SUMMARY OF MATERIAL MODIFICATIONS FOR THE US AIRWAYS, INC. HEALTH BENEFIT PLAN EIN/PN: 53-0218143/501

Section 104 of the Employee Retirement Income Security Act of 1974 ("ERISA") directs the administrator of an ERISA-covered plan to furnish to participants (and beneficiaries receiving benefits under the plan) a summary of any material modifications to the plan (the "SMM") within 210 days following the plan year in which the change was adopted. This summary describes certain changes to the US Airways, Inc. Health Benefit Plan (the "Plan"). This SMM modifies the Summary Plan Description (the "SPD"), revised as of January 1, 2008 and the SMM revised as of January 1, 2010. You should keep this SMM with the Summary Plan Description you previously received, for future reference.

The following changes to the SPD are **effective January 1, 2011**, unless otherwise indicated:

SUMMARY PLAN DESCRIPTION (SPD, Introduction)

The following paragraphs are added to the end of the Introduction:

Grandfathered Health Plan Notice

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at BenefitsUS Customer Service at 1-888-860-6178.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Rescission

Please note that any act, practice, or omission by a Plan participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the terms of the Plan and the Plan may rescind coverage as a result.

ABOUT YOUR PARTICIPATION – ACTIVE EMPLOYEES

Eligibility for YOU (SPD, Page 1)

The first two bullet points of this section are modified to read as follows:

- An active, full-time or part-time employee of the US Airways, Inc. with a work base in the United States, but excluding (i) a pilot listed on the Pilots System Seniority List that, prior to January 1, 2011, was employed by America West Airlines, Inc., and effective January 1, 2011, is employed by US Airways, Inc.; (ii) a pilot hired on or after January 1, 2011 that is listed on the Pilots System Seniority List, is employed by US Airways, Inc., and is domiciled in Phoenix, Arizona; (iii) a flight attendant represented by the Association of Flight Attendants that, prior to January 1, 2011, was employed by America West Airlines, Inc., and effective January 1, 2011, is employed by US Airways, Inc.; (iv) a flight attendant hired on or

after January 1, 2011 that is represented by Association of Flight Attendants, is employed by US Airways, Inc., and is domiciled in Phoenix, Arizona; (v) any temporary, on-call or seasonal employees; or

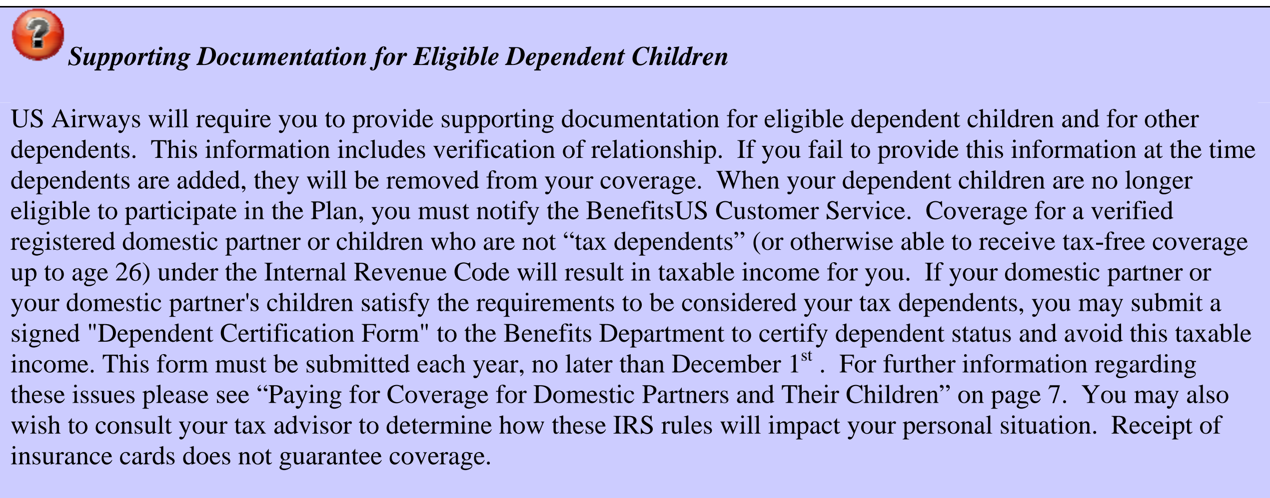
Eligibility for Your Dependents (SPD, Page 2)

The second and third bullet points of this section are modified to read as follows:

- Your children or the children of your registered domestic partner who have not yet attained age 26. However, for Plan years beginning before January 1, 2014, adult dependent children (dependent children age 19 through age 26), are not eligible for coverage under the Plan if they are eligible to enroll in health coverage sponsored by the adult dependent's employer;

- The unmarried children of you or your registered domestic partner age 26 and over who are not self-supporting because of a permanent physical, or mental disability and are dependent upon you, as defined by the Code for income tax purposes, provided that such child became physically or mentally disabled and was covered by the Plan on the day before attaining age 26. Any child who satisfies these conditions will continue to be eligible for coverage as long as the disability remains. The Plan Administrator may require documentation that confirms such child's ongoing disability. "Disability" for dependent eligibility purposes will have the meaning used by the Internal Revenue Service for income tax purposes.

The Supporting Documentation for Eligible Dependent Children is modified as follows:



Supporting Documentation for Eligible Dependent Children

US Airways will require you to provide supporting documentation for eligible dependent children and for other dependents. This information includes verification of relationship. If you fail to provide this information at the time dependents are added, they will be removed from your coverage. When your dependent children are no longer eligible to participate in the Plan, you must notify the BenefitsUS Customer Service. Coverage for a verified registered domestic partner or children who are not "tax dependents" (or otherwise able to receive tax-free coverage up to age 26) under the Internal Revenue Code will result in taxable income for you. If your domestic partner or your domestic partner's children satisfy the requirements to be considered your tax dependents, you may submit a signed "Dependent Certification Form" to the Benefits Department to certify dependent status and avoid this taxable income. This form must be submitted each year, no later than December 1st . For further information regarding these issues please see "Paying for Coverage for Domestic Partners and Their Children" on page 7. You may also wish to consult your tax advisor to determine how these IRS rules will impact your personal situation. Receipt of insurance cards does not guarantee coverage.

Full-time Student Verification (SPD, Page 3)

This section no longer applies.

Paying for Coverage for Domestic Partners and Their Children (SPD, Page 7)

The following paragraph is added to this section:

The above rules will not apply if:

- your domestic partner and/or your domestic partner's children satisfy the requirements to be considered your tax dependents under the Internal Revenue Code, and

- you submit a signed Dependent Certification Form to the Benefits Department to certify dependent status no later than December 1st each year.

The "Dependent Certification Form," which describes the requirements that must be satisfied in order for your domestic partner and/or your domestic partner's children to be considered your tax dependents, is available on the BenefitsUS Customer Service website at www.eBenefitsUS.com or the US Airways' employee website at http://wings.usairways.com. If you do not submit the Dependent Certification Form to the Benefits Department each year on or before December 1st, your domestic partner and your domestic partner's children will not be treated as tax dependents for that year, and coverage will be taxed as described above.

An Overview of Change in Status Events (SPD, Page 9)

The section "Child No Longer Full-Time Student" no longer applies.

An Overview of Change in Status Events (SPD, Page 10)

The section "Child Regains Full-Time Student Status" no longer applies.

YOUR MEDICAL OPTIONS

Schedule of PPO Plan Benefits*, An Overview of PPO Plan Benefits* (SPD, Page 16)

The section "Lifetime Maximum" is now unlimited for both In-Network and Out-of-Network coverage for the PPO80/60, PPO 90/70 and PPO 100/80 plans. The $1,000,000 per person for PPO 80/60, 90/70, 100/80 combined no longer applies.

Schedule of PPO Plan Benefits, *An Overview of PPO Plan Benefits* (SPD, Pages 20 - 21)

This schedule is removed and replaced as follows to comply with ACA and reflect administrative corrections:

Schedule of PPO Plan Benefits						
	PPO 80/60		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health and Chemical Dependency (benefits provided through Behavioral Health Claims Administrator)						
Annual Deductible (1 person/ 2 or more people) – included with Medical Annual Deductible	$450/$900	$900/$1,800	$225/$450	$450/$900	$225/$450	$450/$900
Annual Out-of-Pocket Maximum (1 person/2 or more people) – included with Medical Out-of-Pocket Maximum	$3,000/$6,000	$6,000/$12,000	$1,500/$3,000	$3,000/$6,000	Not applicable	$3,000/$6,000
Inpatient Care	The Plan pays 80% of discounted in-network fees, after annual deductible *No visit maximum*	The Plan pays 60% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 90% of discounted in-network fees, after separate deductible *No visit maximum*	The Plan pays 70% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 100% of discounted in- network fees, after annual deductible *No visit maximum*	The Plan pays 80% of R&C charges, after annual deductible *No visit maximum*

Outpatient Care	$25 co-pay *No visit maximum*	The Plan pays 60% of R&C charges, after annual deductible *No visit maximum*	$25 co-pay *No visit maximum*	The Plan pays 70% of R&C charges, after annual deductible *No visit maximum*	$25 co-pay *No visit maximum*	The Plan pays 80% of R&C charges, after annual deductible *No visit maximum*

Schedule of PPO Plan Benefits, *Important Notes About PPO Plan Benefits* (SPD, Page 25)

Item 3 is removed and replaced by the following:

3. The annual deductible and out-of pocket maximum amounts applicable to expenses for medical services DO apply to covered expenses for mental health and chemical dependency services. There is a combined annual deductible and a combined out-of-pocket maximum you must meet before the plan pays for medical and/or mental health and chemical dependency care.

Schedule of Out-of-Area Program Benefits, *An Overview of Out-of-Area Program Benefits* (SPD, Page 29)

This schedule is removed and replaced as follows to comply with ACA and reflect administrative corrections:

Schedule of Out-of-Area Program Benefits			
	OOA 80	**OOA 90**	**OOA 100**
Mental Health and Chemical Dependency (benefits provided through Behavioral Health Claims Administrator)			
Annual Deductible – included with Medical Annual Deductible (1 person/2 or more people)	$450/$900	$225/$450	$225/$450
Annual Out-of-Pocket Maximum – included with Medical Annual Out-of-Pocket (1 person/2 or more people)	$3,000/$6,000	$1,500/$3,000	Not applicable
Inpatient Care	The Plan pays 80% of R&C charges, after annual deductible *No day maximum*	The Plan pays 90% of R&C charges, after annual deductible *No day maximum*	The Plan pays 100% of R&C charges, after annual deductible *No day maximum*

Outpatient Care	The Plan pays 80% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 90% of R&C charges, after annual deductible *No visit* maximum	The Plan pays 100% of R&C charges, after annual deductible *No visit maximum*

Schedule of Out-of-Area Program Benefits, *Important Notes About Out-of-Area Program Benefits* (SPD, Page 32)

Item 2 is removed and replaced by the following:

2. The annual deductible and out-of pocket maximum amounts applicable to expenses for medical services DO apply to covered expenses for mental health and chemical dependency services. There is a combined annual deductible and a combined out-of-pocket maximum you must meet before the plan pays for medical and/or mental health and chemical dependency care.

Coordination With Medicare for Disabled Individuals (SPD, Page 36)

This section's title is changed to "Coordination with Medicare for Employees on Leave of Absence and Disabled Individuals" and is modified in its entirety to read as follows:

> If you or your covered dependent(s) are enrolled in Medicare while you are actively employed, participation in this Plan will continue as long as you are an active employee and remain enrolled. This Plan will be the primary carrier and Medicare will be the secondary carrier.
>
> If you are on a leave of absence or you are receiving disability benefits, please note the following important rules regarding coverage under Medicare:
>
> Leave of Absence: If you take a leave of absence and retain coverage under the Plan, the Plan will continue to pay primary for as long as you retain your right to return to active employment, i.e., your employment is not terminated by the company. If your employment is terminated by the company, Medicare will become primary.
>
> Disability: If you take a medical leave of absence, retain coverage under the Plan, and start receiving disability benefits from the company, the Plan will continue to pay primary for the first 6 months of your disability coverage, i.e., while disability benefits are subject to FICA tax. After this 6 month period, Medicare will become primary for you and/or any covered dependents.
>
> When Medicare becomes primary, the Plan assumes you are enrolled in both Medicare Part A and B, so review your options when you become eligible for Medicare (either due to age or disability).
>
> If you have questions about Medicare benefits, contact your local Social Security office.

YOUR MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM (SPD, Pages 41 - 49)

The following paragraph is added:

The Mental Health Parity Act of 2008 requires that, effective January 1, 2011, the financial requirements and treatment limitations applicable to mental health and substance-use-disorder benefits be no more restrictive than the requirements and limitations that apply to health benefits based on physical injury or illness. Therefore, effective January 1, 2011 your mental health and chemical dependency plan benefits have been modified to either be richer than your current medical benefits or the same. Additionally, the law requires that deductibles and out-of-pocket maximums are shared or combined between medical and mental health/chemical dependency services. These components of the behavioral health plan will accumulate with the medical as of January 1, 2011.

An Overview of Your Mental Health and Chemical Dependency Program Benefits (SPD, Page 42)

Remove the first sentence as medical necessity review is not required for coverage.

Remove the reference to "medically necessary" in the third sentence of the second paragraph.

Your Deductibles and Annual Out-of-Pocket Maximums (SPD, Page 42)

The first two paragraphs are removed and replaced by the following:

The deductible and out-of-pocket maximum amounts are combined for medical services and mental health and chemical dependency benefits. You must meet your combined mental health and chemical dependency deductible and out-of-pocket maximum before such benefits are paid.

Schedule of Mental Health and Chemical Dependency Benefits (SPD, Page 43)

The section "Lifetime Maximum" is now unlimited for both In-Network and Out-of-Network coverage for the PPO80/60, PPO 90/70 and PPO 100/80 plans. The $1,000,000 per person for PPO 80/60, 90/70, 100/80 combined no longer applies.

This schedule is removed and replaced as follows:

If you are enrolled in the PPO Plan for medical coverage, your mental health and chemical dependency benefits are summarized in the table below:

Mental Health and Chemical Dependency Benefits	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (1 person/2 or more people)	$450/$900	$900/$1,800	$225/$450	$450/$900	$225/$450	$450/$900
Annual Out-of-Pocket Maximum (1 person/2 or more people)	$3,000/$6,000	$6,000/$12,000	$1,500/$3,000	$3,000/$6,000	Not applicable	$3,000/$6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Care	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 90% of discounted in-network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Outpatient Care	$25 co-pay *No visit maximum*	The Plan pays 60% of R&C charges, after annual deductible *No visit maximum*	$25 co-pay *No visit maximum*	The Plan pays 70% of R&C charges, after annual deductible *No visit maximum*	$25 co-pay *No visit maximum*	The Plan pays 80% of R&C charges, after annual deductible *No visit maximum*

Your Coverage – Mental Health and Chemical Dependency (SPD, Page 45)

When You See In-Network Providers

After you meet the combined in-network medical, mental health and chemical dependency annual deductible, in-network benefits are covered like the in-network medical services, according to the medical program option in which you enroll — PPO 80/60, PPO 90/70, or PPO 100/80.

When You See Out-of-Network Providers

After you meet the combined out-of-network medical, mental health and chemical dependency annual deductible, out-of-network benefits are covered like the out-of-network medical services, according to the medical program option in which you enroll — PPO 80/60, PPO 90/70, or PPO 100/80. There are no day or visit limits after January 1, 2010.

Mental Health and Chemical Dependency Benefit Limitations and Exclusions (SPD, Page 47)

The last bullet is replaced by the following two bullets for clarification purposes as follows:

- Any non-medical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety and services, training, educational therapy, boarding schools, wilderness programs, or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

- Education, training, and bed and board while confined in an institution that is mainly a school or training institution, a place of rest, a place for the aged or a rest home.

RETIREE HEALTH COVERAGE

Making Changes After Retirement (SPD, Page 70)

The section “Dependent (Age 19-23) Regains Eligibility” should now be titled “Dependent Regains Eligibility”.

When Coverage Ends (SPD, Page 70)

The second bullet under “Coverage for your spouse (or registered domestic partner) or eligible dependents will end when” is modified as follow:

- Your eligible dependent children are no longer eligible to participate in the Plan;

Coordination With Medicare for Retirees and Disabled Individuals (SPD, Page 71)

The first three paragraphs of this section are modified to read as follows:

> If you or your covered dependent(s) are enrolled in Medicare while you are actively employed, participation in this Plan will continue as long as you are an active employee and remain enrolled. This Plan will be the primary carrier and Medicare will be the secondary carrier.
>
> If you are on a leave of absence or you are receiving disability benefits, please note the following important rules regarding coverage under Medicare:
>
> Leave of Absence: If you take a leave of absence and retain coverage under the Plan, the Plan will continue to pay primary for as long as you retain your right to return to active employment, i.e., your employment is

not terminated by the company. If your employment is terminated by the company, Medicare will become primary.

Disability: If you take a medical leave of absence, retain coverage under the Plan, and start receiving disability benefits from the company, the Plan will continue to pay primary for the first 6 months of your disability coverage, i.e., while disability benefits are subject to FICA tax. After this 6 month period, Medicare will become primary for you and/or your dependents.

When you become eligible for Medicare either due to age or disability, and Medicare is the primary payer, you must enroll in Medicare Part A (hospital) and Part B (physicians and other services), since the Plan assumes you are enrolled in both Medicare Part A and B. If Medicare is the primary payer and the Plan is the secondary payer for your medical benefits, you or your provider should first submit your claim to Medicare each time you have an eligible medical expense. The Plan will coordinate benefits according to the Medicare Allowable Amount.

The Plan includes coverage for prescription drug benefits. However, as a Medicare eligible individual you are also entitled to enroll in a prescription drug plan under Medicare Part D. Please note that you will not receive benefits from both this Plan and a Medicare Part D prescription drug plan. Therefore, if you enroll in a Medicare Part D plan you may be paying for coverage you will not receive. If Medicare verifies that you have prescription drug coverage through this Plan, Medicare may coordinate with your Part D prescription drug plan enrollment. You are therefore urged to consider the options carefully prior to making a Medicare Part D election. Timely enrollment in Medicare Parts A and B will ensure proper coordination of benefits. If you are Medicare-eligible and Medicare would be the primary payer, the Plan will pay benefits as though you had enrolled in Medicare regardless of whether you have actually done so. If Medicare would be the primary payer, the Plan will not pay expenses that would otherwise be covered by Medicare. You may obtain further information on Medicare eligibility by contacting Medicare directly at 1-800-MEDICARE or www.Medicare.gov.

ADDITIONAL RULES THAT APPLY TO THE PLAN

Continuation of Coverage for Retirees (SPD, Page 80)

The example of when an eligible dependent ceases to be eligible for benefits under the Plan is changed to when he or she attains age 26 and the reference to full-time student is removed.

For Additional Information

To request additional information regarding this summary, please contact BenefitsUS Customer Service 1-888-860-6178.