US AIRWAYS, INC. HEALTH BENEFIT PLAN

Updated November 1, 2012

Summary Plan Description

Effective January 1, 2013

SUMMARY PLAN DESCRIPTION

This document summarizes the main provisions of the US Airways, Inc. Health Benefit Plan (Plan), effective as of January 1, 2013, and serves as the Summary Plan Description (SPD) for Medical, Prescription Drug, Employee Assistance Program, Behavioral Health and Chemical Dependency, Dental, Voluntary Vision Care, Voluntary Long-Term Care, Voluntary Critical Illness and Voluntary Accident Insurance program benefits under the Plan. This document replaces the SPD dated January 1, 2008 and incorporates the changes to that SPD that are set forth in the Summaries of Material Modification dated January 1, 2010, January 1, 2011, and January 1, 2012, as well as other changes and clarifications.

In this SPD you will find descriptions of those benefits as they apply to eligible employees and their eligible Dependents. This SPD also covers retirees and their eligible Dependents. The information in this SPD about the benefits available under the Medical, Prescription Drug, Employee Assistance Program and Behavioral Health and Chemical Dependency programs applies to both active employees and retirees (and their eligible Dependents) unless specifically stated otherwise.

This SPD provides a comprehensive overview of the benefits available under the Plan as well as limitations, exclusions, deductible and coinsurance requirements. Additional Plan details are contained in the legal Plan document. If there is any difference between the information in this SPD and the legal Plan document, the legal Plan document will govern. US Airways, Inc. ("US Airways" or "the Company") sponsors the Plan and reserves the right to amend or terminate the Plan at any time, subject to the terms of an applicable collective bargaining agreement. You will be notified of any changes that affect your benefits, as required by federal law.

Throughout this SPD, you will find “information boxes” indicated by this symbol:  When you see the symbol, read what’s inside the accompanying information box to learn more about the highlighted topic in that section of the SPD. Terms used to describe your benefits are generally defined when the term is first introduced. There is also a “Glossary” at the end of this SPD that defines certain additional terms and how they apply to the benefits described in this SPD.

Please read this SPD carefully and share it with your family members who are eligible for coverage or for whom you've elected coverage. If you have any questions about the benefits information contained in this SPD, contact Benefits US Customer Service at 1-888-860-6178. When you hear the telephone prompts, select 1.

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.

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ABOUT YOUR PARTICIPATION – ACTIVE EMPLOYEES

This section includes important information about:

- Eligibility to participate in the Plan;
- When coverage begins;
- Paying for coverage;
- When you can make changes; and
- When coverage ends.

ELIGIBILITY

Eligibility for YOU

You are eligible to participate in the Plan if you are:

- 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 is domiciled in Phoenix, Arizona; (ii) a flight attendant represented by the Association of Flight Attendants that is domiciled in Phoenix, Arizona; and (iii) any temporary, on-call or seasonal employees; or

- A former employee of the Company who was eligible for coverage under the Plan the day before a separation or inactive status from the Company and is subject to a written separation agreement, collectively bargained agreement or Company policy that includes coverage for a pre-determined period of time following the separation.

Please note: For purposes of eligibility, "employees" are individuals who are classified by the Company as employees under Section 3121(d) of the Internal Revenue Code. In the event the classification of an individual who is excluded from eligibility under the preceding sentence is determined to be erroneous or is retroactively revised by a court, administrative agency or other administrative body, the individual shall nonetheless continue to be excluded from the Plan and shall be ineligible for benefits for all periods prior to the date that it is determined that its classification of the individual is erroneous or should be revised.

For eligibility provisions relating to retirees and their eligible Dependents, please see the "Retiree Health Coverage" Section.

Employees with a work location in San Francisco are eligible for an additional health plan option available through Kaiser Permanente. For details about that option, please see the "Additional Health Plan For Employees of San Francisco" Section.

Coverage is available to employees with a work location in Puerto Rico through a separate health plan. For details about that plan, please see the "Health Plan For Employees of Puerto Rico" Section.

Eligibility During a Leave of Absence or Furlough

If you take a Company-approved leave of absence, you may continue, start or stop participation in the Plan, at the beginning of the leave of absence and also upon your return from the leave of absence provided you are still eligible to participate in the Plan at that time. If you make no changes to the elections in place for you (and your Dependents) before a leave of absence begins, those elections will

remain in place until the earliest of (a) the date you make an election change due to a change in status event *(see the "Making Changes During the Year Due to a Change in Status" Section of this SPD for more information on change in status events)* or during an annual enrollment in which you are eligible to participate, (b) the date you stop making any required premium payments, or (c) the date you (or your Dependents) are no longer eligible for coverage under the Plan. You may not enroll additional Dependents for coverage under the Plan unless you experience a change in status event (*see the "Making Changes During the Year" Section of this SPD for more information on change in status events*). If you waive coverage at the beginning of or during a leave of absence or furlough, you will not be able to re-enroll for coverage until you return to active status or retire.

At any time during a leave of absence or furlough, you may contact Benefits US Customer Service at 1-888-860-6178 to reduce your level of coverage or cancel coverage. Please note, however, that if you reduce your coverage level or cancel your coverage while on leave of absence or furlough, you may not increase or reinstate that coverage until you return to active status. If you go on furlough, you are eligible to continue your participation in the Plan according to the terms specified in your collective bargaining agreement. Please see the collective bargaining agreement applicable to you for more details. You can obtain a copy of your collective bargaining agreement by contacting your local management or union representative.

To change or revoke your medical and/or dental elections during a leave of absence or while on furlough, contact Benefits US Customer Service at 1-888-860-6178.

Eligibility for Your Dependents

You may elect coverage for your eligible Dependents under the Plan, provided you enroll them and supply the necessary documentation to verify eligibility. Eligible Dependents include:

- Your Spouse (or domestic partner) *(see the "Domestic Partners" Section of this SPD for eligibility requirements)*;

- Your children who are age 26 and under at any time in a calendar year. 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 children of your domestic partner who are age 26 and under at any time in a calendar year, even if you do not elect coverage for your domestic partner. 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; and

- The unmarried children of you or your domestic partner following the calendar year in which they attain age 26 who are not self-supporting because of a permanent physical, or mental disability and are dependent upon you, as defined by the Internal Revenue Code for income tax purposes, provided that such children were physically or mentally disabled and covered by the Plan on the day before the end of the calendar year in which they attained 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.

Children, for purposes of determining those dependents who are your “eligible dependent children” under the Plan, include:

- Your biological child, legally adopted child for whom you have permanent legal guardianship, a child placed with you for adoption, or your stepchild;

- Your domestic partner’s biological child, legally adopted child for whom your domestic partner has legal guardianship, a child placed with your domestic partner for adoption, or stepchild of your domestic partner.

Supporting Documentation for Eligible Dependent Children

The Company 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 not be eligible to receive coverage under the Plan. When your Dependent children are no longer eligible to participate in the Plan, you must notify the Benefits US Customer Service.

Coverage for a verified 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 by no later than December 1st if you wish to avoid this taxable income. (*See the "Paying for Coverage for Domestic Partners and Their Children" Section of this SPD for further information*). You may also wish to consult your tax advisor to determine how these IRS rules will impact your personal situation.

Domestic Partners

For purposes of the Plan, a domestic partner is an individual who meets all of the requirements outlined in this Section. Eligibility for your domestic partner and your domestic partner's children ends on the date a domestic partner no longer meets these requirements.

A domestic partner is your partner of the same gender who is:

- At least 18 years old;

- Not married to anyone other than yourself, and has dissolved any prior marriages through death or divorce;

- Not related to you by a degree of closeness that would prohibit legal marriage in the state(s) or domicile where you and your domestic partner reside;

- Your sole domestic partner for at least the last six months and is responsible for your common welfare and financial obligation, just as you are responsible for his or hers; and

- One who currently shares a household with you that is the primary residence for both of you and who has done so for the last six months (although you may live apart for reasons of education, health care, work, or military service).

You must demonstrate a valid domestic partnership to the Company in order to elect coverage for your domestic partner or your domestic partner's children. To do so, you must submit documentation that satisfies one of the following categories:

- A marriage certificate from a state or locality that allows or allowed same gendered marriage (provided such marriage has not subsequently been dissolved by the parties);
- Proof of domestic partner registration in a state or locality that allows for registration of domestic partner relationships (provided such registration has not subsequently been dissolved by the parties); or
- An executed Affidavit of Domestic Partnership (which may be made available to you by the Company) and two items, one from List A and one from List B below, with respect to both partners, one dated within two months of the submission of the Affidavit and one dated at least 6 months prior to the submission of the Affidavit:

List A	**List B**
■ A joint mortgage, lease, or deed	■ Joint bank account, joint credit cards, or other evidence of joint financial responsibility
■ Designation of the domestic partner to act on each other's behalf for all purposes under a power of attorney	■ A utility bill invoiced in both names, or two utility bills, one in the employee's name and one in the domestic partner's name, to the employee's current address
	■ Designation of the domestic partner as primary beneficiary for life insurance, retirement benefits, or a legal will or trust

The submission of documentation to register a domestic partnership with the Company alone does not entitle the domestic partner to any benefit coverage from the Company. Eligibility for benefits is governed by each benefit plan or program's terms and will be determined by the administrator of each benefit plan or program.

You and your eligible domestic partner must be aware of and understand the nature of the domestic partnership registration with the Company.

Confidentiality of Supporting Documentation for Domestic Partners

The Company will maintain the confidentiality of these documents, except as required to administer the benefits provided to eligible domestic partners, and except as required by law or in connection with legal proceedings involving the Plan.

If You and Your Spouse (or Domestic Partner) Both Work for the Company

In the case where you and your Spouse (or domestic partner) are both employed by the Company, provided you meet all other eligibility requirements, you may participate in the Plan in one of the following ways:

- You and your Spouse (or domestic partner) may each elect coverage separately; or
- One of you can elect employee coverage and enroll the other as a Dependent (if a Spouse) or a domestic partner.

If you both elect separate coverage, you may either enroll your eligible children as Dependents under your coverage, or enroll them under your Spouse's (or domestic partner's) coverage. You may not, however, enroll them under both your coverage and your Spouse's (or domestic partner's) coverage.

Unless you submit a signed "Dependent Certification Form" to the Benefits Department to certify that your domestic partner and/or your domestic partner's children satisfy the requirements to be considered your tax dependents, domestic partners and their children for whom you elect coverage will not be recognized under this Plan as dependents eligible for tax-free coverage. Therefore, if you elect coverage for them, premiums allocated for their coverage must be paid on an after-tax basis and the value of the Company-paid portion of their coverage will be taxable income to you. Please keep this in mind when making decisions about enrolling domestic partners and their children under your coverage where both you and your domestic partner work for the Company.

Surviving Spouses and Other Eligible Surviving Dependents

In the event you die while covered under the Plan, your surviving spouse (or domestic partner), and your surviving dependent children or your domestic partner's dependent children may be eligible to continue participation per company policy or collective bargaining agreement, if applicable. If they are eligible and they are not enrolled in the Plan, they may choose to enroll within 31 days of your date of death. Information will be provided to your surviving spouse (or registered domestic partner) and eligible dependent children or your registered domestic partner's dependent children upon notification of your death.

When Coverage Begins

Making Your Initial Elections

If you are a new employee enrolling during the year, coverage for you and any eligible dependents you elect to enroll will begin as of your date of hire. You have 31 days from your date of hire to enroll in the Plan. For example, if your hire date is March 15 and you enroll on April 1, your coverage begins as of March 15. Your initial coverage will remain in effect, as long as you are eligible and have provided the required documentation for eligible dependents, until you make an annual enrollment change, or until you experience a change in status. If you do not enroll within 31 days of your date of hire, you cannot enroll in the Plan until the next annual enrollment or if you experience a change of status event *(See the "Making Changes During the Year Due to a Change in Status" Section of this SPD for further details.)*

Annual Enrollment

You may elect coverage or make changes to your existing elections during the annual enrollment period, provided coverage remains available under this Plan and you continue to be eligible. New elections and any changes made during annual enrollment will be effective on the January 1st immediately following the annual enrollment period and remain in effect through December 31st. Aside from this annual enrollment period, Internal Revenue Service rules specify that you can only make changes to your elections during the year if you experience a change in status event. *(See the "Making Changes During the Year Due to a Change in Status" Section of this SPD for further details.)*

During the annual enrollment period, you may make changes to your Plan elections. For example, you may:

- Add or drop medical and/or dental coverage; or
- Increase or reduce the number of eligible Dependents you enroll for medical coverage (however, you must provide the required documentation to verify their eligibility for coverage as your Dependent).

During a leave of absence or furlough, you may participate in annual enrollment for the limited purpose of reducing your level of coverage or waiving coverage. Unless you make such changes during the annual enrollment period, coverage under the Plan will continue based on your existing elections. You may not enroll additional Dependents for coverage under the Plan unless you experience a change in status event (*see the "Making Changes During the Year Due to a Change in Status" Section of this SPD for more information on change in status events*).

Coverage Levels

When you enroll in the Plan, you may choose from one of the following medical and/or dental coverage levels for you and/or your verified eligible Dependents:

- Employee only;
- Employee and Spouse (or domestic partner);
- Employee and child or children with no Spouse or domestic partner; or
- Employee and family, which includes you, your Spouse (or domestic partner) and your eligible Dependent children.

The Employee Assistance Program benefit, discussed later in this SPD, is available to you and each of your eligible Dependents, and you need not enroll for this coverage since US Airways provides it to you automatically. *(See the "EAP" section of this SPD for further details)*

If You Do Not Enroll for Coverage

If you do not enroll in the Plan when you first become eligible, or during the annual enrollment period, you will **not receive coverage under the Plan**. You will not be eligible to enroll in the Plan until the next annual enrollment period, unless you experience a change in status event. *(See the "Making Changes During the Year Due to a Change in Status" Section of this SPD for more information on change in status events.)*

Paying for Coverage

You share in the cost of your medical and dental coverage with the Company. In general, the Company determines your portion of the contribution costs prior to the beginning of each Plan Year (the 12-month period, beginning each January 1st), based on an evaluation of expected medical and dental administrative and claim expenses for the upcoming year.

Contribution Costs Under a Collective Bargaining Agreement

If you are covered under a collective bargaining agreement, your contribution cost under the Plan may be specified by the terms of that agreement. Please see your collective bargaining agreement for more details. You can obtain a copy of your collective bargaining agreement by contacting your local management or union representative.

Each year before the annual enrollment period, you'll have access to information about the options and coverage levels available to you, and the associated costs through the Benefits US Customer Service website at www.ebenefitsUS.com

If you are an active employee, you will pay for the coverage that you elect under the Plan by payroll deduction on a pre-tax basis, before Federal—and, in most cases, state—income taxes and Social Security (FICA) taxes are withheld. The amount of your monthly contributions for coverage under the Plan is based on a group rate — that is, it is based on the cost of providing medical and/or dental coverage to all participants.

If you are on an unpaid Company approved leave of absence or furlough, your payment will be made to a third party administrator on an after-tax basis.

If you cover your domestic partner under the Plan, different tax treatment may apply. *(See the "Paying for Coverage for Domestic Partners and Their Children" in the next Section for more information.)*

There is no payroll deduction for the Employee Assistance Program since US Airways provides this coverage at no cost to you.

Paying for Coverage for Domestic Partners and Their Children

Except as noted below, the payroll contributions for your domestic partner's coverage and for his/her eligible Dependent child(ren)'s coverage are deducted on an after-tax basis. Additionally, you must pay taxes on the value of the Company-paid portion of their coverage. The value of the Company-paid portion of such coverage will be added to your income on your pay stubs and W-2, and is subject to ordinary Federal, state, local, FICA and other applicable payroll taxes.

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 for each year for which you elect coverage for your domestic partner and/or your domestic partner's children.

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 Benefits US 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 on or before December 1st for each year for which you elect coverage for your domestic partner and/or your domestic partner's children, 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 in the first paragraph of this Section.

Making Changes During the Year Due to a Change in Status

The Internal Revenue Service rules governing payroll deductions on a pre-tax basis prohibit you from making changes to your elections under the Plan during the Plan Year unless one of the following change in status events occurs. If you experience a change in status event, you may make a coverage change that is consistent with your change in status. Change in status events include:

- A change in your legal marital status (e.g., marriage, divorce, death of Spouse, or annulment);

  Note: *legal separation does not constitute a change in status event*

- A change in the number of your Dependents (e.g., through the birth, adoption, placement for adoption, or death of a Dependent);

- A change in your, your Spouse's (or domestic partner's), or your Dependent's employment status, including termination or commencement of employment, a strike or lockout, furlough, commencement of (or return from) an unpaid leave of absence, or a change from full-time to part-time status, or vice versa. A change in employment status that does not affect the number of hours you work does not constitute a change in status event;

- Your Dependent meets (or fails to meet) the Plan's dependent eligibility rules; and

- A change in your, your Spouse's (or domestic partner's) or Dependent's place of residence that would prevent access to the Plan's medical and/or dental network service areas.

More About Changes in Employment Status

Please note that a change in employment status that does not affect the number of hours you work does not constitute a change in status event.

You may also be permitted to make changes to your election(s) under the Plan in the event of:

- An eligible employee or Dependent who is not enrolled under the Plan and declined coverage because of coverage under a group health plan or individual coverage loses such coverage;

- A judgment, decree, or order, including a Qualified Medical Child Support Order (QMCSO), resulting from a divorce, annulment or change in legal custody that affects the provision of medical coverage of your Dependent child, or foster child;

- Entitlement (or loss of entitlement) to Medicare or Medicaid benefits. If you, your Spouse (or domestic partner) or your Dependent becomes entitled to Medicare or Medicaid benefits, you may drop or reduce coverage for that individual. Also, if you, your Spouse (or your domestic partner) or Dependent loses entitlement to Medicare or Medicaid benefits, you may commence or increase medical coverage for that individual under the Plan; and

- A significant reduction of coverage for you or your Spouse (or domestic partner) or Dependent that results in the complete loss of coverage, e.g. loss of coverage due to the elimination of a benefit option or due to an overall lifetime or annual limit.

An Overview of Change in Status Events

The following table provides a detailed look at various circumstances that may be considered change in status events under the Plan, as well as what changes to medical, dental, and health care spending account elections may be permitted, according to IRS regulations. For further information regarding the health care spending account and change of status events, please refer to your Flexible Benefit Plan Summary Plan Description.

In the Event of :	**What You May Do:**	
	Medical, Dental, and Vision	Health Care Spending Account
An address change that results in a change into or out of your coverage under the PPO network	• May change coverage option and coverage level. Change must be made within 31 days	• May begin or increase contributions within 31 days.
Marriage	• May enroll or drop coverage for self, spouse and dependents within 31 days. • May change coverage option. Documentation is required.	• May begin or increase contributions within 31 days. Documentation is required.
Divorce	• Must drop spouse within 31 days. • May enroll or drop coverage for self and/or dependents within 31 days. COBRA coverage is available for dropped dependents. • May change coverage option. Documentation is required.	• May begin or increase contributions within 31 days. Documentation is required.

In the Event of :	What You May Do:	
	Medical, Dental, and Vision	Health Care Spending Account
Birth of a Child	• May enroll or drop coverage for self, spouse and dependents within 31 days. • May change coverage option. Documentation is required.	• May begin or increase contributions within 31 days. Documentation is required.
Adoption/Placement for Adoption or Permanent Legal Guardianship	• May enroll or drop coverage for self, spouse and dependents within 31 days. • May change coverage option. Documentation is required.	• May begin or increase contributions within 31 days. Documentation is required.
Spouse Gains Employment/Coverage	• May drop self and dependents from coverage within 31 days. • May decrease coverage option. Documentation is required.	• May decrease contributions within 31 days. Documentation is required.
Spouse Loses Employment/Coverage	• May elect, waive or change coverage level or coverage option within 31 days. • May add spouse and dependents. Documentation is required.	• May begin or increase contributions within 31 days. Documentation is required.
Death of Spouse or Dependent	• May elect, waive or change coverage level or coverage option within 31 days. • May add or drop dependents. Documentation is required.	• May begin or decrease contributions within 31 days. Documentation is required.
Change in employment Status – Full-time to Part-time or Part-time to Full-time	• May enroll or drop coverage for, spouse and dependents within 31 days. • May not change enrollment for self. • May change coverage option and level.	• Full-time to Part-time: No changes allowed. • Part-time to Full time: May increase contributions within 31 days.

In the Event of :	What You May Do:	
	Medical, Dental, and Vision	Health Care Spending Account
Going on Leave/Furlough	• May add or delete spouse, dependent(s), and/or yourself within 31 days. • May change coverage option and level.	• Payroll contributions are suspended. May elect to continue under COBRA if enrolled.
Returning from Leave/Furlough	• May add or delete spouse, dependent(s), and/or yourself within 31 days. • May change coverage level and option. If return from leave is same year you went on leave, and no election changes are made within 31 days, elections will continue at same option and level as before your leave.	• May begin or increase contributions within 31 days. • If you return from leave in the same year you went on leave, and no election change is made within 31 days, contributions will continue at the same rates before your leave.
Rehire	• May add or delete spouse, dependent(s), and/or yourself within 31 days. • May change coverage level and option. If rehired in the same year you terminated and no election changes are made within 31 days, elections will continue at same option and level as before your leave.	• May begin or increase contributions within 31 days. • If you are rehired in the same year you terminated, your contribution rate will continue at the same rates as it was on your date of termination.

Special Enrollment Periods

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you will be able to enroll yourself, your Spouse or your Dependents in this Plan if any of three special enrollment periods apply, as described below.

Special Enrollment for Loss of Coverage

A special enrollment period applies if you or a Dependent did not enroll during the annual enrollment period or initial enrollment period (for newly hired employees), provided that you request enrollment within 31 days after your other coverage ends, and the following requirements are satisfied:

- you or your Dependent had existing health coverage (also known as creditable coverage) under another plan at the time of the initial enrollment period or annual enrollment period.

- Coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including without limitation, divorce or death).
    - The prior employer or policyholder stopped paying the contribution.
    - In the case of COBRA continuation coverage, the coverage ended.

Coverage will become effective as of the first day following the loss of coverage.

Failure to notify the Company of your loss of coverage within 31 days of the loss will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

Special Enrollment for Addition of a Dependent

A special enrollment period applies if you **add a Dependent due to** marriage, birth, adoption, or placement for adoption**,** provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Coverage added due to marriage, birth, adoption or placement for adoption will become effective as of the date of the event.

Failure to notify the Company of your marriage, birth, adoption, or placement for adoption within 31 days of the event will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

Special Enrollment for Medicaid and CHIP

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") requires the Plan to permit you and your Dependent(s) to enroll (or disenroll) in the Plan following the occurrence of either of the following events:

- *Loss of coverage under Medicaid or a state child health plan*: If you or your Dependent(s) lose coverage under Medicaid or a state child health plan, you may request to enroll yourself and/or your Dependent(s) in the Plan not later than 60 days after the date coverage ends under Medicaid or the state child health plan.

- *Gaining eligibility for coverage under Medicaid or a state child health plan*: If you and/or your Dependent(s) become eligible for financial assistance (such as a premium subsidy) from Medicaid or a state child health plan, you may request to enroll yourself and/or your child(ren) under the Plan, provided that your request is made no later than 60 days after the date that Medicaid or the state child health plan determines that you and/ or your Dependent(s) are eligible for such financial assistance. If you and/or Dependent(s) are currently enrolled in the Plan, you have the option of terminating the enrollment of you and/or your child(ren) in the Plan and enroll in Medicaid or a state child health plan. Please note that, once you terminate your enrollment in the Plan, your children's enrollment will also be terminated.

Coverage will become effective as of the first day following the loss of coverage or the date of gain in eligibility.

Failure to notify the Company of your loss or gain of eligibility for coverage under Medicaid or a state children's health plan within 60 days will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

How to Make Changes to Your Elections

If you have a change in status, you may be eligible to make certain changes to your elections that are consistent with this status change. For example, in the event you get married, you would be eligible to elect coverage for your new Spouse. To change your elections under the Plan, log on to Benefits US at www.eBenefitsUS.com or call Customer Service at 1-888-860-6178. When you log on to the Benefits US home page, click on the "Add Life Status Change Event" link to create your status change event and make your election changes.

IMPORTANT! You must notify Benefits US of a change in status event within 31 days of the event if you want to change your benefit elections. This rule does not apply to Special Enrollment for Medicaid and CHIP, for which you have 60 days from the date of the event to notify Benefits US of the loss or gain of coverage under Medicaid or a state child health plan. Otherwise, you must wait until the next annual enrollment period or another change in status event to make any changes to your elections under the Plan.

When Coverage Ends

In general, your Plan coverage will end for you and your Dependents:

- The end of the month in which your employment ends;
- When you stop making required contributions;
- When you or your Dependents are no longer eligible to participate in the Plan (for instance, due to a change in your employment status); or
- When the Plan is terminated.

You may be able to continue your Plan coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). (*See the "COBRA Continuation of Coverage" Section of this SPD for further details.*) You may also be able to continue coverage if you are on an approved Family and Medical Leave Act (FMLA) leave or are on military leave. (*See the "COBRA Continuation of Coverage" section of this SPD for further details.*)

Note: Rules and rates for benefit continuation vary by group and are subject to the terms of your collective bargaining agreements. You can obtain a copy of the respective collective bargaining agreement by contacting your local management or union representative.

Resuming Participation

If You Are Rehired or If You Return from a Leave of Absence or Furlough

If your employment with the Company is terminated, or if you waived coverage during or when you started an approved leave of absence or a furlough, you will again become eligible to participate in the Plan on the date you are rehired, recalled or returned to work.

If you are rehired, recalled or returned to work and resume participation in the Plan in a later Plan Year than the Plan Year in which you terminated, took leave, or were furloughed, you must make new benefit

elections for you and your eligible Dependents at the time you are rehired, recalled or returned to work by re-enrolling in the Plan.

If you are rehired, recalled, or returned to work during the same Plan Year in which you terminated, took leave, or were furloughed, your prior enrollment election will be reinstated for the balance of the Plan Year, although you can make changes within 31 days of the date of your rehire or return to work. For example, if your employment terminated during March and you were rehired in October, the benefit elections that were in place in March immediately prior to your termination would be reinstated in October.

If You Go To Work for Another Employer

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines the circumstances under which eligibility for medical coverage may be limited based on a pre-existing medical condition.

If you leave the Company and go to work for another employer whose medical plan includes a pre-existing condition exclusion from coverage, the HIPAA "prior creditable coverage" provisions may help exempt you from any such exclusion.

When you leave the Company, you and your covered Dependents will automatically receive a certificate of creditable coverage from the Company. This certificate will document that you (and any of your eligible, enrolled Dependents) had medical coverage under the Plan.

If your new employer's medical plan includes a pre-existing condition clause, you can use your certificate(s) of creditable coverage to shorten or eliminate any applicable waiting period for full medical benefits under the new employer's plan.

You can request a certificate of creditable coverage by calling the appropriate medical carrier.

Please note: A certificate of creditable coverage will not be effective to shorten or eliminate any applicable waiting period under a pre-existing condition clause of a new employer if there is a lapse of 63 days or more between the period of creditable coverage under this plan and your enrollment in your new employer's health plan.

YOUR MEDICAL OPTIONS

The Plan includes medical coverage for a wide range of covered health services and supplies your doctor prescribes to treat an illness or injury. Both in-network and out-of-network benefits are available.

This section provides important information about each of the medical coverage options offered under the Plan and the benefits those options include. In this section you will find the following information on your medical coverage under the Plan:

- The claims administrator's responsibilities;
- A detailed summary of each medical coverage option;
- Information about pre-certifying your care for certain medical services;
- How to file a claim;
- An overview of covered medical services;
- A list of medical services not covered; and
- Additional rules that apply to your medical coverage.

Claims Administrator Responsibilities

One or more medical Claims Administrators are responsible for all medical coverage options under the Plan. The carrier(s) maintain medical plan networks, process medical claims, and provide member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan,*" you will find contact information for these administrators.

Wellness Program

US Airways sponsors a wellness program called "Fit For US," which is treated as a component of the Medical Plan. Fit for US is a program that provides tools, resources, and support you need to get healthy. Fit For US is provided free of charge for all eligible US Airways' employees (and their spouse/domestic partner) who are currently enrolled in one of the medical plans sponsored by US Airways. Information about Fit For US can be found at: http://wings.usairways.com.

The PPO Plan

The Plan offers medical benefits through a Preferred Provider Organization, referred to as "PPO" or "PPO Plan." Preferred providers are those who participate in the PPO network of doctors, hospitals, and other health care facilities.

The PPO Plan includes three coverage options from which to choose that vary based on the amounts of your annual deductible and out-of-pocket maximum, and coinsurance levels. The amount of the premium that you will be required to pay also varies based on the PPO option you elect. Current information about the premium costs will be provided each year during annual enrollment.

The PPO Plan provides coverage in nearly all the areas where US Airways employees reside. If you live within a PPO Plan network service area and choose to enroll for medical coverage under the Plan, the PPO Plan Program will provide your medical coverage. If, however, your primary residence is outside all PPO Plan network service areas and you choose to enroll for medical coverage under the Plan, your medical coverage will be provided through an Out-of-Area Program *(See "The Out-of-Area Program" section of this SPD for more information.)*

The chart included in the *"Schedule of PPO Plan Benefits"* section of this SPD provides a detailed summary of the medical benefits available through the PPO Plan.

Using Preferred and Non-Preferred Providers

Under the PPO Plan, each time you need care, you can choose to receive care from a preferred provider who is part of the network (in-network provider) or a non-preferred provider outside the network (out-of-network provider).

When You See In-Network Program Providers

When you receive care from an in-network provider, your out-of-pocket costs are less than they would be if you received care from an out-of-network provider. For example, when you use an in-network provider, your annual deductible for covered services is lower than the amount required for such services from an out-of-network provider. In addition, after you pay any applicable co-pays and/or coinsurance, you will not be subject to any balance billing for charges from in-network providers.

When You See Out-of-Network Providers

When you receive care from an out-of-network provider, you must pay 100% of charges for medical services until you have met the applicable annual deductible amount for your coverage option. After you meet the annual deductible amount, you share the cost of the services you receive with the Plan. Your out-of-pocket costs are higher than they would be if you received care from an in-network provider because the Plan pays benefits based on reasonable and customary (R&C) charges. R&C charges are based on the typical amounts charged by most providers in your geographic area for specific medical services. If an R&C charge is more than the limit set by the Plan, you must pay the amount that exceeds the limit, in addition to any applicable deductible and coinsurance amounts.

The PPO Plan includes separate annual out-of-pocket maximum amounts for in-network and out-of-network care. When you reach these maximums, the Plan will pay 100% of your eligible expenses for the rest of the calendar year (excluding charges above the R&C limit or charges not otherwise covered by the Plan).

More about Co-pays, Annual Deductibles and Out-of-Pocket Maximums

Please note that your co-pays for medical services do not count toward satisfying the annual deductible or the annual out-of-pocket maximum.

Finding In-Network Providers

You can find an in-network provider by:

- Logging onto Benefits US at www.eBenefitsUS.com. There, you'll find a link to online provider directories;
- Going directly to your medical plan administrator's website where you'll find links to online provider directories; or
- Calling your medical plan administrator.

On the following page, you will find an overview of the PPO Plan and the benefits it includes.

Schedule of PPO Plan Benefits

An Overview of PPO Plan Benefits

The following chart is an overview of the key features of the PPO Plan, including the benefits for PPO 80/60, PPO 90/70, and PPO 100/80. The chart is an overview only and does not list every covered service. For more information on how services are covered under the PPO Plan, contact your medical Claims Administrator.

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**
Annual Deductible (1 person/2 or more people)	$450/$900	$900/$1,800	$225/$450	$450/$900	$225/$450	$450/$900
Coinsurance	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of reasonable and customary (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
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	$225/$450	$3,000/$6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Medical Office Services						
Doctor's Office Visits	$25 co-pay for primary doctors; $40 co-pay for specialists	The Plan pays 60% of R&C charges, after annual deductible	$25 co-pay for primary doctors; $40 co-pay for specialists	The Plan pays 70% of R&C charges, after annual deductible	$25 co-pay for primary doctors; $40 co-pay for specialists	The Plan pays 80% of R&C charges, after annual deductible

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**
Preventive Care *includes routine physicals and well child care* (no limit on visits until attaining age 5, then one routine physical per year)	$25 co-pay	Not covered	$25 co-pay	Not covered	$25 co-pay	Not covered
OB/GYN Exams	$25 co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to deductible and coinsurance	$25 co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to deductible and coinsurance	$25 co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to deductible and coinsurance

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**
X-Rays and Lab Tests (pathology and other diagnostic testing)	The Plan pays 100% of discounted in-network fees if performed in doctor's office as part of office visit; if performed in outpatient facility, the Plan pays 100% of discounted in-network fees for lab charges; 80% of discounted in-network fees, after annual deductible, for x-rays and related services, except mammograms performed in outpatient facility $25 co-pay, no deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees if performed in doctor's office as part of office visit; if performed in outpatient facility , the Plan pays 100% of discounted in-network fees for lab charges, 90% of discounted in-network fees, after annual deductible, for x-rays and related services, except mammograms performed in outpatient facility $25 co-pay, no deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees if performed in doctor's office as part of office visit; if performed in outpatient facility , the Plan pays 100% of discounted in-network fees for lab charges and 100% of discounted in-network fees, after annual deductible, for x-rays and related services, except mammograms performed in outpatient facility $25 co-pay, no deductible	The Plan pays 80% of R&C charges, after annual deductible
Immunizations	$25 co-pay	Not covered	$25 co-pay	Not covered	$25 co-pay	Not covered

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**
Inpatient Hospital Care						
Room allowance (semi-private room covered; private room covered only when medically necessary)	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
Surgery	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
Maternity Care						
Obstetric Services (including office visits)	$25 co-pay (initial visit only); thereafter, the Plan pays 80% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 60% of R&C charges, after annual deductible	$25 co-pay (initial visit only); thereafter, the Plan pays 90% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 70% of R&C charges, after annual deductible	$25 co-pay (initial visit only); thereafter, the Plan pays 100% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 80% of R&C charges, after annual deductible
Hospital Charges (including newborn nursery 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

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**
Prescription Drugs (benefits provided Pharmacy Claims Administrator)						
Retail Co-pay (up to 34-day supply)	$15 generic $30 preferred brand $50 non-preferred brand	Not covered	$15 generic $30 preferred brand $50 non-preferred brand	Not covered	$15 generic $30 preferred brand $50 non-preferred brand	Not covered
Mail Order Co-pay (> 34-day supply and up to 90-day supply)	$30 generic* $60 preferred brand $100 non-preferred brand	Not covered	$30 generic* $60 preferred brand $100 non-preferred brand	Not covered	$30 generic* $60 preferred brand $100 non-preferred brand	Not covered
*Effective January 1, 2009, some generic drugs are available through mail order for a $10 co-pay for up to a 90-day supply.						
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	$225/$450	$3,000/$6,000

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**
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*
Other Coverage						
Emergency Room	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)

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**
Durable Medical Equipment (some Durable Medical Equipment may have certain limitations, such as one custom pair of shoe inserts per benefit period)	$500 per year paid at 100%, then the Plan pays 80% of discounted in-network fees, after annual deductible Prior Plan Approval must be obtained after first $500 paid has been met	The Plan pays 60% of R&C charges, after annual deductible	$500 per year paid at 100%, then the Plan pays 90% of discounted in-network fees, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met	The Plan pays 70% of R&C charges, after annual deductible	$500 per year paid at 100%, then the Plan pays 100% of discounted in-network fees, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met	The Plan pays 80% of R&C charges, after annual deductible
Physical Therapy and Occupational Therapy 40-visit maximum per year (in- and out-of-network care is combined for maximums). Visits above 40 per year subject to ongoing medical necessity review.	$40 co-pay	The Plan pays 60% of R&C charges, after annual deductible	$40 co-pay	The Plan pays 70% of R&C charges, after annual deductible	$40 co-pay	The Plan pays 80% of R&C charges, after annual deductible

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**
Speech Therapy (20-visit maximum per year combined for in- and out-of-network care). Visits above 20 per year subject to ongoing medical necessity review.	$40 co-pay	The Plan pays 60% of R&C charges, after annual deductible	$40 co-pay	The Plan pays 70% of R&C charges, after annual deductible	$40 co-pay	The Plan pays 80% of R&C charges, after annual deductible
Chiropractic Care (20-visit maximum per year; visits beyond the per year maximum are covered if a covered health service). Visits above 20 per year subject to ongoing medical necessity review.	$40 co-pay	Not covered	$40 co-pay	Not covered	$40 co-pay	Not covered
Home Health Care (100-visit maximum per year). Visits above 100 per year subject to ongoing medical necessity review.	The Plan pays 100% of discounted in-network fees	Not covered	The Plan pays 100% of discounted in-network fees	Not covered	The Plan pays 100% of discounted in- network fees	Not covered

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**
Hospice Care	The Plan pays 100% of discounted in-network fees, after annual deductible.	Not covered	The Plan pays 100% of discounted in-network fees, after annual deductible.	Not covered	The Plan pays 100% of discounted in-network fees, after annual deductible.	Not covered
Skilled Nursing Care Facility (60-day maximum per year combined for in- and out-of-network 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
Ambulance Services*	The Plan pays 80% of discounted in-network fees, after annual deductible.	The Plan pays 80% of R&C charges, after annual deductible.	The Plan pays 90% of discounted in-network fees, after annual deductible.	The Plan pays 90% of R&C charges, after annual deductible.	The Plan pays 100% of discounted in-network fees, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.
All other covered and medically necessary services including, but not limited to: Medical Supplies (blood, oxygen, prosthetics) and Dialysis Services.	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.

* Air transport and ambulance service between facilities must be medically necessary as determined by the Claims Administrator.

Important Notes About PPO Plan Benefits

1. Deductible amounts and out-of-pocket maximum amounts for in-network and out-of-network services are mutually exclusive. That means that amounts you pay toward the deductible and out-of-pocket maximum for in-network care do not count toward satisfying the out-of-network deductible and out-of-pocket maximum. Likewise, amounts you pay toward the out-of-network deductible and out-of-pocket maximum do not count toward satisfying the deductible and out-of-pocket maximum for in-network care.

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.

3. If you move from a PPO Plan to an Out-of-Area ("OOA") Plan in the same calendar year, the in-network medical and mental health/chemical dependency deductibles and out-of-pocket maximums that you met under the PPO Plan will transfer to the OOA plan deductibles and out-of-pocket maximums for that year.

Pre-certifying Care For Certain Medical Services

Pre-certifying care means notifying your medical Claims Administrator to make sure a treatment plan is approved in advance. All inpatient surgical procedures and hospital stays (including emergency admissions, skilled nursing care facilities and in-patient hospice care facilities) must be pre-certified. **It is important to understand your responsibility for pre-certifying care since failure to do so will result in a $250 penalty**, which does not count toward satisfying your annual deductible or your annual out-of-pocket maximum.

When You See In-Network Providers

When you see an in-network provider, the provider should coordinate the notification process on your behalf. However, it's a good idea to verify with your provider that your care has been pre-certified in advance of any surgery or hospital stay. In the event that the $250 notification penalty is applied to your "In-Network claim" in error, please contact your medical Claims Administrator to have the penalty waived.

When You See Out-of-Network Providers

When you see providers that are not part of the PPO network, notification is *your* responsibility. Before any in-patient surgical procedure or hospital stay (including emergency admissions, and skilled nursing care facilities), you, your doctor, or someone else familiar with your situation must contact your medical Claims Administrator to pre-certify your care in advance. A $250 penalty for failure to pre-certify will apply, which does not count toward satisfying the annual deductible or annual out-of-pocket maximum.

Filing a Claim

When You See In-Network Providers

If you receive care from an in-network provider, you do not need to file a claim to receive benefits — your provider files the claim for you.

When You See Out-of-Network Providers

If you receive care from an out-of-network provider, you must file a claim with your medical Claims Administrator to receive benefits. To file a claim, you must complete a claim form, attach your original itemized bills, and mail them to the address shown on the form. All claims must be filed within 18 months following the end of the Plan Year during which the care was received. If your claim is submitted after that period of time, it will not be eligible for payment.

You can obtain a claim form by contacting Benefits US. Log on to www.eBenefitsUS.com or call 1-888-860-6178. You may be asked to pay for your care at the time of your visit and submit a claim for reimbursement.

The Out-of-Area Program ("OOA")

If you live outside any PPO Plan network service area, medical coverage is available through the Out-of-Area Program. The Out-of-Area Program is a non-network program. With a non-network program, you may receive care from any provider you want. After you pay an annual deductible, the Plan will begin to share the cost of care with you. Generally, the Plan pays a certain percentage of the reasonable and customary (R&C) charges for services and you pay the rest. R&C charges are based on the typical amounts charged by most providers in your geographic area for specific medical services. If the cost of your care is more than the R&C limit set by the Plan, you pay the amount that exceeds the limit in addition to any applicable deductible and coinsurance amounts.

When you reach the annual out-of-pocket maximum, the Plan will pay 100% of your eligible expenses for the rest of the Plan Year (excluding charges above the R&C limit or charges not otherwise covered by the Plan).

The Out-of-Area Program offers three coverage options from which to choose that vary based on the amounts of your annual deductible, annual out-of-pocket maximum, and coinsurance levels.

On the following pages, you will find an overview of the Out-of-Area Program and the benefits it includes.

Schedule of Out-of-Area Program Benefits

An Overview of Out-of-Area Program Benefits

The following chart is an overview of the key features of the Out-of-Area Program ("OOA"), including the benefits for OOA 80, OOA 90, and OOA 100. The chart is an overview only and does not list every covered service. For more information on how the Plan covers services under the Out-of-Area Program, contact your medical Claims Administrator.

Schedule of Out-of-Area Program Benefits

	OOA 80	OOA 90	OOA 100
Annual Deductible (1 person/2 or more people)	$450/$900	$225/$450	$225/$450
Coinsurance	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Annual Out-of-Packet Maximum (1 person/2 or more people)	$3,000/$6,000	$1,500/$3,000	$225/$450
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Medical Office Services			
Doctor's Office Visits	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Preventive Care *includes routine physicals and well child care* (no limit on visits until age 5, then one routine physical per year)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
OB/GYN Exams	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

Schedule of Out-of-Area Program Benefits

	OOA 80	OOA 90	OOA 100
X-Rays and Lab Tests	The Plan pays 100% of R&C charges, after meeting annual deductible, if performed in doctor's office as part of office visit; if performed in outpatient facility , the Plan pays 100% of R&C charges for lab charges and 80% of R&C charges for x-rays and related services	The Plan pays 100% of R&C charges, after meeting annual deductible, if performed in doctor's office as part of office visit; if performed in outpatient facility, the Plan pays 100% of R&C charges for lab charges and 90% of R&C charges for x-rays and related services	The Plan pays 100% of R&C charges, after annual deductible
Immunizations (No age limitation)	The Plan pays 80% of charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Inpatient Hospital Care			
Room Allowance (semi-private room covered; private room covered only when medically necessary)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Surgery	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Maternity Care			
Obstetric Services (including office visits)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Hospital Charges (including newborn nursery care)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

Schedule of Out-of-Area Program Benefits

	OOA 80	OOA 90	OOA 100
Prescription Drugs (benefits provided through Pharmacy Claims Administrator)			
Retail Co-pay (up to 34-day supply) ***You must use a PBM in-network pharmacy.***	$15 generic $30 preferred brand $50 non-preferred brand	$15 generic $30 preferred brand $50 non-preferred brand	$15 generic $30 preferred brand $50 non-preferred brand
Mail Order Co-pay (> 34-day and up to 90-day supply)	$30 generic* $60 preferred brand $100 non-preferred brand	$30 generic* $60 preferred brand $100 non-preferred brand	$30 generic* $60 preferred brand $100 non-preferred brand
*Effective January 1, 2009, some generic drugs are available through mail order for a $10 co-pay for up to a 90-day supply.			
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	$225/$450
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 50% of R&C charges, after separate annual deductible *No visit maximum*	The Plan pays 50% of R&C charges, after separate annual deductible *No visit maximum*	The Plan pays 50% of R&C charges, after separate annual deductible *No visit maximum*

Schedule of Out-of-Area Program Benefits

	OOA 80	OOA 90	OOA 100
Other Coverage			
Emergency Room	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Durable Medical Equipment (some Durable Medical Equipment may have certain limitations, such as one custom pair of shoe inserts per benefit period)	$500 per year at 100% of R&C, then the Plan pays 80% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met	$500 per year at 100% of R&C, then the Plan pays 90% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met	$500 per year at 100% of R&C, then the Plan pays 100% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met
Physical and Occupational Therapy (40-visit maximum per year). Visits above 40 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Speech Therapy (20-visit maximum per year). Visits above 20 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Chiropractic Care (20-visit maximum per year). Visits above 20 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Home Health Care (100-visit maximum per year). Visits above 100 per year subject to ongoing medical necessity review.	The Plan pays 100% of R&C charges	The Plan pays 100% of R&C charges	The Plan pays 100% of R&C charges

Schedule of Out-of-Area Program Benefits

	OOA 80	OOA 90	OOA 100
Hospice Care	The Plan pays 100% of R&C charges, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.
Skilled Nursing Care Facility (60-day max. per year)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
All other covered and medically necessary services including, but not limited to: Ambulance,* Medical Supplies (blood, oxygen, prosthetics) and Dialysis Services	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

*Air transport and ambulance service between facilities must be medically necessary as determined by the Claims Administrator.

Important Notes About Out-of-Area Program Benefits

1. 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.

2. If you move from an OOA Plan to a PPO Plan in the same calendar year, the medical and mental health/chemical dependency deductibles and out-of-pocket maximums that you met under the OOA Plan will transfer to the PPO plan in-network deductibles and out-of-pocket maximums for that year.

Pre-certifying Care For Certain Medical Services (Out-of-Area Program)

Pre-certifying care means notifying your medical Claims Administrator to make sure a treatment plan is approved in advance. All in-patient surgical procedures and hospital stays (including emergency admissions, skilled nursing care facilities and in-patient hospice facilities) need to be pre-certified. It's important to understand your responsibility for pre-certifying care since failure to do so will result in financial penalties you must pay.

Notification is *your* responsibility. Before any surgical procedure or hospital stay, you, your doctor, or someone else familiar with your situation must contact your medical Claims Administrator to pre-certify your care. **If you do not pre-certify your care in advance, a penalty of $250 will apply.** This penalty does not count toward the annual deductible or annual out-of-pocket maximum.

Filing a Claim (Out-of-Area Program)

To receive benefits for care, you must file a claim. To file a claim, you must complete a claim form, attach your original itemized bills, and mail them to the address shown on the form. All claims must be filed within 18 months following the end of the Plan Year during which your care was received. If your claim is submitted after that period of time it will not be eligible for payment. This 12-month requirement does not apply if you are legally incapacitated

You may be asked to pay for your care at the time of your visit and submit a claim for reimbursement from the Plan.

You can obtain a claim form by contacting Benefits US. Log on to www.eBenefitsUS.com or call 1-888-860-6178.

Medical Services Covered Under the Plan

In general, the PPO Plan and Out-of-Area Programs cover a wide range of covered health services and supplies your doctor prescribes or authorizes to treat an illness or injury. *(See the "Schedule of PPO Plan Benefits" and "Schedule of Out-of-Area Program Benefits" sections of this SPD for a summary of covered services).*

If you have further questions about the medical services covered under the Plan, call your medical Claims Administrator.

Medical Services NOT Covered Under the Plan

The PPO Plan and Out-of-Area Programs exclude coverage for certain services. Please contact your medical Claims Administrator if you have questions about what services are excluded.

The following services are excluded from coverage:

- Services and supplies that are not medically necessary covered health services, as determined by your medical Claims Administrator;

- Custodial care, defined as care essentially designed to assist individuals to meet their activities of daily living, such as but not limited to services which constitute personal care (including; help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not entail or require continuous attention of trained medical personnel);

- Cosmetic procedures and supplies, except when reconstructive/cosmetic surgery is necessary as a result of Sickness, Injury or Congenital Anomaly, or to comply with the requirements of The Women's Health and Cancer Rights Act of 1998. *(See the "Additional Rules That Apply to Your Medical Coverage" section of this SPD.)* Examples of procedures that are excluded from coverage include: rhinoplasty (nose), mentoplasty (chin), rhytidoplasty (face lift), glabellar rhytidoplasty, (space between eyebrows) surgical planning (dermabrasion), blepharoplasty (eyelid), mammoplasty (reduction, suspension or augmentation), superficial chemosurgery (chemical peel) and liposuction;

- Treatment or tests performed on an inpatient basis that could have been performed safely and effectively on an outpatient basis;

- Experimental/Investigational or unproven procedures, unless the Plan has agreed to cover them as stated in the Glossary;

- Medically necessary services or expenses associated with the treatment of obesity, weight reduction or dietary control beyond one surgical procedure per lifetime. It is your responsibility to contact your medical Claims Administrator to discuss your eligibility and surgical options covered under this Plan. Failure to do so may result in denial of your claim. Benefits will not be provided for reversals or reconstructive procedures;

- Services or supplies not needed for diagnosis or treatment of a specific illness or injury;

- Treatment resulting from injuries and/or illnesses received as a result of military service (subject to the terms of any applicable collective bargaining agreements);

- Services you are not charged for in Veterans Administration hospitals or other kinds of hospitals or agencies;

- Services or expenses provided by a physician or other health care provider related to the covered person by blood or marriage;

- Services or supplies you received before you had coverage under the Plan, or after your coverage under the Plan ends;

- Services or supplies payable by Medicare, or any other government or private program;

- Private duty services provided by sitters or companions. Private duty services by Registered Nurses or Licensed Practical Nurses will also be excluded unless the services are part of an approved home health care or hospice program;

- Reversals of tubal ligations or vasectomies;

- Infertility treatment, services and associated expenses for artificial insemination including In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs including collection and preparation;

Note: *Diagnostic testing to determine the cause of infertility and prescription medication to treat infertility is covered under the Plan.*

- Prescription drugs purchased at a doctor's office, skilled nursing facility, hospital or any other place that is not a pharmacy licensed to dispense drugs in the state where it is operated;

- Any service or treatment for complications resulting from any non-covered procedures;

- Any service or supply rendered to a covered person for the diagnosis or treatment to change gender or to improve or restore sexual function;

- Marriage, family or child counseling for the treatment of premarital, marital, family or child relationship dysfunction;

- Services and supplies related to routine foot care; except for procedures associated with diabetic treatment;

- Food supplements including infant formula available over the counter. Coverage of food supplements is restricted to sole source nutrients which are not available over the counter or without a prescription;

- Prescription drugs used for cosmetic purposes or hair growth;

- Travel whether or not recommended by a physician, except in connection with medically necessary travel for an organ donor or the delivery of an organ;

- Durable Medical Equipment over $500 when required preauthorization is not obtained;

- Services and supplies related to human organ and tissue transplants when the required pre-approval is not obtained;

- Any service or supply the covered person is not legally obligated to pay;

- Services for the removal of impacted teeth;

- Eyeglasses, contact lenses (except after cataract surgery), hearing aids and examination for the prescription or fitting thereof and any hospital or physician charges related to refractive care;

- Any medical social services, visual, recreational, behavioral, educational or play therapy or bio-feedback, except when part of a pre-authorized home health plan or hospice care program;

- Premarital and pre-employment exams;

- Dental services, except for dental treatment and oral surgery related to the mouth that is required as the result of an accident and started prior to a year after the accident. Dental services required as the result of an accident may be covered under the medical program subject to certain medical necessity limitations and could include treatment for standard reconstruction (plates and crowns). Services are also limited to the replacement of sound and natural teeth. Only when deemed a medically necessary covered health service **and** the only alternative to restore the tooth/teeth/arch to it's functional condition, implants may be a covered expense (to a $15,000 lifetime maximum);

- Services and supplies received for the treatment of any work related accident or illness;

- Services or expenses for treatment of injury sustained in the commission of a crime or for treatment while confined in a prison, jail, or other penal institution;

- Services or expenses for personal hygiene, comfort or convenience items such as air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel and health club memberships. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracts, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles, and related services performed during the same therapy session are also excluded;

- Any surgical procedure relating to the eye other than one which is a result of trauma or disease. This includes, but is not limited to, Lasix, radial Keratotomy; any other procedure to correct refractive disorders not a consequence of trauma, or disease; or repair of prior ophthalmic surgery unless original surgery was a covered expense under this Plan;

- Acupuncture;

- Hair transplants and treatment of baldness;

- Routine prostate screening exams at an out-of-network provider;

- Chelation Therapy, except for treatment of heavy metal poisoning; and

- Alternative treatments including but not limited to: acupressure, aromatherapy, hypnotism, massage therapy, rolfing (holistic tissue massage), and other forms of alternative treatments as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institute of Health.

Additional Rules That Apply to Your Medical Coverage

Breast Reconstruction Benefits

In compliance with the requirements of The Women's Health and Cancer Rights Act of 1998, the Plan provides benefits related to breast reconstruction.

Under this federal law, group health plans that provide medical and surgical benefits for mastectomy must provide certain additional benefits related to breast reconstruction.

If you (or a covered Dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the Plan will provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

Covered services will be provided in a manner determined in consultation between the attending doctor and the patient. Benefits will be provided in the same way as provided for any other surgical expense, and are subject to any deductibles and coinsurance requirements that may apply.

Maternity Admissions

Group health plans (like this Plan) generally may **not,** under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

The Plan must not, under federal law, require that a provider obtain authorization from the Plan or the Claims Administrator for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coordination With Medicare for Employees on Leave of Absence and Disabled Individuals

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. If you are Medicare-eligible and Medicare would be the primary payer, the Plan will pay benefits as though you had enrolled in Medicare Part A (hospital) and Part B (physicians and other services) 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. Timely enrollment in Medicare Parts A and B will ensure proper coordination of benefits. You may obtain further information on Medicare eligibility by contacting Medicare directly at 1-800-MEDICARE or www.Medicare.gov.

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.

Example

The following example shows how benefits coordinate with Medicare where Medicare pays primary (e.g., where you are entitled to Medicare based on disability and you have received disability benefits from the Company for more than 6 months). Let's assume you enroll in Out-of-Area Program, OOA 90, you have already met your annual deductible, and you incur a claim for which the Medicare Allowable Amount is $2,000. Medicare Part B covers these expenses at 80%, while the OOA 90 covers them at 90%. Medicare Part B will first pay 80% of the Medicare Allowable Amount, or $1,600. Then, the Out-of-Area Program will pay 10% of the Medicare Allowable Amount. This is the difference between 90% (what the Out-of-Area Program would pay if it were your primary coverage) and 80% (what Medicare pays), $200 in this example. Both plans coordinate to pay 90% of the total charge, or $1,800—the same benefit you would have received from the Out-of-Area Program if it had been your primary coverage. If you had only enrolled in Medicare Part A, the Plan would still pay as if you were enrolled in both Medicare Part A and Medicare Part B, and you would be responsible for the balance, or $1,800 (the Medicare portion and your payment portion) as in the example below.

Medicare*		**Out-of-Area Plan, PPO 90/70**	
Physician Charges	$2,500	Physician Charges	$2,500
Medicare Allowable Amount	2,000	Medicare Allowable Amount	2,000
Medicare Pays 80% of Medicare Approved Charges	1,600	Plan Benefit at 90% of Medicare Approved Charges	1,800
Remaining balance	400	Less Medicare Payment	-1,600
		Out-of-Area Program Payment	200
		Your Payment	200

* If your physician accepts Medicare assignment, you cannot be charged, by the provider, for amounts over what Medicare approves.

YOUR PRESCRIPTION DRUG PROGRAM

The Plan includes prescription drug coverage through a broad network of retail pharmacies and a convenient mail order program. The prescription drug program provides coverage for both generic and brand name prescription drugs and includes several administrative programs designed to encourage safe, appropriate, and effective use of medications. Current programs include Managed Drug Limitations, Prior Authorization and Step Therapy. Medications and limitations are selected for these programs based on clinically approved prescribing guidelines. They are routinely reviewed by your Claims Administrator to ensure clinical appropriateness and are subject to change.

This section provides important information about the prescription drug coverage available through the Plan including:

- The pharmacy Claims Administrator's responsibilities; and
- A summary of prescription drug benefits at in-network pharmacies and through the mail order program.

Claims Administrator Responsibilities

The Pharmacy Benefit Manager, or "PBM," is responsible for all prescription drug coverage under the Plan. PBM's specialize in prescription drug benefit management and administration. They maintain national networks of retail pharmacies, a mail order program and provide member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the PBM.

An Overview of Your Prescription Drug Program Benefits

Through Participating Retail Pharmacies

You can fill a prescription at any pharmacy that is part of your PBM network. You can also take advantage of the mail order program for maintenance prescriptions or other prescriptions you use on a regular basis. When you fill a prescription through a participating retail pharmacy, there are no claim forms to file. At the pharmacy, you pay one of three co-pay amounts depending on whether the drug you receive is generic, a preferred brand name, or a non-preferred brand name.

A **generic drug** is a chemically equivalent version of a brand-name drug, and is available when patent protection expires on the brand-name drug. Generally, generic drugs are less expensive than brand-name drugs.

A **preferred brand-name drug** is one that is on your PBM's primary/preferred drug list. Drugs on this list are judged by your PBM to maximize clinical results and economic value. Your PBM may update its primary/preferred drug list from time to time, so it's a good idea to review it every so often to see if certain drugs have been added or dropped.

A **non-preferred brand-name drug** is one that is not on your PBM primary/preferred drug list.

Here is a look at the co-pays for generic, preferred brand-name, and non-preferred brand-name prescription drugs when you visit a participating retail pharmacy.

Up to a 34-day supply	At a participating in-network pharmacy	At a non-network pharmacy
Generic drug	$15	No coverage
Preferred brand-name drug	$30	No coverage
Non-preferred brand-name drug	$50	No coverage

When you fill your prescription at an in-network pharmacy, you receive up to a 34-day supply after you make your co-pay.

Through Non-Participating Retail Pharmacies

There is no coverage for prescriptions filled at pharmacies that are not part of your PBM network.

Through the Mail Order Program

The Plan has a mandatory mail order program for maintenance medications. A maintenance medication is a drug that you take on a regular basis, generally for a long period of time. You are required to fill your maintenance drugs through mail order after the third retail fill. When you fill your maintenance prescription drug through the mail order program, you can receive up to a 90-day supply after you make your mail order co-pay.

Here is a look at the co-pays for generic, preferred brand-name, and non-preferred brand-name prescription drugs when you use the mail order program.

Up to a 90-day supply	When you use the mail order program
Generic drug	$30
Preferred brand-name drug	$60
Non-preferred brand-name drug	$100

Effective January 1, 2009, some generic drugs at mail order will have a $10 co-pay subject to change at any time.

Using the Mail Order Program

To fill a prescription through the mail order program, complete a mail order drug form (which you can find online at your PBM's website) and return it, along with your prescription, to the address shown on the form. For all refills after your initial mail order, you can order your refills online at your PBM's website or by calling the PBM Customer Service.

About "vacation supplies" and prescriptions filled outside the United States

If you're planning to be on vacation, you may be able to receive more than the usual maximum day supply of your prescription. Call your PBM for more information on a vacation supply for your prescription.

If you are outside of the United States and need to fill a prescription, note that prescription drug coverage may be different than the benefits described in this SPD. Call your PBM for more information about prescription drug coverage outside the United States.

Other Important Information about Your Prescription Drug Benefits

Quantity Limits for Certain Drugs

To help control the cost of certain high-cost drugs without eliminating their coverage altogether, the Plan includes quantity limits for certain covered medications. For these drugs only, if you exceed the Plan's quantity limits, you pay the full cost. The limits *only* apply to the amount of medication that the Plan covers. You may be able to obtain greater quantities at your own expense. The final decision regarding the amount of medication you receive remains between you and your doctor. If you have any questions related to these limitations, you or your doctor can contact your PBM.

Generic Substitution/Dispense As Written

When a generic is available, but the pharmacy dispenses the brand name for any reason other than your physician indicating "dispense as written," you will pay the difference between the brand name medicine and the generic plus the generic co-payment.

Prior Authorization

In order for some prescription drugs to be covered as part of your benefit, your PBM will conduct an evaluation to determine if the drug's prescribed use meets defined clinical criteria. Through this process, your doctor and your PBM pharmacist will work together to ensure that the drug you are prescribed is the most appropriate for your condition. If prior authorization is required, your doctor will need to contact your PBM. This call will determine whether the drug will be covered under the prescription benefit. If coverage is denied, your doctor may prescribe another drug or you can choose to have the original prescription filled and pay the total cost. To inquire if a drug is subject to prior authorization, contact your PBM.

Step Therapy

Step Therapy helps ensure your safety and that you receive clinically appropriate medication based on your prescription history. The Step Therapy Treatment guidelines are in accordance with current medical literature, manufacturer recommendations and U.S. Food and Drug Administration guidelines. The Plan may require a review for certain drugs under this program before providing coverage to determine if other cost-effective therapies are available and have been tried. To inquire if a drug is subject to Step Therapy, contact your PBM.

YOUR MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM

The Plan includes mental health and chemical dependency coverage through a broad network of qualified behavioral health professionals. Both in-network and out-of-network benefits are available, though many services require pre-approval before benefits begin.

The Mental Health Parity Act of 2008 requires that, effective January 1, 2010, 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, 2010, the lifetime and annual dollar limits, deductibles, co-payments and out-of- pocket expenses are generally the same for mental/substance use benefits as those for physical injury or illness benefits. These changes apply to in-network and out-of network coverage.

Additionally, the law requires that deductibles and out-of-pocket maximums be 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.

This section provides important information about the mental health and chemical dependency coverage available through the Plan including:

- The behavioral health Claims Administrator's responsibilities;
- A summary of your mental health and chemical dependency benefits;
- Information about pre-certifying your care for certain services; and
- How to file a claim.

Claims Administrator Responsibilities

The behavioral health Claims Administrator is responsible for the mental health and chemical dependency program under the Plan. The behavioral health administrator maintains a national network of professionals who specialize in the treatment of:

- Mental illness;
- Behavioral health;
- Alcohol abuse/alcoholism; and
- Drug abuse/addiction.

In the "*Plan Administration*" section under "*Organizations Providing Administrative Services Under the Plan,*" you will find contact information for the behavioral health Claims Administrator.

An Overview of Your Mental Health and Chemical Dependency Program Benefits

To access your behavioral health benefits, you or your doctor should call your behavioral health Claims Administrator. When you call, you will talk to a trained counselor who will discuss your circumstances with you and assess your situation. If you need treatment, the counselor will refer you to a local

participating provider. After you and your provider develop a treatment plan, the behavioral health Claims Administrator will monitor your care to make sure it is appropriate. The behavioral health Claims Administrator will determine what treatment will be covered and how long it will continue. In some cases, you may be approved for less than maximum benefits.

You are covered for both in-network and out-of-network services.

Your Deductibles and Annual Out-of-Pocket Maximums

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.

The table on the following page provides an overview of your mental health and chemical dependency benefits. The table is an overview only and does not list every covered service. For more details about mental health and chemical dependency services covered under the Plan, contact your behavioral health Claims Administrator at 1-800-363-7190.

Schedule of Mental Health and Chemical Dependency Benefits

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

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	$225/$450	$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*

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	$225/$450
Lifetime Maximum	Unlimited	Unlimited	Unlimited
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 Coverage – Mental Health and Chemical Dependency

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.

You may be asked to pay for your care at the time of your visit and submit a claim for reimbursement from the Plan.

If You Are Enrolled in the Out-of-Area Program

If you are enrolled in the Out-of-Area medical program, you may not have access to your behavioral health Claims Administrator's in-network providers. (*See the "Schedule of Mental Health and Chemical Dependency Benefits" section of this SPD for details about Out-of-Area coverage.*)

Pre-certifying Care – Mental Health and Chemical Dependency

All inpatient mental health and/or chemical dependency care you receive must be pre-certified through your behavioral health Claims Administrator. That means you, your doctor, or someone else close to you, must call your behavioral health Claims Administrator *before* you receive services. **It is important to understand your responsibility for pre-certifying care since failure to do so will result in a $250 penalty**, which does not count toward satisfying your separate annual deductible or annual out-of-pocket maximum.

When You See In-Network Providers

If you receive care from an in-network provider, the provider will coordinate the pre-certification process for you. However, it's a good idea to verify with your provider that your care has been pre-certified in advance of any treatment. In the event that the $250 pre-certification penalty is applied to your "In-Network claim" in error, please contact your behavioral health Claims Administrator to have the penalty waived.

When You See Out-of-Network Providers

If you receive care from a provider who is not part of the network, pre-certification is *your* responsibility. Before any treatment or admission, you, your provider, or someone else familiar with your situation must contact your behavioral health Claims Administrator to pre-certify your care. **If you do not pre-certify your care in advance, a penalty of $250 will apply.** This penalty does not count toward your separate annual deductible or annual out-of-pocket maximum.

If You Are Enrolled in the Out-of-Area Program

If you are enrolled in the Out-of-Area Program, pre-certification is *your* responsibility. Before any treatment or admission, you, your provider, or someone else familiar with your situation must contact your behavioral health Claims Administrator to pre-certify your care. **If you do not pre-certify your care in advance, a penalty of $250 will apply.** This penalty does not count toward your separate annual deductible or annual out-of-pocket maximum.

Behavioral Health Providers and Facilities

When you contact your behavioral health Claims Administrator, you will be referred to an in-network, local participating provider or facility. If you choose to receive care outside the network, you can use the following eligible licensed behavioral health care providers:

- Marriage and family counseling clinicians (MFCC);
- Mental health counselors;
- Psychiatrists and osteopaths with a psychiatric specialty;
- Psychiatric nurses; and
- Licensed Clinical Social Workers (LCSWs).

Facilities you use (whether in-network or out-of-network) must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in order for your services to be covered under the Plan.

If You Need Emergency Care

For emergency admissions to a hospital or mental health or chemical dependency treatment facility, you do not need to call your behavioral health Claims Administrator first before being admitted. In this case, benefits will be paid at normal plan levels as long as you (or someone on your behalf) call your behavioral health Claims Administrator within 48 hours after the emergency admission. If you do not call within 48 hours, no benefits will be paid.

If you seek emergency mental health and/or chemical dependency treatment in a non-emergency situation, even with notification of the admission in the required timeframe, your benefits will be reduced to 50%, and you will be responsible for the balance.

What constitutes: a mental health or chemical dependency emergency?
The Plan defines an emergency as a situation where the patient exhibits such severe symptoms that a prudent layperson possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the individual's heath (or for a pregnant woman, the unborn child's health) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Mental Health and Chemical Dependency Benefit Limitations and Exclusions

The following services, treatments, and supplies listed below are not Covered Services.

- Services, treatment or supplies provided without prior authorization as described in this SPD, except those provided as Emergency Treatment;
- Services, treatment or supplies rendered to a participant which are not Covered Health Services;
- Services, treatment and supplies primarily for rest, custodial, domiciliary or convalescent care;
- Diagnosis and treatment for personal growth and/or development, personality reorganization or in conjunction with professional certification;
- Services, treatment or supplies determined to be experimental, investigational or unproven services;
- Private hospital rooms and/or private duty nursing, unless determined to be Covered Health Services and authorized by your behavioral health Claims Administrator;
- Marriage counseling, except for the treatment of a Mental Health/Substance Abuse Condition;
- Treatment of congenital and/or organic disorders, including, but not limited to, organic brain disorder and Alzheimer's disorder;
- Treatment of mental retardation, other than the initial diagnosis;
- Diagnosis and treatment of developmental disorders, including, but not limited to, developmental reading disorder, developmental arithmetic disorder, or developmental articulation disorder;
- 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;

- Services, treatment or supplies provided as a result of any Workers' Compensation or similar law, or obtained through, or required by, any governmental agency or program or caused by the conduct or omission of a third-party for which the participant has a claim for damages or relief, unless the participant provides the behavioral health Claims Administrator with a lien against such claim for damages or relief in a form and manner satisfactory to the Plan;

- Any court-ordered diagnosis and/or treatment, including any diagnosis and/or treatment ordered as a condition of parole, probation or custody and/or visitation evaluation, except as such diagnosis and/or treatment is a Covered Health Service;

- Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings (including but not limited to parole or probation proceedings);

- Other psychological testing, except when conducted for the purpose of diagnosis of a Mental Health/Chemical Dependency condition;

- Services, treatment or supplies for disabilities resulting from service in the military ;

- Treatment of detoxification in newborns;

- Treatment of obesity or weight reduction, or for the cessation of smoking, including supplies;

- Stress management therapy;

- Aversion therapy;

- Treatment of pain, except for a Covered Health Services treatment of pain with psychological or psychosomatic origins;

- Sex therapy, treatment for sexual deviance or diagnosis or treatment in conjunction with sexual reassignment procedures;

- Damage or other harm to an In-Network Provider caused by a participant (the participant shall be solely responsible for all such damage or harm);

- Treatment for a Chronic Mental Condition, except for (i) stabilization of an acute episode of such disorder, or (ii) management of medication;

- Charges for failure to keep medical appointments

Filing a Claim for Mental Health or Chemical Dependency Benefits

When You See In-Network Providers

If you receive care from a behavioral health Claims Administrator in-network provider, you do not need to file a claim to receive benefits. Your provider will file the claim for you.

When You See Out-of-Network Providers

If you receive care from an out-of-network provider, you will need to submit a claim form for reimbursement. Claim forms are available from your behavioral health Claims Administrator.

You'll need to complete and return the claim form to the address shown on the form. To ensure prompt reimbursement, submit claim forms within 90 days after you receive care. All claims must be filed within 18 months following the end of the Plan Year during which the care was received. If your claim is submitted after that period of time, it will not be eligible for payment.

ADDITIONAL HEALTH PLAN FOR EMPLOYEES OF SAN FRANCISCO

An additional health plan is available to employees with a work location in San Francisco (SFO Airport Code). The Kaiser Permanente Health Plan includes medical, prescription drug, mental health and chemical dependency coverage.

You are eligible to participate in the Plan if you are:

- An active, non-contract full-time or part-time employee of US Airways, Inc. with a work location in San Francisco (SFO Airport Code);
- Covered by a collective bargaining agreement that allows you to participate in this Plan with a work location in San Francisco (SFO Airport Code); or
- A former employee of the Company who was eligible for coverage under the Plan the day before a separation [or inactive status] from the Company and is subject to a written separation agreement, collectively bargained agreement or Company policy that includes coverage for a pre-determined period of time following the separation.

Temporary, on-call or seasonal employees are not eligible to participate.

You can also cover your eligible spouse/same sex domestic partner and eligible children.

Claims Administrator Responsibilities

Your Kaiser Permanente Health Plan Claims Administrator is responsible for all coverage options under the Plan. The carrier processes health care claims and provides member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the administrator.

How to File a Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the Evidence of Coverage provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Kaiser Permanente Health Plan.

HEALTH PLAN FOR EMPLOYEES OF PUERTO RICO

A separate health plan is offered to employees with a work location in Puerto Rico. The Triple-S Health Plan includes medical, prescription drug, mental health and chemical dependency coverage.

You are eligible to participate in the Plan if you are:

- An active, non-contract full-time or part-time employee of US Airways, Inc. with a work location in Puerto Rico;
- Covered by a collective bargaining agreement that allows you to participate in this Plan with a work location in Puerto Rico; or
- A former employee of the Company who was eligible for coverage under the Plan the day before a separation [or inactive status] from the Company and is subject to a written separation agreement, collectively bargained agreement or Company policy that includes coverage for a pre-determined period of time following the separation.

Temporary, on-call or seasonal employees are not eligible to participate.

You can also cover your eligible spouse/same sex domestic partner and eligible children.

Claims Administrator Responsibilities

Your Triple-S Health Plan Claims Administrator is responsible for all coverage options under the Plan. The carrier processes health care claims and provides member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan,*" you will find contact information for the administrator.

How to File a Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the Evidence of Coverage provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Triple-S Health Plan.

YOUR EMPLOYEE ASSISTANCE PROGRAM

The Plan includes the Employee Assistance Program, or "EAP." The EAP can help you resolve problems that can affect your health, family life or job performance. If you are eligible for the Plan as an active employee, you will be automatically enrolled in the EAP at no cost to you (even if you waive medical coverage). See the "*Retiree Health Coverage*" Section of this SPD for information about retiree eligibility and cost.

This section provides important information about the EAP benefits available through the Plan including:

- The EAP Claims Administrator's responsibilities;
- An overview of your EAP benefits; and
- Services *not* covered under the EAP benefits.

Claims Administrator Responsibilities

The EAP Claims Administrator is responsible for providing the services connected with the EAP. Their professionals are specifically trained to diagnose and develop solutions to life-work problems. These EAP consultants include psychologists, clinical social workers, certified alcohol and drug counselors, and marriage, family and children's counselors. In the "*Plan Administration*" section, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the EAP Claims Administrator.

An Overview of Your EAP Benefits

The US Airways EAP can provide you and your eligible Dependents with help for problems such as:

- Depression
- Alcohol and/or drug abuse
- Grief
- Parent/child conflicts
- Trauma-related problems
- Emotional problems
- Marital problems
- Work-related problems

Confidentiality

The EAP Claims Administrator treats all EAP records and services with the strictest confidence. No one will know that you contact EAP unless you choose to tell them.

The personal information that you share with your EAP consultant will remain confidential unless:

- You provide written authorization to release such information; or
- The law requires disclosure (e.g., if there is evidence or suspicion of elder or child abuse, or evidence of a serious threat of violence to yourself or others).

EAP Covered Services

All EAP covered services must be obtained from or coordinated by the EAP Claims Administrator. Out-of –Network services are not covered under the EAP. The EAP provides the following types of services:

Telephone Assessments

Under the EAP, you and your eligible Dependents have access to unlimited behavioral health assessment and problem-solving services by phone. Call your EAP Claims Administrator. Consultants are available 24 hours a day, seven days a week. When you call, they will work with you to:

- Clarify the problem— Help you understand the issues that caused you to seek help;
- Identify options — Explore alternatives for addressing the problem;
- Develop a plan — Determine a course of action customized to meet your needs; and
- Help you follow through — Work with you to help you achieve your treatment goals.

If necessary, the EAP consultant will refer you to a community resource or another behavioral health care provider as discussed below.

Face-to-Face Assessments

During the telephone assessment, your EAP consultant may recommend a face-to-face confidential assessment session. The EAP covers up to four face-to-face EAP assessments per problem type per person per year. There is no charge to you for these assessments.

The EAP consultant may:

- Provide feedback to help you put your problem in perspective;
- Help you with your coping skills; or
- Serve as someone you can talk to in times of stress.

In some cases, follow-up sessions may be necessary. If you use all four sessions and need further assistance, the EAP consultant will refer you to another behavioral health resource.

Referrals

Your EAP consultant may refer you to another community resource or behavioral health provider if:

- He or she determines that you need longer-term or more intensive assistance beyond the scope of the EAP; or
- You have used all four of your face-to-face sessions for a specific problem and need further assistance.

If you are enrolled for medical coverage under the Plan, your behavioral health Claims Administrator will coordinate referral care whenever possible so that the additional care you receive is a covered medical service. If you are not enrolled for medical coverage through the Plan, the behavioral health Claims Administrator will make every effort to coordinate referral care with any other medical coverage you may have.

The EAP consultant will:

- Contact your medical program to set up your initial appointment with the behavioral health care provider; and

- Follow up with you to ensure that you met with the provider, and that the care was appropriate.

If you decide to use resources that are outside the scope of the EAP or services not coordinated by an EAP consultant, you will be responsible for the cost of any care you receive.

Accessing Your Benefits

Here's how you to access your EAP benefits:

1. **Call your EAP Claims Administrator.** You will be connected with an EAP consultant who can assist you.

2. **Receive counseling or advice**. In most cases you will be able to speak with an EAP consultant immediately.

3. **Schedule a face-to-face assessment, if necessary**. If appropriate, the EAP consultant will schedule an appointment for a confidential face-to-face assessment session as quickly as possible. Every effort will be made to accommodate your location and work schedule.

4. **Schedule an appointment with the counselor to whom you have been referred, if applicable**. The EAP consultant will refer you to a qualified professional in your community if you need additional assistance.

Services NOT Covered by the EAP

The EAP does not cover:

- Services provided before you were covered under the Plan;

- Face-to-face assessment sessions in excess of four sessions per problem type per person per year;

- Services not provided or coordinated by the EAP under the Plan; or

- Charges for failure to keep EAP appointments.

YOUR DENTAL OPTIONS

The Plan includes benefits for a wide variety of services for preventive dental care, minor dental care, major dental care and orthodontia. Both in-network and out-of-network benefits are available.

This section provides important information about the dental benefits available through the Plan including:

- The dental Claims Administrator's responsibility;
- A summary of your dental benefits;
- Information on predetermination of benefits for certain services;
- How to file a claim;
- A list of covered dental services; and
- A list of dental services *not* covered.

Claims Administrator Responsibilities

Your dental Claims Administrator is responsible for all dental coverage options under the Plan. Your dental Claims Administrator maintains dental coverage networks, processes dental claims, and provides member services to Plan participants. In the "*Plan Administration*" section, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the dental Claims Administrator.

Dental PPO Program

If you live in your dental Claims Administrator's network service area, you are eligible to participate in the dental PPO program. Under the dental PPO program, you can receive care from a dental provider who is part of the dental PPO network or from a dental provider outside the network. No matter where you receive care, the Plan will pay a certain level of benefits for covered services.

If Your Provider Is An In-Network Provider

When you see dental providers that are part of your dental claim administrator's dental PPO network, you will pay less, overall for your dental services, because the fees for your service are lower than what an out-of-network provider may charge. That is because in-network providers have agreed to provide services at negotiated or discounted rates.

If Your Provider is an Out-of-Network Provider

When you see dental providers that are not part of your dental Claims Administrator's dental PPO network, the Plan will pay benefits based on the reasonable and customary (R&C) charge for a particular service. If the out-of-network provider charges more than the R&C amount, you will be responsible for paying the amount that exceeds the R&C charge, in addition to the applicable coinsurance and deductible. You may be asked to pay for your care at the time of your visit and submit a claim form for reimbursement.

An Overview of Dental PPO Program Benefits

The following chart summarizes services that are covered by the dental PPO Program. The chart is an overview only and does not list every covered service. (For a more detailed list of covered dental services, see the "*Dental Services Covered Under the Plan"* section of this SPD, or contact your dental Claims Administrator.)Dental PPO Program Benefits

Dental PPO Program Benefits

	In-Network	**Out-of-Network**
Annual deductible (1 person/2 or more people)	None	$50/$100
Preventive care *Exam* (twice per calendar year) *Prophylaxis* (twice per calendar year) *Fluoride treatment* (once per year, up to age 19) *Sealants* (once every 36 months up to age 15) *X-rays* (bitewing—as part of routine exam, once per year; full-mouth—once every 60 months)	The Plan pays 100% of discounted in-network fees	The Plan pays 80% of reasonable and customary (R&C) charges, with no deductible
Minor care *Oral surgery* *Extractions* *Fillings* *Endodontics* *Periodontics*	The Plan pays 80% of discounted in-network fees	The Plan pays 50% of R&C charges, after annual deductible
Major care *Bridgework* *Dentures* *Crowns* *Inlays and onlays* *Repairs and replacement of bridges, crowns, inlays, onlays, dentures* *Implant services and repairs*	The Plan pays 50% of discounted in-network fees	The Plan pays 50% of R&C charges, after annual deductible
Orthodontia *Services for children and adults*	The Plan pays 50% of discounted in-network fees *$2,000 lifetime maximum*	The Plan pays 50% of R&C charges *$2,000 lifetime maximum*
Annual Benefit Maximum (excluding orthodontia)	$1,500 per person	$1,000 per person

The Out-of-Area Dental Program

If you do not live within your dental Claims Administrator's PPO network service area, you are eligible to participate in the Out-of-Area Dental Program. The Out-of-Area Dental Program is a non-network program. With this type of program, you may receive care from any licensed dentist. In general, the Plan pays 100% of the cost of approved preventive care services up to reasonable and customary (R&C) charges with no annual deductible. For minor and major restorative care, you and the Plan share in the cost of care with no annual deductible.

Out-of-Area Dental Program benefits are paid based on R&C charges. R&C charges are based on the typical amounts charged by most providers in your geographic area for specific dental services. If your dentist's fee for services is more than the R&C charge for a service, you will pay the amount that exceeds the R&C charge, in addition to any applicable deductible and coinsurance amounts.

An Overview of Out-of-Area Dental Program Benefits

The following chart summarizes the services covered under the Out-of-Area Dental Program. The chart is an overview only and does not list every covered service. *(*For a more detailed list of covered dental services, see the *"Dental Services Covered Under the Plan"* section of this SPD, or contact your dental Claims Administrator.*)*

Out-of-Area Dental Program Benefits

Annual deductible	None
Preventive Care *Exam* (twice per calendar year) Prophylaxis (twice per calendar year) *Fluoride treatment* (once per year, up to age 19) *Sealants* (once every 36 months up to age 15) *X-rays* (bitewing – as part of routine exam, once per year; full-mouth—once every 60 months)	The Plan pays 100% of R&C charges
Minor Care *Oral surgery* *Extractions* *Amalgams* *Endondontics* *Periodontics*	The Plan pays 80% of R&C charges
Major care *Prosthetics* *Bridgework* *Dentures* *Crowns* *Inlays and onlays* *Reparation and replacement of bridges, crowns, inlays, onlays, dentures* *Implant services and repairs*	The Plan pays 50% of R&C charges

Out-of-Area Dental Program Benefits	
Orthodontia *Services for children and adults*	The Plan pays 50% of R&C charges $2,000 *lifetime maximum*
Annual Benefit Maximum (excluding orthodontia)	$1,500 per person

What to Do in an Emergency

The Plan does not cover services provided in a hospital room, surgi-center or urgent care facility. You are covered for procedures provided in a dental office by a licensed dentist, provided the services are covered under the Plan.

Predetermination of Benefits

If you need specialist care, orthodontic care, or any other dental care and the expected cost of care will be $150 or more, you should ask your dentist to prepare a treatment plan and send it for a predetermination of benefits to your dental Claims Administrator.

Your dental Claims Administrator will review the treatment plan and within 10 days will send you and your dentist an explanation of benefits that details the benefits payable under the Plan. The predetermination of benefits is valid for six months.

After reviewing your dentist's treatment plan, your dental Claims Administrator may suggest a different, less costly treatment if it meets accepted dental standards. Your benefits will be based on the less expensive treatment. You and your dentist can follow any treatment plan you want, but you will pay any charges above the cost of any less expensive treatment suggested and approved by your dental claim administrator.

Filing a Claim

When You See In-Network Providers – Dental Program

If you see an in-network provider, the provider may file a claim for you. You should confirm this with your provider's office.

When You See Out-of-Network Providers – Dental Program

If you see an out-of-network provider, you must file a claim using a claim form to receive benefits.

To get a claim form, log on to the Benefits US Customer Service at www.eBenefitUS.com, or call toll-free at 1-888-860-6178. Complete and send your claim form with the original bills and receipts to the address on the claim form. Claims should be submitted within 90 days after the expense is incurred to ensure prompt payment. However, all claims must be filed within 18 months following the end of the Plan Year during which the care was received. If your claim is submitted after that period of time, it will not be eligible for payment.

If you use an out-of-network provider or receive in-network care not covered 100%; you must pay the provider any amount the Plan doesn't pay. This amount will be shown on an Explanation of Benefits (EOB), which you will receive, from your dental Claims Administrator.

Claims for Services Provided under Out-of-Area Coverage – Dental Program

If you see an out-of-area provider, you must file a claim form to receive benefits.

To get a claim form, log on to the Benefits US Customer Service at www.eBenefitUS.com, or call toll-free at 1-888-860-6178. Complete and send your claim form with the original bills and receipts to the address on the claim form. Claims should be submitted within 90 days after the expense is incurred to ensure prompt payment. However, all claims must be filed within 18 months following the end of the Plan Year during which the care was received. If your claim is submitted after that period of time, it will not be eligible for payment.

Payment for Orthodontia Services

You must receive approval from your dental Claims Administrator to receive orthodontic care. Once you receive approval, benefits are considered on a monthly basis and will be paid at the end of each quarter. If the monthly amount the orthodontist charges is more than the fixed monthly amount, you will be responsible for any amounts over the benefits paid. If the orthodontist's charges are less than the fixed monthly amount, benefits are paid on the actual amount charged.

In order for benefits to be paid, the orthodontist must install the first appliance while you (or your covered Dependent) are covered under the Plan. Also, you (or your covered Dependent) must be covered on the first day of the month to receive a payment for that month.

If orthodontic treatment is stopped for any reason before it is completed, you'll receive only benefits for the period during which you were receiving active treatment.

The Plan will not pay for orthodontic treatment that began before you (or your covered Dependent) were covered under the Plan.

If you lose coverage under the Plan while in the middle of a course of orthodontic treatment, the Plan will only pay benefits in connection with the services you receive prior to losing coverage.

Dental Services Covered Under the Plan

The dental PPO and Out-of-Area Dental Programs cover the following dental services and supplies, which meet the Plan's definition of covered dental services:

Preventive and Diagnostic Care

- Two exams per person per Plan Year;
- Two cleanings per person per Plan Year;
- Adult bitewing x-rays, once per Plan Year;
- X-rays to diagnosis a specific condition needing treatment;

- Full mouth x-rays, once every 60 months;
- Fluoride treatments up to age 19, once each calendar year;
- Sealants for permanent molars for children under age 15, once every 36 months; and
- Space maintainers for children up to age 19.

Restorative Care

- Silver (amalgam), silicate, plastic, porcelain, and composite fillings (all teeth); and
- Crowns and gold fillings to repair a tooth broken down by decay if the tooth cannot be repaired with a less expensive type of filling and only if the old crown or filling is at least five years old and unserviceable.

Endodontic Care

- Root canals; and
- Apicoectomy.

Periodontal Care

- Treatment of gum and mouth tissues;
- Surgical gum treatment, including gingivectomy, gingivoplasty, and osseous surgery; and
- Periodontal scaling and root planing.

Prosthodontic Care

- Full and partial dentures and adjustments;
- Bridgework and bridge re-cementing;
- Repairs to broken crowns, inlays, bridgework, and dentures;
- Rebasing or relining dentures at least six months old (once per 36 consecutive months);
- Adding teeth to bridgework or partial dentures, if the natural tooth was lost or extracted while you were covered under the Plan;
- Replacing dentures or bridges that are at least five years old and no longer effective;
- 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; and

- Implant supported removable Dentures, but no more than once for the same tooth position in an 84 month period.

Oral Surgery

- Extractions; and

- General anesthesia for oral surgery, fractures, dislocations, and gum treatment.

Therapeutic Care

- Extractions and cutting procedures in the mouth; and

- Antibiotic drugs injected by dentist or doctor.

Orthodontic Care

- Diagnostic procedures; and

- Braces and other appliances to re-align the teeth.

- Please contact your dental Claims Administrator if you have questions about covered services

Dental Services NOT Covered Under the Plan

The following dental services are excluded from coverage under the Plan:

- Treatment that does not meet accepted standards of dental practice;

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

- Treatment associated with a pre-existing dental condition for which treatment was received during the 12-month period prior to your becoming covered under the Plan;

- Treatment by someone other than a dentist, except cleaning and fluoride treatment by a hygienist who is supervised by your dentist;

- Cosmetic dental services, such as whitening of teeth;

- Services or supplies that are covered under your medical coverage;

- Treatment of temporomandibular joint dysfunction (TMJ) that may be covered under medical Plan services;

- Work done to increase distance between nose and chin or to change the way top and bottom teeth meet or mesh (other than as a part of authorized Orthodontia services);
- Charges exceeding calendar year and/or lifetime maximums;
- Treatment of dental injuries received as a result of military service;
- Replacement or repair of orthodontic appliances;
- Prescription drugs;
- Duplicate and temporary devices and appliances;
- Replacement of dentures or dental appliances, which are lost or stolen;
- Services that are reimbursable or provided at no cost through a U.S. public program, government agency or covered by Workers' Compensation or similar laws;
- Charges for failure to keep dental appointments;
- Charges for replacement of a bridge or denture unless they are at least five years old and unserviceable;
- Charges for any special work that you request on a standard denture; and
- Charges for special techniques or precision attachments.

YOUR VOLUNTARY VISION PLAN

The voluntary vision care plan provides basic eye care refraction services and supplies once every year for you and your eligible covered Dependents. If you choose to enroll in the plan you are responsible for the entire cost of the plan. Details of coverage and costs are available on the Benefits US website at www.ebenefitsUS.com.

Claims Administrator Responsibilities

Your vision Claims Administrator is responsible for all vision coverage options under the Plan. In the "*Plan Administration*" section, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the vision Claims Administrator.

YOUR VOLUNTARY LONG-TERM CARE PLAN

The voluntary long-term care plan provides long-term care if you or your eligible Dependents suffer a chronic illness. If you choose to enroll in the plan, then you are responsible for the entire cost of the plan. Details of coverage and costs are available on the Benefits US website at www.ebenefitsUS.com.

The Long-Term Care Plan

The plan pays cash benefits to help you and your family defray the substantial costs of long-term care. It provides a long-term care facility monthly benefit of $2,000 to $10,000 per month in $1,000 increments for 3 or 6 years. You may choose a home care benefit that will pay up to 50% of your long-term care facility monthly benefit. 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 long-term care Claims Administrator.

Claims Administrator Responsibilities

Your long-term care Claims Administrator is responsible for all long-term care coverage options under the Plan. The carrier processes long-term care claims and provides member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the administrator.

How to File a Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the insurance certificate provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Voluntary Long-Term Care Plan.

YOUR VOLUNTARY CRITICAL ILLNESS PLAN

The voluntary critical illness plan provides benefits if you or your eligible Dependents suffer a critical illness. If you choose to enroll in the plan, then you are responsible for the entire cost of the plan. Details of coverage and costs are available on the Benefits US website at www.ebenefitsUS.com.

The Critical Illness Plan

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 Administrator Responsibilities

Your critical illness Claims Administrator is responsible for all critical illness coverage options under the Plan. The carrier processes critical illness claims and provides member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan,*" you will find contact information for the administrator.

How to File a Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the insurance certificate provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Voluntary Critical Illness Insurance Plan.

YOUR VOLUNTARY ACCIDENT INSURANCE PLAN

The voluntary accident insurance plan provides benefits if you or your eligible Dependents suffer an accident. If you choose to enroll in the plan, then you are responsible for the entire cost of the plan. Details of coverage and costs are available on the Benefits US website at www.ebenefitsUS.com.

The Accident Insurance Plan

The plan pays cash benefits that help you manage the expenses incurred after an accidental injury, such as co-payments and treatment-related travel, as well as the ongoing expenses of your ordinary bills such as rent, electricity, and car payments. 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 accident insurance Claims Administrator.

Claims Administrator Responsibilities

Your accident insurance Claims Administrator is responsible for all accident insurance coverage options under the Plan. The carrier processes accident insurance claims and provides member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the Claims Administrator.

How to File a Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the insurance certificate provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Voluntary Accident Insurance Plan.

RETIREE HEALTH COVERAGE

Eligibility for YOU

You are eligible for retiree health coverage (referred to as the "Access Plan") if you are an employee of US Airways or America West Airlines, Inc. who meets the following requirements:

- You are less than age 65, and have attained the minimum retirement age of 55 as determined by US Airways' corporate policy or the minimum age as required under a collective bargaining agreement (between US Airways and a labor union) that regulates the terms and conditions of your employment; and
- You are retiring from either an active or leave/furlough payroll status that was based in the US; and
- You have at least five years of service with US Airways, unless otherwise specified in your collective bargaining agreement.

The medical plan and options available under the Access Plan are the same PPO and OOA plans and options that were available to you as an active employee. This coverage can continue until you reach age 65, providing all premiums are paid. Dental coverage is not included in the Access Plan.

Eligibility for Your Dependents upon Retirement

You may enroll your Spouse (or domestic partner) and any other eligible Dependents at the same time that you enroll for retiree health coverage under the Plan. Please refer to the following provisions of this SPD for further information relating to eligibility of Dependents: *"Eligibility for your Dependents"; "Domestic Partners"; "If You and Your Spouse (or Domestic Partner) Both Work for US Airways."*

Retiree Health Coverage for Those who Retired Prior to March 1, 2005

Pre-merger US Airways employees who retired on or before March 1, 2005 may have received health coverage including dental benefits in accordance with the Section 1114 ruling (in accordance with the Bankruptcy Court) dated January 6, 2005. Coverage for these individuals is pursuant to the medical and/or dental "PPO Plan," "Prescription Drug Program" and "Mental Health and Chemical Dependency Program" sections of this SPD. For those retirees/survivors with coverage beyond age 65, the medical coverage may transition to the Out-of-Area Program. Eligibility criteria for those employees who retired prior to March 1, 2005, can be found under *Pre-Merger Retiree Coverage* on www.eBenefitsUS.com.

When Coverage Begins

Your coverage begins on the first of the month coincident to or following your retirement date.

Coverage Levels

When you enroll in the Plan, you may choose from one of the following medical and/or dental coverage levels:

- Retiree only;
- Spouse only (if provided for in your collective bargaining agreement);

- Retiree and Spouse (or domestic partner);
- Retiree and child or children with no Spouse (or domestic partner); or
- Retiree and family, which includes you, your Spouse (or domestic partner) and your eligible Dependent children.

Employee Assistance Program

The Employee Assistance Program ("EAP") benefit, discussed in this SPD, is also available to you and each of your eligible Dependents if you enroll in the medical benefits under the Plan. If you are enrolled in the medical benefits under the Plan, US Airways will automatically enroll you in EAP coverage at no additional cost to you. (*See the "EAP" section of this SPD for further details*.)

If You Do Not Enroll for Coverage

If you do not elect retiree health coverage when you first become eligible, you will lose your eligibility and will not be allowed to participate in the Plan at any time in the future.

Paying for Coverage

You are responsible for the full cost of your Access Plan coverage. US Airways determines your cost for the Access Plan prior to the beginning of each Plan Year, based on an evaluation of expected medical administration and claim expenses for the upcoming year for all retirees. Payments will be made to a third party administrator.

You may be eligible to offset a portion of your cost by electing to apply your sick bank accrual (if you have one) at the time of your retirement.

Making Changes After Retirement

In general, after you make your retiree health elections, you will not be able to increase your level of coverage in the future. However, you may change your level of coverage after retirement if a change in status event occurs, as outlined in the chart below. Changes must be made within 31 days following the event. You can decrease or terminate your level of coverage at any time after your retirement.

Note: If, for any reason, you drop your retiree health coverage, you will not be permitted to re-enroll at any time in the future.

In the Event of:	**What You May Do:**
An address change that results in a change into or out of your coverage under the PPO network *For pre-65 retirees participating in a PPO Plan only*	▪ May change coverage option and coverage level. Change must be made within 31 days.
You or your Spouse attaining age 65 *Coverage Effective Date is the first of the*	▪ May change coverage option. ▪ May not increase coverage level.

In the Event of:	What You May Do:
month following attainment of age 65	▪ May decrease or drop coverage at any time.
Marriage	▪ May change coverage option. ▪ May change coverage level to add your Spouse and new Dependents. ▪ May decrease or drop coverage at any time. *Documentation is required.*
Divorce	▪ Must drop Spouse coverage within 31 days. *Former Spouse is eligible for COBRA up to 60 days after divorce date*. ▪ May change your coverage option. ▪ May change coverage level to drop Spouse and add/drop Dependents. ▪ May decrease or drop coverage at any time. *Documentation is required.*
Birth or Adoption of a Child, Legal Guardianship or other Gain of Dependency Status	▪ May change coverage option. ▪ May change coverage level. *Documentation may be required*. ▪ May decrease or drop coverage at any time.
Retiree Death	▪ May change your coverage option. ▪ May decrease or drop coverage at any time. *Surviving Dependents may be eligible for coverage*.
Dependent Death	▪ May change coverage option. ▪ May change coverage level. ▪ May decrease or drop coverage at any time. ▪ *Note: If your Spouse dies while covering eligible Dependents under another plan, you may add Dependents to your coverage*.
Spouse Gains Employment/Coverage	▪ May drop self and Dependents from coverage within 31 days. ▪ May decrease or drop coverage at any time. *Documentation is required.*
Spouse Loses Employment/Coverage	▪ May elect, waive or change coverage level or coverage

In the Event of:	What You May Do:
	option within 31 days. ▪ May add Spouse and Dependents. *Documentation is required.*
Loss of Dependent's Eligibility	▪ May decrease or waive coverage ▪ May change coverage option if notified within 31 days of the event date. *Documentation of loss of eligibility is required.* ▪ May decrease or drop coverage at any time.
Dependent Regains Eligibility	▪ May change coverage option. ▪ May increase coverage level. *Documentation of Dependent eligibility is required; only Dependents causing the event may be added.* ▪ May decrease or drop coverage at any time.
Address Change/Relocation—that results in a transfer into or out of the /TO service area	▪ May change coverage option. ▪ May not change coverage level. ▪ May decrease or drop coverage at any time.

How to Make Changes to Your Elections

To change your elections under the Plan, call the Benefits US Customer Service at 1-888-860-6178.

You must notify Benefits US of a change in status event within 31 days of the event if you want to change your benefit elections.

When Coverage Ends

In general, your Plan coverage will end for you when:

- You stop making required contributions;
- You die;
- You are no longer eligible to participate in the Plan; or
- The Plan is terminated.

Coverage for your Spouse (or domestic partner) or eligible Dependents will end when:

- Your Spouse (or domestic partner) is no longer eligible to participate in the Plan;
- Your eligible Dependent children are no longer eligible to participate in the Plan;

- The responsible party stops making required contributions;
- Your Spouse dies; or
- The Plan is terminated.

Your eligible Dependents may be able to continue Plan coverage under certain circumstances in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). *(See "Continuation of Coverage for Retirees" under the "COBRA Continuation of Coverage" section of this SPD for further details.)*

Surviving Spouses and Other Eligible Surviving Dependents

In the event you die while covered under these retiree health coverage provisions, your surviving Spouse (or domestic partner), and your surviving Dependent children may be eligible to continue participation provided they were enrolled prior to your death. This continuation coverage is provided pursuant to company policy or your respective collective bargaining agreement as applicable and is separate from COBRA continuation coverage. Information will be provided to your surviving Spouse (or domestic partner) and eligible Dependent children upon notification of your death.

Coordination With Medicare for Retirees

If you or your covered Dependent(s) are enrolled in Medicare while you are retired, participation in this Plan will continue as long as you remain enrolled. However, this Plan will be the secondary carrier and Medicare will be primary carrier.

When you become eligible for Medicare due to age 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.

Example

The following example shows how benefits coordinate with Medicare. Let's assume you enroll in Out-of-Area Program, OOA 90, you have already met your annual deductible, and you incur a claim for which the Medicare Allowable Amount is $2,000. Medicare Part B covers these expenses at 80%, while the

OOA 90 covers them at 90%. Medicare Part B will first pay 80% of the Medicare Allowable Amount, or $1,600. Then, the Out-of-Area Program will pay 10% of the Medicare Allowable Amount. This is the difference between 90% (what the Out-of-Area Program would pay if it were your primary coverage) and 80% (what Medicare pays), $200 in this example. Both plans coordinate to pay 90% of the total charge, or $1,800—the same benefit you would have received from the Out-of-Area Program if it had been your primary coverage. If you had only enrolled in Medicare Part A, the Plan would still pay as if you were enrolled in both Medicare Part A and Medicare Part B, and you would be responsible for the balance, or $1,800 (the Medicare portion and your payment portion) as in the example below.

Medicare*		**Out-of-Area Plan, PPO 90/70**	
Physician Charges	$2,500	Physician Charges	$2,500
Medicare Allowable Amount	2,000	Medicare Allowable Amount	2,000
Medicare Pays 80% of Medicare Approved Charges	1,600	Plan Benefit at 90% of Medicare Approved Charges	1,800
Remaining balance	400	Less Medicare Payment	-1,600
		Out-of-Area Program Payment	200
		Your Payment	200

Important Reminder:

Covered services and benefit levels under Medicare are subject to change by the Federal government. Remember that enrollment in Medicare is not automatic. You must apply for it with your local Social Security office. You can contact your local Social Security office by calling 1-800-772-1213 or on the Internet at www.ssa.gov.

* If your physician accepts Medicare assignment, you cannot be charged, by the provider, for amounts over what Medicare approves.

ADDITIONAL RULES THAT APPLY TO THE PLAN

Unless otherwise stated in this SPD, the following rules apply to both active employees and retirees covered under the Plan and enrolled in one or more of the following benefits: Medical, (including Prescription Drug and Mental Health and Chemical Dependency), Employee Assistance and Dental. These provisions do not apply to other programs under the Plan unless specifically stated or addressed in materials provided by the applicable Claims Administrator.

Qualified Medical Child Support Order (QMCSO)

The Medical, Dental, and EAP coverage options under the Plan will comply with all the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order, decree or judgment from a court or administrative body, which directs the Plan to provide coverage to the child of a participant under the Plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the Plan's receipt of the order and a copy of the Plan's procedures for determining if the order is valid. Coverage under the Plan pursuant to a medical child support order will not become effective until the administrator of the Plan determines that the order is a QMCSO. Once a determination is made, the Plan Administrator will notify the affected participant and each child (or the child's representative) as to whether the order is a QMCSO. If you have any questions or would like to receive a free copy of the written procedures for determining whether a QMCSO is valid, please contact the Benefits US Customer Service at 1-888-860-6178.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably requests to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's or its agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

    Your failure to cooperate with us is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with us. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against a third party before you receive 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.
- The Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys’ fees, shall be deducted from our recovery without the Plan’s express written consent. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, 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 shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery we might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all individuals and entities administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Coordination of Benefits If You Are Covered by More than One Plan

In situations where you have medical and/or dental coverage under another plan, the Plan includes a provision to ensure that the total payment from all of your group medical and/or dental plans for a particular service does not exceed the amount the Plan would pay if it were your only source of coverage. This is called non-duplication or maintenance of benefits, and when it applies, the Plan follows the rules described below. Note that maintenance of benefits will not apply to any individual private, personal insurance you may have.

Non-Duplication of Benefits

If you and your eligible Dependents are covered under more than one group medical and/or dental plan, the primary plan (the one responsible for paying benefits first) needs to be determined. If this Plan is the secondary plan, you will receive benefits up to but not exceeding the amount you would have received had this Plan been your only source of coverage.

An Example

Here is an example of how the Plan coordinates benefits with other group medical and/or dental plans. Assume your spouse has a covered health service procedure with a reasonable and customary (R&C) charge of $100. If your spouse's plan (which we will assume is your spouse's primary plan) pays 70% for that procedure, your spouse will receive a $70 benefit (70% of $100). Also assume that this Plan (which we will assume is your spouse's secondary plan) would pay 80% for this covered health service procedure. In this case, your spouse normally would receive an $80 benefit (80% of $100) from this Plan. Because your spouse already received $70 from his or her primary plan, he or she would receive the difference or $10 from this Plan. NOTE: If the cost of care is more than the R&C limit set by the Plan, you must pay the amount that exceeds the limit.

Determining the Primary Plan

To determine which plan pays first as the primary plan, here are some general guidelines:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

- If you are an active US Airways employee, this Plan will consider claims for your medical or dental expenses first. Even if you or a covered dependent becomes entitled to Medicare while you are an active employee, the Plan will remain the primary plan. (Different rules apply if your employment has terminated or if you are receiving long-term disability benefits from US Airways.)

- If your covered dependent has a claim, the plan covering your dependent as an employee will pay first. If your claim is for a covered dependent child, the plan covering the parent who has the earlier birthday in a calendar year will pay first. In the event of divorce and in the absence of a QMCSO, the plan covering the parent with court-decreed financial responsibility will pay first. If there is no court decree, the plan of the parent who has custody of the covered dependent child will pay first. *(See the "Qualified Medical Support Order (QMCSO)" section of this SPD for more information on a QMCSO.)*

- If you are a US Airways retiree employed elsewhere and covered under another employer's plan, that plan will be the primary plan for paying claims first for you and your dependents.

- If your other medical plan does not have a coordination of benefits provision, that plan will be the primary plan for you and your covered dependents.

- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest is the primary plan.

After it is determined which plan is the primary plan, you will need to submit your initial claim to that plan. After the primary plan pays your benefits (up to the limits of its coverage), you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You will need to include a copy of the written explanation of benefits (EOB) from your primary plan with your claim to the secondary plan.

Protecting Your Health Information: The HIPAA Privacy Rules

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information (the "Privacy Rule"). The private health information protected under the Privacy Rule includes any individually identifiable health information maintained or transmitted by the Plan in any form or medium. Individually identifiable health information is health information that identifies you or creates a reasonable basis to believe it could be used to identify you, including information relating to your health condition or receipt of health care. This Plan, and US Airways as the Plan sponsor, will not use or disclose information that is protected under the Privacy Rule except as necessary for treatment, payment, health care operations, and Plan administration, or as permitted by law. In particular, the Plan will not, without authorization, use or disclose private health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Company. Under the Privacy Rule, all of the benefit administrators providing medical services under the Plan must also protect your private health information.

Under the Privacy Rule, you have certain rights with respect to your private health information, including certain rights to inspect and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices. A copy of the notice is available to you, upon request, from the Benefits US Customer Service by calling 1-888-860-6178.

The Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits group health plans from using "genetic information" about employees (and their Dependents or other family members) for setting or adjusting premium rates, for underwriting purposes, and for determining eligibility for enrollment in the group health plan. For example, under GINA a plan cannot require or request that an employee or family member undergo a genetic test prior to or as a condition of enrollment under the plan. Also, restrictions are placed on the collection and use of family medical history information prior to enrollment. Specifically, the rules prohibit the use of rewards or incentives for completion of family medical histories prior to enrollment. GINA does not restrict genetic testing as ordered by a medical provider or the use of

family medical history or genetic testing data to enhance plan benefits after enrollment has occurred and a medial provider has been consulted. GINA becomes effective for the Plan on January 1, 2010.

Worker's Compensation

The benefits under the Plan are not designed to duplicate any benefit for which you are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to you or a Dependent shall be reimbursed by, or on behalf of, you or a Dependent to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation or equivalent employer liability or indemnification law.

Rescission in Event of Fraud

Any act, practice or omission by a Plan participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the Plan and the Plan may rescind coverage as a result. Any such fraudulent statements, including on Plan enrollment forms and in electronic submissions, will invalidate any payment or claims for services and will be grounds for rescinding coverage.

Certificate of Coverage

If you lose your medical coverage under the Plan, you will automatically be sent a certificate of coverage showing the length of your coverage under the Plan. This certificate will provide the proof of coverage you may need to reduce any pre-existing medical condition limitation period under your subsequent employer's group health plan that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will also receive a certificate of coverage.

QUALIFYING EVENTS FOR CONTINUATION COVERAGE UNDER FEDERAL LAW (COBRA)

You may be able to continue your medical coverage under this Plan under certain conditions. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) you, your Spouse (or domestic partner) and Dependent children may elect to temporarily continue medical coverage under this Plan in certain instances where coverage otherwise would be reduced or terminated. Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your Spouse (or domestic partner) and your Dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you or adopted by or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary. Also, any child covered pursuant to a QMCSO is a qualified beneficiary. The table below provides a summary of the COBRA provisions outlined in this Section of the SPD.

Qualifying Events that Result in Loss of Coverage	**Maximum Continuation Period**		
	Employee	**Spouse**	**Child**
Employee's work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee or Dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of the COBRA continuation period that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 Months	36 Months
Employee and Spouse legally divorce	N/A	36 Months	36 Months
Employee and Domestic Partner Terminate Partnership	N/A	36 Months	36 Months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 Months*	36 Months
Child no longer qualifies as a Dependent	N/A	N/A	36 months

* 36-month period is counted from the date of eligibility for Medicare benefits.

Qualifying Events

As summarized in the preceding table, the following are examples of "qualifying events:"

- Termination;
- Reduction in hours;
- Disability;

- Death of employee;
- Divorce;
- Termination of Domestic Partnership; and
- Loss of dependency status.

If any of the above events occur, you may be entitled to continue your benefits under the Plan with COBRA.

If your employment terminates for any reason other than gross misconduct, or if your hours worked are reduced so that your Plan coverage terminates, you, your covered Spouse (or domestic partner) and Dependent children may continue health coverage under the Plan for up to 18 months.

If you (the employee) should die, become divorced or become entitled to Medicare, your covered Dependents whose health coverage under the Plan would be reduced or terminated may continue health coverage under the Plan for up to 36 months. Also, your covered children may continue health coverage for up to 36 months after they no longer qualify as covered Dependents under the terms of the Plan.

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- If you, your Spouse (or domestic partner), or your Dependent(s) experience a second qualifying event within the original 18-month period that was due to termination of employment or reduction in hours, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event). (start here)
- If you (the employee) become entitled to Medicare (even if it was not a qualifying event for your covered Dependents because their coverage was not lost or reduced) and then a second qualifying event due to either your termination of employment or reduction in hours of work happens within 18 months, your Dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.
- If you or your Dependent is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA continuation coverage, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months) if the original qualifying event was termination or reduction in hours. To qualify for this disability extension, the Plan Administrator must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator within 30 days after this determination.

Important Note

If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a Spouse or Dependent child (whether or not disabled) may further

extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation coverage upon your divorce or loss of your child's Dependent status under the Plan, you or one of your Dependents must notify the Plan Administrator of your divorce or loss of Dependent status within 31 days of the later of the date of the event or the date the individual would lose coverage under the Plan. Your covered Dependents will then be provided with instructions for continuing their health coverage. Individuals already on COBRA continuation must notify the Plan Administrator within the same time frame if a divorce or loss of a child's Dependent status occurs that would extend the period of COBRA coverage for your Spouse (or domestic partner) or Dependent child(ren).

For other qualifying events (if your employment ends, your hours are reduced or you become entitled to Medicare), you and your covered Dependents will be provided with instructions for continuing your health coverage under the Plan. In the event of your death, the Company will contact your covered Dependents to inform them how to continue health coverage under the Plan.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered Dependents must elect to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered Dependents(s) lose coverage as a result of the qualifying event; or

- The date the Plan notifies you and/or your covered Dependents of your right to elect to continue coverage as a result of the qualifying event.

Premium Due Date

If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation coverage, but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your COBRA continuation coverage will be terminated retroactively to the last day for which timely payment was made.

Cost of COBRA Continuation of Coverage

Continuing Coverage

The cost of COBRA continuation of coverage, including any extended period for disability is 102% of the full cost of Plan coverage.

Coverage During the Continuation Period

If coverage under the Plan is changed for active employees during the COBRA continuation period, the change also applies to individuals on COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections under COBRA continuation coverage during the annual enrollment

periods, if a change in status occurs, or at other times under the Plan to the same extent that similarly situated employees not receiving COBRA continuation coverage may do.

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will end when any of the following first occurs:

- The applicable COBRA continuation period ends;
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due;
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare (This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA coverage if bankruptcy is the qualifying event);
- The qualified beneficiary becomes covered under another group health plan with no exclusion or limitation for any pre-existing condition;
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months;
- In the case of newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, COBRA continuation coverage ends for them on the date your COBRA continuation period ends unless a second qualifying event has occurred; or
- Group health coverage for all employees is terminated.

When your COBRA continuation coverage terminates, you may be able to convert to individual coverage under the Plan's conversion rights feature. Contact your COBRA administrator for more information about your conversion rights.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, eligible employees are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted due to military service, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

You may continue your medical and dental coverage for a period of time by paying premiums as stated per Company policy or your collectively bargained agreement.

If you choose not to continue your medical and dental coverage while on military leave, you are entitled to reinstated coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled work day following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days;

- Return to or reapply for reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days; or

- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Continuation of Coverage While on a Family and Medical Leave

Under the Family and Medical Leave Act (FMLA), eligible employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical and dental coverage benefits during this time. If you take this unpaid leave and wish to continue your medical and dental coverage under the Plan, you will be billed directly on a monthly basis, at the same rates applicable before the unpaid leave began.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care;

- To care for a Spouse, child, or parent who has a serious health condition; or

- For your own serious health condition.

- The number of weeks of unpaid leave available to you for family and medical reasons may vary based on the applicable state law requirements.

Eligible employees may take up to twenty-six weeks of leave in a single 12-month period to care for a covered military member recovering from a serious injury or illness incurred in the line of duty on active duty. Eligible employees are entitled to a combined total of up to twenty-six (26) weeks of all types of Family and Medical Leave during a single 12-month period.

Continuation of Coverage for Retirees

Coverage for the Retiree (and his Spouse or Dependents) under the Access Plan at the date of retirement is considered alternative COBRA coverage and no further COBRA benefits are generally available to the Retiree. However, the Spouse or Dependent of a Retiree who is covered under the Access Plan at the date of the Retiree's retirement may incur a subsequent Qualifying Event when there is a divorce or death of the retiree, or when an eligible Dependent ceases to be eligible for benefits under the Plan, for example, when he or she attains age 26. A retiree, Spouse (or domestic partner) or eligible Dependent, as applicable, must notify the Plan Administrator in the event of divorce, death or when an eligible Dependent ceases to eligible for coverage under this Plan. Failure to notify the Plan Administrator within 60 days will result in the loss of COBRA continuation coverage. The prior provisions regarding notice, election and paying for COBRA continuation coverage will apply once timely notice has been received by the Plan Administrator.

CLAIMS PROCEDURES

Unless otherwise stated in this SPD, the following rules apply to both active employees and retirees. Generally, your provider will file your claim with the appropriate Claims Administrator. Under certain circumstances you must file your claim (e.g., for out-of-network claims or claims under Out-of-Area coverage). Once filed, all claims are subject to the following rules.

Time Frame for Initial Claim Determination

For **urgent care claims** *(see the "Urgent Care Claims" section of this SPD for a definition)* and **pre-service claims** (claims that require approval of the benefit before receiving medical care), the appropriate Claims Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- 72 hours after receipt of an **urgent care claim** (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification); and

- 15 days after receipt of a **pre-service claim**.

For **post-service claims** (claims that are submitted for payment after receiving medical care), the appropriate Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit or a failure to provide or make a payment, in whole or in part, for a benefit under the Plan.

For **urgent care claims**, if you fail to provide the appropriate Claims Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the appropriate Claims Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The appropriate Claims Administrator's receipt of the requested information; or

- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For **pre- and post-service claims**, a 15-day extension may be allowed to make a determination, provided that the appropriate Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the appropriate Claims Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for **pre- and post-service claims** due to your failure to submit necessary information, the applicable claim administrator's time frame for making a benefit determination is tolled or suspended from the date the appropriate Claims Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fail to follow the Plan's procedures for filing a **pre-service claim**, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving **urgent care**) following the Plan's knowledge of such failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that is:

- A communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; or

- A communication that names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is required.

Urgent Care Claims

Urgent care claims are a special type of pre-service claim which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function;

- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson with an average knowledge of health and medicine will determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

If the Claims Administrator denies the claim, the initial notice of denial of an urgent care claim may be provided orally, provided that written notification is provided to you within three days after the oral notification.

Concurrent Care Claims

There are two types of concurrent care claims: 1) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and 2) where an extension is requested beyond the initially-approved period of time or number of treatments. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours after receipt of your claim, provided your request is made at least 24 hours prior to the end of the approved course of treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent claim, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: *Any reduction or termination of a course of treatment will be considered an adverse benefit determination, unless the reduction or termination of such course of treatment is the result of a Plan amendment or Plan termination.*

If You Receive an Adverse Benefit Determination

The appropriate Claims Administrator will provide you with a written notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination;
- References to the specific Plan provisions on which the benefit determination is based;
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ER1SA after an appeal of an adverse benefit determination;
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- If the adverse benefit determination concerns a claim involving **urgent care**, a description of the expedited review process applicable to the claim.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review by contacting the appropriate Claims Administrator/Claims Fiduciary. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. A failure to file a request for review within 180 days will constitute a waiver of your right to request a review of the claim denial. *(For more details, see the "How to Contact Your Claims Administrator/Claims Fiduciary" section of this SPD)*

You have the right to:

- Authorize a representative to act on your behalf, as long as such designation is in writing and submitted to the Claims Administrator. Submit written comments, documents, records and other information relating to the claim for benefits;
- Upon a request, and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document record, or other information is treated as "relevant" to your claim if it:

- Was relied upon in making the benefit determination;

- Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;

- Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination; and

- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination;

- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination;

- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate;

- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental);

- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advise was relied upon in making the decision; and

- In the case of a claim for **urgent care**, an expedited review process in which:

    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination; and

    - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly prompt method.

- Ordinarily, a decision regarding your appeal will be reached within:

    - 72 hours after receipt of your request for review of an **urgent care claim**;

    - 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**.

- The notice of an adverse benefit determination on appeal, from the appropriate Claims Administrator/Claims Fiduciary, will contain all of the following information:

- The specific reason(s) for the adverse benefit determination;

- References to the specific Plan provisions on which the benefit determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;

- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request;

- If the adverse benefit determination was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- You may not bring a lawsuit to recover benefits under this Plan until you have exhausted all levels of appeals (2 levels) offered through the administrative process described in this Plan. No legal action to recover benefits under the Plan may be filed beyond three years after the date a final decision is made on your claim for benefits. The three-year statute of limitations on suits for all benefits shall apply in any forum where the Beneficiary may initiate such suit.

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 (medical judgment includes a decision based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a decision that a treatment is experimental or investigational).

- 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 an External Review Program:

MetLife Dental
Superior Vision

Your decision to seek External Review will not affect your rights to any other benefits under this Plan and nothing contained in this section will affect an employee's grievance rights under the collective bargaining agreement. 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

Here is a contact list for each of the Claims Administrators/Claims Fiduciaries who provide services under the Plan.

Claims Administrator/ Claims Fiduciary	Phone Number	Web Site Address
United Healthcare Services, Inc. (UHC) (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
CVS Caremark (prescription drug benefits)	1-800-898-5698	www.caremark.com
United Behavioral Health (OptumHealth Behavioral Solutions administered by United Behavioral Health) (mental health and chemical dependency benefits)	1-800-363-7190	www.liveandworkwell.com (Access code US Airways)
Kaiser Permanente (health benefits for SFO)	1-800-278-3296	www.kp.org
Triple-S, Inc. (health benefits for Puerto Rico)	1-787-774-6060	www.sspr.com
United Behavioral Health (OptumHealth Behavioral Solutions administered by United Behavioral Health) (EAP Benefits)	1-800-817-4498 (United States) 1-800-817-4498 (call collect) (International, include country code) 0800-731-0934 (from UK only) 800-363-7190 (toll-free from Canada and Puerto Rico)	www.liveandworkwell.com (Access code US Airways)
Superior Vision (Underwritten by National Guardian Life Insurance Co.)	1-800-507-3800	www.superiorvision.com
MetLife (dental benefits)	1-800-942-0854	www.metlife.com/dental
Unum (Voluntary Long-Term Care, Critical Illness and Accident Insurance)	1-866-679-3054	www.unum.com

PLAN ADMINISTRATION

This information about the administration of the Plan is provided in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Plan.

Plan Sponsor

The name, address and telephone number of the Plan sponsor are:

US Airways, Inc.
4000 E. Sky Harbor Blvd.
Phoenix, AZ 85034
480-693-0800

The US Airways Health Benefit Plan is a group health plan providing medical, dental and vision (including prescription drug, mental health and chemical dependency benefits) and employee assistance services benefits.

Plan Administrator

The name, address and telephone number of the Plan Administrator are:

US Airways, Inc.
4000 E. Sky Harbor Blvd.
Phoenix, AZ 85034
480-693-0800

The Plan Administrator (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the Plan described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the Plan Administrator (or its delegate(s)) made pursuant to the Plan described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The Plan Administrator may delegate this discretionary authority to selected service providers. In certain circumstances, for all purposes of overall costs savings or efficiency, the Plan Administrator (or its delegate(s)) may, in their sole discretion, offer benefits for services that would not otherwise be covered. The fact that the Plan Administrator (or its delegate(s)) do this in any particular case shall not in any way be deemed to require the Plan Administrator (or its delegate(s)) to do so in similar cases.

Agent for Service of Legal Process

The name, address and telephone number of the agent for service of legal process:

US Airways, Inc.
Legal Department
4000 E. Sky Harbor Blvd.
Phoenix, AZ 85034
480-693-0800

Legal process also can be served on the Plan Administrator.

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to US Airways is 53-0218143. The plan number for the Plan is 501.

Plan Year

The Plan Year for purposes of the Plan's fiscal records is January 1 through December 31.

Organizations Providing Administrative Services under the Plan

Listed below are the names, addresses, phone numbers, and web site addresses of the organizations that provide administrative services under the Plan. These services include administering claims, administering appeals, and providing participant assistance.

Type of Benefits	**Claims Administrator and Claims Fiduciary**
Medical	United HealthCare P.O. Box 30555 Salt Lake City, UT 84130-0555 1-800-520-0811 +44 (0) 1273 718425 (International – BUPA) www.myuhc.com United HealthCare appeals should be directed to: United HealthCare National Appeals Center ASO P.O. Box 30432 Salt Lake City, UT 84130-0432 or Blue Cross Blue Shield of North Carolina P.O. Box 2291 Durham, NC 27702 1-888-722-7441 1-800-810-2583 (International) www.bcbsnc.com or Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 www.anthem.com Anthem appeals should be directed to: Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348
Prescription Drugs	CVS Caremark, Inc. ATTN: Client Services/US Airways, Inc. PO Box 52196 Phoenix, AZ 85072-2196 1-866-760-4276 www.caremark.com CVS Caremark appeals should be directed to: CVS Caremark, Inc. Appeals Department

Type of Benefits	Claims Administrator and Claims Fiduciary
	MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172 Additional Contract Information: Complementary blood glucose meters: 1-800-588-4456 CVS Caremark internet help desk (web support): 1-877-460-7766
Wellness	Quest Diagnostics, Inc. 1-913-888-1770 My.blueprintforwellness.com OptumHealth 1-800-478-1057 https://client.myoptumhealth.com/usairways
Mental Health and Chemical Dependency and Employee Assistance Program	OptumHealth Behavioral Solutions administered by United Behavioral Health P.O. Box 30755 Salt Lake City, UT 84130-0755 1-800-363-7190 (United States, Canada & Puerto Rico) 0800-731-0934 (from UK only) Intl. country code for country calling from +44-1865-397-221 (all other countries) TDD/TTY Line: 866-216-9926 www.liveandworkwell.com (access code is "US Airways")
Health Plan for San Francisco	Kaiser Permanente ATTN: Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923 1-800-464-4000 www.kp.org
Health Plan for Puerto Rico	Triple-S, Inc. P.O. Box 363628 San Juan, PR 00936-3629 1-787-774-6060 www.sspr.com
Vision Care	Superior Vision P.O. Box 967 Rancho Cordova, CA 95741 1-800-507-3800 www.superiorvision.com
Dental	MetLife Insurance Company P.O. Box 981282 El Paso, TX 79998-1282 1-800-942-0854 http://www.metlife.com/dental
Voluntary Long-Term Care	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122

Type of Benefits	Claims Administrator and Claims Fiduciary
	1-866-679-3054 www.unum.com
Voluntary Critical Illness	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 1-866-679-3054 www.unum.com
Voluntary Accident Insurance	Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 1-866-679-3054 www.unum.com

Plan Funding

The Plan is a self-insured plan for benefits provided through the medical and dental coverage portions of the plan. Benefits are paid from employee contributions, as applicable, and from the general assets of US Airways. US Airways has contracted with third party administrators to administer the Plan. Certain programs under the Plan are funded by insured arrangements: the Voluntary Long-Term Care Plan, the Voluntary Critical Illness Plan and the Voluntary Accident Insurance Plan. These programs are currently employee-pay-all arrangements that employees can elect to pay through payroll deduction. The Vision Plan, Kaiser Permanente Health Plan and Triple S Health Plan are fully insured; premium costs are paid by employee contributions and from the general assets of US Airways. The costs of the Employee Assistance Program are paid entirely from the general assets of US Airways.

Plan Document

This SPD is intended to help you understand the main features of the Plan. It should not be considered a substitute for the Plan document, which governs the operation of the Plan. That document sets forth all of the details and provisions concerning the Plan and is subject to amendment; the official Plan document may consist of one or more documents designated as Plan documents by the Company. If any questions arise that are not covered in this SPD or if this SPD appears to conflict with the official Plan document, the text of the official Plan document will govern.

For certain employee groups, coverage under the Plan is maintained pursuant to a collective bargaining agreement. You can obtain a copy of your collective bargaining agreement by contacting your local management or union representative. A copy is also available for examination at the office of the Plan Administrator during normal business hours.

Future of the Plan

The Company reserves the right, in its sole discretion, to change, modify amend or terminate the Plan, in whole or in part, to the extent it deems advisable, at any time for any reason. Such changes, modifications, amendments or termination will be undertaken by action of the Company's Board of Directors or an authorized officer or as otherwise required by the Plan document. Furthermore, the Company reserves the right, in its sole discretion, to change any third party providing services to the Plan, including the Claims Administrator, and reserves the right to insure the benefits through insurance carrier(s) of its choice. Upon termination, any amounts payable under the terms of the Plan as in effect immediately before the termination will be paid in accordance with Plan terms. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

The benefits under this Plan do not vest. The Company reserves the right, in its sole discretion, to determine the nature and amount of benefits, if any, that will be provided to individuals (and their Dependents) under the Plan, as well as the right to reduce, terminate or modify the terms or the amount of such benefits.

Limitation on Assignment

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to your creditors or anyone else. However, you may assign your right to benefits to the health provider who rendered the services under the Plan.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report nine months after the end of the plan year or two months after the SAR is due (if an extension has been granted by the IRS).

Continue Group Health Plan Coverage

- Continue group health coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuers when you lose coverage under a group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 18 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court.

If it should happen that the plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR EMPLOYMENT

Your eligibility or your right to benefits as an active employee under the Plan should not be interpreted as a guarantee of employment. The Company's employment decisions are made without regard to the benefits to which you are entitled under the Plan upon employment.

This SPD provides detailed information about the Plan and how it works. This SPD does not constitute an expressed or implied contract or guarantee of employment.

GLOSSARY

Claims Administrators — The third-party organizations with which US Airways maintains contracts to maintain provider networks, provide case and disease management programs, provide payment and customer services for US Airways, Inc. Health Benefit Plan participants.

Claims Fiduciaries — The parties designated by US Airways to make initial claims determinations, including review of claims appeals for benefits under the Plan. The decision of the applicable claims fiduciary upon review of claims appeals is final and binding. US Airways does not have the authority to change the decision of the claims fiduciary.

Coinsurance — The portion (usually expressed as a percentage) of the total covered benefit costs that the Plan pays (or that you pay).

Company – US Airways, Inc. (US Airways)

Congenital Anomaly — A physical development defect that is present at birth and is identified within the first twelve months of birth.

Coordination of Benefits ("COB") — When considering a claim for reimbursement of an eligible expense that is payable by the US Airways, Inc. Health Benefit Plan and at least one other plan, the process of determining how much of the expense should be paid by US Airways. Coordination of benefits ensures US Airways will pay no more for such an expense than it would have had you been eligible for benefits under only the US Airways, Inc. Health Benefit Plan.

Cosmetic Procedure — Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be changed or improved, but there would be no improvement in function like breathing.

Co-pay/Co-payment — The fixed amount you pay up front for certain services covered under the Plan. After you pay the applicable co-pay, some services are subject to coinsurance.

Cost Effective — The least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services — Those health services and supplies that are: provided for the purposes of preventing, diagnosing or treating Sickness, Injury, Mental Health/Chemical Dependency Condition or their symptoms, provided to a Covered Person who meets the Plan's eligibility requirements, and not identified as an exclusion in this SPD.

Custodial Care — Services that do not require special skills or training and that provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating); do not seek to cure, or which are provided during period when the medical condition of the patient who requires the service is not changing or do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible — An annual amount you must pay for certain services before the Plan pays benefits for eligible expenses.

Dependent - Dependents eligible for coverage under the Plan include your Spouse or domestic partner (as that term in defined in the "*Domestic Partners*" Section of the SPD). Dependents eligible for coverage under the Plan also include all children, including those of a domestic partner, who have not yet reached the age limit stated in the "*About Your Participation- Active Employees*" and "*Retiree Health*" Sections of the SPD. Children include biological children, legally adopted children, children placed for adoption, and stepchildren. Also included are your children (or children of your Spouse or domestic partner) for whom you have legal responsibility resulting from a valid court decree.

The unmarried children of you or your domestic partner age 26 and over who are not self-supporting because of a permanent physical or mental disability and who are dependent upon you, as defined by the Internal Revenue Code for income tax purposes, remain covered under the Plan no matter what age, provided that the children remain disabled and that such children were physically or mentally disabled *and* covered by the Plan on the day before attaining age 26. Proof of incapacity may be required annually by the Plan, and you may be required to give the Claims Administrator evidence of your child's incapacity within 31 days of the child attaining age 26.

Durable Medical Equipment — Non-disposable, non-implantable equipment that is primarily used within the home and serves a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

Experimental/Investigational Services — Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, procedures, drug therapies, medications or devices that at the time the health care providers and Claims Administrators make a treatment/coverage/claims determination, are: not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use; not identified in the American Hospital Formulary Service or the United States Pharmacopoeia of Dispensing Information as appropriate for the proposed use; not subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the Humanitarian Use Device exemption are not considered to the Experimental or Investigational); or not the subject of an ongoing Clinical Trial and meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight. If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the health care providers and Claims Administrator may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered health Service for that Sickness or condition. Prior to such consideration, it must be determined that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Injury — Bodily damage other than Sickness, including related conditions and recurrent symptoms

In-Network — Refers to benefits and services you receive from doctors, dentists, hospitals, pharmacies, and other service providers that contract with the Claims Administrators. Generally, your benefits under the Plan are higher (and your out-of-pocket expenses lower) when you use in-network services.

Mail Order — An option available for receiving prescription drugs through the mail or other process as defined by the Plan. Mail Order prescriptions include up to a 90-day supply and may be mandated for maintenance medications after a certain number of approved retail drug store "monthly" fills.

Medicare — The hospital and medical insurance program sponsored by the U.S. Government.

Mental Health/Chemical Dependency Condition — A nervous, mental, or chemical dependency condition that is (i) a clinically significant behavioral or psychological syndrome or pattern; (ii) associated with present distress or substantial or material impairment of the patient's ability to function in one or more major life activities {for example, employment); (iii) not merely an expectable response to a particular event (for example, the death of a loved one); (iv) listed as an Axis I disorder (other than a V Code of the DSM-IV, or its replacement).

Network — A group of hospitals, doctors, pharmacies, dentists, and other health care professionals that provide services at discounted rates. (See the definition of "in-network" for more details)

Out-of-Area — Refers to medical, mental health and chemical dependency, and dental care received through the Out-of-Area portion of the US Airways, Inc. Health Benefits Plan for Employees. Out-of-area is different from out-of-network. You are eligible to participate in the Out-of-Area medical program only if you live outside a PPO Plan network service area. You are eligible to participate in the Out-of-Area Dental program only if you live outside the Dental PPO network. If you are enrolled in an out-of-area program, you may use any licensed provider you wish. Once you meet your annual deductible, the out-of-area program will share the cost of most services with you through coinsurance up to reasonable and customary charges.

Out-of-Network — Refers to benefits and services received from doctors, dentists, hospitals, and other service providers that are not part of the medical and dental Claims Administrator's networks. The Plan includes Out-of-Network benefits for medical, mental health and chemical dependency and dental benefits. Prescription drugs are available in-network only. Generally, your benefits under the Plan are lower (and your Out-of-Pocket expenses higher) when you use Out-of-Network services.

Out-of-Pocket Maximum — An annual individual or family limit on the amount you spend out of your own pocket for expenses that the Plan does not cover in full, including deductibles but excluding co-payments.

PBM — The prescription drug benefits provider and Claims Administrator for US Airways prescription drug benefits.

PPO — Short for "Preferred Provider Organization," an organization that contracts with a network of doctors, dentists, hospitals and other health care providers who deliver services for set fees, usually at a discount. PPO is often used as the name of a plan type as well. PPO plans offer both in-network and out-of-network benefits. You may use any licensed provider you like, but your benefits are highest (and your out-of-pocket costs lower) when you use in-network providers.

Plan Administrator — In its role as Plan Administrator, US Airways maintains sole responsibility of the US Airways, Inc. Health Benefits Plan and the benefits it provides. The Plan Administrator has the sole discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, including entitlement to benefits. The Plan Administrator also has the sole discretion to determine all matters relating to interpretation and operation of the Plan and may contract with third parties to provide some or all of these services to participants.

Pre-Certification — The notification, review and approval process your health care provider will conduct with the applicable Claims Administrator before you begin receiving certain services covered under the Plan. Your doctor, you, or anyone close to you can start the process by notifying your Claims Administrator before the services are rendered. Financial penalties apply for failure to pre-certify care.

Primary Doctor (Primary Care Physician) — A physician who is a General Practitioner, Family Practice Physician, Pediatrician or Internist. An Obstetrician or Gynecologist is a Primary Doctor for maternity or annual preventive care female physical services but is a Specialist Physician for all other services.

Provider — A medically licensed practitioner or facility providing services under the Plan.

Reasonable and Customary Charges (R&C Charges) — The average prevailing cost in a particular geographic area for medical and dental plan services, subject to change over time.

Reconstructive Procedure — A procedure performed to address a physical impairment where the expected outcome is restored or improved function.

Right of Reimbursement — The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery; you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Sickness — Physical illness, disease or pregnancy. The term Sickness as used in this SPD does not include Mental Health/Chemical Dependency Condition or substance abuse, regardless of the cause or origin of the Mental Health/Chemical Dependency Condition.

Specialist — A specialist is any medical provider or entity, other than **a Primary Physician.**

Spouse — For the purpose of this Plan, a Spouse is defined as a person who is married, as evidence by a valid marriage certificate, to a person of the opposite sex from that of the enrolling employee.