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, the SMM effective as of January 1, 2010 and the SMM effective as of January 1, 2011. You should keep this SMM with the SPD and SMMs you previously received for future reference.

The following changes to the SPD are **effective January 1, 2012**, unless otherwise indicated:

YOUR MEDICAL OPTIONS (SPD, Pages 13-36)

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

Effective January 1, 2011, replace item 3 with 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 **100%** for medical and/or mental health and chemical dependency care.

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

Effective January 1, 2011, replace item 2 with 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 **100%** for medical and/or mental health and chemical dependency care.

Schedule of Mental Health and Chemical Dependency Benefits (SPD, Page 44-45)

The Out-of-Area schedule is removed and replaced as follows effective January 1, 2011:

If you are enrolled in the Out-of-Area Programs, your mental health and chemical dependency benefits are summarized in the table below.

Mental Health and Chemical Dependency Benefits	OOA 80	OOA 90	OOA 100
Annual Deductible (1 person/2 or more people)	$450/$900	$225/$450	$225/$450
Annual Out-of-Pocket Maximum (1 person/2 or more people)	$3,000/$6,000	$1,500/$3,000	Not applicable
Lifetime Maximum	Unlimited	Unlimited	Unlimited

Mental Health and Chemical Dependency Benefits	OOA 80	OOA 90	OOA 100
Inpatient Care	The Plan pays 80% of discounted Medicare Allowable Amount after annual deductible *No day maximum*	The Plan pays 90% of the Medicare Allowable Amount, after annual deductible *No day maximum*	The Plan pays 100% of the Medicare Allowable Amount, after annual deductible *No day maximum*
Outpatient Care	The Plan pays 80% of the Medicare Allowable Amount, after annual deductible *No visit maximum*	The Plan pays 90% of the Medicare Allowable Amount, after annual deductible *No visit maximum*	The Plan pays 100% of the Medicare Allowable Amount, after annual deductible *No visit maximum*

YOUR DENTAL OPTIONS (SPD, Pages 54-62)

Dental PPO Program Benefits (SPD, Page 56)

Modify coverage for Fluoride treatment under Preventive care by replacing the language with the following:

(once **per year**, up to age 19)

Modify coverage for X-rays under Preventive care by replacing the language with the following:

(bitewing—as part of routine exam, **once** per year; full-mouth—once every **60** months)

Modify Major care to add the following:

Implant services and repairs

An Overview of Out-of-Area Dental Program Benefits (SPD, Pages 57-58)

Modify coverage for X-rays under Preventive care by replacing the language with the following:

(bitewing—as part of routine exam, **once** per year; full-mouth—once every **60** months)

Modify Major care to add the following:

Implant services and repairs

Dental Services Covered Under the Plan (SPD Pages 59-61)

Under Preventive and Diagnostic Care:

- Remove ",including bitewing x-rays" from the first bullet
- Add a bullet "Adult bitewing x-rays, once per Plan Year"
- Modify the 4th bullet by replacing the language with the following: "Full mouth x-rays, once every **60** months";

Under Restorative Care:

- Modify the 1st bullet by replacing the language with the following: "Silver (amalgam), silicate, plastic, porcelain, and composite fillings (**all teeth**); and"

Under Prosthodontic Care:

- Add the following bullets:
    - Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in an 84 month period.
    - Repair of implants, but not more than once in a 12 month period.
    - Implant supported Cast Restorations, but no more than once for the same tooth position in an 84month period.
    - Implant supported fixed Dentures, but no more than once for the same tooth position in an 84 month period.
    - Implant supported removable Dentures, but no more than once for the same tooth position in an 84 month period.

Dental Services NOT Covered Under the Plan (SPD, Page 61-62)

Modify the 2nd bullet by replacing the language with the following:

- Replacement of teeth that were lost or extracted before your dental coverage began under the Plan; **including congenitally missing teeth**

YOUR VOLUNTARY CRITICAL ILLNESS PLAN (SPD, Page 65)

The Critical Illness Plan

Replace the paragraph with the following:

The plan pays a lump-sum benefit upon diagnosis **or occurrence** of a critical illness or condition. It provides a payment to you if you are diagnosed with a specified critical illness, such as heart attack, stroke, renal failure, permanent paralysis due to a covered accident, major organ transplant surgery coronary artery bypass surgery **or other critical illness**. The amounts of your benefit and premium depend on the level you select. For more details on benefit and premium levels under the plan, please contact your critical illness Claims Administrator.

CLAIMS PROCEDURES (SPD, Pages 81-85)

Procedures for Appealing an Adverse Benefit Determination (SPD, Page 84)

The second and third bullets from the bottom of the page are deleted and replaced with the following:

- **15** days after receipt of your request for review of a **pre-service claim**; or
- **30** days after receipt of your request for review of a **post-service claim**.

Procedures for Appealing an Adverse Benefit Determination (SPD, Page 85)

Add the following to the bottom of page 85:

External Review

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the External Review Program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons/medical judgment;
- The exclusions for Experimental or Investigational Services or Unproven Services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Claims Administrator fails to respond to your appeal in accordance with applicable regulations.

If the above conditions are satisfied, you may request an independent review of the adverse benefit determination. Neither you nor the Claims Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. You or an authorized designated representative must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination. A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement.

The independent review will be performed by an independent review organization (IRO). The IRO has been contracted by the Claims Administrator and has no material affiliation or interest with the Claims Administrator or US Airways, Inc. The Claims Administrator will choose the IRO based on a rotating list of appropriately accredited IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of the Claims Administrator's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by the Claims Administrator in making a decision on the case; and
- All other information or evidence that you or your Physician has already submitted to the Claims Administrator.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Claims Administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes required by law. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claims Administrator with the reviewer's decision, and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan is required to provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

The following Claims Administrators do not have a Voluntary External Review Program:
Metlife Dental
Superior Vision

Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

HOW TO CONTACT YOUR CLAIMS ADMINISTRATORS/CLAIMS FIDUCIARIES (SPD, Page 86)

Claims Administrator/ Claims Fiduciary	**Phone Number**	**Web Site Address**
United HealthCare Services, Inc. (UHC) (medical benefits)	*Medical benefits*: 1-800-520-0811 +44 (0) 1273 718425 (International)	www.myuhc.com
Blue Cross Blue Shield of North Carolina (medical benefits through 12/31/11)	1-888-722-7441 1-800-810-2583 (International)	www.bcbsnc.com
Anthem Blue Cross and Blue Shield (medical benefits effective 1/1/12)	1-855-267-1772 1-800-810-2583 (International)	www.anthem.com

PLAN ADMINISTRATION (SPD, Pages 87-90)

Organizations Providing Administrative Services under the Plan (SPD, Pages 88-89)

Modify the Medical benefits section as follows:

Type of Benefits	**Claims Administrator and Claims Fiduciary**
Medical	United HealthCare Services, Inc. P.O. Box 30555 Salt Lake City, UT 84130-0555 1-800-520-0811 +44 (0) 1273 718425 (International – BUPA) www.myuhc.com or Blue Cross Blue Shield of North Carolina P.O. Box 2291 Durham, NC 27702 1-888-722-7441 1-800-810-2583 (International)

Type of Benefits	Claims Administrator and Claims Fiduciary
	www.bcbsnc.com or Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 www.anthem.com All appeals should be directed to: Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

For Additional Information

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