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**UNITED STATES BANKRUPTCY COURT  
SOUTHERN DISTRICT OF NEW YORK**

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: **In re:** :  
: : **Chapter 11 Case No.**  
: : **DELTA AIR LINES, INC., et al.,** : **05-17923 (PCB)**  
: : **Debtors.** : **(Jointly Administered)**  
: :  
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**DECLARATION OF ROBERT L. KIGHT IN SUPPORT OF DEBTORS'  
(1) LIMITED OBJECTION TO DP3 AMENDED MOTION AND DALRC  
APPLICATION FOR APPOINTMENT OF RETIREMENT COMMITTEES  
UNDER SECTION 1114, AND (2) OBJECTION TO DALRC APPLICATION TO  
AUTHORIZE EMPLOYMENT OF COUNSEL**

Robert L. Kight, declares and says:

1. I am Vice President, Compensation and Benefits, of Delta Air Lines, Inc. (“**Delta**”). I was first employed by Delta in 1985 as a Human Resources Analyst. Since that time, I have held various positions and titles in the Human Resources area at Delta. I left Delta’s employment in January of 2000 and returned in June of 2004. Earlier this year, I was named to my current position of Vice President, Compensation and Benefits.

2. I submit this declaration on behalf of Delta and those of its subsidiaries that are debtors and debtors in possession in these chapter 11 cases (collectively, the “**Debtors**”) in support of the Debtors’ (1) limited objection to the amended motion of DP3, Inc. d/b/a/ Delta Pilots’ Pension Preservation Organization (“**DP3**”) to appoint an official committee of retired pilots and the application of the Delta Air Lines Retirement Committee (“**DALRC**”) for an order to appoint a non-pilot retiree committee, and (2) objection to the application of DALRC to authorize employment of counsel. In particular, I submit this declaration to provide the Court with an overview of certain aspects of Delta’s retiree benefits and to address certain factual issues raised in the papers submitted by DALRC with respect to its application for an order to appoint a non-pilot retiree committee.

3. As Vice President, Compensation and Benefits, among other duties, I lead the department responsible for most aspects of Delta’s active and retired employee health and welfare plans, including the design and administration of Delta’s health-care, life insurance, disability and survivorship plans, and the communication of benefits programs and initiatives to active and retired employees.

4. Except as otherwise indicated, all facts set forth in this declaration are based upon my personal knowledge, my review of relevant documents, information provided to me by

persons working under my supervision, persons working in other areas of Delta and certain professionals retained by Delta, or my opinion based upon my experience, knowledge, and information concerning Delta's human resources practices and procedures. If called upon to testify, I would testify competently to the facts set forth in this declaration.

### **Health-Care Benefits for Active and Retired Employees**

5. Since at least the early 1970s, Delta has offered active and eligible retired U.S.-based<sup>1</sup> employees, their spouses, and eligible dependents a variety of fully paid or heavily subsidized health and welfare benefits, including health-care, life insurance, disability, and survivor plans.<sup>2</sup> Delta currently offers health-care benefits to its approximately 51,000 active and 32,500 eligible retired employees.<sup>3</sup> These 83,500 individuals (the “**Primary Participants**”) are provided the ability to cover their eligible dependents (Primary Participants and their eligible dependents together, the “**Beneficiaries**”). Subject to certain eligibility criteria, dependents are generally the spouse or domestic partner of the Primary Participant and their minor, dependent children.

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<sup>1</sup> Throughout this Declaration, references to employees and retirees will include only U.S. payroll-based employees.

<sup>2</sup> This Declaration focuses on health-care benefits, which are the costliest component of the health and welfare benefits offered by Delta to its retirees. The other two principal components of such benefits are modest life insurance benefits and survivor benefits that are pre-funded for at least the next several years through a tax-advantaged trust. Substantial life insurance benefits exist for approximately sixty former executives.

<sup>3</sup> Certain employees on “inactive” status due to leave of absence, disability status, or furlough are offered essentially the same health-care benefits as active employees. Except as otherwise indicated, these individuals are included among the references to and data for active employees in this Declaration.

Some surviving spouses and children of employees who died while on active status or after retirement remain eligible to elect health-care coverage after the death of the retiree or employee. Except as otherwise indicated, these individuals are included among the references to and data for retired employees in this Declaration. In light of the continually changing composition of the various populations addressed herein, all figures in this Declaration are necessarily approximate.

6. Currently,<sup>4</sup> approximately 45,000 active Primary Participants and 27,000 retired Primary Participants have elected to enroll in health-care coverage provided by Delta (with the other 11,500 choosing to “opt out” of coverage for the year), and together they cover approximately 64,000 qualifying dependents of active Primary Participants and 19,500 qualifying dependents of retired Primary Participants, for a total of approximately 155,500 covered individuals, as set forth below:

**Delta Health-Care Enrollments**

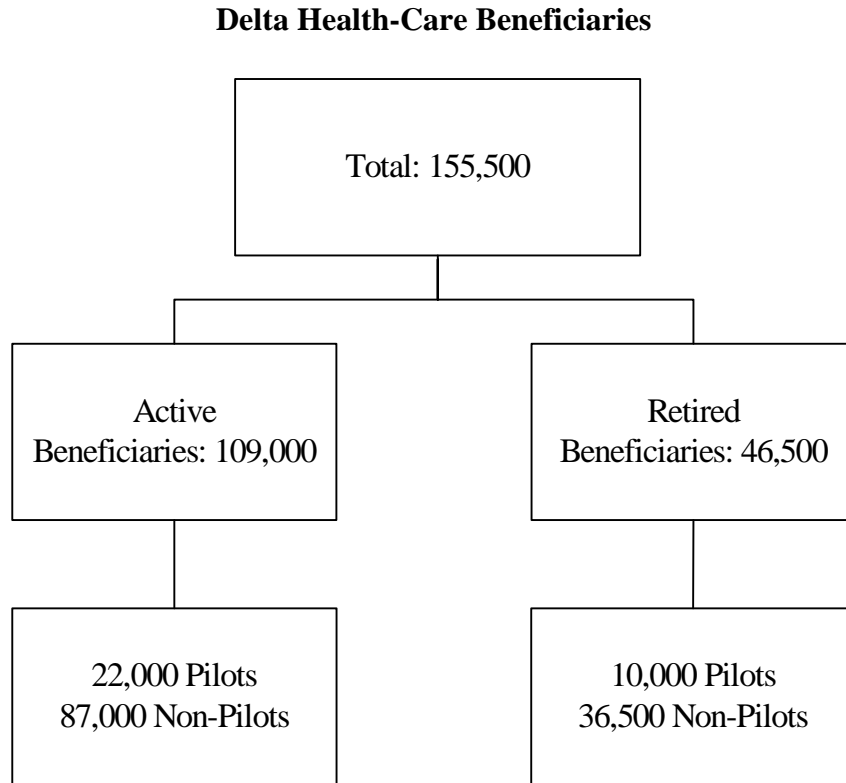
	<u>Actives</u>	<u>Retirees</u>	<u>Total</u>
<i>Primary Participants</i>	45,000	27,000	72,000
<i>Dependents</i>	64,000	19,500	83,500
<i>Total Beneficiaries</i>	109,000	46,500	155,500

7. Of the retired Primary Participants enrolled in health-care coverage, (a) approximately 5,000 are retired pilot Primary Participants and 22,000 are retired non-pilot Primary Participants, and (b) approximately 16,000 are under age 65 (Medicare ineligible) and 11,000 are age 65 or over (Medicare eligible).

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<sup>4</sup> Late in each year, Primary Participants are offered an “open enrollment” period during which they choose, on behalf of themselves and their dependents, among healthcare options, including a choice to have no coverage under Delta’s health-care plans for the following year. With very few limitations, those choosing no coverage for a particular year may elect to re enroll in Delta’s plans for later years without the requirement of providing evidence of insurability or being subject to any pre-existing conditions limitations.

8. The following chart summarizes the various categories of Delta health-care beneficiaries:



9. The costs of Delta health-care benefits for active and eligible retired Beneficiaries are generally not covered by insurance purchased by Delta. Instead, after Delta collects premiums from active and retired Primary Participants and after Beneficiaries pay certain co-payments, deductibles, and coinsurance payments directly to providers (co-payments, deductibles and co-insurance together the “**Out-of-Pocket Charges**”), all remaining costs are paid directly by Delta. Such costs include both the actual claims for health-care services provided to Beneficiaries as well as the costs to administer the Plans.

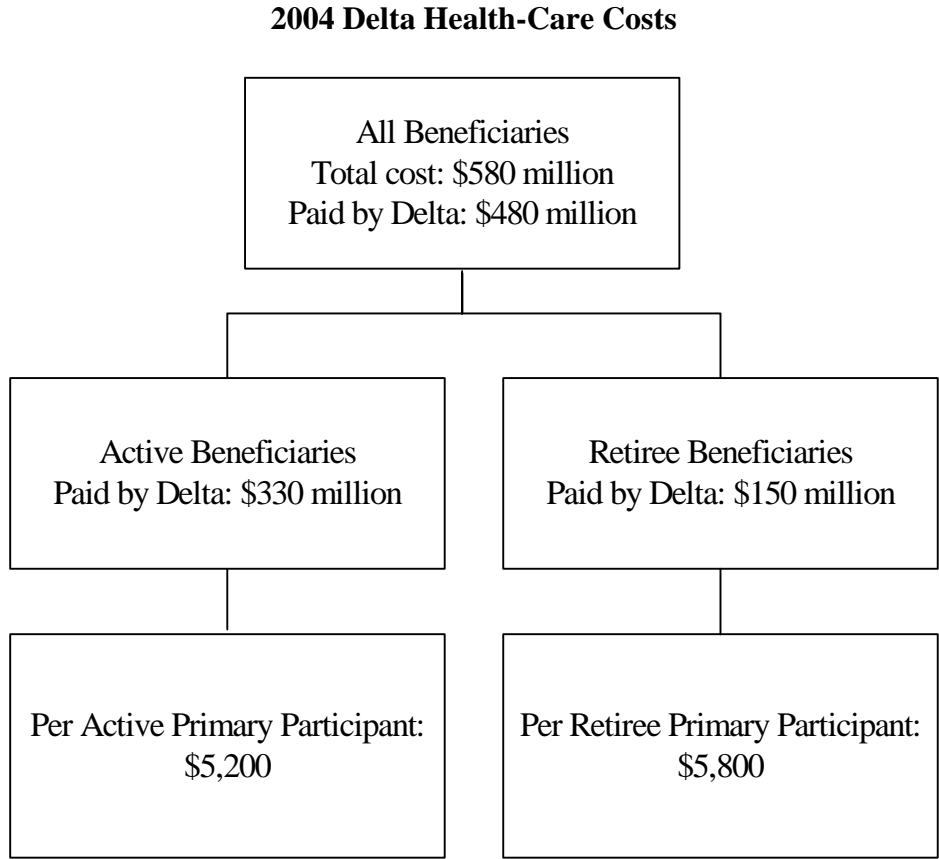
10. For calendar year 2004,<sup>5</sup> total health-care costs for Delta active and retiree Beneficiaries were approximately \$580 million, including employee and retiree premiums, administrative and claims costs but excluding Out-of-Pocket Charges. Of that amount, approximately \$100 million was collected in premiums and Delta itself paid roughly \$480 million. \$150 million of this latter amount was paid by Delta for retiree Beneficiary health-care benefits.

11. On average in 2004, Delta paid approximately \$5,200 per active Primary Participant and \$5,800 per retired Primary Participant. The cost for pre-65 retirees will generally be much greater than that for Medicare eligible retirees since Delta health-care programs pay second to Medicare benefits for Beneficiaries age 65 and over, and thus do not provide the main comprehensive coverage for these Beneficiaries other than for prescription drugs.

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<sup>5</sup> 2004 is the last complete year for which data is available.

12. The following chart summarizes the 2004 approximate costs of Delta health-care programs, excluding Out-of-Pocket Charges:



13. As with many group health plans, Delta’s health-care plan costs are driven by a relatively small number of beneficiaries with costly health-care needs. For example, in 2004, about 1.5% of Delta health-care plan Beneficiaries accounted for almost 33% of claim costs, and 5.5% accounted for 55% of claim costs. That same year, by contrast, the 42% of Beneficiaries with the lowest claims represented but 3% of claim costs.

14. Given these circumstances and other factors, Delta has increasingly focused the design of its health care program on encouraging preventive care and “consumerism” among

beneficiaries. As my department reported to non-pilot active employees in a September 21, 2005 “Fact Sheet” on the upcoming changes to health-care benefits:

Good health care spending choices by our employees and proactive care management programs are beginning to pay dividends. A moderate increase in shared costs is unavoidable due to rising health care inflation and Delta’s serious financial situation. However, we are currently beating the health care trend. *It is Delta’s goal to continue to reinforce good health care behaviors by making health plan design changes that encourage continued wise use of our health care dollars and promote good health.*

(Emphasis added). A true and correct copy of the September 21, 2005 “Fact Sheet” on “2006 Healthcare Benefit Changes for Ground and Flight Attendant Employees” is attached as Exhibit A.

### **The Delta Health-Care Plans**

15. Delta offers health-care benefits to active and retired employees primarily through two plans, the Delta Family Care Medical Plan (the “**Family Care Medical Plan**”) and the Delta Pilots Medical Plan (the “**Pilot Medical Plan**”). Both these plans are subject to the Employee Retirement Income Security Act (“**ERISA**”).

16. In general terms, the main options for 2005 under the Family Care Medical Plan are (i) a point of service option (“**POS**”), (ii) an “out of area” indemnity option (the “**Out of Area Option**”), and (iii) in certain locations health maintenance organization (“**HMO**”):

- (i) The POS option encourages participants to seek services within a defined network of providers with which discounted fees have been pre-negotiated. Beneficiaries in this option pay significantly less Out-of-Pocket Charges when they use network providers, though they generally retain the option to seek services from providers outside the network. Within the POS, there are currently two choices. The first, the Standard Medical Option (“**Standard Medical Option**”), generally requires lower monthly premiums from Primary Participants for participation but has a higher schedule for Out-of-Pocket Charges. The

second, the Enhanced Medical Option (“**Enhanced Medical Option**”), generally requires significantly higher monthly premiums with lower Out-of-Pocket Charges.

- (ii) The Out of Area Option is limited to the relatively few Beneficiaries who live in areas not served by network providers. This option allows the use of any provider at a deductible and co-insurance rate that are less than those for non-network services under the POS option.
- (iii) The HMO option generally provides a full range of services at a fixed cost with limited co-payments, but providers are limited to a set group within a given geographic region.<sup>6</sup>

17. In addition to the options above, the Family Care Medical Plan also offers retirees a High Value indemnity option that allows the use of any service provider but includes higher deductibles, co-insurance, and out-of-pocket limits. Retirees 65 and over (Medicare eligible) must use either the High Value indemnity option, the Out of Area Option, or one of several Medicare HMO plans in order to coordinate their coverage with their Medicare benefits.

18. As provided by the collective bargaining agreement between Delta and the Air Line Pilots Association, as amended (the “**Pilot Working Agreement**”), for pilots who retired after January 1, 1997 options under the Pilot Medical Plan are limited to (i) a POS option with the same defined network of providers as the POS option under the Family Care Medical Plan, and (ii) an “out-of-area” indemnity option. In 2005, the plan design and premium costs of the POS option are identical to the Enhanced Medical Option in the Family Care Medical Plan, and the design and costs of the “out-of-area” indemnity option are identical to the similar option in the Family Care Medical Plan. In each year, these two options follow the plan design offered to

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<sup>6</sup> The HMO option includes a variety of specific HMO plans available to Beneficiaries residing in selected regions of the country. As noted above, Delta’s health-care costs are generally not insured. However, about 15% of Family Care Medical Plan Beneficiaries, both active and retired, select the HMO option, and most of the offered HMOs are “fully insured” programs in which the HMO, not Delta, bears the risk of costs in excess of total premiums. To this limited extent, Delta’s health-care costs for some Beneficiaries are fully insured.

active pilots during that year.<sup>7</sup> As provided by the Pilot Working Agreement, however, active and retired pilots may also select any one of the options offered by the Family Care Medical Plan in any given year.

19. As a part of the Pilot Medical Plan and in accordance with the Pilot Working Agreement, there are a series of six separate pilot health plan versions that were established over the years for pilots who retired at various times before 1997. Each of these versions provides indemnity coverage only, with varying levels of deductibles, coinsurance, and lifetime maximums. About 3,600 retired pilot Beneficiaries are members of these versions, all of which charge no premiums for participation.

20. Both the Pilot Medical Plan and the Family Care Medical Plan also include a drug benefit at no additional premiums, and options for dental coverage for additional premiums.

#### **Determination of Premium Payments**

21. The dollar amount of premium payments for active and retired participants in the Pilot Medical Plan and the Family Care Medical Plan are determined as a percentage (which varies) of the actuarially estimated cost of the following year's health-care benefits. We determine four different cost levels for each coverage category (employee, employee and spouse, employee and child(ren), and employee and family) in each option under both the Family Care Medical Plan and the Pilot Medical Plan. Where applicable, we also determine separate costs within each coverage category for those retirees not eligible for Medicare versus those who are eligible for Medicare.

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<sup>7</sup> Approximately 180 active employees who are flight dispatchers represented by the Professional Airline Flight Control Association ("PAFCA") are offered a health-care plan that tracks the provisions of the Pilot Medical Plan. Upon retirement, PAFCA members may enroll only in the Family Care Medical Plan on the same terms and conditions as other non-pilot retirees. At present, there are some 88 PAFCA retirees, of whom 78 are enrolled as Primary Participants in Delta's Family Care Medical Plan.

22. Premium cost percentages for active Primary Participants under the Family Care Medical Plan are generally set at fixed levels. The percentage for active, non-pilot Primary Participants enrolled in the Standard Medical Option is currently 22%, having been raised from 16% as of January 1, 2005. This means that an active, non-pilot who chose to enroll in the Standard Medical Option in 2005 has been paying a premium equal to 22% of the actuarially estimated cost of the coverage. Those choosing to enroll in the Enhanced Medical Option or one of the HMO options generally pay higher premiums that reflect the difference between the cost of the Standard Medical Option and the option they select.

23. Under October 2004 amendments to the Pilot Working Agreement, the premium percentage for active pilot Primary Participants selecting the POS option under the Pilot Medical Plan (which in 2005 is identical to the Enhanced Medical Option in the Family Care Medical Plan) is or will be 31% in 2005, 34% in 2006, 37% in 2007, and 40% in 2008. A true and correct copy of relevant excerpts from the October 2004 amendments are attached as Exhibit B. Different percentages of premium cost apply for the Out of Area Option. Active pilots who elect coverage under the Family Care Medical Plan (as the majority do) pay the applicable premium set under that Plan for non-pilot active employees.

24. For non-pilot retirees, there are three components to the percentage premium under the Family Care Medical Plan: (i) the Retiree Medical Premium, (ii) the Service-Related Premium, and (iii) the Full Early Retirement Premium:

- (i) The *Retiree Medical Premium* is, in effect, a minimum premium amount. On January 1, 1994, a 10% premium was introduced for all retirees. As of January 1, 2005, this amount was increased from 10% to 22% for retirees who retired after November 1, 1993.

- (ii) The *Service-Related Premium* is an additional premium amount that is set at a cost percentage inversely proportional to a retiree's length of service at Delta. Introduced in 1991, the premium applies to retirees who retire (i) before the age of 65 with less than 30 years of service or (ii) on or after age 65 with less than 10 years of service.
- (iii) The *Full Early Retirement Premium* is a 100% premium paid by retirees who retire before the age of 65 until they reach Medicare age (currently age 65).

25. Since the premium can never exceed 100% of cost, retirees who are paying the Full Early Retirement Premium do not also pay the Retiree Medical Premium or Service-Related Premium. Similarly, the Service-Related Premium for retirees with relatively few years of service may be limited to the extent that the combined Service-Related Premium and Retiree Medical Premium could otherwise exceed 100%. As described below, some or all of these premium components have been reduced or waived under certain early retirement programs.

26. In early 2005, Delta announced that active non-pilot employees who retire after January 1, 2006 would be required to pay 100% of the cost of the Family Care Medical Plan coverage throughout retirement, with no subsidy from Delta. This policy was put into place for new hires effective January 1, 2003. For this reason, the three-component structure of Family Care Medical Plan premiums will become irrelevant for new non-pilot retirees beginning next year.

27. As with active pilot premium percentages, the pilot retiree premium percentages for the Pilot Medical Plan (other than the six older versions of the Pilot Medical Plan mentioned above, which are premium-free) are set according to the October 2004 amendments to the Pilot Working Agreement. Pilot retirees who elect coverage under the Family Care Medical Plan pay the applicable premium set for non-pilot retirees under that Plan. Currently, approximately 40% of retired pilot Beneficiaries have elected coverage under the Family Care Medical Plan. Of

those not eligible for the premium-free older versions of the Pilot Medical Plan, over 60% have elected coverage under the Family Care Medical Plan options.

28. In general terms, the Pilot Medical Plan retiree premium schedule sets premium cost percentages according to factors similar to the three elements of the premium percentage under the Family Care Medical Plan: a minimum percentage, a service component inversely related to years of service, and a 100% premium for retirement before the pilot mandatory retirement age of 60.<sup>8</sup>

29. In 2005, the minimum premium cost percentage under the Pilot Medical Plan retiree schedule was increased from 0% to 22% – the same as the Family Care Medical Plan minimum premium. In 2006, the retired pilot minimum premium cost percentage will increase to 25%, in 2007, to 28%, and in 2008, 31% (see Ex. B at 63). Again, pilots who retired prior to 1997 pay no premiums as long as they select coverage under the version of the Pilot Medical Plan applicable to them based on their retirement date.

#### **The Family Care Medical Plan Reservation of Rights**

30. As noted, the terms of the Pilot Medical Plan and premium cost percentages for that Plan for active and retired pilots are determined by the Pilot Working Agreement. On the other hand, the terms of the Family Care Medical Plan and the premium percentages for active and retired non-pilots (with the exceptions of waivers of certain premiums pursuant to certain early retirement programs described below) are not limited by any contract or agreement.

31. Indeed, Delta has unequivocally reserved its rights unilaterally to change the terms of the Family Care Medical Plan and the premium rates for non-pilot employees and

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<sup>8</sup> Because pilots must retire at age 60, the pilot service-related premium is based on a 10- or 25-year service period, depending on whether age at retirement is less than 60 years.

retirees at any time and for any reason. For example, The Delta Family Care Medical Plan dated January 1, 1994, the legal document that governs the plan, states as follows:

*The Company reserves to itself the unilateral right at any time to amend, modify, or terminate the Plan in whole or in part, or suspend contributions to the Plan. Any amendment, termination or suspension made pursuant to this Section 16.03 may in the Company's sole discretion be effective as to all participants in the Plan, including those not on Active Payroll Status or retired as of the effective date of such amendment, termination or suspension. The Company does not intend this Plan to constitute a contract with any retired or disabled participant, or survivor, or their Eligible Family Members and no retired or disabled participant or survivor or any of their Eligible Family Members shall have any non-modifiable right to any level of benefits hereunder. Benefits for all participants, including retired and disabled participants and survivors and their Eligible Family Members, may be unilaterally changed, modified, reduced, increased, or terminated by the Company at any time in its sole discretion.*

(Emphasis added). A true and correct copy of excerpts from The Delta Family Care Medical Plan dated January 1, 1994 is attached as Exhibit C.

32. Over the years, Delta has regularly and consistently re-stated this reservation of rights in summary descriptions of the Family Care Medical Plan, descriptions of Plan changes, Plan enrollment materials, and other health-care communications with both active and retired employees.

33. For instance, the 1997 Family Care Medical Plan Summary Plan Description, set forth in the "Nonpilot Regular Full-Time Benefits Handbook" provides:

*As with all Delta benefits, Delta reserves the right at any time to amend, modify, or terminate all or any part of its benefit plans in its sole discretion . . . . Any such amendment, modification or termination may apply to active employees, their dependents and survivors, as well as, former employees, inactive employees, retirees, disabled personnel and personnel on leave of absence and each of their dependents and survivors. . . . Any amendment or modification may be applied prospectively or retroactively and may be applied only to*

one group of participants, such as to retirees, but not to other groups of participants.

(Emphasis added). A true and correct copy of relevant excerpts from the “Nonpilot Regular Full-Time Benefits Handbook” is attached as Exhibit D.

34. Additional communications prominently displaying this or a substantially identical reservation of rights include “Your 2002 Nonpilot Benefits Handbook Update” and the “Benefits Enrollment 2005: Benefit Options” brochure. True and correct copies of relevant excerpts from these health-benefit communications are attached as Exhibits E and F.

#### **Non-Pilot Early Retirement Programs**

35. Between mid-1993 and early 2005, a large number of non-pilot employees retired under several early retirement programs that were offered during different periods of time known as “election windows.” Among the provisions of these early retirement programs were various waivers or adjustments of one or more components of otherwise applicable health-care premiums for retirees under age 65. A few also included waivers or adjustments to premiums for retirees 65 or older.

36. The chart below summarizes for each of these early-retirement programs the election window, the waived or adjusted premium components,<sup>9</sup> and the approximate number of existing pre- and post-65-year-old Primary Participants:

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<sup>9</sup> The majority of these premium waivers only apply with respect to the Primary Participant and his or her spouse, and not to eligible children.

<u>Program</u>	<u>Election Window</u>	<u>Premium Waivers</u>	<u>Current Primary Participants</u>
<i>Special Early Retirement</i>	August-October 1993	Waived Full Early Retirement Premium  Added 5 years of service credit for calculating Service-Related Premium	316 pre-65  904 post-65
<i>Leadership 7.5 Retirement</i>	1994-95 (several periods)	Waived Full Early Retirement Premium  Added 5 years of service credit for calculating Service-Related Premium	1,713 pre-65  1,172 post-65
<i>Early Retirement Medical Option</i>	March-April 2000	Waived Full Early Retirement Premium  Waived Service-Related Premium  Waived pre-65 Retiree Medical Premium	2,169 pre-65  257 post-65
<i>PensionPLUS</i>	October 2001	Waived Full Early Retirement Premium  Waived pre-65 Service-Related Premium & added 5 years of service credit for calculating Service-Related Premium  Waived pre-65 Retiree Medical Premium	3,737 pre-65  327 post-65
<i>Early Retirement Medical Enhancement</i>	November-December 2002	Waived Full Early Retirement Premium  Waived pre-65 Service-Related Premium	718 pre-65  16 post-65
<i>Alternate Early Retirement Option</i>	November 2004	Waived Full Early Retirement Premium  Waived pre-65 Service-Related Premium	2,427 pre-65  26 post-65

37. While the details of these programs are many, there are three critical facts relevant to the overall arrangements:

- (i) Out of 22,000 Delta non-pilot retirees, about 13,700, or 63%, are Primary Participants in an early retirement program.

- (ii) All such programs include (a) an outright waiver of the Full Early Retirement Premium, and (b) a partial or complete waiver of or 5-year adjustment to calculation of the Service-Related Premium.
- (iii) Two of the largest programs, Early Retirement Medical Option (“**ERMO**”) and PensionPLUS, waive *all* premium components for participating pre-65 retirees. As a result, the approximately 5,900 pre-65 retired Primary Participants in the ERMO and PensionPLUS programs – comprising over 25% of all non-pilot retirees and almost 50% of all pre-65 non-pilot retirees – pay no premiums for their medical benefits.

38. To participate in any of the early retirement programs, a non-pilot employee had to meet certain eligibility criteria and agree to the terms of the program during the appropriate enrollment window. The terms of each program were set forth in materials distributed to eligible employees, such as the “ERMO Decision Booklet” dated February 2000, and the “PensionPLUS Decision Booklet” dated October 2001. True and correct copies of these early-retirement program communications are attached as Exhibits G and H.

39. Like almost all Delta communications relating to the Family Care Plan, these materials describing the ERMO and PensionPLUS retirement programs expressly provide that Delta reserves its rights to change all aspects of the Plan and non-pilot medical benefits, with the sole exception of the premium waivers and service credits that were specifically granted under the respective programs.

40. Thus, for example, the October 2001 “PensionPLUS Decision Booklet” includes a separate section entitled “Important Notice” in which Delta warned potential participants:

Except for the specific retiree medical premium waivers and additional service credits described in this booklet, all provisions of the Delta Family-Care Plans remain subject to termination or modification, and any such changes may be applied to retirees, including those who retired under PensionPLUS.

Ex. H at 12; see also Ex. G at 9 (“ERMO Decision Booklet” (Feb. 2000)) (“Except for the specific retiree medical premium waivers described in this booklet, all provisions of the Delta Family-Care Medical Plan remains [sic] subject to termination or modification, and any such changes may be applied to retirees, including those who retired under the ERMO.”).

41. Similarly, the “Frequently Asked Questions and Answers: PensionPLUS,” dated October 2001, specifically warned of Delta’s right to change the health-care benefits provided under the Family Care Medical Plan:

**Q4. Can the company reduce my medical benefits after I retire under PensionPLUS?**

*Except for the specific retiree medical premium waivers and post-retirement additional service credits granted under PensionPLUS, the medical benefits provided to retirees and survivors are subject to change at Delta’s discretion. It is necessary that Delta reserve the right to make changes in the Delta Family-Care Plans from time to time, as may be determined necessary. Such changes could be applied to you, regardless of whether you retire under PensionPLUS or not.*

(Emphasis added). A true and correct copy of “Frequently Asked Questions and Answers: PensionPLUS” (dated October 2001) is attached hereto as Exhibit I.

**2001-05 Family Care Medical Plan Changes**

42. Delta annually reviews health-care benefit costs, plan design structure, and cost-sharing percentages to determine if changes to the Family Care Medical Plan should be made for a next calendar year.

43. From 2001 to 2005, these reviews have resulted in a consistent pattern of changes to the plan design and premium percentages that apply to both active and retired Primary Participants enrolled in the Family Care Medical Plan. These changes have been intended both to improve the plan’s scope of coverage, especially in the area of preventive care, and to control

health-care costs by enacting more efficient consumption of health services and increasing employee and retiree cost sharing. Participants have been regularly informed of these changes in annual enrollment materials. A true and correct summary of plan design and cost-sharing percentages under the Family Care Medical Plan between 2001 and 2006 is attached as Exhibit J. As contemplated by the program documents, all of these changes have also applied to participants in all the early retirement window programs, except to the extent the changes related to premium cost percentages which were waived under a given program.

#### **2006 Family Care Medical Plan Changes**

44. In keeping with its annual practice, and within its fully disclosed rights to amend the Family Care Medical Plan, Delta has formulated various changes to the Plan design which we have intended to implement as of January 1, 2006, for both active and retired Beneficiaries.

45. These Family Care Medical Plan changes include (i) increases in deductibles and maximum out-of-pocket costs; (ii) improvement in the coverage of preventive services to 100% after applicable co-payments; (iii) elimination of the pre-certification requirement and introduction of a notification requirement for all inpatient and certain outpatient procedures; (iv) increases in co-payments for certain lifestyle drugs and brand-name drugs that have less expensive over-the-counter, or other equivalents; (v) elimination of several HMO options; and (vi) elimination of the Enhanced Medical Option.

46. I have described these changes in the September 21, 2005 "Fact Sheet" for active non-pilot employees (see Ex. A) and in an October 18, 2005 memorandum to retired employees. A true and correct copy my October 18, 2005 memorandum to retirees and survivors is attached as Exhibit K.

47. These design changes would allow Delta to offset almost all of an otherwise projected \$37 million increase in the overall cost of the Plans in 2006. If this projected cost

increase were avoided through the proposed design changes, active and retired employees would have to pay only a small increase in cash premiums at current levels of percentage cost-sharing. Of the overall projected savings, \$27 million relate to active employees and \$10 million to retirees. The Family Care Medical Plan changes will be implemented for active employees as of January 1, 2006.

48. Although the proposed 2006 changes are consistent with Family Care Medical Plan changes in 2001-05, and well within Delta's reservation of rights under the Plan, Delta will not proceed with the implementation of the 2006 changes with respect to retirees and their dependents, unless and until this Court rules that section 1114 of the Bankruptcy Code does not apply to such changes or the Court otherwise allows the changes to proceed.<sup>10</sup>

49. As retirees were informed by my October 18, 2005 memorandum, Delta will delay until November 28, 2005 their open enrollment period previously scheduled for late October 2005. Unless Delta obtains a ruling soon as to whether the Plan changes may be implemented for retired employees without prior approval under section 1114 of the Bankruptcy Code, Delta will be compelled to apply the Family Care Medical Plan changes to active employees only as of January 1, 2006. This would force an administratively expensive and disruptive bifurcation of the Plan as between retirees and non-retirees, in addition to the loss of some of the savings anticipated from applying the Plan design changes to retirees as of January 1, 2006.

#### **Response to the Affidavit of Cathy Cone**

50. I have reviewed the September 22, 2005 Affidavit of Cathy Cone, Chair of DALRC, in support of the DALRC application for an order to appoint a retirement committee

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<sup>10</sup> Nevertheless, Delta must change certain HMO offerings for active employees and pre-65 retirees, as three HMO plans have refused to continue participating in the Family Care Medical Plan.

pursuant to section 1114(d) of the Bankruptcy Code (the “September 22 Cone Affidavit”), as well as the September 22, 2005 Affidavit of Robert G. Adams, a member of DALRC, likewise submitted in support of the DALRC application for an order to appoint a retirement committee pursuant to section 1114(d) of the Bankruptcy Code.

51. Among the inaccuracies contained in these affidavits is the assertion by Ms. Cone that early retirees under the October 2001 PensionPLUS program were promised “enhanced medical coverage.” (September 22 Cone Affidavit ¶ 28; see also id. ¶ 18) by which she seems to imply that she was promised a right to the Enhanced Medical Option plan design. In fact, the only benefit “enhancements” promised under the PensionPLUS program were the premium waivers and service credits described above. These waivers did not include any statement that plan design or other non-premium benefit features would not change, and in fact, specifically advised that such changes could occur and could apply to PensionPLUS participants (see Ex. H at 12).

52. In late 2003, Delta announced that as of January 1, 2004, the Family Care Medical Plan would have two versions of the POS option: the Standard Medical Option and the Enhanced Medical Option, as described above. However, because the Enhanced Medical Option was not implemented until January 2004, it was obviously not part of the “enhancements” described in the October 2001 PensionPLUS materials.

53. Ms. Cone also suggests that a large portion of the savings from the proposed retiree Family Care Medical Plan changes would come from increased out-of-pocket maximums, as well as increased prescription drug co-payment levels (see September 22 Cone Affidavit ¶¶ 28, 29). Ms. Cone’s analysis is incomplete and tends to overstate the overall impact of the proposed retiree out-of-pocket and co-payment changes.

54. For example, while it is true that for someone participating in the Enhanced Medical Option in 2005, the increase in their out-of-pocket maximum limits for the 2006 POS option would go from \$2000 to \$3500 per individual and from \$4000 to \$7000 per family, most individuals and families do not consume enough healthcare to reach those out-of-pocket maximum limits. For example, of the roughly 11,000 retired Beneficiaries enrolled in the Enhanced Medical Option in 2004, less than 700 individuals and 100 families reached or exceeded the \$2000/\$4000 out-of-pocket maximums limits.

55. As for drug co-payments, the proposed plan changes for 2006 are relatively minor. The Family Care Medical Plan currently divides its drug benefit into three tiers. The first two tiers have low co-payments, and cover generic and preferred brand name drugs (for which the Plan provider is typically able to obtain favorable discounts). The third tier has a higher co-payment amount, and covers non-preferred brand name drugs. For those participating in the Standard Medical Option in 2005, the proposed 2006 changes will not alter co-payment levels for the first two tiers, and will *decrease* co-payments for the third tier. For those in the Enhanced Medical Option in 2005, the first tier co-pay would remain unchanged at \$10; the second tier co-pay would increase \$25 to \$30; and the third tier co-pay would increase from \$40 to \$50. The changes will also introduce a fourth tier with higher co-payments amounts for a limited number of drugs in certain classes (e.g., erectile dysfunction, growth hormones, infertility treatments) and brand-name drugs that have less expensive, therapeutic equivalents among the lower-tier drugs or over-the-counter medications. The increased co-pay level for these fourth tier drugs will be \$70.

56. For most retirees who are currently enrolled in the 2005 Enhanced Medical Option, the primary increase in costs of the 2006 Standard Medical Option would be (i) up to

\$350 per individual or \$1050 per family due to increased deductibles, which would go from \$150 to \$500 per individual and \$450 to \$1500 per family, and (ii) to the extent that the deductible is exceeded, an additional 10% of the cost of services consumed due to an increase in the co-insurance rate from 10% to 20% (limited by the out-of-pocket maximum limits discussed above). Offsetting these increases would be, among other things, improvements to preventive services such as wellness visits, immunizations, routine mammograms, and routine colonoscopy so that these services are paid at 100% after the co-payment without having to apply charges for these services toward the deductible.

57. Finally, Ms. Cone suggests that active and retired pilots through “contractual” protections (presumably meaning the Pilot Working Agreement) “would continue to receive the ‘enhanced’ medical benefits package . . . .” (September 22 Cone Affidavit ¶ 28). I believe Ms. Cone is referring to the Pilot Medical Plan POS option. Ms. Cone ignores, however, that unlike the approximately 5,900 pre-65 retirees under the ERMO and PensionPLUS programs, participants in the Pilot Medical Plan pay premiums for their POS option and those premiums will increase substantially in 2006. It is likely that this premium increase will drive even more pilots to elect coverage under the Family Care Medical Plan rather than the Pilot Medical Plan in 2006.

### **Conclusion**

58. As a 20-year human-resources employee, I know that Delta is a company uniquely committed to the welfare of both its active and retired employees.

59. Nonetheless, as I believe the vast majority of the company’s active and retired employees understand, Delta confronts severe challenges from, among other things, low-cost carriers (“LCCs”), Internet-driven fare transparency, and massive fuel cost increases.

60. Given these harsh circumstances, all stakeholder groups, including Delta's active and retired employees, will be required to participate equitably in the cost reductions that are needed if Delta is to survive.

61. As my supervisor Beth Johnston, Senior Vice President, Human Resources, reported in a September 22, 2005 internal memorandum to Delta employees:

As we begin the hard work of the bankruptcy process, we are accelerating our transformation. While we have made remarkable progress, our efforts are not enough to overcome the unprecedented cost of fuel and pressures brought on by LCCs . . . . *Even with record high fuel prices, employment costs remain Delta's largest expense, and simply cannot be overlooked as we work to compete in a new environment. More shared sacrifice by all Delta people is required.*

(Emphasis added). A true and correct copy Ms. Johnston's September 22, 2005 memorandum to All Delta Employees is attached as Exhibit L.

I, the undersigned Robert L. Kight, declare under penalty of perjury that the foregoing is true and correct.

Dated: Atlanta, Georgia  
October 24, 2005

/s/ Robert L. Kight  
Robert L. Kight