitions to SLOA within the 7-Day Waiting Period will receive a benefit equal to FAE x 70.3%. This benefit applies for the number of days the Member does not receive Delta D&S Plan benefits up to seven (7) days of SLOA, then reverts to the Normal Benefit (see Note 1).

Note 1: In situations where a Member files for Delta D&S Plan benefits, but no D&S Plan benefits are paid, DPMA will pay the Enhanced Benefit for up to five (5) weeks, following the latter of:

(1) Termination of Delta sick leave; or

(2) Termination of any Delta D&S Plan benefits.

After such five (5) week period, the DPMA Disability Benefit will be reduced to either the Normal Benefit or the New Hire Benefit, as applicable.