US AIRWAYS, INC. FLEXIBLE BENEFIT PLAN

Summary Plan Description

Effective January 1, 2013

SUMMARY PLAN DESCRIPTION

This document summarizes the main provisions of the US Airways, Inc. Flexible Benefit Plan, effective January 1, 2013, and serves as the Summary Plan Description ("SPD") for these benefits. It describes the benefits as they apply to eligible employees and their eligible dependents. This document replaces the SPD dated January 1, 2005, and incorporates the changes to that SPD that are set forth in the Summary of Material Modification dated January 1, 2011, as well as other changes and clarifications.

This is also the SPD for the US Airways, Inc. Health Care Account Plan and the US Airways, Inc. Dependent Care Account Plan, which are offered under the Flexible Benefit Plan (collectively, the "Plans").

This SPD provides a comprehensive overview of the benefits available under the Plans. Complete details of these Plans are contained in legal Plan documents. If there is any difference between the information in this SPD and in the legal Plan documents, the Plan documents 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.

Please read this SPD carefully. If you have any questions about the benefits information contained in this SPD, please contact BenefitsUS Customer Service at 1-888-860-6178, or online at **www.eBenefitsUS.com**.

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HOW THE FLEXIBLE BENEFIT PLAN WORKS

The US Airways, Inc. Flexible Benefit Plan (the "Flexible Benefit Plan") offers eligible employees a choice of health, survivor and accident benefit options. Each year, during annual enrollment, you can elect coverage under the following benefit plans:

- Medical
- Dental
- Voluntary Vision
- Voluntary Group Accident Insurance
- Health Care Account ("HCA")
- Dependent Care Account ("DCA")
- US Airways, Inc. Pilot Disability Plan
- US Airways, Inc. Flight Attendant Long Term Disability Benefit Plan

Your contributions for your benefit elections are deducted from your paycheck on a pre-tax basis. Pre-tax dollars can save you money because they are deducted from your paycheck before taxes are calculated, including Federal, Social Security and, in most cases, state and local taxes.

Who Is Eligible

You are eligible to participate in the Flexible Benefit 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.

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.

Eligible Dependents

You can enroll your eligible spouse (or domestic partner) and dependent children for medical, dental and voluntary vision coverage. You can also enroll your eligible spouse and dependent children for voluntary group accident insurance (domestic partners may not be eligible for this coverage depending on workgroup).

Eligibility for your spouse (or domestic partner) and dependent children is determined under the terms of the applicable medical, dental, voluntary vision, voluntary group accident or disability plan.

When Participation Begins

If you are a new hire and you are eligible, you can enroll yourself and your eligible dependents in the Flexible Benefit Plan within 31 days of your hire date. Your participation will begin on your first day of work, provided you enroll within that 31-day period. Your initial election will remain in effect through December 31 of that year. If you do not enroll within 31 days of your hire date, you will not be able to participate that year. You will have to wait until the next annual enrollment period and your participation will begin January 1 of the following calendar year, unless you experience a qualifying change in family or work status as described in "Making Changes During the Year" on the next page.

Annual Enrollment

Each fall, during annual enrollment, you have the opportunity to change your coverage and your dependents' coverage under the Flexible Benefit Plan. You can enroll or re-enroll for coverage during annual enrollment through the BenefitsUS Customer Service website which is **www.eBenefitsUS.com**. Any changes you make will take effect the following January 1 and remain in effect through December 31 of that year. If you are on a leave of absence during annual enrollment and return in the following Plan year, you must re-enroll within 31 days of your return. If you return in the same Plan year you went out on leave, you do not have to re-enroll.

Default Coverages

If you do not re-enroll for coverage during annual enrollment, your current elections (except for HCA and DCA coverage) will automatically renew effective January 1 of the following year.

If you participate in the HCA or the DCA, you will need to re-enroll in order to participate for the following year. If you do not re-enroll, your HCA and DCA participation will end on December 31 of the current year.

Making Changes During the Year

You can make coverage changes during the year only if you experience a qualified change in family or work status. Approved changes in status include:

- A change in your legal marital status (e.g., marriage, divorce, annulment or death of a spouse);
- A change in the number of your dependents (e.g., through birth, adoption, placement for adoption, appointment of legal guardianship, loss of dependent status or death);
- 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 or part-time status, or vice versa;
  - Note that a change in work shift that does not change the number of hours you work does not constitute a qualifying family or work status change.
  - If you terminate employment and are rehired in the same calendar year, or if you are furloughed and recalled in the same year, your most recent elections will be reinstated. If you are rehired or recalled in a different year from the year you terminated employment or were furloughed, you must make new benefit elections.
- Your dependent meets (or fails to meet) the Plan's dependent eligibility rules.

Any change you make as a result of a qualified family or work status event must be permitted by law and consistent with the qualifying event. Election changes are consistent with the event if they:

- Result in you, your spouse or your dependent gaining or losing eligibility to participate in this Plan or the plan sponsored by your spouse's or your dependent's employer; or
- Correspond with the gain or loss of coverage. For example, if you have or adopt a child, you can enroll, but you would not be able to drop coverage or decrease your contributions.

You must notify BenefitsUS Customer Service at 1-888-860-6178 of any qualified family or work status change within 31 days of the event.

When Participation Ends

Your participation in the Flexible Benefit Plan will end when:

- Your employment ends;
- You retire;
- US Airways terminates this Plan;
- You are no longer eligible for the Plan;
- You stop making the required contributions; or
- You die.

In addition, your participation in the HCA and/or DCA will end on March 15th following the close of the plan year if you do not enroll for the next calendar year (all expenses incurred on or before that date need to be submitted as claims by June 15th to be eligible for reimbursement).

If you leave US Airways during the year for any reason, including termination of employment, furlough or leave, you may be able to continue your HCA contributions on an after-tax basis through the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). (See page 28 for details.) If you leave US Airways, COBRA does not allow for continued participation in the DCA.

THE HEALTH CARE ACCOUNT AND DEPENDENT CARE ACCOUNT PLANS

The US Airways, Inc. Health Care and Dependent Care Account Plans are two benefit options under the Flexible Benefit Plan. When you enroll in the HCA and/or a DCA, you decide how much to contribute to your account(s). Your elected contributions will generally be deducted from your paycheck on a pre-tax basis throughout the year. However, your maximum elected contributions may not exceed your compensation for the year. To the extent your paychecks are not enough to cover the amount of your elected contribution during the plan year, the Company reserves the right to deem your annual election to be an amount that is equal to the contribution amount that you requested less the missed contribution.

- **Health Care Account:** You may contribute up to $2,500 per year to your HCA (as indexed for inflation beginning 1/1/14).
- **Dependent Care Account:** If you are single, or married and filing a joint income tax return, you may contribute up to a maximum of $5,000 per year to your DCA. If you are married, special limits may apply as follows:

If this is your situation...	Then your maximum annual contribution is...
You or your spouse earns less than $5,000	The amount the lower-paid spouse earns
Your spouse also participates in a DCA	$5,000 combined for both accounts
You file separate federal income tax returns	$2,500

The DCA reimburses you for dependent care expenses that are necessary in order for:

- You and your spouse to work or to look for work;
- You to work and your spouse to attend school full-time for at least five months during the year; or
- You to work if your spouse is mentally or physically disabled and needs care, or is unable to provide care for a dependent.

You and your spouse's work can be done for others or in your own business. It can be either full-time or part-time. However, it does not include volunteer work.

If your spouse is looking for work, is a full-time student, or is physically or mentally unable to care for himself or herself, your spouse is considered to earn an income of $200 (if you have one eligible dependent) or $400 (if you have two or more eligible dependents) per month to calculate the maximum contribution amount.

How the Health Care And Dependent Care Accounts Work

If you want to participate in one or both of the accounts:

- **Plan.** First, carefully estimate what your eligible, out-of-pocket health and/or dependent care expenses will be from January 1 through March 15 of the following year. Keep in mind that:
  - You can set aside HCA contributions to cover dependents who are and are not covered under a US Airways medical, dental and/or voluntary vision plan. Remember to exclude from your estimate any expenses that will be covered by these plans.
  - US Airways deducts your HCA and DCA contributions from your paycheck over the 12-month period beginning January 1 and ending December 31, but you are allowed to submit eligible health care and/or dependent care expenses incurred during the 14½ month period beginning January 1 and ending March 15 of the following year.

- **Decide.** Decide how much you want to contribute to your account(s) to cover your estimated, out-of-pocket expenses.

- **Enroll.** If you choose to participate in both the HCA and the DCA, you must make separate elections for each. Your contributions are deducted from your paycheck before Federal and, in most cases, State[*] and FICA taxes are applied. This means you do not pay Federal, FICA and, in many cases, State[*] taxes on the money you deposit in your account.

- **Submit for reimbursement.** When you have an eligible health care or dependent care expense, you pay for it out-of-pocket, then submit the claim using the appropriate claim form (and including all applicable receipts) to the HCA and DCA administrator. See "Requesting Reimbursements" on page 25 for more information about submitting a claim.

  If your claim is approved, you will be reimbursed with tax-free dollars from your account, up to the amount that you elected to contribute, minus reimbursements already made during the

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[*] Note: In certain states, your contributions under the Plan may be taxable for state tax purposes. For example, *if you live in Pennsylvania, contributions to your DCA are subject to Pennsylvania State tax.*

January 1 – March 15 period. You must submit all claims for the year by June 15 of the year in which the 14½-month period ends. In addition, please note the following:

— Under the HCA, the amount you elect to contribute for the year is available to you at any time during the year. For example, if you elect to contribute $100 per month ($1,200 for the year) and file a $750 claim in April of that year, you will receive the full $750 reimbursement, although you have only contributed $400 to your account to date.

— Under the DCA, you will be reimbursed only up to the amount you have contributed to your account to date. If you make a claim for an amount that is greater than your account balance, you will be automatically reimbursed as you make payroll contributions; you will not have to resubmit a claim for these expenses. For example, if you elect to contribute $300 per month ($3,600 for the year) and file a $2,000 claim in April of that year, you would receive an initial $1,200 reimbursement (the amount contributed to your account to date), followed by automatic payments of $300 per month until you receive the full $2,000 reimbursement.

How You Save on Taxes

Participating in a HCA and/or DCA reduces your taxable income because your contributions (and reimbursements you receive) are never subject to Federal income taxes, or, in many cases, State[*] or local taxes. In addition, your contributions are not subject to FICA (Social Security) taxes. Although this reduction may lower your eventual Social Security benefit slightly at retirement, the immediate tax advantages of participating in a HCA and/or DCA will generally be of greater value to you.

How much you save on taxes will depend on your personal financial situation and the amount you choose to contribute to the HCA and/or DCA. For specific advice about your situation, you may want to consult a tax advisor.

An Example

Here's an example of how paying for eligible expenses through a HCA or DCA can lower your taxes and increase your take-home pay. For this example, we will assume that:

- You are married with two children;

[*] Note: In certain states, your contributions under the Plan may be taxable for state tax purposes. For example, *if you live in Pennsylvania, your DCA contributions are subject to Pennsylvania State tax.*

- Your combined annual income is $50,000;
- You contribute $1,500 to a HCA; and
- You do not qualify to itemize health care expenses on your tax return. (See “Health Care Tax Deduction” on page 14 for more information.)

	Without Health Care Account	With Health Care Account
Combined annual income	$50,000	$50,000
Pre-tax contributions	– 0	– 1,500
Adjusted gross income	$50,000	$48,500
Federal and FICA taxes*	– 7,500	– 7,275
After-tax income	$42,500	$41,225
After-tax contributions	– 1,500	– 0
Take-home pay	**$41,000**	**$41,225**
Federal and FICA tax savings	**$0 ($7,500 – 7,500)**	**$225 ($7,500 – 7,275)**

* Estimates are based on a combined withholding rate of 15% (includes Federal and FICA taxes) and assume you file a joint tax return, take the standard deduction, and claim four exemptions. The examples do not account for State taxes. Your actual tax savings will depend on your personal situation.

The tax savings work the same way when you contribute to the DCA.

Use It or Lose It

Be sure to plan your annual flexible spending account contributions carefully, because they include a “use it or lose it” provision. In accordance with IRS rules, you will forfeit any unused HCA or DCA balance that remains after June 15 of the following year.

You have until June 15 of the following calendar year to submit claims for eligible expenses incurred before March 15 of that year. Claims are eligible for reimbursement only if you were actively participating (making contributions) in the Plan on the date of service. Services provided while you are on leave or furlough or after you terminate are not eligible for reimbursement unless you have continued your HCA participation through COBRA. If you return to work in the same

year, you may make up your contributions in order to bridge participation so that services provided while you were out will also be reimbursable. If you wish to do this, you should contact BenefitsUS Customer Service at 1-888-860-6178.

Health Care Account Reimbursements

You can use the HCA to reimburse yourself with pre-tax dollars for any IRS-approved health care expenses not covered by your medical or dental plans — such as deductibles and co-payments, coinsurance, eyeglasses, prescription drugs, over-the-counter drugs with a prescription, chiropractors and hearing aids. Your contributions can be used to cover eligible health care expenses that you, your spouse or natural, step or adopted children who have not yet attained age 26 incur while you are contributing to your account. In addition, if your domestic partner and/or your domestic partner's children or any other child satisfies the requirements to be considered your tax dependent under the Internal Revenue Code, and you submit a signed Dependent Certification Form to the Benefits Department to certify dependent status no later than December 1st each year, you can also request reimbursement from the health care account for expenses incurred by these individuals. The "Dependent Certification Form," which describes the requirements that must be satisfied in order for your domestic partner and/or domestic partner's or other children to be considered your tax dependents, is available on the BenefitsUS Customer Service website at **www.eBenefitsUS.com** or the US Airways' employee website at **http://wings.usairways.com**.

Eligible Health Care Account Expenses

Due to a change in the law, expenses incurred on or after January 1, 2011 for medicines and drugs may only be paid or reimbursed by an employer sponsored accident and health plan, including a health flexible spending account (FSA), if the medicine or drug is prescribed by a physician (determined without regard to whether such drug is available without a prescription), or is insulin. A prescription means "a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state."

These rules do not apply to over-the-counter items that are not medicines or drugs, including but not limited to equipment (such as crutches), supplies (such as bandages), and diagnostic devices (such as blood sugar test kits). Such items may qualify for reimbursement under a health FSA if they otherwise meet the definition of medical care in Code Section 213(d).

Here is a partial list of IRS-approved health care expenses for which you can seek reimbursement through the HCA:

Professional Services

- Chiropodist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Dentist
- Gynecologist
- Neurologist
- Obstetrician
- Oculist
- Optician
- Optometrist
- Orthopedist
- Osteopath
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Psychiatrist
- Psychoanalyst
- Psychologist
- Registered Nurse
- Surgeon (except for elective cosmetic surgery)

Medical Treatments

- Abortion
- Acupuncture
- Blood transfusion
- Diathermy
- Electric shock treatments
- Hearing services
- Injections
- Insulin treatments
- Organ transplant
- Pre-natal and post-natal care
- Psychotherapy
- Radium therapy
- Sterilization
- Ultra-violet ray treatments
- Vasectomy
- X-ray treatment

Laboratory Exams/Tests

- Blood tests
- Cardiographs
- Metabolism tests
- Spinal fluid tests
- Sputum tests
- Stool examination
- Urine analyses
- X-ray examinations

Hospital Services

- Anesthetist
- Oxygen mask, tent
- Use of operating room
- X-ray technician

Equipment and Supplies

- Abdominal supports
- Air conditioner (if necessary for relief from allergy or difficulty in breathing)
- Ambulance hire
- Artificial teeth, eyes
- Auto device for handicapped person, but not for travel to work
- Back supports
- Braces
- Contact lenses
- Cost of installing stair-seat elevator for person with heart condition
- Crutches
- Elastic hosier
- Eyeglasses
- Fluoridation unit in home
- Hearing aids
- Insulin
- Invalid chair
- Iron lung
- Over-the counter medications with a prescription
- Prescriptions (with limitations)
- Reclining chair (if prescribed by physician)
- Repair of telephone equipment for the deaf
- Sacroiliac belt
- Special mattress and plywood bed boards for relief of spinal arthritis
- Splints and truss
- Wig (if advised by physician due to hair loss from disease)

Miscellaneous

- Alcoholism inpatient care
- Birth control pills or other birth control items prescribed by a physician
- Braille books (excess cost of Braille works over cost of regular editions)
- Capital expenses for special equipment installed in your home if main purpose is for medical care
- Costs of special equipment for a car for the use of a person with a disability
- Clarinet lesson if advised by dentist for treatment of tooth defects
- Drug treatment center for inpatient care
- Fees paid to health institute (if services are prescribed by a physician to alleviate a physical or mental defect or illness
- Guide for blind person
- Kidney donor's or possible kidney donor's expenses
- Legal fees for guardianship of mentally ill spouse where commitment was necessary for medical treatment
- Nurse's board and wages, including Social Security taxes you pay
- Remedial reading for child with dyslexia
- Sanitarium and similar institutions
- School costs for physically and mentally handicapped children
- Seeing-eye dog and its maintenance
- Telephone-teletype costs and television adapter for closed caption service for deaf person
- Travel expenses related to medical treatment

For a complete list of eligible health care expenses, please refer to IRS Publication 502[*], *Medical and Dental Expenses*, which is available from the IRS by calling 1-800-829-3676 or on the IRS web site at **www.irs.gov**.

If you have questions about specific expenses, please contact the HCA administrator.

Health Care Account Expenses That Are Not Eligible

You cannot claim reimbursement for expenses that are paid through a US Airways medical plan or any other medical coverage or expenses for which you take a deduction on your annual tax return. In addition, you cannot claim reimbursement for premiums and contributions you make for other health coverage.

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[*] *Please note that this Plan defines an expense as "incurred" on the date a participant receives the medical care or product, not on the date he or she is billed, charged or pays for it. The Plan's definition of an incurred expense, which differs from the "incurred expense" definition in IRS Publication 502, will always govern.*

Here are some health care expenses that are not payable through the HCA, as defined by the IRS:

- Athletic or health club expenses to maintain or improve physical fitness unless prescribed by a doctor for a specific medical condition
- Babysitting expenses incurred while you go to the doctor
- Boarding school fees paid for child while parent is recuperating from illness
- Bottled water
- Dance lessons (even if advised by physician)
- Diaper service
- Domestic help (even if needed because of spouse's illness)
- Ear piercing
- Elective cosmetic surgery
- Food or beverage substitutes (except cost of special foods over what would have ordinarily been spent on food is deductible if necessary because of allergy)
- Hair transplants for cosmetic purposes
- Illegal operations and drugs
- Insurance premiums
- Marriage counseling or legal fees for divorce
- Maternity clothes
- Over-the-counter medications without a prescription
- Patent medicines
- Scientology fees
- Tattooing
- Toothpaste
- Transportation costs of a disabled person to and from work
- Travel for reasons of health (even if prescribed by physician)
- Tuition and travel expenses to send a child to a particular school for a beneficial change in environment
- Vitamins, tonics, etc. (even if prescribed by a physician)
- Weight reduction or stop-smoking programs unless undertaken to treat a specific ailments

Health Care Tax Deduction

The HCA is one way to get a tax break on medical costs.

If you are reimbursed from your HCA for a specific health care expense, you cannot claim that expense as an itemized deduction on your income tax return, so you should think about which arrangement — tax deduction or HCA reimbursement — is better for you.

Dependent Care Account Reimbursements

You can use the DCA to reimburse yourself with pre-tax dollars for IRS-approved dependent care expenses. The expenses must be incurred in order for:

- You and your spouse to work or look for work;
- You to work and your spouse to attend school full-time for at least five months during the year; or
- You to work if your mentally or physically disabled spouse is unable to care for your dependent.

Your work and your spouse's work can be either full- or part-time; and it can be done for others or for your own business. However, it does not include volunteer work.

Dependent Care Account Eligible Dependents

You may request reimbursement from your DCA for dependent care expenses you pay on behalf of your eligible dependents. Eligible dependents include:

- Children under the age of 13 who:
  - Live at home with you for more than half the calendar year; and
  - Do not provide more than half of their own support for the calendar year (excluding educational scholarships).
- A spouse of any age who:
  - Is physically or mentally unable to care for himself or herself; and
  - Lives at home with you for more than half of the calendar year.
- Dependents (other than a spouse) of any age who:
  - Are physically or mentally unable to care for themselves;
  - Live at home with you for more than half of the calendar year; and

— Do not provide more than half of their own support for the calendar year (excluding educational scholarships).

You can also use your DCA to reimburse dependent care expenses for your domestic partner's eligible dependent children, if claimed for tax purposes.

Eligible Dependent Care Account Expenses

Here is a partial list of IRS-approved dependent care expenses for which you can seek reimbursement through the DCA:

- A day care (includes before/after school) center that meets local regulations, provides care for more than six non-residents and receives a fee for such services, whether or not for profit;
- Elder/dependent care facility;
- Housekeeper, maid or cook, as long as he/she is at least responsible for the well-being and protection of an eligible dependent (including meal and lodging expenses);
- Babysitters or companions, including your children (age 19 or over) and relatives whom you cannot claim as exemptions on your federal tax return;
- Nursery school or preschool; or
- Day camp.

For a complete list of eligible dependent care expenses, please refer to IRS Publication 503[*], *Dependent Day Care Expenses*, which is available from the IRS by calling 1-800-829-3676 or on the IRS web site at **www.irs.gov**.

If you have questions about specific expenses, please contact the DCA administrator.

[*] *Please note that this Plan defines an expense as "incurred" on the date a participant receives dependent care services,* ***not*** *on the date he or she is billed, charged or pays for it. The Plan's definition of an incurred expense, which differs from the "incurred expense" definition in IRS Publication 503, will always govern.*

Dependent Care Account Expenses That Are Not Eligible

Here are some dependent care expenses that are not payable through the DCA, as defined by the IRS:

- Nursing home charges;
- Overnight camp for children;
- Schooling (tuition) fees for children in kindergarten and up;
- Expenses you deduct or for which you take a tax credit on your federal income tax return;
- Food or clothing expenses for your dependent (except for small amounts paid for these items which cannot be separated from the cost of caring for the person);
- Transportation expenses;
- Payments to an individual who could be claimed as a dependent on your (or your spouse's) tax return;
- Payments to your child (or stepchild) who is under age 19 at the end of the taxable year; or
- Amounts you pay for dependent care while you are off work because of illness.

Dependent Care Account vs. Federal Income Tax Credit

The DCA is not the only way that you can reduce the impact of dependent care expenses. Under current tax law, you may claim a federal tax credit for eligible dependent care expenses when you file your federal income tax return. The spending account lowers the amount of your taxable income (before taxes are calculated), while the tax credit simply reduces the amount of taxes you pay. You can use both approaches, but you cannot apply them toward the same expenses, and certain restrictions will apply.

Keep in mind that DCA contributions will reduce, dollar for dollar, the expenses you can claim toward a credit on your federal income tax return. For example, if you have one dependent, you can generally apply $3,000 in eligible expenses toward a federal income tax credit on your federal income tax return. However, if you also contribute $2,000 to your DCA, the maximum amount of eligible expenses that you can apply toward the federal income tax credit will be $1,000 ($3,000 - $2,000 = $1,000).

You should review your personal circumstances carefully to determine which method or combination offers the greatest tax savings. For specific advice about your situation, you may want to consult a tax advisor.

Plan Your Flexible Spending Account Expenses and Contributions

The worksheets on the following pages can help you estimate your health care and/or dependent care expenses for the upcoming year, so you can determine how much you might want to contribute to either account.

During annual enrollment, you can also estimate these expenses using the online Health Care and Dependent Care Expense Modelers, available through the BenefitsUS Customer Service website at **www.eBenefitsUS.com**. After you begin the election process, you can access the modelers by clicking the "Calculate Expenses" button in the HCA/DCA section of your benefits worksheet. Please keep in mind that these modelers are available through the website only if you are enrolling as a new hire or during annual enrollment.

Health Care Account Worksheet

Write in the health care expenses that you expect to have for yourself and your dependents in the upcoming year. To estimate upcoming expenses, you may want to take a look at last year's medical, dental, vision and hearing care bills for you and your covered family members.

PLANNING YOUR HEALTH CARE EXPENSES AND ACCOUNT CONTRIBUTIONS	
Medical copayments. Medical copayments for in-network care received under your medical plan, or your spouse's medical plan, such as hospital admission copayments and doctor's office visit copayments.	$__________
Prescription and Over-the-Counter ("OTC") drug expenses. Prescription and OTC drug expenses not covered by the medical plan and copayments for covered prescription drugs. Over-the-counter drug expenses require a prescription for reimbursement.	$__________
Medical coinsurance. Medical coinsurance under your medical plan or your spouse's medical plan.	$__________
Amounts paid toward an annual deductible. This applies to the annual deductible feature you, your spouse or your dependent pays toward an annual deductible under his or her medical plan.	$__________

PLANNING YOUR HEALTH CARE EXPENSES AND ACCOUNT CONTRIBUTIONS

Expense	Amount
Dental expenses. The amounts not reimbursable under your dental plan or amounts that exceed the maximum reimbursement amount for certain dental procedures or the annual maximum per covered person. Also, any eligible dental expenses not covered for you, your spouse or your dependent children.	$__________
Vision expenses. Expenses not covered under your voluntary vision plan or any eligible vision expenses not covered for you, your spouse or your dependent children.	$__________
Hearing expenses. Expenses not covered under the medical plan for eligible hearing expenses for you, your spouse or your dependent children.	$__________
Expenses that exceed the Usual, Customary and Reasonable ("UCR") limit. Amount over the UCR limit for covered expenses under some medical plans.	$__________
Expenses that exceed plan limits. Medical plan expenses that exceed the annual limits on certain services. Some common examples of benefits with annual visit and/or day limits include inpatient and outpatient mental health care, physical therapy and rehabilitation services, chiropractic care and acupuncture.	$__________
Other eligible health care expenses. Other non-covered eligible health care expenses for you, your spouse or your dependent children. (Refer to IRS Publication 502.)	$_________
Total Eligible Expenses	$_________

Remember that the maximum annual contribution you can make to the HCA is $2,500 (as indexed for inflation beginning 1/1/14).

Dependent Care Account Worksheet

Write in the dependent care expenses that you expect to have each week. Multiply that amount by the number of weeks you expect to use dependent care during the year. Keep in mind that you can also contribute money toward infrequent dependent care (e.g., summer day camp). Also, remember that when you spend holidays or vacation time with your children, you should exclude that time from your expected day care expenses.

PLANNING YOUR DEPENDANT CARE EXPENSES AND ACCOUNT CONTRIBUTIONS					
Type of Expenses			**Number of Weeks**		**Annual Total**
Weekly Day Care	$________	x	________	=	$________
Infrequent Day Care					
(e.g., summer day camp)	$________	x	________	=	$________
					MINUS
Vacation/Holidays	$________	x	________	=	$________
			GRAND TOTAL	=	**$________**

Remember that the maximum annual contribution you can make to the DCA is generally $5,000. See page 6 for special limits that may apply.

Additional Rules That Apply to Flexible Spending Accounts

Keeping Spending Accounts Separate

You cannot transfer or mix funds between your HCA and DCA. The money set aside in a HCA can only be used for eligible health care expenses, and the money in a DCA can only be used for eligible dependent care expenses.

Leaves of Absence

- If you participate in the HCA and you go on an unpaid leave of absence:
  - — You can continue to contribute to your account, but only on an after-tax basis. You will receive COBRA information shortly after your leave date and may elect to continue your HCA participation through COBRA; or
  - — You can choose not to contribute while on leave. In this case, you can only request reimbursement for services or products purchased while you were in pay status. If you return in the same year, you can (i) increase the level of contributions you were making prior to your leave of absence to an amount that will satisfy your original annual pledge, or

(ii) resume the same level of contributions you were making prior to your leave of absence, with your original annual pledge correspondingly reduced. If you return in a different year from the one in which your leave began, you will be allowed to re-enroll in the Plan within 31 days of your return.

- If you participate in the DCA and you go on an unpaid leave of absence:
  - Only eligible dependent care services paid for in the same Plan year as the year your leave began while you are actively participating (making contributions) in the Plan are eligible for reimbursement; and
  - When your leave of absence ends, and if you return in the same Plan year your leave started, you can (i) increase the level of contributions you were making prior to your leave of absence to an amount that will satisfy your original annual pledge, or (ii) resume the same level of contributions you were making prior to your leave of absence, with your original annual pledge correspondingly reduced. If you return in a different year from the one in which your leave began, you will be allowed to re-enroll in the Plan within 31 days of your return.

Continuation of Spending Account Participation 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, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

When you go on military leave, your work hours are reduced. As a result, you may become eligible to continue your HCA participation through COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible. During the COBRA continuation period you will be charged your full contribution amount plus a 2% administrative fee.

If you choose not to continue your participation in the HCA while on military leave, you are entitled to reinstated participation with no waiting periods or exclusions 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.

Requesting Reimbursements

When you receive an eligible health care service or product or an eligible dependent day care service, you pay for it and then submit a completed claim form and applicable receipts to the HCA and DCA administrator. Claim forms are available through the BenefitsUS Customer Service website at **www.eBenefitsUS.com**.

Alternatively, for Health Care Account reimbursements, you may pay for such expenses with a debit/credit card provided by the Company, subject to the rules described below.

Health Care Account Reimbursements

When you submit your claim form for HCA reimbursement, you also need to submit:

- A receipt and/or bill indicating the patient's full name, service provider's name, dates of service, services performed and amount charged for each service; or
- A copy of the "Explanation of Benefits" ("EOB") from the insurance carrier for the services for which you're requesting reimbursement. FSA claims will not be paid for EOBs that have been denied due to insufficient information.

You must submit all claims for the year by June 15 of the following year. If your claim is approved, you will be reimbursed with tax-free dollars for the full amount of your claim, up to the amount that you elected to contribute to your account for the year minus reimbursements already made during the 14½ month period beginning January 1 of the current Plan year and ending March 15 of the following year.

If you pay for an eligible health care service with a debit/credit card provided by the Company, the following rules apply:

Conditional Debit Card Charges

Any debit/credit card charges that do not fit within one of the categories of automatic substantiation described below are treated as conditional, pending confirmation of the charge. For all conditional charges, you must file a claim for reimbursement with and submit additional third-party information, such as merchant or service provider receipts, as described above, for review and substantiation. If, upon review, the Plan Administrator determines that these charges are not eligible health care services, the Plan Administrator will notify you. The Plan Administrator will then recoup the improper payment by requiring you to reimburse the Company by check, or alternatively, by requesting the Company to reduce your salary on an after-tax basis in an amount equal to the improper payment.

Automatic Substantiation of Debit Card Charges

The following categories of debit card/credit card transactions are considered "automatically substantiated." This means that you do not have to provide a receipt for review by the Plan Administrator:

- Transactions that match co-payment amounts that are not more than five times the dollar amount for a particular service; and
- Transactions that are recurring and match previously approved claims (e.g., refill of the same prescription drug on a regular basis at the same provider for the same amount).

Over-the Counter Drug Purchases

You may only use your debit/credit card to purchase an over-the-counter drug if you obtain a prescription from a doctor as described in the section above, entitled "Eligible Health Care Account Expenses." You must then present the prescription to the pharmacist, have the medication dispensed by the pharmacist and make sure that the receipt reflects an Rx number.

Dependent Care Account Reimbursements

When you submit your claim form for DCA reimbursement, you also need to submit a receipt and/or bill indicating the service provider's name and tax ID number, dates of service and amount paid.

You must submit all claims for the year by June 15 of the following year. If your claim is approved, you will be reimbursed with tax-free dollars for the full amount of your claim, up to the

amount that has already been deposited through contributions to your account at that time minus reimbursements already made during the 14½ month period beginning January 1 of the current Plan year and ending March 15 of the following year. If your claim amount exceeds your current account balance, you will receive a partial payment. You will receive the remainder when your account contributions can cover the amount needed to make the remaining payment.

If you have questions about requesting HCA or DCA reimbursements, please contact the HCA and DCA administrator.

Circumstances That May Result in Denial, Loss or Forfeiture of Flexible Spending Account Benefits

You will not be eligible to participate in the Plan (for the Plan year) if you:

- Do not enroll by the annual enrollment deadline;
- Were on leave, chose not to continue participation during leave (for HCA only) and did not enroll within 31 days of your return to work; or
- Were on leave and chose not to participate (for HCA only) during leave.

You will not be entitled to request reimbursements if you fail to submit eligible expenses for reimbursement by June 15 of the following year and you will lose any unused account balance. Unclaimed funds will be used to offset the Plans' future administrative expenses.

Remember that you cannot claim the same amount of eligible expenses for both a health care tax deduction and reimbursement through a HCA. You may want to consult with a tax advisor before you determine your HCA contribution amount.

Also, remember that you cannot claim the same amount of eligible expenses for both a dependent care tax credit and reimbursement through a DCA. You may want to consult with a tax advisor before you determine your DCA contribution amount.

If your employment ends:

- Your contributions will end as of your last paycheck. Only services or products purchased before your last day of employment will be eligible for reimbursement. Your contribution will remain in your account until the latest of the following:

— The date you exhaust your balance with submitted eligible claims, or

— June 15 of the following year, the deadline for filing claims.

- If you fail to submit eligible expenses by June 15 of the following year, you will lose the remaining account balance(s).

You can choose to continue making contributions to the HCA through the end of the year in which your employment ends (under the provisions of COBRA). Since you will not be receiving pay from US Airways, your contributions will be made on a post-tax basis and will include a 2% administrative fee.

Rules Applicable to the Health Care Account

Qualified Medical Child Support Order

The HCA will comply with all the terms of a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is an order or judgment from a court or administrative body, which directs a plan to cover a child of a participant under the HCA. 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 receipt of the order and a copy of the procedures for determining if the order is valid. Coverage under the HCA pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedures for determining whether a QMCSO is valid, please contact BenefitsUS Customer Service at 1-888-860-6178.

COBRA Continuation

Under a federal law commonly known as COBRA (Consolidated Omnibus Budget Reconciliation Act), you, your spouse and your dependent children may elect to continue coverage temporarily under the HCA, in certain instances, where coverage otherwise would be reduced or terminated. Individuals entitled to COBRA continuation coverage (qualified beneficiaries) are you, your spouse and your dependent children who are covered at the time of a qualified family or work status event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

You may continue participation in your HCA under COBRA on a post-tax basis for the remainder of the year in which your qualified family or work status event occurs. Generally, if the COBRA premium for the remainder of the Plan year would exceed the maximum benefit still available

under the HCA as of the date of the qualified family or work status event, US Airways is not required to offer COBRA continuation. In contrast, if the maximum benefit available under your HCA is greater than the remaining COBRA premium, US Airways must offer you COBRA continuation within the current Plan year. For the year after a qualified family or work status event occurs, you will not be able to elect HCA participation, even if your COBRA continuation period is still in effect for your other health care coverage(s).

Qualified Family or Work Status Events

If you experience one of the following qualified family or work status events, you may be eligible to continue your HCA participation under COBRA:

- You terminate employment for any reason (other than gross misconduct);
- You become entitled to benefits under Medicare;
- You and your spouse divorce;
- Your child no longer qualifies as an eligible dependent;
- You retire; or
- You die.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation upon divorce or loss of your child's dependent status under the Plan, you, your spouse or one of your covered dependents must notify BenefitsUS Customer Service of the divorce or loss of dependent status within 60 days of the later of the event date or the date the individual would lose coverage under the Plan. Your spouse and your covered dependents will then be provided with instructions for continuing your health coverage.

If your employment ends or you retire, you, your spouse and covered dependents will receive instructions for continuing your participation in the HCA. In the event of your death, US Airways will notify your spouse and covered dependents about how to continue participation.

Electing and Paying for COBRA Continuation Coverage

You must choose to continue coverage within 60 days after the later of the following dates:

- The date you would lose coverage as a result of the qualified family or work status event; or

- The date the COBRA administrator notifies you of the right to choose to continue coverage as a result of the qualified family or work status event.

Premium Due Date: If you elect COBRA continuation coverage, you must make the initial contribution (including all contributions 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 and fail to make the contribution due within the initial 45-day grace period, or you fail to pay any subsequent contribution within 30 days after the date it is due, your participation will be terminated retroactive to the last day on which timely payment was made.

***Cost*: The cost of COBRA coverage is 102% of your contribution amount.**

When COBRA Continuation Coverage Ends

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

- The applicable continuation period ends;
- The initial contribution for continued participation is not made within 45 days after the date COBRA is elected, or any subsequent contribution is not made within 30 days after it is due; or
- US Airways terminates participation in the HCA for all employees.

For questions, please contact the COBRA administrator.

Reporting Dependent Care Provider Information on Your Tax Return

The IRS requires you to report on your federal tax return the "taxpayer identification number" of any dependent care providers you use. You must also report the appropriate taxpayer identification number(s) when you request a reimbursement from your DCA.

Remember that the HCA and DCA are not interchangeable. You cannot use money from your HCA to pay dependent care expenses, or vice versa.

PRIVACY PRACTICES

This section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

US Airways has certain obligations regarding the privacy of your medical information according to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

"We" refers to the Plan, also referred to as "the Plan," and "you" or "your" refers to individual participants in the Plan.

Use and Disclosure of Protected Health Information

We are required by federal law to protect the privacy of your individual health information ("Protected Health Information" or "PHI"). We are also required to provide you with this information regarding our policies and procedures regarding your PHI, and to abide by their terms, as they may be updated from time to time.

Under applicable law, we are permitted to make certain types of uses and disclosures of your PHI, without your authorization, for treatment, payment and health care operations purposes.

For treatment purposes, such use and disclosure may take place in providing, coordinating or managing health care and its related services by one or more of your providers, such as when your primary care physician consults with a specialist regarding your condition.

For payment purposes, such use and disclosure may take place to determine responsibility for coverage and benefits, such as when we confer with other health plans to resolve a coordination of benefits issue. We also may use your PHI for other payment-related purposes, such as to assist in making Plan eligibility and coverage determinations, or for utilization review activities.

For health care operations purposes, such use and disclosure may take place in a number of ways involving Plan administration, including for quality assessment and improvement, vendor review and underwriting activities. Your information could be used, for example, to assist in the evaluation of one or more vendors who support us, or we may contact you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Plan.

We may disclose your PHI to the Plan Sponsor in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose PHI to the Plan Sponsor in connection with payment, treatment or health care operations.

Other Permitted Uses and Disclosures

In addition, we may use or disclose your PHI without your authorization under conditions specified in federal regulations, including:

- As required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
- For public health activities;
- Disclosures to an appropriate government authority regarding victims of abuse, neglect or domestic violence;
- To a health oversight agency for oversight activities authorized by law;
- In connection with judicial and administrative proceedings;
- To a law enforcement official for law enforcement purposes;
- To a coroner or medical examiner;
- To cadaveric organ, eye or tissue donation programs;
- For research purposes, as long as certain privacy-related standards are satisfied;
- To avert a serious threat to health or safety;
- For specialized government functions (e.g., military and veterans activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations); and
- For workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

We may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person's involvement with your care or payment related to your care. In addition, we may use or disclose the PHI to notify a member of your family, your personal representative, another person responsible for your care or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding

such disclosure and will disclose only the information that is directly relevant to the person's involvement with your health care.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization in writing at any time, provided the Plan has not yet taken action in reliance on your authorization.

Your Rights Regarding Protected Health Information

You may ask us to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request, except in limited circumstances. You may exercise this right by contacting the individual or office identified at the end of the section. They will provide you with additional information.

You have the following rights with respect to your PHI:

- The right to inspect and copy your PHI (the Plan may charge a reasonable, cost-based fee);
- The right to request an amendment or correction;
- The right to request an accounting of certain disclosures of your PHI by us for the 6 years prior to your request (you are not entitled to an accounting of disclosures made for payment, treatment or health care operations, or disclosures made pursuant to your written authorization). The Plan may deny your request if it believes your information is accurate and complete, or if the information was created by a party other than the Plan;
- The right to receive a paper copy of this information upon request, even if you agreed to receive it electronically.

About US Airways' Privacy Policy

We reserve the right to change the terms of this policy and to make the new provisions effective for all PHI we maintain. If we change the policy, you will receive written notice.

If you believe that your privacy rights have been violated, you may file a written complaint with US Airways or the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC 20201.

To file a complaint with US Airways, contact the office identified below for additional information.

US Airways, Inc.
Attention: Privacy Office
4000 E Sky Harbor Blvd.
Phoenix, AZ 85034

YOUR RIGHT TO APPEAL

For Health Care Account and Dependent Care Account Plans

Time Frame for Initial Claim Determination

The Plan Administrator will notify you of an adverse benefit determination within 30 days of the date the claim was filed. An additional 15-day extension may be allowed to make a determination, provided the Plan Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Plan Administrator must notify you before the end of the first 30-day period of the reason(s) for the extension and the date it expects to provide a decision on your 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.

If an extension is necessary due to your failure to submit necessary information, you will be given at least 45 days to submit the information. The Plan will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

If You Receive an Adverse Benefit Determination

The Plan Administrator will provide you with a notification of any adverse benefit determination, which will include:

- 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 ERISA 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; and

- 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.

How to Appeal an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. 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.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will have access to all documents that are relevant to your claim. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, the Plan Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Plan Administrator will provide you with the identification of any medical expert whose advice was obtained on behalf the Plan in connection with your appeal.

A decision regarding your appeal will be reached within 60 days after receipt of your request for review of your claim. The Plan Administrator's notice of an adverse benefit determination on appeal will include:

- 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 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.

You may not bring a lawsuit to recover benefits under this Plan until you have exhausted all claims and appeals 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.

For All Other Flexible Benefit Plan Claims

Claims for benefits under all other benefit options available under the Flexible Benefit Plan will be determined according to the procedures set forth in the SPDs and plan documents describing such benefit options.

PLAN ADMINISTRATION

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

Names of Plans

The names of the Plans described in this SPD are:

- The US Airways, Inc. Flexible Benefit Plan
- The US Airways, Inc. Health Care Account Plan
- The US Airways, Inc. Dependent Care Account Plan

Types of Plans

The Flexible Benefit Plan offers eligible employees the opportunity to elect to pay the cost for certain qualified benefits provided by US Airways on a pre-tax basis in lieu of cash compensation.

The HCA and DCA Plans provide for participation in a Health Care and/or Dependent Care Account.

Plan Sponsor

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

Plan Administrator

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

The administration of the Plans will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plans. The Plan Administrator will also have the discretion to determine all matters relating to interpretation and operation of the Plan. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding.

Agent for Service of Legal Process

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

Legal process can also 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 assigned to the Health Care Account is 501.

Plan Year

The Plan year is January 1 through December 31.

Organizations Providing Administrative Services

Listed below are the names, addresses, phone numbers and websites of the organizations that provide administrative services. These services include administering claims and providing customer assistance.

Flexible Spending Account

WageWorks®
PO Box 14053
Lexington, KY 40512
Phone: 877-924-3967
www.wageworks.com

COBRA

CONEXIS
PO Box 650407
Dallas, TX 75265-0407
866-747-0045
www.mybenefits.conexis.com

Plan Funding/Sources of Contributions

The spending accounts are funded by pre-tax and/or after-tax contributions made by employees who elect to participate in the Plan(s).

Plan Document

This booklet is intended to help you understand the main features of the Plans. It should not be considered a substitute for the Plan documents, which govern the operation of the Plans. If you have any questions about information not covered in this booklet, or if this booklet appears to conflict with the official Plan documents, the text of the official Plan documents will determine how questions will be resolved.

You can request a copy of the Plan documents by contacting

US Airways, Inc.
4000 E Sky Harbor Blvd.
Phoenix, AZ 85034
490-693-0800

Limitation on Assignment

Your rights and benefits under the Plans cannot be assigned, sold, or transferred to your creditors or anyone else.

Future of the Plans

US Airways intends to continue the Plans indefinitely. However, US Airways reserves the right to amend, modify, suspend or terminate the Plans, in whole or in part. Any such action would be taken in writing and maintained with the records of the Plans. Plan amendment, modification, suspension or termination may be made for any reason, and at any time.

If the Plans, or any part of the Plans, are terminated, you will receive the benefits due you to the extent funded or provided contractually under the terms defined in the Plans' legal contracts.

YOUR RIGHTS UNDER ERISA

As a participant in the Plans, 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 Plans and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plans, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration ("EBSA").
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plans, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plans' annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual reports.

Continue Group Health Plan Coverage (Applicable to the Health Care Account Only)

You can continue coverage under the HCA Plan for yourself, spouse or dependents if there is a loss of coverage under that Plan as a result of a qualified family or work status 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 coverage rights.

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 these Plans. The people who operate your Plans, called "fiduciaries" of the Plans, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, 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 a claim for a Plan benefit is denied or ignored, in whole or in part, you or your beneficiary has 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 Plans' fiduciaries misuse the Plans' 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 Plans, 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 Employee Benefits Security Administration ("EBSA"), 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, DC 20210.

NOT A CONTRACT OF EMPLOYMENT

Your eligibility or your right to benefits under the Plans 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.

This SPD provides detailed information about the Plans and how they work. This SPD does not constitute an expressed or implied contract or guarantee of employment.