Summary Plan Description

of

US Airways, Inc. Health Care Plan for Pilots and Flight Attendants Domiciled in Phoenix, Arizona

Revised 01/01/2013

Updated 02/12/2013

Pilots

US Airways, Inc.

Health Care Plan for Pilots and Flight Attendants Domiciled in Phoenix, Arizona

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Preface

The US Airways, Inc. Health Care Plan for Pilots and Flight Attendants Domiciled in Phoenix, Arizona ("Plan") is an employee welfare benefit Plan under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. It is comprised of the following programs of benefits:

- Medical and Prescription Drug
- Wellness Program
- Dental
- Vision
- Employee Assistance Program (EAP) and Behavioral Health
- Flexible Benefits (Section 125) Plan
- Voluntary Benefits

This booklet is divided into separate sections that describe each program of benefits under the Plan. All together, they comprise the summary plan description ("SPD") for pilots covered by the collective bargaining agreement between the US Air Line Pilots Association and US Airways, Inc. ("the Company"). It is written in plain language to help you understand how the Plan works. Separate SPDs have been prepared for all other work groups.

The Company is the Plan Administrator. In its role as Plan Administrator, US Airways, Inc. maintains sole responsibility for the 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.

Plan Amendments and Terminations

The Company has the right to change or terminate this Plan at any time, for any reason. If any part of the Plan is changed or terminated, benefits you receive may not be the same as described in the Plan's SPD. All changes will be promptly communicated to you as required by law. If a program is discontinued, benefits, if any, will be paid for all charges incurred for covered expenses prior to that date. A change to or termination of the Plan can happen at any time, even after you retire. You do not have vesting rights in this Plan.

Participation in this Plan is not, and should not be considered, a contract of employment.

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 BenefitsUS Call Center 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.

Administrative Information

Plan Name

The formal name of this Plan is US Airways, Inc. Health Care Plan for Pilots and Flight Attendants Domiciled in Phoenix, Arizona.

The Plan includes several distinct benefit programs, as follows:

- Medical and Prescription Drug plan
  - (a) Choice Plan
  - (b) Choice Plus High
  - (c) Choice Plus Low
  - (d) Indemnity Plan
- "Fit for US" Wellness Program
- Dental plan
  - (a) High and Low Option Dental
- Vision plan
- EAP and Behavioral Health Services
- Flexible Spending Accounts
- Voluntary Benefit Plans
  - (a) Long-Term Care Plan
  - (b) Critical Illness Plan
  - (c) Accident Insurance Plan

Employer Identification Number (EIN) and Plan Number

The Employer Identification Number is 53-0218143. The Plan Number is 515.

Type of Plan

This Plan is a welfare benefit plan that provides various types of benefits, including health care benefits.

Employer, Plan Sponsor and Plan Administrator

US Airways, Inc.
4000 East Sky Harbor Boulevard
Phoenix, AZ 85034
Telephone: 480-693-0800

Funding for the Plan

This Plan is funded through a combination of self-insured and fully insured arrangements. “Self-insured” means that the benefit is paid out of the general assets of the Plan Sponsor. “Insured” means that the benefit is paid by the insurance company.

Plan Year

January 1 – December 31.

Qualified Medical Child Support Order (QMCSO)

The Plan Administrator must comply with any judgment, decree or order issued by a Court regarding extension of coverage to children. A QMCSO must be sent to the Plan Administrator to ensure compliance with the order. Contact the Plan Administrator for a free copy of the Plan’s QMCSO procedures and a model QMCSO.

Agent for Legal Process

All papers concerning a lawsuit should be sent to the Plan Sponsor/Plan Administrator at its offices located at the address shown above.

COBRA Continuation Of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides you and your eligible dependents the right to pay to continue the following health care benefits: medical and prescription drug, dental, vision, EAP, behavioral health, wellness, and health care spending account (HCSA) (you may only elect COBRA for HCSA for remainder of plan year). Under COBRA, if your health care coverage terminates as the result of a "qualifying event," as described in the chart below, you or they may be offered the right to continue coverage for up to the length of time indicated. You and your eligible dependents must pay 102% of the premium for COBRA coverage.

Eligible dependents include your Spouse, natural born children, adopted children or children placed with you for adoption. Domestic Partners are eligible to continue their coverage under COBRA if covered under the Plan at the time of the employee's termination and are eligible only as a dependent as defined under the Domestic Partner Program.

Participants who elect to continue coverage have the right to add dependents to their coverage under the same terms applicable to active employees, e.g. annual enrollment and qualifying life event changes.

Children born to, adopted by or placed with an eligible employee during the COBRA period qualify for coverage under COBRA for the remainder of the covered employee's COBRA period unless they qualify for the extension due to a second Qualifying Event on page 4.

General Notice (Initial COBRA Notice)

The Plan Administrator must provide written notice of the right to continue coverage to each covered employee and Spouse (if applicable) within 90 days after coverage under the Plan commences. (If a Qualifying Event occurs during the first 90 days of coverage under the Plan and before the general notice has been distributed, the Plan may provide only the COBRA election notice, as described below). In lieu of, or in addition to, such written notice, the Plan Administrator is hereby providing the general notice to the employee by delivery of the Summary Plan Description.

The Plan may notify a covered employee and the covered employee's Spouse with a single general notice addressed to their joint residence, provided the Plan's latest information indicates that both reside at the address. However, when a Spouse's coverage under the Plan begins later than the employee's coverage, a separate general notice must be sent to the Spouse within 90 days after the Spouse's coverage commences.

Note: It is important for the Plan Administrator to be kept informed of the current addresses of all Covered Persons under the Plan who are, or who may become, Qualified Beneficiaries.

COBRA Qualifying Event	COBRA Maximum Coverage Duration (actual duration may be shorter)
Termination of employment (for any reason other than gross misconduct or disability)	18 months (employee and eligible dependents)
Reduction in employee's hours worked	18 months (employee and eligible dependents)
Death of employee	36 months (eligible dependents)
Divorce (or loss of Domestic Partner status)	36 months (Spouse/former Spouse/former Domestic Partner and eligible dependent children)
Dependent child ceases to qualify as a dependent	36 months
Disability	18 or 29 months based on eligibility for Social Security disability benefits

Plan participant or eligible dependent who becomes disabled anytime during the first 60 days of COBRA; notifies the plan administrator in writing within 60 days of the Social Security disability determination and before the end of the normal 18 month continuation period	29 months

Notice That Qualified Beneficiaries Must Provide

Continuation of health coverage shall be available for the following Qualifying Events only if the employee or Qualified Beneficiary notifies the Plan Administrator in writing of the Qualifying Event within 60 days of the date of such event:.

- For a Spouse, divorce from a covered employee;
- For a dependent child, loss of dependent status under the Plan; or
- The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

An employee or Qualified Beneficiary who does not provide timely notice to the Plan Administrator of one of the above such Qualifying Events will not have the right to elect COBRA continuation coverage under the Plan.

Disability Notices

Upon termination of employment or reduction in hours, a Qualified Beneficiary who is determined under the Social Security Act to be disabled on such date, or at any time during the first 60 days of COBRA continuation coverage, will be entitled to continue coverage for up to 29 months if the Plan Administrator is notified in writing of such disability within 60 days from the later of (and before the end of the 18-month period): the date of the Social Security Administration determination, the date on which the Qualifying Event occurs, or the date on which the Qualified Beneficiary loses coverage. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

A Qualified Beneficiary who is disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the date of final determination that he is no longer disabled.

Notice of Second Qualifying Event

If your family experiences another Qualifying Event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during the disability extension period as described above), the Spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum period of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator. This extension may be available to the Spouse and any dependent children receiving COBRA coverage if the employee or former employee dies or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second Qualifying Event is available only if the employee or Qualified Beneficiary notifies the Plan Administrator in writing of the second Qualifying Event within 60 days after the later of: the date of the second Qualifying Event; and the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

Plan Administrator's Notice Obligation – Election Notice

The Plan Administrator will notify any Qualified Beneficiary of his right to continue coverage under the

Plan within the time frame required under ERISA and Department of Labor Regulations (generally 44 days from the date of the Qualifying Event for termination of employment and reduction of hours, and for the other Qualifying Events, 14 days from the date notice is provided to the Company). Notice to a Qualified Beneficiary who is the employee's Spouse shall be notice to all other Qualified Beneficiaries residing with such Spouse when such notice is given.

Election Procedures
A Qualified Beneficiary must elect Continuation of Health Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A new Spouse, a newborn child, or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the "Eligibility Requirements" section of the Plan. A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time and in accordance with the procedures established by the Plan Administrator.

Any election by an employee or his Spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contributions from the first day of COBRA eligibility to the Plan Administrator. All subsequent contribution payments must be paid by the Qualified Beneficiary to the Plan Administrator no later than the first of each month plus a 30-day grace period. If the initial payment is not made within 45 days of the date for the election, COBRA coverage will not take effect. If subsequent payments are not made within the allotted 30 day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full payment was made.

Except as provided herein, if the initial coverage election and required payments are made in a timely manner, as described in this section, coverage under the Plan will be reinstated retroactively back to the date of the Qualifying Event.

If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the 60-day election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements such as timely contribution payments, are met.

Plan Administrator's Notice Obligation – Notice of Unavailability of Continuation Coverage
The Plan Administrator will provide a notice of unavailability to an individual within 14 days after receiving a request for continuation coverage if the Plan determines that such individual is not entitled to continuation coverage. The notice will include an explanation as to why the individual is not entitled to COBRA. This notice will be provided regardless of the basis of the denial and regardless of whether it involves a first or second Qualifying Event or a request for disability extension.

Plan Administrator's Notice Obligation – Early Termination Notice
The Plan Administrator will provide a notice to Qualified Beneficiaries when COBRA terminates earlier than the maximum period of COBRA applicable to the Qualifying Event as soon as practicable following its determination that continuation coverage shall terminate. This notice will contain the reason that continuation coverage has terminated earlier than the maximum period triggered by the Qualifying Event, the date of termination of continuation coverage, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage (such as a conversion right).

Trade Act of 2002
The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade

adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of premiums paid for qualified health insurance, including continuation coverage. The Plan shall fully comply with the Trade Act of 2002.

Continuation of coverage will end for any of the following reasons:

- your Employer no longer provides health care coverage to any of its employees;
- the contribution for continuation coverage is not timely paid;
- the covered individual becomes covered under another group health plan (excluding health plans provided by the government) unless such Plan has a pre-existing condition exclusion or limitation that applies to such individual.

You may obtain additional information regarding health care continuation of coverage from the COBRA Administrator.

Special Considerations in Deciding Whether to Elect COBRA Coverage
In considering whether to elect COBRA coverage, a Qualified Beneficiary should take into account that a failure to elect COBRA coverage will affect future rights under federal law. First, a Qualified Beneficiary can lose the right to avoid having pre-existing condition exclusions applied to him or her by another group health plan if he or she has more than a 63-day gap in health coverage, and election of COBRA coverage may help him or her not have such a gap. Second, a Qualified Beneficiary will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if he or she does not get COBRA coverage for the maximum time available. Finally, a Qualified Beneficiary should take into account that he or she has special enrollment rights under federal law. Qualified Beneficiaries have the right to receive special enrollment in another group health plan for which he or she is otherwise eligible (such as a plan sponsored by his or her Spouse's employer) within 30 days after his or her group health coverage under the Plan ends because of the Qualifying Event listed above. A Qualified Beneficiary will also have the same special enrollment rights at the end of the COBRA coverage if he or she gets COBRA coverage for the maximum time available to him or her.

USERRA and COBRA Coverage are Concurrent
The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain employees who are involved in the uniformed services. In addition to the rights that you have under COBRA, you are entitled under USERRA to continue your health coverage that you (and your covered dependents, if any) have under the Plan.

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered Spouse or dependents) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in this Section (for example the procedures how to elect COBRA coverage and paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the procedures is impossible or unreasonable under the circumstances.

If you elect to continue your health coverage (or your Spouse or dependent's coverage) pursuant to USERRA:

- you will be required to pay 102% of the premium for USERRA coverage (the same rate as COBRA coverage). However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

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

Claims Administrators

Each program of benefits under this Plan is administered by various Claims Administrators. With respect to the medical and prescription drug, dental and behavioral health benefits, the Claims Administrators do not insure the benefits described in this SPD; they serve as contract administrator and claims payer while the actual benefit is paid out of the general assets of the Plan Sponsor. With respect to vision and voluntary benefits, benefits are insured and the Claims Administrator processes the claims and serves as the insurer. With respect to the EAP and wellness program, the Claims Administrator provides services in exchange for fees that are billed to and paid by the Plan Sponsor. In addition, this Plan's enrollment function is administered by an enrollment administrator (see below). See the Appendix for additional information.

You may contact the enrollment administrator as follows for newly eligible enrollment, annual enrollment, or qualifying event changes:

For Enrollment Administration:

BenefitsUS	1-888-860-6178 www.eBenefitsUS.com

For COBRA and Direct Bill Administration:

CONEXIS	P.O. Box 650407 Dallas, TX 75265-0407 1-866-747-0045 www.mybenefits.conexis.com

You may, depending on the type of health care service, contact the appropriate Claims Administrator as follows:

For Medical Benefits

United HealthCare Services, Inc. (United HealthCare)	P.O. Box 30555 Salt Lake City, UT 84130-0555 1-800-520-0811 www.myuhc.com

***For Prescription Drugs** (for United HealthCare administered plans only)*

CVS Caremark, Inc.	ATTN: Client Service/US Airways, Inc. P. O. Box 52196 Phoenix, AZ 85072-2196 1-866-760-4276 www.caremark.com

For Wellness Program

Quest Diagnostics, Inc.	1-913-888-1770 My.blueprintforwellness.com
OptumHealth	1-800-478-1057 (Telephonic Wellness Coaching) https://client.myoptumhealth.com/usairways

For Dental Benefits

MetLife Dental	P.O. Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.metlife.com/dental

For Vision Benefits

Superior Vision	P.O. Box 967 Rancho Cordova, CA 95741 1-800-507-3800 www.superiorvision.com

For Mental Health, Chemical Dependency and Employee Assistance Services

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) Intl. country code for country calling from +44-1865-397-221 (all other countries) www.liveandworkwell.com (access code is US Airways)

For Flexible Spending Accounts

CONEXIS (until 12/31/12) **Or** **WageWorks (1/1/13 and later)**	P.O. Box 227197 Dallas, TX 75222-7197 1-866-279-8385 www.conexis.com P.O. Box 14053 Lexington, KY 40512 1-877-924-3967 www.wageworks.com

For Voluntary Plans

Unum Life Insurance Company of America **(Voluntary Long-Term Care, Critical Illness and Accident Insurance)**	2211 Congress Street Portland, ME 04122 1-866-679-3054 www.unum.com

How To File A Claim

In-Network

When you receive services from In-Network providers, there are no claim forms to complete. The provider of service will file the claim.

If you are required to pay a Copayment, you will pay the required amount at the time of your office visit. If you are required to pay a coinsurance amount, it will be collected according to your Doctor's billing procedures. Some Doctors may ask you to pay the required coinsurance amount at the time services are provided.

In most cases, you will receive an explanation of benefits from the Plan after the Plan has paid its portion.

If you have any questions about a claim, contact the Claims Administrator of the plan of benefits you have chosen.

Out-of-Network

When you receive services from Out-of-Network providers, you must file a claim to receive reimbursement from the Plan. To ensure consideration of your claims under the Plan, claims must be filed no later than 12 months immediately following the date on which services are received. Claims received after the grace period will be denied.

You can get paper claim forms from the enrollment administrator's website or from the Claims Administrator's website by downloading and printing the form. Fill out the employee section, sign the form and attach the original copy of an itemized bill. Canceled checks and cash register receipts are not acceptable. Any bills you send become a permanent part of your claim file. If you need copies for yourself, make them before sending in your claim. If you have already paid your bill, do not assign benefits to your provider so that the reimbursement is sent directly to you. Additionally, you must provide the Claims Administrator with verification of payment.

The Claims Administrator is responsible for processing and paying claims that are filed for reimbursement and for making the necessary adjustments to your claims. Such adjustments may include collection of overpayments.

Send your claims to the Claims Administrator at the address shown in this Section I. Should you have any questions regarding how your claim was processed, contact the Claims Administrator.

Claims Procedures And Time Frames

The following applies to medical, prescription drug and behavioral health coverage. For information on claims procedures and time frames for other benefits, please see the corresponding sections of this document.

Claims determinations are based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary and/or appropriate for you is between you and your Physician. However, just because you or your physician decide a service is necessary or appropriate does not mean the service will be paid for by the Plan.

The Claims Administrator has full discretion to deny or grant a claim in whole or part. Such decisions shall be made in accordance with the governing Plan documents and, where appropriate, Plan provisions

will be applied consistently with respect to similarly situated claimants in similar circumstances. The Claims Administrator shall have the discretion to determine which claimants are similarly situated in similar circumstances.

In general, health services and benefits must be Medically Necessary to be covered under the Plan. The procedures for determining Medical Necessity vary according to the type of service or benefit requested and the type of health plan.

Claims determinations are made on a

(A) Pre-Service basis

- Non-urgent care
- Urgent care

(B) Concurrent basis, or

(C) Post-Service basis

(A) Pre-Service Claims

Non-Urgent Care

Pre-Service claims are those claims that require notification or approval prior to receiving medical care. A claim is only a pre-service claim if failure to obtain approval prior to service results in a reduction or denial of benefits that would otherwise be covered.

If your claim was a Pre-Service claim that was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim unless an extension of 15 days is necessary due to circumstances beyond the Plan's control.

If additional information is needed to process the Pre-Service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and suspend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received.

If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures. (See *Questions and Appeals* below.)

Urgent Care Claims that Require Immediate Action

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain.

In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

- Notice of denial may be verbal with a written or electronic confirmation to follow within 3 days.

If you filed an urgent care claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

For urgent claim appeals, the Claims Administrator has been delegated the exclusive right to interpret and administer provisions of the plan. The Claims Administrator's decisions are conclusive and binding.

You will be notified of a determination no later than 48 hours after:

- The Claim 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 timeframe.

(B) Concurrent Care Claims

If an on-going 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 above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies. A reduction or termination of the course of treatment before the approved time period or number of treatments will be considered a claim denial. If this occurs, you will be notified sufficiently in advance in order to appeal the decision before the benefit is reduced or terminated.

(C) Post-Service Claims

Post-Service claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, unless an extension of 15 days is necessary due to circumstances beyond the Plan's control. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and suspend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Notice of Adverse Pre-Service, Concurrent Care or Post-Service Benefit Decision

Any notice of an adverse benefit decision whether a pre-service claim, post-service claim or concurrent care claim, shall include the following:

The specific reason or reasons for the adverse determination;

Reference to the Plan provisions on which the determination is based;

A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why the information is necessary.

A description of the Plan's review procedures, the time limits applicable to such procedures, and the claimant's right, at no charge, to have reasonable access to and to obtain copies of all relevant documents upon request therefore, and a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse determination on review;

If an internal rule or guideline was applied in making the determination, a statement that the rule will be provided free of charge upon request;

If the determination is based on a medical necessity or experimental exclusion, a statement that an explanation of the scientific or clinical judgment applied to make the determination will be provided free of charge upon request; and

If the determination affects a claim for urgent health care, a description of the expedited review process applicable to such claims.

Questions And Appeals

This section provides you with information to help you with the following:

• A question or concern about covered medical services or your benefits.

• You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the plan and you wish to appeal such determination.

If a claim is denied, you will have 180 days from receipt of the denial to submit a written appeal of the determination.

The Claim Administrator's review will take into account all comments, documents on appeal, records and other information submitted regardless of whether the information was previously considered on initial review. The Claim Administrator will have discretion to deny or grant the appeal in whole or part. Such decisions shall be made in accordance with the governing Plan documents and, where appropriate, Plan provisions will be applied consistently with respect to similarly situated claimants in similar circumstances. The Claim Administrator shall have discretion to determine which claimants are similarly situated in similar circumstances.

To resolve a question or appeal, just follow these steps:

Step 1: What to Do First

If you are not satisfied with a benefit determination, you may appeal it as described below, without first informally contacting Member Services. However, if you would like to try to informally resolve a claim before filing a formal appeal, you can contact Member Services.

The Member Services telephone number is shown in this summary plan description. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

Step 2: How to Appeal a Claim Decision

If you disagree with a claim determination and are unable or choose not to attempt to resolve your claim with Member Services, you can contact the Claims Administrator in writing or by telephone, fax or similar method for Urgent Care claims to formally request an appeal. If you wish to file a second level appeal you would need to follow this same procedure. If the appeal relates to a claim for payment, your request should include:

• The patient's name and the identification number (Social Security number).

• The date(s) of medical service(s).

• The provider's name.

• The reason you believe the claim should be paid.

• Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Step 3: Appeal Process

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claim Administrator. Your second level appeal request must be submitted in writing within 60 days from receipt of the first level appeal decision.

The Claims Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination.

Upon request, and free of charge, you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

The decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Step 4: Appeals Determinations

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of **urgent care claims** the **first level** appeal will be conducted and you will be notified by the Claims Administrator of the decision as soon as possible but no later than 72 hours from receipt of a request for appeal of a denied claim. The **second level** appeal will be conducted and you will be notified by the Claims Administrator of the decision as soon as possible but no later than 72 hours from receipt of a request for review of the first level appeal decision.
- For appeals of **pre-service claims** the **first level** appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The **second level** appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of **post-service claims** the **first level** appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The **second level** appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

External Review Program

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

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

This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if the 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 health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Filing a Lawsuit

No lawsuit may be brought with respect to Plan benefits until the foregoing administrative procedures (other than the External Review program) have been exhausted. You are not required to use the External Review program in order to bring a lawsuit.

Your ERISA Rights

As a participant in the US Airways, Inc. Health Care Plan for Pilots and Flight Attendants Domiciled in Phoenix, Arizona, you have 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 worksites 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 Employee Benefits Security 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 administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The administrator is required by law to furnish you with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care 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 summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage 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 issuer when:

- you lose coverage under the Plan,
- you become entitled to elect COBRA continuation coverage,
- 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 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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 interests of you and other Plan participants and beneficiaries. No one, including your Employer, your union or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you have a 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 pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is ignored or denied, in whole or in part, you have a right to file suit in Federal or state court but only after you have exhausted the Plan's administrative remedies. 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 Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or 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 your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area 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 NW, 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.

This Plan is maintained pursuant to the collective bargaining agreements between the Company and the US Airline Pilots Association and Association of Flight Attendants-CWA, AFL-CIO (the "Unions"). You may obtain additional copies of the collective bargaining agreement and copies of any other Plan documents during regular workings hours in the Company's Benefits Department or at the applicable Union's office. If the Union's office does not have a copy of the documents you would like to inspect, you may contact the Company's Benefits Department directly or ask the Union representatives to contact the Company's Benefits Department. The Company's Benefits Department will then make the documents available for inspection within 10 days following the receipt of the request.

Your Privacy

HIPAA Privacy Rules

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rules, you have the right to the confidentiality of certain health care information (referred to as "protected health information") and the right to approve or refuse the release of specific information except when the release is authorized under the Privacy Rules or is otherwise required by law. On behalf of this Plan, US Airways, Inc. maintains policies and procedures regarding the confidentiality of your protected health information.

This Plan (other than the Dependent Care Spending Account component and Voluntary Benefits component) is a "covered entity" for purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rules. HIPAA requires that "covered entities" protect the confidentiality of your protected health information ("PHI").

"PHI" means health information that:

1. is created or received by a health care provider, health plan, public health authority, Employer, life insurer, School or university or health care clearinghouse;
2. relates to the past, present and future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
3. identifies the individual or reasonably could be used to identify the individual.

A complete description of your rights under HIPAA can be found in the Health Care Plan's privacy notice,

distributed to you upon enrollment and as legally required thereafter and available upon request from the Plan Sponsor.

The Plan will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment and health plan operations, or as otherwise permitted under the Privacy Rules or as required by law. The Plan requires all of its service providers to also observe HIPAA's Privacy Rules.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see 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 Health Care 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.

HIPAA Security Rules
To comply with the Security Standards and Implementation Specifications issued by the Department of Health and Human Services pursuant to HIPAA (the "HIPAA Security Rule"), the Plan Sponsor will reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

The Plan Sponsor will:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that the adequate separation required by the Standards for Privacy of Individually Identifiable Health Information is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

4. Report to the Plan any security incident of which the Plan Sponsor becomes aware.

Certificate of Creditable Coverage

There is a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a 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 issuer when:

- You lose coverage under the plan,
- You become entitled to elect COBRA continuation coverage,
- 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 12 months (18 months for late enrollees) after your enrollment date in your coverage.

HIPAA requires group health plans and health insurers to issue certificates of creditable coverage (HIPAA certificates) to all individuals who lose coverage under the plan. You may need to furnish this certificate if you become eligible under a Group Health Plan that excludes coverage for certain medical conditions before you enroll. This certificate may need to be provided if medical advice, care or treatment was recommended or received for the condition prior to your enrollment in the new plan.

Genetic Information and Nondiscrimination

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 medical provider has been consulted.

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End of Section I

This section provides general information about, and information which is common to, all of the benefits described under the Plan. Specific benefit information appears in the applicable section describing that particular benefit.

About The Terms Used In The Plan

In this SPD, words that have special meaning are capitalized. Those words are defined under the *Definitions* section of the SPD.

Although you will see references, for example, to the medical *plan,* the vision *plan,* or the dental *plan,* please keep in mind that these are actually *programs* of benefits provided under the umbrella of the US Airways, Inc. Health Care Plan for Pilots and Flight Attendants Domiciled in Phoenix, Arizona (the "Plan"). They are not stand-alone employee benefit plans.

About The Plan Summaries

In the event there is a discrepancy between this SPD and the official documents that govern this Plan, e.g. the Plan document or policies of insurance, etc., the official documents will prevail.

Who Participates In The Plan

You can participate in the Plan if you are an employee of US Airways, Inc., an affiliate or any member of a controlled group of corporations that has adopted the plan who:

- is a pilot listed on the Pilots System Seniority List that is employed by US Airways, Inc., and is domiciled in Phoenix, Arizona;
- is a Retired Pilot who has not yet reached Social Security normal retirement age (does not apply to Flexible Benefits – Section VII); or
- is a former pilot of the Plan Sponsor (Company) who was eligible for and covered under the Plan the day before a separation from the Company and included in a classification of former employees for whom coverage is available to be extended for a pre-determined period of time following the separation from employment (e.g. former employees subject to collectively bargained agreement related provisions, former employees subject to written separation agreements, furloughed employees with written agreement on eligibility for continued coverage). (This does not apply to Flexible Benefits – Section VII.)

For purposes of eligibility, employees are individuals who are classified by the Employer 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, the individual shall nonetheless continue to be excluded from the Plan and shall be ineligible for benefits for all periods prior to the date the Employer determines its classification of the individual is erroneous or should be revised.

Your dependents who can participate are:

- your Spouse
- your Domestic Partner (provided you are employed in Active Service and your Domestic Partner meets eligibility requirements and submits verification acceptable to the Plan Administrator);

Note: Domestic Partners are eligible to continue their coverage under COBRA if covered under the Plan at the time of the employee's termination.

- your natural children, Adopted Children (regardless of whether the adoption is final), stepchildren, Foster Children, and children for whom you or your Spouse are a legal guardian who meet all of the following requirements:

- Are age 26 or under (coverage is extended through the last day of the calendar year in which they attain age 26);

- For adult dependent children (dependent children age 19 through age 26), are not eligible to enroll in health coverage sponsored by the adult dependent's employer (this rule applies only for Plan years beginning before January 1, 2014);

- If your child became physically or mentally disabled and was covered by the Plan on the day before the last day of the calendar year in which he/she attained age 26, your child will continue to be eligible for coverage as long as the disability remains. The Plan Administrator may require documentation that confirms your child's ongoing disability. "Disability" for dependent eligibility purposes will have the meaning used by the Internal Revenue Service for income tax purposes.

  When asked by the Plan Administrator, you will have to provide proof of the disability. Proof of the disability may consist of:

  • diagnosis;
  • name of the physician;
  • medical history; and/or
  • other information requested by the Claims Administrator.

Enrolling In The Plan

You and your eligible dependents are eligible for coverage on the first day of the month after you complete 90 days of Active Service. As a new employee, you must, unless otherwise specified, properly complete the enrollment process through the enrollment administrator no later than the last day of the month in which you first became eligible.

If you do not enroll yourself or your eligible dependents when you are first eligible, you may enroll during annual enrollment. Annual enrollment is held once a year and you will be notified of the annual enrollment period each year.

Be sure to list all of your eligible dependents when you first enroll as you cannot add dependents later, except that you may add new dependents acquired because of birth, adoption, placement for adoption, marriage, or because of a Qualified Medical Child Support Order (QMCSO). If you do not enroll the dependent within 31 days of the date acquired, you can enroll the dependent during annual enrollment.

US Airways will require you to provide supporting documentation for eligible dependent children and for other dependents. This information includes verification of relationship. If you fail to provide this information at the time dependents are added, they will be removed from your coverage. When your dependent children are no longer eligible to participate in the Plan, you must notify the BenefitsUS Customer Service. Coverage for a verified registered domestic partner who is not a "tax dependent" under the Internal Revenue Code will result in taxable income for you. If your domestic partner satisfies the requirements to be considered your tax dependent, you may submit a signed "Dependent Certification Form" to the Benefits Department to certify dependent status and avoid this taxable income. This form must be submitted each year, no later than December 1st. For further information regarding these issues please see *Who Pays for the Plan* in this Section II" on page 23. You may also wish to consult your tax advisor to determine how these IRS rules will impact your personal situation. Receipt of insurance cards does not guarantee coverage.

Enrollment Requirements – at a glance

Please keep in mind that you must meet certain eligibility requirements, as stated above, before enrollment is permitted.

Plan	***Enrollment is:***	***The cost is:***
Medical	Not automatic. You must complete the enrollment process in order to participate. (Enrolling in a medical plan will automatically enroll you in a prescription drug program.)	Shared by you and the Company. (Prescription drug cost is included in the medical premium.)
Wellness	Automatic when you enroll in a medical plan. If you don't elect medical coverage, you are not eligible for the Wellness Program.	Shared by you and the Company; your share is included in your medical contribution.
Dental	Not automatic. You must complete the enrollment process in order to participate.	Shared by you and the Company.
Basic Vision	Automatic when you enroll in a medical plan. If you do not elect an applicable medical plan you are not eligible for Basic Vision benefits.	Paid entirely by the Company.
Buy-Up Vision	Not automatic. You must complete the enrollment process in order to participate.	Paid entirely by you.
EAP	Automatic. There are no enrollment forms to complete.	Paid entirely by the Company.
Behavioral Health	Automatic when you enroll in a medical plan. If you don't elect medical coverage, you are not eligible for Behavioral Health benefits.	Shared by you and the Company; your share is included in your medical contribution.
Flexible Benefits: • Premium Conversion	Automatic when you enroll in an underlying benefit plan that is included in pre-tax premium payments under the Flexible Benefits program.	Paid entirely by you (except for any company match under dependent care). You elect how much to set aside in a spending account each year.
• Medical FSA	Not automatic. You must complete the enrollment process in order to participate from year to year.	Paid entirely by you. You elect how much to set aside in a spending account each year.
• Dependent Care FSA	Not automatic. You must complete the enrollment process in order to participate from year to year.	Paid by you and the Company (see Section VII). You elect how much to set aside in a spending account each year.
Long-Term Care Plan	Not automatic.	Paid entirely by you.
Critical Illness Plan	Not automatic.	Paid entirely by you.
Accident Insurance Plan	Not automatic.	Paid entirely by you.

Medical and Prescription Drug Identification (ID) Cards

If you enroll in a medical plan, the Claims Administrator will send you an ID card for you and, if applicable, your covered dependents. (Note, some plans may issue ID cards in only your name and some will issue in the names of all covered persons.)

The medical ID card should be presented to your medical service providers when you first need services or when requested by the provider. This card contains basic information about your plan of benefits including claims address and customer service phone number.

The prescription drug ID card will identify you as an eligible participant for this Prescription Drug program at In-Network retail pharmacies.

If you lose your ID cards or need additional cards, contact the Claims Administrator for the applicable benefit program.

Special Enrollment Periods and Enrollment Changes

As an active employee, you pay for your medical coverage with pre-tax premiums, therefore, the Internal Revenue Service places restrictions on when you can add and cancel coverage. Premiums for Domestic Partners may need to be on an after-tax basis.

If you are declining enrollment for yourself or your dependents, including your Spouse, because of other health care coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request coverage in this Plan within 31 days after your coverage in the other plan ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You can only add or cancel coverage if you experience one of the following status changes:

- Marriage
- Divorce or loss of Domestic Partner status
- Death of a Spouse or eligible dependent
- Birth, adoption or placement for adoption of a child *
- Change in the eligible status of a dependent child
- Termination or commencement of employment by the employee, Spouse or eligible dependent that causes the individual to become or cease to be eligible under the individual's employer's plan
- A reduction or increase in hours of employment by the employee, Spouse or eligible dependent including a switch between part-time and full-time, a strike, lockout, or commencement of return from unpaid leave of absence, relocation of employee, Spouse or eligible dependent
- Receipt by the Plan Administrator of a Qualified Medical Child Support Order (QMCSO)
- Entitlement to Medicare or Medicaid
- Any other event approved by the Company and determined to be a permissible change in status under the Internal Revenue Service regulations.

If one of the above events occurs and the "consistency rule" is met, you can add or cancel coverage within 30 days (60 days if the event is a "COBRA Qualifying Event" – see page 3) of the date of the event. To satisfy the consistency rule, the change in status must result in gaining or losing eligibility for coverage and your election must be on account of and correspond with that gain or loss of coverage. For example, if you and your Spouse adopt a child, you would be able to change from "employee + 1" coverage to "family" coverage under the plan. You would not be allowed to change to "employee only" coverage or discontinue your coverage because that change would be inconsistent with the change in your family status.

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") requires that the Plan must permit you and your dependent(s) to enroll (or disenroll) in the Plan upon your request **within 60 days** following the occurrence of either of the following events:

1. *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.

2. *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.

Failure to notify us 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 open enrollment period.

*Note: Notification timeframe in which an employee can advise the Plan that they want to add a newborn child (newly acquired dependent child < 12 months of age) to applicable self-funded medical plan (including medical, prescription, basic vision and EAP/behavioral health) is within 31 days of the birth event.

When Coverage Begins

For those plans in which you must complete an enrollment process, your coverage will begin on the first day of the month following or coincident to the date you complete 90 days of Active Service, provided that you enroll within 31 days of the applicable first of the month. For those plans in which you are automatically enrolled, you will be automatically enrolled on the first day of the month following or coincident to the date you complete 90 days of Active Service.

Coverage for your eligible dependents begins on the same day your coverage begins. If you enroll newly acquired dependents after the date you first become eligible, their coverage will begin on the day they become your dependents, provided you enroll them within 31 days of the date you acquire them.

Enrollment of an authorized Domestic Partner begins on the first day of the month following the completion of the authorization process, or the date your coverage is effective whichever is later.

If you add yourself or your dependents during annual enrollment, coverage will begin on January 1st immediately following the annual enrollment period unless otherwise specified by the Plan Administrator.

Coverage for your newborn child begins at birth, provided you enroll the child within 31 days from the date of birth. Coverage for your adopted child begins on the date the child is placed for adoption, provided you enroll the child within 31 days of the adoption placement.

Who Pays For The Plan

Unless otherwise specified (see *Enrollment Requirements – At A Glance* in this Section II), you and the Company share in the cost of coverage. Your share is called a premium. Your premium is automatically taken out of your paycheck on the first two paychecks of every month. Each monthly premium pays for coverage for that same month. Contact the enrollment administrator for current premium rates. Although premiums are subject to change at any time, your annual enrollment materials will describe the following year's premiums for coverage.

Generally, except as noted below, your premiums are paid with pre-tax dollars if you are an active employee. This means your premiums are deducted from your pay before federal income and Social Security taxes (and in most cases, state and local taxes, if applicable) are deducted. Pre-tax premiums save you money because they reduce the amount of income on which you pay taxes. Coverage you pay

for with pre-tax dollars is subject to special IRS rules. Please see Section VII for information about these special rules.

Domestic Partners generally do not qualify as Spouses or dependents for federal income tax purposes. Therefore, your premium contribution for your Domestic Partner's medical, dental or vision buy-up coverage will be deducted from your paycheck on an after-tax basis. In addition, the value of Company-paid medical and dental insurance coverage for your Domestic Partner generally will be considered imputed income and will be taxable to you on each paycheck that the benefits are maintained. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings will be made from your paycheck and the value of those benefits will be included in your Form W-2. During any period in which Domestic Partner benefits that have an imputed income are maintained by you but you are not receiving a paycheck from the Company, the Company reserves the right to collect the employee FICA tax liability directly from you.

The above rules will not apply if:

- your Domestic Partner 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.

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

Exclusions And Limitations

This plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following. *This is not an all-inclusive listing. In addition to this section on Exclusions and Limitations, refer to each plan section, including the applicable plan Appendix for services that are specifically excluded under the plan of benefits you have chosen.* You should contact the Claims Administrator of the plan of benefits you have chosen directly for additional information or if you have any questions.

You should keep in mind that some of the items listed below ***may*** be covered under a Section 125 medical reimbursement account. Refer to Section VII for details.

The following Exclusions and Limitations are common to all the plans described in this SPD.

(1) Services or supplies received before an employee or his or her Dependent becomes covered under this plan, or after coverage terminates.

(2) Expenses incurred by a Dependent if the Dependent is covered as an employee for the same services under this plan.

(3) Cosmetic Treatment or Reconstructive Procedures, such as breast reduction surgery, breast asymmetry correction, abdominoplastys, rhinoplastys, dermabrasion and collagen procedures, the cosmetic use of "Botulinum Toxin" (BOTOX), liposuction, breast augmentation, pharmacological regiments, nutritional procedures or treatments, tattoo or scar removal or revision, replacement of existing breast implant if earlier implant was performed as a cosmetic procedure and varicose vein treatment of the lower extremities, when it is considered cosmetic. *(This is non-Medically Necessary surgery or treatment primarily to change appearance.)* It does not matter whether it is for psychological or emotional reasons.

Note: the exclusion does not apply to the following services:

a) Medically Necessary breast asymmetry correction, as determined by the plan. Only reduction of the larger breast is covered. Mastopexy or augmentation of the larger breast is not covered.

b) Breast reduction surgery when Medically Necessary to correct macromastia when signs and symptoms of macromastia are present. Covered Persons must have failed an effort at conservative management of their macromastia including efforts to approve or correct conditions that may be contributing to the macromastia before breast reduction surgery is a covered benefit.

c) As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphodema. Call the Plan Administrator for more information.

(4) Custodial Care. This is care made up of services and supplies that meets one of the following conditions:

a) Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.

b) Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Care that meets one of these conditions is custodial care regardless of any of the following:

a) Who recommends, provides or directs the care.

b) Where the care is provided.

c) Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.

(5) Eyeglasses, hearing aids or examinations for prescription or fitting thereof, except as otherwise specified in this section. However, Covered Expenses will include the purchase of the first pair of contact lenses that follows cataract surgery. Charges in connection with the purchase or replacement of contact lenses except as specifically provided; however, the purchase of the first pair of contact lenses that follows cataract surgery will be covered; Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.

(6) Food of any kind. Foods that are not covered include:

a) enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;

b) foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;

c) oral vitamins and minerals;

d) meals you can order from a menu, for an additional charge, during an Inpatient Stay; and

e) other dietary and electrolyte supplements.

(7) Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak.

(8) Routine foot care including corn and callous removal, nail trimming, and other hygienic or maintenance care; and cleaning, soaking, and skin cream application for ambulatory and bed-confined patients are not covered.

(9) Services, supplies, medical care or treatment given by one of the following members of the employee's immediate family:

a) The employee's Spouse.

b) The child, brother, sister, parent or grandparent of either the employee or the employee's Spouse.

(10) Charges for procedures which facilitate a pregnancy but do not treat the cause of infertility, such as

(a) in vitro fertilization

(b) artificial insemination

(c) embryo transfer

(d) gamete intrafallopian transfer (GIFT)

(e) zygote intrafallopian transfer (ZIFT)

(f) tubal ovum transfer

(g) surrogate pregnancy and related maternity and obstetric benefits

(h) sperm, ova or embryo acquisition, retrieval or storage

(i) medications to treat infertility that exceed a $15,000 lifetime maximum

(11) Charges for procedures to reverse sterilization and associated expenses

(12) Expenses and associated expenses incurred for services and supplies for non-FDA approved, Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for services which are otherwise Experimental, Investigational, or Unproven that are deemed to be, in the Claims Administrator's judgment, covered transplant services. The fact that an Experimental, Investigational or Unproven Service, treatment, device and pharmacological regimen, is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

(13) Services or supplies which are not Medically Necessary, including any confinement or treatment given in connection with a service or supply which is not Medically Necessary.

(14) Charges made by a Hospital owned by or performing services for the US government if such charges are related to a Sickness or Injury connected to military service.

(15) Occupational Injury or Sickness. An occupational Injury or Sickness is an Injury or Sickness which is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational Injury or Sickness includes any Injury or Sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.

(16) Transsexual surgery, i.e. sex change surgery, including hormonal therapy.

(17) Treatment of hyperhidrosis (excessive sweating).

(18) Procedures, appliances for minor tooth guidance or to control harmful habits.

(19) Services associated with the placement or prosthetic restoration of a dental implant.

(20) Cosmetic dentistry or cosmetic dental surgery (this is surgery or treatment primarily to change appearance). It does not matter whether it is for psychological or emotional reasons.

(21) Services associated with the placement or prosthodontic restoration of a dental implant.

(22) Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect.

(23) The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage under this Plan.

(24) Services or supplies which are not Dentally Necessary, including any confinement or treatment given

in connection with a service or supply which is not Dentally Necessary.

(25) Procedures, appliances or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact).

(26) Charges for services that exceed the allowable frequency of certain covered services (such as cleanings).

(27) Charges or oral surgery, such as surgical removal of an impacted wisdom tooth if the tooth is not diseased or if the removal is only for orthodontic reasons.

(28) Charges for pediatric dentistry for children older than age 7 (unless Dentally Necessary as determined on an individual basis).

(29) Orthoptics or vision training.

(30) Subnormal vision aids.

(31) Plano (non-prescription) lenses.

(32) Two pair of lenses in lieu of bifocals.

(33) Replacement of lenses or frames that are lost or broken, except when normally eligible for services.

(34) Any medical or surgical treatment of the eyes.

(35) Eye examinations required as a condition of employment.

(36) Vision services provided for cosmetic purposes rather than visual needs.

(37) Conditions that are (1) within the scope of usual medical practices and (2) normally handled by non-EAP clinicians.

If You Are On An Unpaid Leave Of Absence (Including FMLA Leave)

If you are on an unpaid leave of absence, including an unpaid leave of absence that is governed by the Family Medical Leave Act of 1993, you can continue your medical, dental and vision coverage under the Plan by paying the applicable premiums. Contact the Plan Administrator for information about the cost, when your first premium is due and where to send it. Note, these procedures and premium costs will depend upon the type of leave you're on and its duration.

Once your payment amount and the schedule of your payments has been defined, if the Plan Administrator does not receive your payment within 30 days from the date payment is due, your coverage will end on the last day of the month for which you paid a premium. When you return to work, the coverage you had before your leave began will be reinstated effective the date you return to work.

You can discontinue your coverage while you are on a leave of absence. Your coverage and premiums will resume on the date you return to work if you return in the same Plan Year in which you take the leave of absence. If you return to work in a later Plan Year than the Plan Year in which you took leave, you must make new benefit elections for you and your eligible Dependents within 31 days of the date you return to work by re-enrolling in the Plan. Your coverage and premiums will be effective on the date you return to work. You will not have to provide evidence of good health.

Coordination Of Benefits

This Plan will coordinate benefits with benefits under any other group or government plan for medical and/or dental coverage. You must also file a claim with the other group or government plan. In addition, you must provide the Claims Administrator any information they may request to coordinate your benefits.

When coordinating benefits, the total payments from all plans will not be more than 100% of the actual charges.

An individual may not be reimbursed for expenses incurred as a dependent if such individual is also

enrolled as an employee under the Plan.

When two or more plans coordinate benefits, one plan pays first (and is called primary), another plan pays second, another plan pays third and so on. The Claims Administrator determines when and how it will pay benefits according to the following rules:

- The plan that covers you or your dependent as an active employee pays first.
- The plan that covers you or your dependent as a dependent pays second.
- The plan that covers you or your dependent as a retiree pays third.
- The plan that covers you or your dependent as a dependent of a retiree pays fourth.
- If you and your Spouse both cover your children under two different plans and your birthday is earlier in the year than your Spouse's, then this plan will pay first for your children's claims. If your Spouse's birthday is earlier in the year than yours, then your Spouse's plan will pay first.
- If you and your Spouse have the same birthday, the plan that covered you or your Spouse longer will pay first.

In the case of a child whose parents are divorced and both parents cover the child, the following rules apply in the order listed:

- If there is a court order placing financial responsibility on one parent for the child's health care expenses, that parent's plan pays first.
- If the parent with custody of the child has not remarried, that parent's plan pays first.
- If the parent with custody of the child has remarried, that parent's plan pays before the stepparent's. The stepparent's plan pays before the plan of the parent without custody.
- Coordination with Medicare/Medicaid will be determined in accordance with Medicare Secondary Payer requirements.

If the above rules do not set an order of payment, then the plan that has covered you or your dependent longer pays first.

Another plan will not affect the payment of this plan's benefits if the rules call for this plan to pay first.

The Claims Administrator has the right to exchange information about this plan's payments with other insurance companies, organizations or individuals.

If You Or Your Covered Dependent Are Eligible For Medicare

If you or your covered dependent(s) are enrolled in Medicare on the basis of age or disability 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 but are not receiving disability benefits from the Company, 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, even if you are still on leave of absence and retain your right to return to active employment. After this 6-month period, Medicare will become primary for you and/or any covered dependents.

When Medicare becomes primary, the Plan assumes you are enrolled in both Medicare Part A and B, so review your options when you become eligible for Medicare (either due to age or disability).

If you or your covered dependent is enrolled in Medicare on the basis of having end-stage renal disease, the Plan will be the primary carrier and Medicare will be the secondary carrier during the 30-month period which begins with the first month in which you or your covered dependent enrolls in Medicare Part A or, if earlier, the first month in which you or your covered dependent would have been enrolled if you or your covered dependent had filed an application for such benefits. After such 30-month period, the Plan will be the secondary carrier and Medicare will be the primary carrier as permitted by applicable law.

If you have questions about Medicare benefits, contact your local Social Security office.

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.

Note: If these subrogation and reimbursement provisions conflict with the subrogation and reimbursement/right to recovery provisions in an insurance contract governing benefits at issue, the subrogation and reimbursement provisions in the insurance contract will govern.

Recovery of Overpayment

When an overpayment has been made by the Claims Administrator, the Claims Administrator will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

False or Fraudulent Claims or Intentional Misrepresentation of Material Fact

Please note that any act, practice, or omission by a Plan participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the terms of the Plan and the Plan may rescind coverage as a result. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

When Coverage Ends

Your coverage will end on the earliest of the following dates that apply

1. The end of the month in which:
   - you start an unpaid leave of absence for which you do not pay the applicable premiums when required;
   - you start an unpaid leave of absence and specifically elect to discontinue coverage while you're on the leave;
   - you no longer meet the eligibility requirements for this Plan (including eligibility requirements that apply with respect to a leave of absence);
   - you voluntarily terminate your employment, are released or discharged; or

- you paid a final premium for coverage.

2. The day before you are covered by another medical plan of the Company

3. The date on which:

- your Employer no longer offers a medical Plan;
- the Plan terminates or changes so that you are no longer eligible; or
- you die.

Your dependent's coverage ends on the earliest of the following dates:

1. The end of the month in which:

- your dependent is no longer eligible; or
- you paid a final premium for your dependent's coverage.

2. The day before your dependent becomes eligible for coverage as an employee or a dependent under any medical plan of the Company or its subsidiaries.

3. The date on which:

- your coverage ends, except in the case of your death. In this case, coverage ends the end of the month that you die; or
- the plan terminates or changes so that your dependent is no longer eligible;
- your dependent dies.

You and your dependents, if eligible, may continue medical coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. Refer to *COBRA Continuation of Coverage* in Section I.

Definitions

Accidental Injury means bodily injuries caused solely by, or as a result of, a covered accident.

Active Service means

- Any scheduled work day in which you perform your regular work duties on a full-time or part-time basis, either at the Company's place of business or at another location to which you are required to travel for Company business; or
- A day which is not one of the Company's scheduled work days if you were in Active Service on the preceding scheduled work day.

Acute Care means treatment for a short-term or episodic Illness or health problem.

Adopted Children means any child(ren) under the age of 26 as of the date of being legally adopted or being placed with the employee for adoption.

Ambulance means Medically Necessary transportation to the nearest Hospital or Urgent Care Facility capable of treating a condition.

Ambulatory Surgical Center means a specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

Where licensing is not required, it meets all of the following requirements:

a. It is operated under the supervision of a licensed Doctor of medicine (M.D.) or Doctor of osteopathy (D.O.) who devotes full time to supervision and permits a surgical procedure to be performed only

by a duly-qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.

b. It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.

c. It provides at least one operating room and at least one post-anesthesia recovery room.

d. It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.

e. It has trained personnel and necessary equipment to handle Emergency situations.

f. It has immediate access to a blood bank or blood supplies.

g. It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.

h. It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

An Ambulatory Surgical Center which is part of a Hospital will be considered an Ambulatory Surgical Center for the purposes of this Plan.

Anisometropia means a condition of unequal refractive state for the two eyes; one eye requiring a different lens correction than the other.

Approved Health Care Facility or Program means a facility or program that is licensed or certified under laws of the state of its location to provide health care services and is approved by the Claims Administrator to provide services covered by this SPD.

Birth Control Services/Supplies include oral Prescription contraceptives, vasectomy and tubal ligation.

Birth Center means a specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

2. It meets all of the following requirements:

It is operated and equipped in accordance with any applicable state law.

It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity.

It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.

It is operated under the full-time supervision of a licensed Doctor of medicine (M.D.), Doctor of osteopathy (D.O.) or registered graduate nurse (R.N.).

It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.

It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.

A Birth Center that is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of this Plan.

Blended Lenses means bifocals that do not have a visible dividing line.

Blood means transfusions, including the cost of Blood and Blood plasma if such Blood or Blood plasma is not replaced.

Brand Name Drugs are drugs protected by a patent issued to the original innovator or marketer. The drug is not allowed to be produced by other companies as long as the patent remains in effect.

Calendar Year means the period beginning on the coverage effective date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Chemical Dependency. See the definition "Substance Abuse."

Chiropractic Services means charges of a Chiropractor and X-ray and laboratory services ordered by a Chiropractor.

Chiropractor means a Doctor of Chiropractic (D.C.) legally licensed to practice in the area where you receive services.

Claims Administrator means any insurer, third party administrator or other entity as described in Section I, who is appointed by the Plan Sponsor for the administration of benefits described in this summary plan description, including initial and/or appeals claims determinations.

Coated Lenses means a substance is added to a finish on one or both surfaces of eyeglass lenses.

Concurrent Review means the process whereby staff from the Claims Administrator's medical management team reviews pertinent clinical and/or diagnostic information for service authorization purposes.

Congenital Anomaly is a physical, developmental defect that is present at birth and is identified within the first twelve months of birth.

Cosmetic Treatment is services that are provided by a Doctor or Dentist that are not considered Medically Necessary, including surgery specifically for improving appearance, except when the procedure is required to correct a dysfunctioning body part as a result of an accidental Injury.

Cost-Effective is the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and Prosthetic Devices.

Covered Person (or Member) means an employee, dependent or COBRA continuee who is eligible to participate, and is participating in this Plan.

Covered Services means the health care services and supplies covered under this SPD.

Custodial Care means care designed to assist a Covered Person with the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, supervision of medication that usually can be self-administered and care that does not require the continuing attention of a Qualified Health Care Provider. Custodial Care also includes rest cures, respite care and home care provided by family members. Custodial Care also means care rendered to a Covered Person in a Skilled Nursing Facility but which is not covered under the Skilled Nursing Facility benefits described in this SPD.

Dentally Necessary see Medically Necessary.

Dentist means a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) licensed to practice in the area where you receive services.

Designated Transplant Facility means a facility designated by the Claims Administrator to render Medically Necessary Covered Services and Supplies for Qualified Procedures under this Plan.

Doctor (or Physician) means a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), Podiatrist (D.P.M.), or a licensed clinical psychologist (operating under the direction of an M.D. or D.O.) legally licensed to practice in the area where you receive services, or a Christian Science Practitioner currently listed in the Christian Science Journal.

Domestic Partner of an employee covered under this Plan is eligible for medical Choice Plan or Indemnity Plan (which includes prescription drug, behavioral health, basic vision and wellness), EAP, dental and vision buy-up where permitted by the Claims Administrator and in accordance with applicable state laws.

In order to qualify as a Domestic Partner, you and your Partner must meet the following requirements:

- Both Partners must be 18 or older;
- Neither Partner can be married to anyone else, and both you and your Partner must have dissolved any prior marriages through death or divorce;
- The Partners must be each other's sole Domestic Partner for at least the last six months and both Partners must intend for it to remain as such indefinitely;
- Neither Partner can have had a different Domestic Partner in the last six months (this condition does not apply if a previous Domestic Partnership ended within the last six months due to the death of the Partner) unless otherwise dictated for compliance of city or state regulations;
- The Partners cannot be so closely related by blood that legal marriage would otherwise be prohibited in the state(s) or domicile where you and your Partner reside;
- The Partners must have shared the same principal residence on a continuous basis for, at a minimum, the six months preceding registering the Domestic Partnership (although you may live apart for reasons of education, health care, work, or military service) and must intend on doing so indefinitely;
- The Partners must have been jointly responsible for common welfare and financial obligations for at least the preceding 6 months.

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.

Durable Medical Equipment (DME) is equipment used solely for therapeutic purposes to treat Sickness or Injury, such as crutches or a wheelchair, not ordinary household items. If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment.

Elective Surgery is an operation or surgical procedure for a condition that is not considered an Emergency or life threatening. Such surgery is subject to the choice or decision of the patient and the Physician.

Eligible Expenses are expenses for covered health services received from an In-Network provider. Eligible expenses are the contracted fee(s) with that provider. When covered Health Services are received from Out-of-Network providers as a result of an Emergency or as otherwise approved by the Claims Administrator, Eligible Expenses are the fee(s) negotiated by the Claims Administrator or the Reasonable Charge for Covered Services.

Emergency (or Emergency Care/Services) is medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of medical attention could reasonably be expected to result in any of the following:

The patient's health would be placed in serious jeopardy;

Body function would be seriously impaired;

There would be a serious dysfunction of a body organ or part.

Emergency Ambulance Services means services provided by an Ambulance service authorized to operate following the onset of a medical condition that manifests itself by symptoms of pain, illness, or injury that the absence of accessing an Ambulance or Emergency response by calling 911 or a designated telephone number to reach a public safety answering point and receiving time-sensitive medical attention could reasonably be expected to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Room is a facility that is used for immediate medical treatment of an Injury or Sickness that is life or limb threatening.

Employer means the Plan Sponsor.

Experimental Procedures see *Investigational Procedures*.

Family Unit means you and your covered dependents.

Formulary means a listing of Prescription Drugs covered by the Plan which may be revised from time to time.

Foster Child means a child who is a ward of the state and is placed in your home through court order or by a public or private agency recognized by the state for placement.

Gatekeeper is the primary care provider responsible for managing the treatment rendered to participants in the EAP and Behavioral Health programs.

Generic Drugs are drugs that are therapeutically equivalent to their Brand Name counterpart, but which are manufactured under a different name. Generic Drugs contain the same active ingredients as the

Brand Name Drug.

Group Health Plan (or Plan) means the US Airways, Inc. Employees' Group Health Plan and the various plans of benefits it offers.

Home Health Care means alternative care that is provided in the patient's home in lieu of a Hospital stay. Care must be provided by a licensed Home Health Care Agency that employs Qualified Health Care Providers.

Home Health Care Agency is a Hospital or other organization which is either recognized as a home health agency by Medicare or licensed or certified under a public health law or a similar law to provide Home Health Care services.

Hospice Care is treatment which is accredited by the National Hospice Organization and approved by the Claims Administrator. The care must be prescribed by a Qualified Health Care Provider as necessary for the treatment of a terminal Illness and the individual's life expectancy is approximately six months or less.

Hospice Team must include a Doctor and a Registered Nurse. The team can also include a social worker, clergyman-counselor, clinical psychologist, physical therapist, occupational therapist and volunteers.

Hospital is an institution which is legally licensed as a Hospital and which is operated for the care and treatment of Sicknesses and Injuries and having facilities for diagnosis, 24-hour nursing service, and except in the case of a Hospital primarily concerned with the treatment of chronic diseases, major surgery. The term "Hospital" shall not include an establishment that is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, or a hotel or motel. It can, however, be a Christian Science Sanitarium operated by or listed and certified by the First Church of Christian Science in Boston, Massachusetts.

Hospital Services/Supplies are charges for the care of Ill/Injured patients in a Hospital.

Illness see the definition *Sickness*.

In-Network means that the provider, service or entity, as applicable, are part of a Network that has been established by the Claims Administrator.

Injectable Prescription Drug is a product that meets the definition of Prescription Drug (below), but which is administered by injection. For purposes of this SPD, insulin and sumatriptan (Imitrex) are considered to be Prescription Drugs and not Injectable Prescription Drugs.

Injury means accidental bodily Injury. All Injuries you have in one accident will be considered one Injury. "Injury" does not include disease or infection, except infection through an accidental wound.

Intermediate Care is health care and services provided to individuals who do not require the degree of care and treatment that a Hospital or a Skilled Nursing Facility is designed to provide. The individuals must, however, require care and services above the level of room and board.

Investigational, Experimental or Unproven Procedures refers to the medical use of a service or supply that is under study and/or is not recognized throughout the Doctor's profession in the United States as safe and effective for diagnosis or treatment, or is being used in a manner different to the recognized profile of the service or supply as determined by the Claims Administrator.

Keratoconus means a developmental or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.

Lifetime Maximum means the highest or lifetime benefit that can be paid by the Plan.

MAC List means the Maximum Allowable Cost for Generic Drugs that the Prescription Drug Claims Administrator will reimburse In-Network pharmacies.

Mail Order Drugs are Prescription Drugs that can, depending on the plan in which you have chosen to participate, be purchased through the mail from a pharmacy which specializes in this service.

Medically Necessary (or Medical Necessity) means health care services and supplies which are determined by the Claims Administrator to be medically appropriate, and

1. necessary to meet the basic health needs of the covered person; and

2. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply; and

3. consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Claims Administrator; and

4. consistent with the diagnosis of the condition; and

5. required for reasons other than the convenience of the Covered Person or his or her Physician; and

6. demonstrated through prevailing peer-reviewed medical literature to be either:

   (a) safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,

   (b) safe with promising efficacy

      for treating a life threatening Sickness or condition, and

      in a clinically controlled research setting; and

      using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

   (For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

   The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, Sickness, or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary used in this booklet relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

Medically Necessary Contact Lenses means contact lenses which are required to help correct the following conditions:

- Post-cataract surgery
- Extreme visual acuity problems that cannot be corrected with regular spectacle lenses.
- Anisometropia
- Keratoconus

Medicare means the program established by Title XVIII of the United States Social Security Act of 1965, as amended.

Mental or Nervous Disorders means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Network is a group of Qualified Health Care Providers in a geographic area. The Network is established by the Claims Administrator who negotiates a fee schedule for health care services the participating Qualified Health Care Providers perform.

Orthoptics means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Other Professional Providers include a licensed Physician’s Assistant (P.A.), Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.), Nurse Practitioner (N.P.) or a licensed social worker (M.S.W.) acting within the scope of their license.

Out-of-Network means that the provider, service, or entity, as applicable, are not part of a Network that has been established by the Claims Administrator**.**

Oversize Lenses means spectacle lenses that are larger than standard lenses, i.e. 61mm and larger, to accommodate prescriptions.

Physical Therapy means therapeutic treatment by a Registered Physical Therapist (R.P.T.) or Registered Occupational Therapist (R.O.T.).

Photochromic Lenses means spectacle lenses that change color with intensity of sunlight.

Plan means the US Airways, Inc. Health Care Plan for Pilots and Flight Attendants Domiciled in Phoenix, Arizona.

Plan Administrator as defined in section 3(16)(A) of ERISA means US Airways, Inc.

Plan Sponsor as defined in section 3(16)(B) of ERISA means US Airways, Inc.

Prescription Drug is a legend drug found safe and effective by the United Stated Food and Drug Administration (FDA) and that can be dispensed only upon a Prescription from a Physician or other Qualified Health Care Provider. This term also includes insulin and Imitrex and medicines that contain a Prescription Drug and must be compounded by a pharmacist according to the order of the Physician or other Qualified Health Care Provider.

Prior Notification means that your In-Network Physician is required to notify the Claims Administrator regarding certain proposed or scheduled health services. When your In-Network Physician notifies the Claims Administrator, they will work together to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Prosthetics & Orthopedic Devices means any artificial limb or other prosthetic devices, including their repair or replacement if Medically Necessary. Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Provider Directory means the listing containing the names of and other pertinent information about In-Network Providers. Please note, the information in the Provider Directory is subject to change from time to time. Please contact the Claims Administrator or the specific Provider to confirm his or her current participation status.

Qualified Beneficiary in context to COBRA is a person who generally must satisfy two conditions:

1) The person must be a covered employee, the Spouse of a covered employee or the dependent child of a covered employee; and
2) The person must be covered by the employee's group health plan immediately before the qualifying event (the triggering event).

A covered employee can be a qualified beneficiary only with respect to the qualifying events of termination of employment or reduction of hours of employment. Domestic Partners can only be a qualified beneficiary with respect to the qualifying event of termination of employment. Qualified beneficiaries who do not elect COBRA coverage when they are entitled to do so are no longer qualified beneficiaries when the 60 day election period expires.

Qualified Health Care Provider is any one of the following but does not include a close relative including, but not limited to, immediate family members:

- Chiropractor
- Dentist
- Doctor

- Hospitals
- Hospice Team
- Other Professional Providers

Reasonable and Customary (or Reasonable Charge; R&C)

a) As to charges for services rendered by or on behalf of an In-Network Physician, an amount not to exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule.

b) As to all other charges, an amount measured and determined by the Claims Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator determines the prevailing charge taking into account all pertinent factors including:

The complexity of the service.

The range of services provided.

The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Reconstructive Procedure is a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with a Sickness, Injury or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Referral Notification is the process whereby your PCP advises the plan of his or her intentions of directing you to receive Covered Services from another In-Network provider.

Rehabilitative (Rehabilitation) means those therapies and services designed to significantly improve or restore certain body functions following an Illness or Injury.

Retired Pilot is a pilot who has reached at least age 60 and has retired from Active Service.

School means a state accredited organization that has a regular faculty, curriculum and a body of students in attendance. This includes technical and mechanical Schools and other vocational institutions.

Skilled Nursing Facility is an institution that furnishes room and board and skilled nursing care 24 hours a day by, or under the supervision of, a Registered Nurse (R.N.), provided that such institution:

- is accredited by the Joint Commission on Accreditation of Hospitals as an Extended Care Facility or is recognized as an Extended Care Facility by Medicare; and
- is not, other than incidentally, a place for rest, a place for domiciliary care, a place for the aged, a place for drug addicts, alcoholics, mental Illness, mental retardation or senile deterioration, a hotel or motel.

Sickness means any physical or mental Illness that's not excluded by this Plan. This includes pregnancy.

Speech Therapy means services of a qualified speech therapist for correcting speech impairment caused by Sickness, Injury or Congenital Anomaly for which the patient had surgery.

Spouse refers only to a person of the opposite sex who is your husband or wife under applicable state law.

Substance Abuse means a continuing pattern of psychoactive Substance Abuse, such as alcohol, Prescription Drugs or street drugs.

Surgical Expenses mean charges of a primary surgeon, assistant surgeon, and/or anesthesiologist for covered surgical procedures.

Testing means diagnostic Testing when ordered by a Doctor. This includes preadmission Testing.

Tinted Lenses means spectacle lenses that have an additional substance to produce a constant tint, i.e. blue, pink, gray, etc.

Total Disability (or Totally Disabled) means a participant's inability to perform all of the substantial and material duties of his or her regular employment or occupation or a dependent's inability to perform the normal activities of a person of like age and sex.

Treatment or Medical Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Unproven Services means health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

Urgent Care Facility is a facility which provides immediate treatment for an Illness or Injury that is not life or limb threatening. Usually not associated with a Hospital.

Utilization Review means a review and determination as to the Medical Necessity of services and supplies.

Well-Baby Care means outpatient, routine care of a healthy dependent child. Includes such things as physicals and immunizations.

Written Treatment Plan means a medical plan of care submitted in writing by the patient's In-Network provider describing the prescribed treatment plan. This plan can be sent via fax.

For More Information Or Help

More information about the Plan, including your rights and ERISA rights under law, is in *Important Plan Information* in Section I and in the following plan sections including the plan Appendices. If you have questions about the Plan, contact the Plan Administrator.

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End of Section II

About The Medical and Prescription Drug Plans

US Airways, Inc. offers a variety of medical and prescription drug programs for you to choose from nationwide:

• An Exclusive Provider Organization (EPO); or

• A Preferred Provider Option (PPO); or

• An Indemnity medical plan (if you reside in an area that is *outside* of the EPO or PPO service area).

The Company has arrangements with Claims Administrators to process claims and provide certain other services under the medical plan.

A complete description of each plan's benefits, covered services and exclusions and limitations is in the Appendix of this booklet.

Wellness Program

US Airways, Inc. 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 or stay 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.

Claims Administrators

See Section I *Claims Administrators.*

Medical Plan Highlights

The medical plan, including prescription drugs, provides protection for you and your family members against the high cost of health care. Participation is not automatic; in other words, you must follow enrollment procedures in order to elect coverage. If you decide to join, you share with your Employer in the cost for coverage.

See the Appendix for a detailed explanation of how each program works. If you have any questions about the plan, including costs, contact the Plan Administrator.

Requirements for Notification

In-Network providers are generally responsible for notifying the Claims Administrator before they provide certain services to you. However, there are some In-Network Benefits for which you are responsible for notifying the Claims Administrator.

When you choose to receive certain Covered Services from Out-of-Network providers, you are responsible for notifying the Claims Administrator before you receive these Covered Services. In many cases, your Out-of-Network Benefits will be reduced if the Claims Administrator is not notified.

The services that require notification are:

• breast reduction and reconstruction (except after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;

• Congenital Anomaly related heart disease services;

• dental services - accident only;

• Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent;

• Home Health Care;

- Hospice Care - inpatient;
- Hospital inpatient stay, including Emergency admission;
- maternity care that exceeds the delivery timeframes as described in the Newborns' and Mothers' Health Care Protection Act described on page 43;
- mental health services - inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility);
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- substance use disorder services - inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility); and
- transplantation services.

When you choose to receive services from Out-of-Network providers, we urge you to confirm with the Claims Administrator that the services you plan to receive are Covered Services. In some instances, certain procedures may not meet the definition of a Covered Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- the Cosmetic Treatment or Reconstructive Procedure exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reduction and reconstruction (except after cancer surgery when it is always considered a Covered Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- the Experimental, Investigational or Unproven Services exclusion; or
- any other limitation or exclusion of the Plan.

Special Rights Following Mastectomy

The Women's Health and Cancer Rights Act of 1998 requires this Group Health Plan to make certain benefits available to plan participants who have undergone a mastectomy covered by the Plan. The Plan must offer mastectomy patients' benefits for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomies, including lymphedemas.

This Group Health Plan complies with the above requirements. The extent to which any of the above services is appropriate following a mastectomy is a matter to be determined by consultation with the Physician and the patient.

This Group Health Plan does not:

- Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan solely for the purpose of avoiding the requirements of this law; and
- Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with the law.

Newborn's And Mother's Health Care Protection Act

The Plan may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a normal delivery or 96 hours following a cesarean section. The Hospital or other provider is not required to get authorization from the Claims Administrator for the time period stated above. Authorizations are required for longer lengths of

stay.

Federal law also does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable).

How To Choose Your Program Of Benefits

The Plan offers a broad choice of medical benefit programs. In most cases, the program available to you depends on your area of residence. Read each program description in the Appendix that follows.

Appendix A
Medical and Prescription Drug Plans

There are three (3) programs of benefits under this Appendix A.

Appendix A-1	Choice Plan
Appendix A-2	Choice Plus High and Choice Plus Low Plans
Appendix A-3	Indemnity Plan

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 "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the medical Claims administrator(s).

Appendix A-1
Choice Plan

How Choice Plan Works

There are no Primary Care Physician (PCP) referrals required. The member may go to any PCP or specialist In-Network throughout the nation where there is a Network available without a referral. The Network is available to the member in its entirety. The Network is not limited to the member's geographic area.

The Eligible Expenses must be incurred for the Medically Necessary care of an Accidental Injury or Sickness. A Covered Expense is considered incurred on the date that the Covered Service or Supply is performed or given.

This Plan pays for Covered Services and Supplies received from In-Network Providers only. If you receive care from an Out-of-Network Provider, no benefits will be payable. Exception: Out-of-Network care is covered for Emergencies or if you are traveling outside the Network area and have an Emergency or need for Urgent Care.

Summary Of Choice Plan Benefits

Annual Deductible • Individual • Family	 None None
Annual Out-of-Pocket Maximum • Individual • Family	 $1,500 $3,000
Pre-existing Condition Limitation	No
Lifetime Maximum Benefits	Unlimited
PCP Office Visit Copay	$15
Specialist Office Visit Copay	$25

Covered Expense	**Plan Pays**
Preventive Care	
• Routine Preventive Care for Children up to age 18 (including immunizations)	100% after $15 Copay per visit
• Initial Hearing Screening (Children up to age 18)	100% after $15 Copay per PCP visit / $25 Copay per Specialist visit
•Well Man Care Exam by PCP (including PSA Test)	100% after $15 Copay per PCP visit / $25 Copay per Specialist visit
• Well Woman Care Exam by PCP (including Pap Test)	100% after $15 Copay per PCP visit / $25 Copay per Specialist visit
• Mammography Screening Exam (Two exams per calendar year for any reason and unlimited quantity thereafter for Medically Necessary reasons)	100% after $15 Copay per visit
Office Visit	
• Illness or Injury	100% after $15 Copay per PCP visit / $25 Copay per Specialist

	visit
• Allergy Treatment – copay applies when services are billed and connected with office visit, otherwise 100%	100% after $15 Copay per PCP visit / $25 Copay per Specialist visit
Outpatient Surgical Facility	90%
Lab & X-ray Services Preventative care – Lab 100%	100% when associated with an office visit for which a copay is applied; 90% when billed by a separate outpatient diagnostic facility
Maternity Care	
• Initial visit to confirm pregnancy	100% after $15 Copay per PCP visit / $25 Copay per Specialist visit
▪ Hospital	90%
• Pre/Post Delivery Exams	90%
Home Health Care (Up to 120 days per calendar year)	90%
Hospice Care	90%
Durable Medical Equipment	90%
Prosthetics *(external prosthetic appliances)*	90%
Emergency Services	
• Emergency Room	$75 Copay waived if admitted
• Ambulance (for Emergency or Medically Necessary transport)	90%
Hospital Services - Inpatient	90%
Hospital Services - Outpatient	90%
Surgery	
• Surgeon's Fee	90%
• Second Surgical Opinion Consultation	100% after $25 Copay per visit
Infertility *(Benefits limited to services for testing, diagnosis and corrective procedures only. Expenses for, or in connection with, in-vitro fertilization, artificial insemination or any other similar procedure are not covered.)*	
• Initial Office Visit (testing and diagnosis only)	100% after $25 Copay
• Surgery, Injections, or treatment	Not Covered
Sterilization	90%
Outpatient Rehabilitation (Includes Physical, Occupational, Speech, and Chiropractic Therapy. Up to 20 visits per therapy per calendar year. Speech therapy which is not restorative in nature is not covered)	100%; after $25 Copay per visit
Skilled Nursing Facility *(Up to 60 days per calendar year)*	90%
Urgent Care Facility	$50 Copay

Mental Health/Substance Abuse	See Section VI: EAP/Behavioral Health Plan
Prescription Drugs – See Prescription Drug Benefit schedule below	

Prescription Drug Benefits For Choice Plan

The Pharmacy Benefit Manager, or "PBM," is responsible for all prescription drug coverage under the Plan. This is a Three Tier Formulary program, which enables you to choose Generic or Preferred Brand Name or Non Preferred Brand Name drugs. Maintenance medications are required to be filled at mail order, after two fills allowed at retail annually. Biotech medications, Specialty medications, (typically injectables and some oral) covered at 50% up to a maximum out of pocket of $100 per 30-day retail prescription and $250 per 90-day mail order. Certain biotech medications are dispensed solely through the PBM's specialty services. Some prescriptions may have an age restriction. Prescriptions purchased at Out-of-Network pharmacies are not covered. In the "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the PBM.

Schedule of Prescription Drug Benefits *(includes oral contraceptives, contraceptive devices, pre-natal vitamins, insulin needles & syringes)*

Schedule of Benefits	
• Retail Pharmacies *(Up to a 30-day supply)*	
Generic	$15
Preferred Brand	$30
Non-Preferred Brand	$45
• Mail Order Pharmacy *(up to a 90-day supply)*	
Generic*	$30
Preferred Brand	$60
Non-Preferred Brand	$90
Prescriptions purchased at Out-of-Network pharmacies are not covered.	
* Some Generic Drugs at mail order will have a $10 Copayment subject to change at any time.	

Choice Plan Exclusions And Limitations

The following exclusions and limitations are in addition to those excluded or limited services/supplies described in Section II. If you have any questions or need more information about a specific service or supply, contact the Claims Administrator.

The following are not covered expenses:

- Amniocentesis, ultrasound or any other procedures requested solely to determine the sex of a fetus unless Medically Necessary to determine the existence of a sex-linked disorder.
- Charges made by a Physician
  - for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures;
  - to the extent that they are more than Reasonable and Customary Charges

- No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
  - a "no-fault" insurance law; or
  - an uninsured motorist insurance law.

  The Claims Administrator will take into account any adjustment option chosen under such part by you or any one of your Dependents
- Routine physical examinations not required for health reasons including, but not limited to, employment, insurance, government license, court-ordered, forensic or custodial evaluations
- Benefits are not payable according to the "General Limitations" section; except that the following will not apply to this section: (a) limitations with respect to a maximum for multiple surgical procedures, an allowable charge for an assistant surgeon or co-surgeon and covered providers being family members; (b) the limitation, if any, with respect to a Dependent child under 15 days old; and (c) any notification shown in The Schedule
- Charges which would not have been made if the person had no insurance
- Charges for unnecessary care, treatment or surgery, except as specified in any notification requirement shown in The Schedule
- Exclusions imposed by any notification requirement shown in The Schedule
- Injury arising out of, or in the course of, any employment for wage or profit
- Replacement prosthesis due to normal wear and tear and for penile prosthesis
- Organ procurement costs that are not directly related to procurement of an organ from a cadaver or a donor having a blood relationship with the recipient
- Charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts)
- Rehabilitative therapy by a licensed physical, occupational or speech therapist, on an outpatient basis, which is provided for any one condition more than 60 consecutive days after the date of the first such treatment for that condition
- Therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation
- Massage therapy or rolfing (holistic tissue massage), acupressure, aromatherapy, hypnotism, and art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health
- Speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered
- Payment that is unlawful where the person resides when the expenses are incurred

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End of Appendix A-1

Appendix A-2
Choice Plus High and Choice Plus Low Plans

There are two (2) levels of coverage under this option available to all pilots: Choice Plus High and Choice Plus Low.

This Plan pays Covered Services and Supplies at the In-Network level provided you receive the care from a preferred provider (anywhere in the Choice Plus High and Choice Plus Low Network throughout the nation). Benefits under the Plan are reduced and payable at the Out-of-Network level if you receive services from an Out-of-Network provider.

Summary Of Benefits

The Choice Plus High and Choice Plus Low Plans feature In-Network services, for which you receive the highest level of benefits (when compared to Out-of-Network benefits), and Out-of-Network services which allow you to choose any provider for treatment. However, you pay a greater portion of the expenses when you seek Out-of-Network services.

Once the plan's Out-of-Pocket maximum is reached, the plan will pay 100% of Covered Expenses for the remainder of the Plan Year.

All in-patient Hospital admissions require prior notification. Call the toll-free number on your ID card. If you do not follow these guidelines, there may be a reduction in or denial of coverage.

The benefits shown in the following table apply to both the Choice Plus High and Choice Plus Low programs. Unless otherwise specified within the table, plan payments are based on Reasonable and Customary (R&C) charges and are payable after the annual deductible has been met.

Except where otherwise indicated, all services covered under the plan must be medically necessary. PCP is defined as family practice, general practice, internal medicine and pediatrician; Specialist is defined as all other medical practices, e.g. Obstetrician/Gynecologist, Cardiologist, Dermatologist, Neurologist, Radiologist, Anesthesiologist, etc. Benefits will be paid as the percentage of reasonable and customary charges for the medical service provided.

Comparison of Benefits: Choice Plus High vs. Choice Plus Low

	Choice Plus High		**Choice Plus Low**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible • Individual • Family	 $500 $1,500	 $1,500 $4,500	 $1,000 $2,000	 $2,000 $6,000
Annual Out-of-Pocket Maximum • Individual • Family	$1,500 Excluding Deductible $3,000 Excluding Deductible	$3,000 Excluding Deductible $9,000 Excluding Deductible	$2,000 Excluding Deductible $6,000 Excluding Deductible	$6,000 Excluding Deductible $18,000 Excluding Deductible
Pre-existing Condition Limitation	None	None	None	None
Lifetime Maximum Benefits	Unlimited	Unlimited	Unlimited	Unlimited
PCP Office Visit Copay	$20	70% after deductible	$25	60% after deductible
Specialist Office Visit Copay	$30	70% after	$35	60% after

		deductible		deductible

PPO Benefits At A Glance

	Choice Plus High		Choice Plus Low	
	In-Network	**Out-of-Network**	**In-Network**	**Out of-Network**
Preventive Care				
• Routine Preventive Care for Children up to age 18 (including immunizations)	100% after $20 Copay per visit	70% after deductible	100% after $25 Copay per visit	60% after deductible
• Initial Hearing Screening (Children up to age 18)	100% after $20 Copay per visit	70% after deductible	100% after $25 Copay per visit	60% after deductible
•Annual Well Man Care Exam by PCP (including PSA Test)	100% after $20 Copay per PCP visit / $30 Copay per Specialist visit	70% after deductible	100% after $25 Copay per PCP visit / $35 Copay per Specialist visit	60% after deductible
• Annual Well Woman Care Exam by PCP (including Pap Test)	100% after $20 Copay per PCP visit / $30 Copay per Specialist visit	70% after deductible	100% after $25 Copay per PCP visit / $35 Copay per Specialist visit	60% after deductible
• Mammography Screening Exam (Two exams per calendar year for any reason and unlimited quantity thereafter for Medically Necessary reasons)	100% after $20 Copay per visit	70% after deductible	100% after $25 Copay per visit	60% after deductible
Office Visit				
• Illness or Injury	100% after $20 Copay per PCP visit / $30 Copay per Specialist visit	70% after deductible	100% after $25 Copay per PCP visit / $35 Copay per Specialist visit	60% after deductible
• Allergy Treatment - Copay applies when services are billed and connected with office visit, otherwise 100%	100% after $20 Copay per PCP visit / $30 Copay per Specialist visit	70% after deductible	100% after $25 Copay per PCP visit / $35 Copay per Specialist visit	60% after deductible
Outpatient Surgical Facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Lab & X-ray Services Preventative care – 100% In-Network	100% when associated with an office visit for which a copay is applied; 90% when billed by a separate outpatient diagnostic facility	70% after deductible	100% when associated with an office visit for which a copay is applied; 80% when billed by a separate outpatient diagnostic facility	60% after deductible
Maternity Care				

• Initial visit to confirm pregnancy	100% after $20 Copay per PCP visit / $30 Copay per Specialist visit	70% after deductible	100% after $25 Copay per PCP visit / $35 Copay per Specialist visit	60% after deductible
• Pre/Post Delivery Exams	90% after deductible	70% after deductible	80% after deductible	60% after deductible
• Hospital	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Home Health Care (Up to 120 days per calendar year)	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Hospice Care	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Prosthetics *(external prosthetic appliances)*	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Emergency Services				
• Emergency Room	100% after $75 Copay waived if admitted (if not life threatening emergency 90% after deductible)	100% after $75 Copay waived if admitted (if not life threatening emergency 70% after deductible)	100% after $100 copay (if not life threatening 80% after deductible)	$100 copay (if not life threatening emergency 60% after deductible)
• Ambulance (for Emergency or Medically Necessary transport)	90% after deductible	90% after deductible (if not life threatening emergency 70% after deductible)	80% after deductible	80% after deductible (if not life threatening emergency 60% after deductible)
Hospital Services - Inpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Hospital Services - Outpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Surgery				
• Surgeon's Fee	90% after deductible	70% after deductible	80% after deductible	60% after deductible
• Second Surgical Opinion Consultation	100% after $30 Copay per visit	70% after deductible	100% after $35 Copay per visit	60% after deductible
Infertility *(Benefits limited to services for testing, diagnosis and corrective procedures only. Expenses for, or in connection with, in-vitro fertilization, artificial insemination or any other similar procedure are not covered.)*				
• Initial Office Visit (testing and diagnosis only)	100% after $30 Copay per visit	70% after deductible	100% after $35 Copay per visit	60% after deductible

• Surgery, Injection, and Treatment	Not Covered	Not Covered	Not Covered	Not Covered
Sterilization	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Outpatient Rehabilitation (Includes Physical, Occupational, Speech, and Chiropractic Therapy. Up to 20 visits per therapy per calendar year In and Out-of-Network combined. Speech therapy, which is not restorative in nature, is not covered.*)*	100% after $30 Copay per visit.	70% after deductible	100% after $35 Copay per visit	60% after deductible.
Skilled Nursing Facility *(Up to 60 days per calendar year* In and Out-of-Network combined*)*	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Urgent Care Facility	100% after $50 Copay	100% after $50 Copay	100% after $75 copay	100% after $75 copay
Mental Health/Substance Abuse	See Section VI: EAP/Behavioral Health Plan			
Prescription Drugs – See Prescription Drug Benefit schedule below				

Prescription Drug Benefits For Choice Plus High and Choice Plus Low

The Pharmacy Benefit Manager, or "PBM," is responsible for all prescription drug coverage under the Plan. This is a Three Tier Formulary program, which enables you to choose Generic or Preferred Brand Name or Non Preferred Brand Name drugs. Maintenance medications are required to be filled at mail order, after two fills allowed at retail annually. Biotech medications, Specialty medications, (typically injectables and some oral) covered at 50% up to a maximum out of pocket of $100 per 30-day retail prescription and $250 per 90-day mail order. Certain biotech medications are dispensed solely through the PBM's specialty services. Some prescriptions may have an age restriction. Prescriptions purchased at Out-of-Network pharmacies are not covered. In the "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the PBM.

Schedule of Prescription Drug Benefits *(includes oral contraceptives, contraceptive devices, pre-natal vitamins, insulin needles & syringes)*

Retail Pharmacies *(Up to a 30-day supply)*	**Choice Plus High**	**Choice Plus Low**
• Generic	$15 Copay	$15 Copay
• Preferred Brand	$30 Copay	$30 Copay
• Non-Preferred Brand	$45 Copay	$45 Copay

Mail Order Pharmacy *(Up to a 90-day supply)*	**Choice Plus High**	**Choice Plus Low**
• Generic *	$30 Copay	$30 Copay
• Preferred Brand	$60 Copay	$60 Copay
• Non-Preferred Brand	$90 Copay	$90 Copay

* Some Generic Drugs at mail order will have a $10 Copayment subject to change at any time.

Prescriptions purchased at Out-of-Network pharmacies are not covered.

Choice Plus High and Choice Plus Low Exclusions And Limitations

The following exclusions and limitations are in addition to those excluded or limited services/supplies described in Section II. If you have any questions or need more information about a specific service or supply, contact the Claims Administrator.

The following are not covered expenses:

- Amniocentesis, ultrasound or any other procedures requested solely to determine the sex of a fetus unless Medically Necessary to determine the existence of a sex-linked disorder
- Charges made by a Physician:
  - for or in connection with surgery that exceeds the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures;
  - that are more than Reasonable and Customary Charges
- No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
  - a "no-fault" insurance law; or
  - an uninsured motorist insurance law.

The Claims Administrator will take into account any adjustment option chosen under such part by you or any one of your Dependents.

- Charges for:
  - oral contraceptives, except those considered essential for the necessary care and treatment of an Injury or Sickness, or for contraceptive devices, including implantable contraceptive devices
  - birth control pills or any form of birth control other than surgery
- Routine physical examinations not required for health reasons including, but not limited to, employment, insurance, government license, court-ordered, forensic or custodial evaluations
- Charges for which benefits are not payable according to the "General Limitations" section; except that the limitations with respect to a maximum for multiple surgical procedures and an allowable charge for an assistant surgeon or co-surgeon will not apply to charges made by a Participating Provider
- Charges which would not have been made if the person had no insurance
- Unnecessary care, treatment or surgery, except as specified in any notification requirement shown in The Schedule
- Exclusions that are imposed by any notification requirement shown in The Schedule
- Standard pilot examinations
- Non-surgical treatment of TMJ even following surgery
- Massage therapy or rolfing (holistic tissue massage), acupressure, aromatherapy, hypnotism, and art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health
- Speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered
- Injury arising out of, or in the course of, any employment for wage or profit
- Marriage counseling
- Penile prosthesis

- Replacement prosthesis due to normal wear and tear
- Non-human organ transplants
- Charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts)
- Rehabilitation maintenance
- Charges made by a naturopath or homeopath
- Glucose test strips
- Pre-natal vitamins and other prescription vitamins
- Smoking cessation products
- Weight loss medications or drugs dispensed in a Physician’s office
- Payment that is unlawful where the person resides when the expenses are incurred
- Charges that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- Injury incurred while committing a felony or engaged in an illegal act

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End of Appendix A-2

Appendix A-3
Indemnity Plan

You may choose the Indemnity plan if you do not reside within a Network area and are therefore ineligible to choose a Choice Plan, Choice Plus High, or Choice Plus Low program of medical benefits.

How Indemnity Plan Works

This plan enables you to choose your own Doctors and other medical providers. There are no networks or provider organizations.

You are required to satisfy a deductible each year before the plan will pay for any covered services.

After the annual deductible is satisfied, each time you or an eligible covered family member receives covered services, you'll be required to pay the percentage of the expenses (allowed under the plan) incurred for those services. You must submit a claim to the Claims Administrator for reimbursement of your eligible expenses. Plan payments are based on Reasonable and Customary (R&C) charges.

Once the annual out-of-pocket maximum is reached in a calendar year, the plan will reimburse 100% of eligible expenses for the remainder of that year.

In the event you are preparing for a Hospital stay, you must first contact the Claims Administrator for authorization. If your Hospitalization is authorized, it will be covered according to the plan provisions. If you fail to contact the Claims Administrator as required, a penalty will apply. See the schedule of benefits that follows.

Summary Of Indemnity Benefits

Annual Deductible • Individual • Family	 $500 $1,500
Annual Out-of-Pocket Maximum • Individual • Family	 $2,000 Excluding Deductible $6,000 Excluding Deductible
Pre-existing Condition Limitation	None
Lifetime Maximum Benefits	Unlimited
PCP Office Visit Copay	N/A
Specialist Office Visit Copay	N/A

Indemnity Benefits At-A-Glance

Covered Expense	Plan Pays
Preventive Care	
• Routine Preventive Care for Children up to age 18 (including immunizations)	80%
• Initial Hearing Screening (Children up to age 18)	80%
•Well Man Care Exam by PCP (including PSA test)	80%
• Well Woman Care Exam by PCP (including Pap Test)	80%
• Mammography Screening Exam (Two exams per calendar year for any reason and unlimited quantity thereafter for medically necessary reasons)	80%
Office Visit	

• Illness or Injury	80% after deductible
• Allergy Treatment– copay applies when services are billed and connected with office visit, otherwise 100%	80% after deductible
Outpatient Surgical Facility	80% after deductible
Lab & X-ray Services Lab and x-ray expenses associated with preventative care are covered at 100%	80%
Maternity Care	
• Initial visit to confirm pregnancy	80% after deductible
• Pre/Post Delivery Exams	80% after deductible
Home Health Care (Up to 120 days per calendar year)	80% after deductible
Hospice Care	80% after deductible
Durable Medical Equipment	80% after deductible
Prosthetics *(external prosthetic appliances)*	80% after deductible
Emergency Services	
• Physician's Office	80% after deductible
• Emergency Room	80% after deductible
• Ambulance (for Emergency or Medically Necessary transport)	80% after deductible
Hospital Services - Inpatient	80% after deductible
Hospital Services - Outpatient	80% after deductible
Surgery	
• Surgeon's Fee	80% after deductible
• Second Surgical Opinion Consultation	80% after deductible
Infertility *(Benefits limited to services for testing, diagnosis and corrective procedures only. Expenses for, or in connection with, in-vitro fertilization, artificial insemination or any other similar procedure are not covered.)*	
• Initial Office Visit	80% after deductible
• Surgery, Injections, or treatment	Not Covered
Sterilization	80% after deductible
Outpatient Rehabilitation (Includes Physical, Occupational, Speech, and Chiropractic Therapy. Up to 20 visits per therapy per calendar year. Speech therapy, which is not restorative in nature, will not be covered.*)*	80% after deductible
Skilled Nursing Facility *(Up to 60 days per calendar year)*	80% after deductible
Urgent Care Facility	80% after deductible
Mental Health/Substance Abuse	See Section VI: EAP/Behavioral Health Plan
Prescription Drugs – See Prescription Drug Benefit schedule below	

Prescription Drug Benefits For Indemnity Plan

The Pharmacy Benefit Manager, or "PBM," is responsible for all prescription drug coverage under the Plan. This is a Three Tier Formulary program, which enables you to choose Generic or Preferred Brand Name or Non Preferred Brand Name drugs. Maintenance medications are required to be filled at mail order, after two fills allowed at retail annually. Biotech medications, Specialty medications, (typically injectables and some oral) covered at 50% up to a maximum out of pocket of $100 per 30-day retail prescription. Certain biotech medications are dispensed solely through the PBM's specialty pharmacy. Some prescriptions may have an age restriction. Prescriptions purchased at Out-of-Network pharmacies are not covered. In the "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the PBM.

Schedule of Prescription Drug Benefits *(includes oral contraceptives, contraceptive devices, insulin needles & syringes)*

Retail Pharmacy: **(Up to a 30-day supply) Mail Order Pharmacy: 90-day supply**	
• Generic	$15
• Preferred Brand	$30
Non-Preferred Brand	$45
Mail Order Pharmacy: (Up to a 90-day supply)	
• Generic *	$30
• Preferred Brand	$60
Non-Preferred Brand	$90
Prescriptions purchased at out-of-network pharmacies are not covered. * Some Generic Drugs at mail order will have a $10 Copayment subject to change at any time.	

Indemnity Plan Exclusions And Limitations

The following exclusions and limitations are in addition to those excluded or limited services/supplies described in Section II. If you have any questions or need more information about a specific service or supply, contact the Claims Administrator.

The following are not covered expenses:

- Amniocentesis, ultrasound or any other procedures requested solely to determine the sex of a fetus unless Medically Necessary to determine the existence of a sex-linked disorder
- Charges made by a Physician for or in connection with surgery that exceed the following maximum when two or more surgical procedures are performed at one time:
  - the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures;
  - that are more than Reasonable and Customary Charges
- No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
  - a "no-fault" insurance law; or
  - an uninsured motorist insurance law

The Claims Administrator will take into account any adjustment option chosen under such part by you or any one of your Dependents.

• Routine physical examinations not required for health reasons including, but not limited to, employment, insurance, government license, court-ordered, forensic or custodial evaluations

• Benefits that are not payable according to the "General Limitations" section; except that the limitations with respect to a maximum for multiple surgical procedures and an allowable charge for an assistant surgeon or co-surgeon will not apply to charges made by a Participating Provider

• Charges

− that would not have been made if the person had no insurance

− for treatment or surgery, except as specified in any notification requirement shown in The Schedule

− to the extent of the exclusions imposed by any notification requirement or shown in The Schedule

• Prescription drug charges made for a person who is not Confined in a Hospital

• Massage therapy or rolfing (holistic tissue massage), acupressure, aromatherapy, hypnotism, and art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health

• Speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered

• Injury arising out of, or in the course of, any employment for wage or profit

• Vocational rehabilitation and recreational or educational therapy

• Charges that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid

• Payment that is unlawful where the person resides when the expenses are incurred

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End of Appendix A-3 and Conclusion of Section III

About The Dental Plan

The dental plan provides coverage for services including preventive, basic and major dental work, and orthodontia. The plan offers you a choice of a *high or low option*.

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 "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the dental Claims administrator.

A complete description of the benefits under each program, including covered services and exclusions and limitations is in the Appendix of this Section IV.

Types Of Covered Dental Services

The plan pays benefits for the following types of covered services. See the Appendix for information on deductibles, maximums and plan benefit payments.

Type of Service	Description
Type A	**Preventive/Diagnostic Services** Oral exams • Routine: not more than once every six months • Emergency • Prophylaxis (teeth cleaning): not more than twice in a Plan Year • Fluoride treatment for patients under age 24: not more than twice in a Plan Year • Radiographs (dental x-rays) a) bitewing x-rays (showing the surface of both upper and lower teeth): not more than once in a Plan Year b) complete mouth x-rays (full mouth series or panorex): not more than once every 60 consecutive months unless required by a second Dentist to diagnose a specific condition that needs treatment c) additional x-rays if needed for the diagnosis and treatment of a specific Disease • Dental sealants for patients age 6 through age 13 (one application of sealant material for each permanent molar tooth of a dependent child under age 14, but not more than once every 36 months) • Space maintainers
Type B	**Basic Services:** are more complicated dental procedures • Fillings: amalgam, silicate*, acrylic*, synthetic porcelain* or itfilli* composite fillings (all teeth)* • Extractions (removal of teeth) • Root Canal treatment • Treatment of periodontal Disease and other Diseases of the gums and tissues of the mouth • Oral Surgery • Administration of general anesthesia when Dentally Necessary as determined by the Claims Administrator in terms of generally accepted Dental standards in connection with oral surgery, extractions and other covered services • Injections of antibiotic drugs

Type B	*(continued)* • Relinings and rebasings of existing removable dentures which are more than six months old • Repair or re-cementing of crowns, inlays / onlays, dentures or bridgework • Adding teeth to an existing partial removable denture when needed to replace one or more natural teeth that were removed after the existing bridgework was installed
Type C	**Major Services:** dental services needed to replace one or more natural teeth which are lost while this coverage is in effect • First-time installation of fixed bridgework • First-time installation of a partial removable denture or a full removable denture • Replacing an existing removable denture if it is needed because of the loss of one or more natural teeth after the existing denture was installed and the existing denture can no longer be used • Replacing an existing removable denture or fixed bridgework if it is needed because the existing denture or bridgework can no longer be used and was installed at least five years prior to its replacement • Replacing an existing immediate temporary full denture by a new permanent full denture • 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 84 month period. • Implant supported fixed Dentures, but no more than once for the same tooth position in an 84 month period. • Implant supported removable Dentures, but no more than once for the same tooth position in an 84 month period. • Inlays, onlays and crown restorations, but not more than one such restoration to the same tooth surface within 60 months of the prior restoration
Type D	**Orthodontia:** including appliance therapy for all dependent children to age 26 regardless of student status, Spouse and self

*Subject to Alternate Benefit Provision

ALTERNATE BENEFIT PROVISION

Plan benefits will be based on the materials and method of treatment that, according to the Claims Administrator, meets generally accepted dental standard and which are the most cost effective. For example:

Inlays, Onlays, Crowns and Gold Foil

If, in the Claims Administrator's opinion and expertise, a tooth can be repaired using a method that meets generally accepted dental standards and is less costly than an inlay, onlay, crown or gold foil, plan benefits will be based on the appropriate method of repair that cost the least.

Crown, Pontics and Abutments

Veneer materials may be used for front teeth or bicuspids. However, plan benefits will be based on the veneer materials that are the most appropriate and which cost the least.

Bridgework and Dentures

Plan benefits will be based on the most appropriate method of treating the dental arch which costs the least. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced fixed bridgework, plan benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

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.

When you see In-Network 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.

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.

Annual Deductibles, Plan Maximums And Covered Percentages

About Covered Percentages. Covered Percentages are based on the PDP *contracted* fee for In-Network services and *R&C* charges for Out-of-Network services.

High Option Plan

Annual Deductible [1]	**In-Network** *(applies to Type B and C Services combined)*	**Out-of-Network** *(applies to Type A, B and C Services combined)*
• Individual	$50	$50
• Family	$150	$150
Plan Maximums [2] *(per person, per calendar year unless otherwise specified)*		
• Orthodontia	$1,000/lifetime	$1,000/lifetime
• Other Covered Expenses	$1,000	$1,000
Covered Percentages	*(Type B, C, & D benefits are payable <u>after</u> deductible)*	*(Out-of-Network benefits are payable <u>after</u> deductible)*
• Type A Expenses	Plan pays 100% of contracted fee. You pay nothing. *	Plan pays 100% of R&C charges. You pay charges over and above R&C charges. *
• Type B Expenses	Plan pays 80% of contracted fee. You pay 20%. *	Plan pays 70% of R&C charges. You pay 30% plus any charges over and above R&C charges. *
• Type C Expenses	Plan pays 50% of contracted fee. You pay 50%. *	Plan pays 50% of R&C charges. You pay 50% plus any charges over and above R&C charges. *

• Type D Expenses	Plan pays 50% of contracted fee. You pay 50%. **	Plan pays 50% of R&C charges. You pay 50% plus any charges over and above R&C charges. **

NOTE: If you are a resident of Texas, your only dental option is MetLife High and your Out-of-Network benefit level is the same as the In-Network benefit level.

* Subject to calendar year maximum

**Subject to lifetime orthodontia maximum

[1] Reasonable & Customary (R&C) charges are based on dentists usual, actual & community average charge.

[2] Deductible, annual and lifetime maximums cross-accumulate between In and Out-of-Network benefits.

Low Option Plan

Annual Deductible [1]	**In-Network**	**Out-of-Network** *(applies to Type A, B and C Services combined)*
• Individual	None	$100
• Family	None	$300
Plan Maximums [2] *(per person, per calendar year unless otherwise specified)*		
• Orthodontia	$1,000/lifetime	$500/lifetime
• Other Covered Expenses	$1,000	$500
Covered Percentages		*(Out-of-Network benefits are payable after deductible)*
• Type A Expenses	Plan pays 100% of contracted fee. You pay nothing. *	Plan pays 70% of R&C charges. You pay 30% plus any charges over and above R&C charges. *
• Type B Expenses	Plan pays 50% of contracted fee. You pay 50%. *	Plan pays 40% of R&C charges. You pay 60% plus any charges over and above R&C charges. *
• Type C Expenses	Plan pays 30% of contracted fee. You pay 70%. *	Plan pays 20% of R&C charges. You pay 80% plus any charges over and above R&C charges. *
• Type D Expenses	Plan pays 35% of contracted fee. You pay 65%. **	Plan pays 20% of R&C charges. You pay 80% plus any charges over and above R&C charges. **

* Subject to calendar year maximum

**Subject to lifetime orthodontia maximum

[1] Reasonable & Customary (R&C) charges are based on dentists usual, actual & community average charge.

[2] Deductible, annual and lifetime maximums cross-accumulate between In and Out-of-Network benefits.

Claims Procedure

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

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.

Predetermination Of Benefits

If you want to find out how much the plan will pay before you receive services, you should ask for a predetermination of benefits or *pretreatment estimate*. Obtaining a pretreatment estimate lets you budget your expenses and is especially helpful before you begin a costly or extensive dental treatment, but you can obtain one for any dental treatment. A pretreatment estimate is strongly recommended for services that are expected to be more than $300. Ask your Dentist to complete the regular dental claim form indicating the type of service that will be performed and the cost. MetLife will send you and your Dentist a statement showing the estimate of benefits that are payable under the plan.

Requesting a Review of Claims Denied in Whole or In Part

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by the Claims Administrator. This request for review should be sent to the Claims Administrator within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, your beneficiary deems appropriate.

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End of Section IV

About The Vision Plan

The vision plan provides basic eye care services and supplies to you and your eligible dependents enrolled in the medical plan.

In addition to basic vision plan services, there is also a Buy-Up vision plan option available based on the medical plan in which you participate.

Your vision Claims Administrator is responsible for all vision coverage options under the plan. In the "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the vision Claims Administrator.

Enrolling In The Plan And Your Cost For Coverage

Coverage	Coverage Begins	Your Cost for Coverage
Basic	Automatically provided when you enroll in a Company-sponsored medical plan. You do not need to enroll in this coverage.	None. Your Employer pays the entire cost.

Coverage	Coverage Begins	Your Cost for Coverage
Buy-Up	On the first of the month after you complete 90 days of Active Service provided you have completed the enrollment process.	You pay the entire cost. Contact the Plan Administrator for current premium rates. Although premiums are subject to change at any time, your annual enrollment or new hire materials will describe the following year's premiums for coverage.

Coverage For Dependents

Your dependent's coverage is based on your status as a full-time employee (FTE).

Full-Time Employees

Coverage	Dependent's Coverage Begins
Basic	Automatically provided when you enroll your eligible dependents in a Company-sponsored medical plan. You do not need to enroll in this coverage.
Buy-Up	On the first of the month after you complete 90 days of Active Service provided you have completed the enrollment process.

Notice to all employees: If you are declining vision buy-up for yourself or your eligible dependents, including your Spouse, because of other coverage, you may in the future be able to enroll yourself and your dependents, provided that you request coverage in this Plan within 31 days after your coverage in the other Plan ends. See *Special Enrollment Periods And Enrollment Changes* in Section II.

How The Plan Works

Basic Vision Plan

This plan is available to employees and their eligible dependents who are covered under any Company-sponsored medical Plan. Basic vision benefits consist of In-Network and Out-of-Network benefits.

Schedule of Basic Benefits: *every 24 months*

Covered Service	In-Network – You pay	Out-of-Network – Plan reimburses

Comprehensive eye exam	$10 Copayment	Up to $40.00
Lenses • Single vision • Bifocal • Trifocal • Lenticular	$10 Copayment for all eyeglass lenses	 Up to $40.00 Up to $60.00 Up to $80.00 Up to $80.00
Frames • Selective	Covered up to $140 after a $10 Copayment. *(N/A if in conjunction with lenses for which you have already paid a Copayment)*	Up to $53.00
Contact Lenses – (*in lieu of lenses and a frame)* (Once every 24 months) • Medically necessary Covered-in-full selection contact lenses • Elective All other non-covered selection contacts	Covered in full. $25 Copayment for standard contact lens fitting exam fee. Covered up to $120.	Up to $210 for Non Selection contact lenses Up to $105 (Medically Necessary*)
Laser Refractive Eye Surgery	Participants receive access to discounted refractive eye surgery from numerous provider locations.	N/A

Medically necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts medically necessary, you should ask your provider to contact the Claims Administrator concerning the reimbursement amount before you purchase such contacts.

NOTE: Benefit frequency every 24 months is cross-accumulated between In-Network and Out-of-Network benefits.

Vision Buy-Up

You can enhance your basic vision coverage with a buy-up benefit. The Buy-up option enhances the frequency of most services to once every 12 months

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End of Section V

About The Employee Assistance Program/Behavioral Health Plan

Sometimes employees may face certain problems or situations they cannot handle. If these problems or situations become overwhelming, they may affect personal happiness, family and friends relationships, performance at work and even general health. Without proper attention, these situations usually worsen resulting in unpleasant and expensive consequences.

The Company provides an Employee Assistance Program (EAP) that offers counseling sessions for each family member. If you need additional counseling, your EAP counselor will refer you to an outside professional who specializes in the type of problem you are experiencing. 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 "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the EAP Claims Administrator.

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. Your behavioral health Claims Administrator is responsible for the mental health and chemical dependency program under the Plan. In the "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the behavioral health Claims Administrator.

Enrolling In The Plan And Your Cost For Coverage

Coverage	Your Coverage Begins…	Your Cost For Coverage Is…
EAP	Automatically on the first of the month after you complete 90 days of Active Service. There are no enrollment forms to complete.	Paid by your Employer. There is no cost to you for this coverage.
Behavioral Health	On the first of the month after you complete 90 days of Active Service *provided you have enrolled in a Company-sponsored medical plan*.	Shared with your Employer. Your cost is included in the medical plan premium you pay.

Coverage For Your Dependents

Coverage for your eligible dependents begins on the same day your coverage begins. If you add dependents during annual enrollment, their coverage will begin on January 1st immediately following the annual enrollment period unless otherwise specified by the Plan Administrator.

The EAP offers up to four free counseling sessions per problem type for the family unit.

How The Plan Works

If you or a member of your family needs help with a problem, you or your family member can call the EAP for assistance. You may be referred to an EAP counselor so you can discuss your problem in person. If you need additional counseling, your EAP counselor will refer you to an outside professional who specializes in the type of problem you are experiencing.

Examples of problems an EAP counselor can help you with are:

- Marital difficulties;
- Burnout/depression;
- Alcohol/drug abuse;
- Family situations;
- Financial difficulties; and

- Legal issues.

If you have legal or financial problems, the EAP will refer you to a lawyer or financial counselor.

Sometimes after the first evaluation, an EAP counselor will decide that the four sessions will not provide you with the help you need. In that situation, the EAP counselor will refer you to a professional in the community. If the EAP counselor refers you to an outside professional, you have to pay for any services that are not covered by your behavioral health Plan.

The EAP is the Gatekeeper of the Behavioral Health benefits included in your medical plan. The EAP is your first contact when you need behavioral health care services.

The EAP Counselors

A team of dedicated service specialists are available when you call the EAP. Additionally, master-level clinical professionals are available immediately to address clinical issues and make a referral if necessary.

Confidential Services

EAP services are strictly confidential. The Plan Administrator's records never become part of Company files, and *no one from the Company may review your EAP records for any reason*. The Company receives periodic statistical reports without individually identifiable health information to ensure the EAP is providing the services employees need and that such services are being utilized.

24-Hour Crisis Hotline

Emergency service is available 7 days a week, 24 hours a day by calling **1-800-363-7190**.

Your Cost For EAP Services

EAP services including assessment, short-term therapy or telephone crisis intervention, are available to you at no charge. If additional assistance is necessary, the EAP counselor will try to minimize your cost by referring you to Network providers or to local community services based on your ability to pay for those services.

Behavioral Health Plan Summary of Plan Benefits

For Choice Plan

Covered Service	**In-Network**	**Out-of-Network**
Deductible	None	$500 per person per year
Out of Pocket Maximum	$1,500 single/ $3,000 family	None
Initial assessment and up to 4 visits	No charge	Not covered
Inpatient Care [1,1A] • Hospital: *room & board; Drug, x-ray, lab and Physician charges; Detoxification; Residential and Partial Hospital – counted as 2 partial days to 1 inpatient day.*	Plan pays 90%	Plan pays 60% UCR [3], after deductible
• Calendar Year Limit	No limit	30 days/Calendar Year; 60 days/lifetime

Structured Outpatient Substance Abuse Program		
	Plan pays 100%	Covered under Out-of-Network outpatient benefit
• Calendar Year Limit	No limit	
Outpatient Mental Health/Substance Abuse Care		
• Group therapy	You pay $10 Copayment/visit	
• Individual therapy	You pay $15 Copayment/visit	60% of UCR [3] after deductible
• Calendar Year Limit	No Limit	80 visits/Plan Year
Lifetime Limit *(combined for all In-Network and Out-of-Network benefits)*	• No Limit	• 60 days inpatient • 285[2] outpatient visits
Preauthorization & Review	[1]You must contact EAP to obtain Network benefit levels. Failure to obtain pre-authorization will result in payment at Out-of-Network levels. For Emergency admissions, you must notify the EAP by the next scheduled work day to be covered at the Network benefit level.	[1A]Precertification is required for all inpatient care. Failure to call within 24 hours of an admission or comply with care management recommendations will result in payment at 50% of the Out-of-Network benefit levels. For Emergency admissions, you must notify the EAP by the next scheduled work day to be covered at the Network benefit level.
[2] Accumulated from 01/01/1997. Inpatient days cross-accumulate for In-Network and Out-of-Network benefits. [3] UCR: Usual & Customary Rate to be determined by the Claims Administrator's formulas by geographical location		

For Choice Plus High Plan

Covered Service	**In-Network**	**Out-of-Network**
Deductible	None	$500 per person per year
Out of Pocket Maximum	$1,500 single/ $3,000 family	$3,000 single/ $9,000 family
Initial assessment and up to 4 visits	No charge	Not covered
Inpatient Care [1,1A] • Hospital: *room & board; Drug, x-ray, lab and Physician charges; Detoxification; Residential and Partial Hospital – counted as 2 partial days to 1 inpatient day.*	Plan pays 90%	Plan pays 70% UCR [2] after deductible
• Calendar Year Limit	No limit	No limit
Structured Outpatient Substance Abuse Program		

	Plan pays 100%	Covered under Out-of-Network outpatient benefit
• Calendar Year Limit	No limit	
Outpatient Mental Health/Substance Abuse Care		
• Group therapy	You pay $10 Copayment/visit	
• Individual therapy	You pay $20 Copayment/visit	70% of UCR [2] after deductible
• Calendar Year Limit	No limit	Unlimited
Lifetime Limit *(combined for all In-Network and Out-of-Network benefits)*	No limit	No limit
Preauthorization & Review	[1]You must contact EAP to obtain Network benefit levels. Failure to obtain pre-authorization will result in payment at Out-of-Network levels. For Emergency admissions, you must notify the EAP by the next scheduled work day to be covered at the Network benefit level.	[1A]Precertification is required for all inpatient care. Failure to call within 24 hours of an admission or comply with care management recommendations will result in payment at 50% of the Out-of-Network benefit levels. For Emergency admissions, you must notify the EAP by the next scheduled work day to be covered at the Network benefit level.
[2] UCR: Usual & Customary Rate to be determined by the Claims Administrator's formulas by geographical location		

For Choice Plus Low Plan

Covered Service	**In-Network**	**Out-of-Network**
Deductible	None	None
Out of Pocket Maximum	$2,000 single/ $6,000 family	$6,000 single/ $18,000 family
Initial assessment and up to 4 visits	No charge	Not covered
Inpatient Care [1,1A] • Hospital: *room & board; Drug, x-ray, lab and Physician charges; Detoxification; Residential and Partial Hospital – counted as 2 partial days to 1 inpatient day.*	Plan pays 80%	Plan pays 60% UCR [2] after deductible
• Calendar Year Limit	No limit	No limit
Structured Outpatient Substance Abuse Program		

	Plan pays 100%	Covered under Out-of-Network outpatient benefit
• Calendar Year Limit	No limit	
Outpatient Mental Health/Substance Abuse Care		
• Group therapy	You pay $10 Copayment/visit	
• Individual therapy	You pay $20 Copayment/visit	60% of UCR [2] after deductible
• Calendar Year Limit	No limit	No limit
Lifetime Limit *(combined for all In-Network and Out-of-Network benefits)*	No limit	No limit
Preauthorization & Review	[1]You must contact EAP to obtain In-Network benefit levels. Failure to obtain pre-authorization will result in payment at Out-of-Network levels. For Emergency admissions, you must notify the EAP by the next scheduled work day to be covered at the In-Network benefit level.	[1A]Precertification is required for all inpatient care. Failure to call within 24 hours of an admission or comply with care management recommendations will result in payment at 50% of the Out-of-Network benefit levels. For Emergency admissions, you must notify the EAP by the next scheduled work day to be covered at the In-Network benefit level.
[2] UCR: Usual & Customary Rate to be determined by the Claims Administrator's formulas by geographical location		

For Indemnity Plan

Covered Service	**In-Network**	**Out-of-Network**
Deductible	None	None
Out-of-Network Maximum	$2,000 single/ $6,000 family	None
Initial assessment and up to 4 visits	No charge	Not covered
Inpatient Care [1,1A] • Hospital: *room & board; Drug, x-ray, lab and Physician charges; Detoxification; Residential and Partial Hospital – counted as 2 partial days to 1 inpatient day.*	Plan pays 80%	Plan pays 80% UCR [2] after deductible
• Calendar Year Limit	No limit	No limit
Structured Outpatient Substance Abuse Program		

	Plan pays 100%	Covered under Out-of-Network outpatient benefit
• Calendar Year Limit	No limit	
Outpatient Mental Health/Substance Abuse Care		
• Group therapy	You pay $10 Copayment/visit	
• Individual therapy	You pay $20 Copayment/visit	80% of UCR [2] after deductible
• Calendar Year Limit	No limit	No limit
Lifetime Limit *(combined for all In-Network and Out-of-Network benefits)*	No limit	No limit
Preauthorization & Review	[1]You must contact EAP to obtain In-Network benefit levels. Failure to obtain pre-authorization will result in payment at Out-of-Network levels. For Emergency admissions, you must notify the EAP by the next scheduled work day to be covered at the In-Network benefit level.	[1A]Precertification is required for all inpatient care. Failure to call within 24 hours of an admission or comply with care management recommendations will result in payment at 50% of the Out-of-Network benefit levels. For Emergency admissions, you must notify the EAP by the next scheduled work day to be covered at the In-Network benefit level.
[2] UCR: Usual & Customary Rate to be determined by the Claims Administrator's formulas by geographical location		

How To Access Services

When you need help, follow these steps:

1. Call your EAP Claims Administrator at **1-800-363-7190**.
2. Be prepared to provide the following information
   - Name, address and phone number
   - Age and date of birth
   - Name of Covered Person and his/her Social Security Number
   - Name of Employer
   - Reason for referral
3. A staff member will assist you with a referral to the appropriate provider located in your area.

In an Emergency situation, the EAP Claims Administrator will provide you with immediate information, referral and crisis intervention.

Note: Failure to follow the above procedures will result in non-payment or reduced payment of claim.

Claims Procedure for Behavioral Health Services

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 a claim for you.

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

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 behavioral health Claims Administrator.

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End of Section VI

About The Flexible Benefits Plan

The Company offers a Flexible Benefits plan or “cafeteria” plan. The plan is called a cafeteria plan because it enables you to redirect a portion of your salary to purchase benefits from a “menu” of benefits. These amounts are redirected before your salary is taxed for Federal, State or FICA withholding. The plan is also known as the “125 plan" because it governed by Section 125 of the Internal Revenue Code.

Currently the plan consists of three (3) components:

1. Premium Conversion (pretax premiums)
2. Dependent Care Spending Account (DCSA)
3. Health Care Spending Account (HCSA).

Premium conversion enables you to pay your share of costs for the medical, dental and vision buy-up and mandatory LTD plans with pre-tax dollars. This means your premiums are deducted from your pay before federal income and Social Security taxes (and in most cases, state and local taxes, if applicable) are deducted. Pre-tax premiums reduce the amount of income on which you must pay taxes. The result -- your take-home pay is greater.

The reimbursement accounts (also known as *flexible spending accounts* “FSA”) enable you to set aside pretax dollars from your pay and use those pretax dollars to reimburse yourself for eligible dependent care and health care expenses you have during the Plan Year. You may enroll in one or both accounts.

Effect On Other Benefits

Your participation in the Flexible Benefits Plan will not change the amount of salary used to determine benefits under other company-sponsored plans such as the life insurance, 401(k) or disability plans.

Your pre-tax wages are not included in the wages used to determine your Social Security benefits; therefore, the benefits you receive from Social Security may be slightly reduced.

Who Participates In This Plan

Premium Conversion

You automatically participate in the premium conversion plan when you enroll in the medical, dental, vision or mandatory LTD plans. (Refer to those SPDs for further information about enrolling in the plans.)

Dependent Care Spending Account (DCSA)

You can participate in the DCSA if:

you are:

(a) single and working; or

(b) married and both you and your Spouse work; or

(c) married and your Spouse is a full-time student or physically or mentally disabled.

Health Care Spending Account (HCSA)

You can participate in the HCSA if:

you are:

(a) an eligible employee

Enrolling In The Plan

Premium Conversion

You do not have to enroll in the premium conversion plan. Enrollment is automatic when you enroll in the medical, dental, vision buy-up or mandatory LTD plans.

Flexible Spending Accounts

As a new employee, you can enroll in the FSAs on the first day of the month after you complete 90 days of active service ("Benefit Eligibility Date."). For the date deductions actually begin see “When Deductions Begin” on page 76.

You must contact the enrollment administrator, BenefitsUS, to enroll within 31 days of your Benefit Eligibility date. Upon completion of enrollment, the Employee Benefits Department will:

- set up the deductions to be withheld from your paycheck; and
- forward your information to the Claims Administrator to set up the account(s) in your name.

If you decide not to enroll in the FSAs when you are first eligible, you may enroll during annual enrollment. You will be notified when annual enrollment begins.

Note: in order to continue coverage from one year to the next, you must reenroll and designate your contribution amount for the upcoming year during the annual enrollment period. You must reenroll, even if you wish to contribute the same amount as in the previous year. Reenrolling enables you to reevaluate your expenses and change your payroll contributions from year to year.

Enrollment Administration – BenefitsUS 1-888-860-6178

Special Enrollment

The only time you are able to enroll outside of an annual enrollment period is when you:

Are a newly eligible employee.

Experience a change in your eligibility status. (See *Changes In Status* next.)

Changes In Status

In certain instances, a change in your job, family or other circumstances will enable you to change your reimbursement account participation, such as starting a new contribution, changing your existing contribution, or stopping your contributions altogether.

You must request a change in participation within 31 days of the event (60 days if the event is also a COBRA Qualifying Event) and you must provide any supporting documentation or the change request will be not be approved.

Dependent Care Spending Account

You may change your DCSA participation only if you experience one of the following qualified changes in status:

- You marry, divorce or your marriage is annulled.
- You acquire a new dependent such as by birth, adoption or placement for adoption.
- Your Spouse or qualified dependent dies.
- You or your Spouse changes from full-time to part-time (or part-time to full-time) employment status.
- You or your Spouse either starts or stops working or your Spouse stops attending school full-time.
- You or your Spouse experiences a change in work shift affecting your needs for dependent care.

- You or your Spouse leave on or return from an unpaid leave of absence.
- Your dependent's eligibility status changes, such as a change of custody because of divorce.

A change in dependent care provider, a change in the rate paid, or a child beginning school are not considered qualified changes in status and, therefore, do not permit you to change your existing contribution amount. If you change providers, the only action you must take is to include the information about the new provider on the claim form.

Health Care Spending Account

You may change your HCSA participation only if you experience one of the following qualified changes in status:

- You marry, divorce or your marriage is annulled.
- You acquire a new dependent such as by birth, adoption or placement for adoption.
- Your Spouse or dependent dies.
- You, your Spouse or your dependent starts or stops working.
- You, your Spouse or your dependent is scheduled to work more or fewer hours, including changes from full-time to part-time (or part-time to full-time) employment status, or beginning or returning from an unpaid leave of absence.
- Your dependent becomes eligible for, or is no longer eligible for health coverage due to age limits, student status or similar eligibility requirements.
- You have a change in work location or division transfer that affects your eligibility for benefits under the HCSA.

You may also change your coverage to comply with a court order to provide or cancel coverage for your child resulting from a divorce, annulment or change in legal custody.

Your change in participation must be consistent with the change in status. To be consistent, the event must cause a family member to gain or lose eligibility for the HCSA and your participation change must correspond to the gain or loss of eligibility.

When Deductions Begin

As a new employee, when you enroll in the reimbursement accounts, deductions begin on the first paycheck after the Employee Benefits Department receives and processes your initial enrollment from the enrollment administrator.

If you enroll or reenroll during annual enrollment, deductions begin with your first paycheck in January.

If you enroll or increase/decrease the amount of your deduction during the year because of a change in status, your deductions begin the first paycheck after Employee Benefits receives and processes your enrollment change from the enrollment administrator.

How To File A Claim

Obtaining a Claim Form

Claims forms are available through the BenefitsUS Customer Service website at www.ebenefitsUS.com.

Documentation to be included

In all cases, cancelled checks and/or balance forward bill are not acceptable documentation.

Health Care Claims – acceptable documentation will include:

- Provider of service,
- Type of service,

• Date of service (not the billing date of payment date),

• Amount of expense, or

• Explanation of Benefits (EOB) -- from a medical or dental plan that has already paid its portion of the claim.

Dependent Care Claims – acceptable documentation will include:

• Receipt or invoice signed by the provider that itemizes the date(s) of service and the amount(s) charged. Be sure the receipt or invoice includes the provider's:

(a) Name,

(b) Address,

(c) Employee File Number preceded by 3 zeros, or

(d) Tax Identification Number (TIN). The TIN is not necessary if the provider is a not-for-profit, religious, charitable or educational organization under Section 501(c)(3) of the Internal Revenue Code.

Submitting your claim

In the "*Introduction to Your Plan Benefits*" section of this SPD, under "*Claims Administrators*," you will find contact information for the flexible benefits Claims Administrator.

When To File A Claim

Claims are processed weekly. You should file a claim as soon as possible after an eligible expense is incurred in order to avoid possible delays if you wait to file during the heavy year-end cycle.

Date You Incur an Eligible Expense	File Your Claim	But no later than
Jan 1 – Mar 15 of the following year	As Soon As Possible	June 15 of the following year

How Claims Are Paid

Before you file a claim for reimbursement, you must pay for the expense.

HCSA

You can receive reimbursement for all qualifying health care expenses, up to the amount you elected to set aside in your account, even if you have not yet deposited enough money to your account.

There are Special Procedures for qualifying Orthodontia expenses –

When covered by a dental plan, send the following information:

• Signed claim form and EOB, and

• Copy of agreement from your Orthodontist that states the time period and total cost of the orthodontia procedure.

Reimbursements will be sent automatically, once per month, based on expected service dates, up to the amount of your annual HCSA election.

When not covered by a dental plan, include the following information:

• Send a copy of agreement from your Orthodontist that states the time period and total cost of the orthodontia procedure.

Reimbursements will be sent automatically, once per month, based on expected service dates, up to the amount of your annual HCSA election.

In either case, if you don't want automatic payment, you may submit a monthly itemized payment receipt. In addition, if installation and removal charges are not shown separately, the reimbursement amount will be determined by dividing the total cost by the number of months during which the service is received.

Special payment schedules that do not coincide with the date(s) of service, such as full payment at installation, will be prorated by the period of service. The Claims Administrator will determine the amount eligible for reimbursement.

- Installation charges are eligible for reimbursement on the installation date – less any dental plan benefits
- Removal charges are eligible for reimbursement when the braces are removed date – less any dental plan benefits
- The remaining charges – less any dental plan benefits – will be prorated for the number of months of projected payments.

DCSA

The amount of your reimbursement cannot be more than your account balance.

In other words, your reimbursement will be equal to the lesser of:

(a) The amount of the claim; or

(b) The amount of money in your account at the time the claim is processed.

If your account balance is less than the amount of your claim, the unpaid portion will be paid to you when you have deposited additional funds and there is enough money in your account to cover the amount of the unpaid portion. This is called “pending” your claim. Pended claims will be paid automatically on the next available payment cycle. The Company also contributes a subsidy for employees that participate in the DCSA. See page 81 for details.

Debit /Credit Card

Instead of filing a claim form as described above, you may pay for qualifying health care expenses under the Health Care Spending Account with a debit/credit card provided by the Company. The following rules apply to the use of such debit/credit card:

Conditional Debit Card Charges

Any debit card/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. 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.

When Your Eligibility For Participation Ends

The following events, as discussed below, will affect your eligibility to participate:

- Termination
- Leave of Absence
- Death

Termination Dates

Your coverage will end on the earliest of the following dates. The date on which:

- you are no longer eligible to participate;
- US Airways, Inc. no longer offers this plan;
- the plan terminates or changes so that you are no longer eligible;
- a calendar year begins and you have not enrolled;
- the tax laws change so that pre-tax arrangements are no longer allowed; or
- you die.

The day before:

- you retire;
- you are covered by another plan of the Company.

Generally, if any of the above events occur, you can no longer make deposits. However, you can continue to make contributions into your HCSA under COBRA. See "COBRA Continuation of Coverage" in Section I.

Leaves Of Absence

Unpaid Leave of Absence (Including FMLA Leave)

DCSA	HCSA
If you go on an unpaid leave of absence:	
your DCSA deposits will cease. When you return to work, 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.	your HCSA deposits will be suspended unless you continue contributions under COBRA (see Section I). When you return to work, 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 do not return to work from an unpaid leave of absence you can continue contributions under COBRA for the current calendar year (see Section I).

If you elect to discontinue making HCSA deposits your coverage will terminate when your family leave/unpaid leave begins. This means you may only be reimbursed (up to the amount you elected to set aside in your account) for claims incurred before your leave started. When you return to work, you may resume coverage and begin making HCSA deposits as described above, but you will not be reimbursed for any expenses incurred during your leave of absence.

If you elect to continue HCSA deposits during a leave, you must elect COBRA. In that event, your deposits will be made on an after-tax basis (unless you are receiving compensation from your Employer during the leave). You may continue to submit claims for reimbursement while you are on a leave if you have elected to continue coverage.

Unused Account Balances

Federal law requires that unused account balances be forfeited. Therefore, if you have any money left in your reimbursement accounts after you have been reimbursed for all your eligible expenses (i.e., by June 15th following the end of the Plan Year), you will lose the money you have not used.

Limits On Your Contributions

IRS guidelines require the Flexible Benefits Plan pass special tests each year. IRS guidelines also place limits on how much you can deposit into the reimbursement accounts if you are a highly compensated employee. The limit ensures that the plan does not discriminate in favor of highly compensated employees. If you are a highly compensated employee and these limits apply to you, a representative from Employee Benefits will contact you.

Dependent Care Spending Account

You may open a DCSA to cover qualified dependent care expenses. To qualify for reimbursement, dependent care expenses must be for the care of one or more qualified dependents.

If you are single you must be working during the time your children and other dependents are receiving care. If you are married, you and your Spouse must both be working during the time your dependents are receiving care. You may also use your account if your Spouse is a full time student for at least five months during the year or if your Spouse is mentally or physically disabled and unable to provide care for your children.

Note:

Unlike the other plans of benefits described in this SPD, the Dependent Care Spending Account is not a health care plan. As such, it is NOT subject to the following statutory requirements:

- **Continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**
- **Privacy of health care information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- **Qualified Medical Child Support Orders (QMCSO)**
- **Department of Labor Claim Procedures**

Tax Advantages

You make deposits to your DCSA with pre-tax dollars. This means your deposits are deducted from your pay before federal income and Social Security taxes (and in most cases, state and local income taxes) are deducted. The result is lower taxable income and lower taxes.

The following example illustrates how the DCSA helps you reduce your taxable income.

**Assumes married with 4 withholding allowances. **Does not include deductions for state or local taxes.*	After-Tax Dollars	Pre-Tax Dollars
Annual Pay	$30,000	$30,000
Pre-Tax Dependent Care Expenses	-0-	$ 3,000

Adjusted Gross Income	$30,000	$27,000
Federal Tax*	$ 2,078	$ 1,628
Social Security Tax	$ 2,295	$ 2,065
After-Tax Dependent Care Expenses	$ 3,000	-0-
Take home pay**	$22,627	$23,307
Tax savings	-0-	$ 680

This is just an example; the amount of your taxable income will vary based on your personal situation.

How Much You Can Deposit In Your DCSA

When you enroll in the DCSA, you will designate how much you wish to have deducted from your paycheck in equal amounts each month. If you enroll in the DCSA during the year due to a change in your family status, the deductions will be taken from your paycheck in equal amounts each month for the remainder of the year.

How much you can deposit in your DCSA each year depends on your income tax filing status and your annual earned income as follows.

If you are:

- single, you can deposit up to $5,000* or the amount of your annual earned income, whichever is less.
- married and file a separate tax return, you can deposit up to $2,500 or the amount of your annual earned income, whichever is less.
- married and file a joint return, you can deposit up to $5,000. Your deposit cannot be more than the amount of your annual earned income or your Spouse's, whichever is less.

  If you and your Spouse enroll in separate DCSA plans (for example, you enroll in this plan and your Spouse enrolls in a plan at his/her Employer), the total combined deposits you and your Spouse can make are $5,000*. However, the total combined deposits cannot be more than the amount of your annual income or your Spouse's, whichever is less.

If your Spouse doesn't work and is a full-time student or physically or mentally disabled, the most you can deposit is $3,000 for one eligible dependent or $6,000 for two or more eligible dependents (or such other amount as required by law).

***** including company match

Dependent Care Subsidy Program

The Company provides a non-taxable benefit subsidy to assist employees with eligible dependent care expenses. You must enroll in the Dependent Care Tax-Free Spending Account in order to be eligible for the subsidy.

The amount of your subsidy depends on your employment status and the amount you contribute to the DCSA:

Employment Status	**Amount of Subsidy**
Full-time	The lesser of $1,000 or 30% of your annual contribution

Your annual contribution plus the Company subsidy cannot exceed $5,000 in one Plan Year.

Eligible Dependents

You can use your DCSA to pay for expenses for dependents you claim on your income tax return. The

dependent also has to meet the following requirements:

If the dependent is a child, the child must:

- be under age 13;
- be living with you in a normal parent/child relationship on the date your DCSA becomes effective; and
- be enrolled in a day-care facility that is licensed if it cares for more than six children at a time.

If the dependent is a disabled child age 13 or older, or an adult, the dependent:

- must be living with you, spending at least eight hours a day in your home on the date your DCSA becomes effective;
- must depend on you for at least 50% of the dependent's financial support; and
- may not receive care at a nursing facility.

What Types Of Expenses Qualify

The types of eligible expenses you can pay for through your DCSA include, but are not limited to:

- Licensed day care center;
- Day camp (not overnight) if the camp qualifies as a day care center;
- Maid or housekeeper if part of their job is to take care of an eligible dependent;
- Social Security and unemployment taxes paid for the person caring for an eligible dependent;
- A person who takes care of your dependent while you are at work if:
  - the person cannot be claimed as a dependent on you or your Spouse's income tax return, and
  - the person is not your child or stepchild under age 19.

If you have questions about what type of eligible expenses can be paid for through your DCSA, contact the Claims Administrator.

Income Tax Credits For Dependent Care

The IRS allows tax credits for qualifying dependent care expenses on your income tax return. You can have credits of $3,000 for one child or $6,000 for two or more children (or such other amount as required by law). If you choose the income tax credit, you can also use your dependent care account for expenses greater than the $3,000 or $6,000 limits (or such other amount as required by law). The total expense available for both the dependent care account and tax credit is $5,000*, or $2,500 if you are married and you file your returns separately.

If you use your account to pay for a dependent care expense, you cannot claim the same expense as an income tax credit. For example, if the tax credit is $6,000 and you use your dependent care account to pay $4,000 in dependent care expenses, you can only claim up to a $2,000 credit on your income tax return.

Using Income Tax Credits Or Dependent Care Spending Account

You should consider whether it is better for you to use income tax credits or the DCSA.

Here are some guidelines to help you decide. *These are only guidelines — they are not intended as, nor should they be considered, tax advice. Always consult a tax advisor regarding your personal tax situation.*

If your adjusted gross income (your total family income minus qualifying deductions) is more than $28,000, you should consider using the DCSA for the first $5,000* of child care expenses. If your adjusted gross income is less than $20,000, you're probably better off using the income tax credit first. If

your income is between $20,000 and $28,000, call a tax advisor to find out which alternative is best for you.

Whether you use a DCSA or an income tax credit, the IRS requires that you provide the tax identification number of the dependent care provider on your tax return. Day care centers will give this number to you. For individual providers, you will have to ask for the person's Social Security number.

For additional information about tax credits, see **IRS Publication 503, Child and Dependent Care Expenses**, which can be downloaded from the IRS website at www.irs.gov.

* including company match

Ineligible Dependent Care Expenses

Expenses that are not eligible for reimbursement include, but are not limited to, the following. Expenses for:

- the education of your qualified dependent(s);
- food, clothing or entertainment of your dependent(s);
- services of a gardener or chauffeur;
- transportation of your dependent(s) to daycare outside of your home;
- tuition for kindergarten;
- payments to a housekeeper while you're sick at home;
- payments to a dependent to care for another dependent;
- overnight camp.

Health Care Spending Account

You may open a HCSA to cover qualified health care expenses for yourself, your Spouse and any dependent you claim on your federal income tax return (even if that person is not covered under a company-sponsored health plan), as well as a child you cover under a qualified medical child support order (QMCSO). In addition, you may cover the qualified health care expenses for your natural, step, adopted or foster children who have not yet attained age 26.

Tax Advantages

Deposits to your HCSA are made with pre-tax dollars. This means your deposits are deducted from your pay before federal income and Social Security taxes (and in most cases, state and local income taxes) are deducted. The result is lower taxable income and lower taxes.

The following example illustrates how the HCSA helps you reduce your taxable income.

*Assumes Married with 4 withholding allowances. **Does not include deductions for state or local taxes.	After-Tax Dollars	Pre-Tax Dollars
Annual Pay	$30,000	$30,000
Pre-Tax Health Care Expenses	-0-	$ 1,000
Adjusted Gross Income	$30,000	$29,000
Federal Tax*	$ 2,078	$ 1,928
Social Security Tax	$ 2,295	$ 2,219
After-Tax Health Care Expenses	$ 1,000	-0-

Take home pay**	$24,627	$24,853
Tax savings	-0-	$ 226

This is just an example; the amount of your taxable income will vary based on your personal situation.

How Much You Can Deposit In Your HCSA

When you enroll in the HCSA, you will designate how much you wish to have deducted from your paycheck in equal amounts each month. If you enroll in the HCSA during the year due to a change in your family status the deductions will be taken from your paycheck in equal amounts each month for the remainder of the year.

You can deposit up to $2,500 each Plan Year in your HCSA. You may not deposit less than $120 for a Plan Year.

Eligible Dependents

You can use your HCSA to pay for expenses for yourself and dependents you claim on your income tax return.

What Types Of Expenses Qualify

You can pay for a health care expense through your HCSA provided:

- the expense is not paid for by any medical, dental or vision plan;
- the expense qualifies as a “health care” expense under the Internal Revenue Code. For example, expenses for cosmetic procedures do not qualify under the Internal Revenue Code; therefore, the expenses cannot be paid for through your HCSA; and
- you do not deduct the expense on your federal income tax return.

The types of eligible expenses you can pay for through your HCSA include, but are not limited to:

- deductibles;
- Copayments – for example, the payments you may make for an office visit;
- coinsurance — for example, if your medical plan pays 80% of expenses, the 20% balance for which you are responsible is called a coinsurance;
- charges over and above the Reasonable and Customary (R&C) fee allowed by a plan;
- charges over a plan’s pre-existing condition dollar limit or other specific dollar limits, such as limits on chiropractic care;
- hearing care, including hearing aids;
- professional services: Christian Science practitioner; oculist, optician, unlicensed practitioner -- if the type and quality of the services is not illegal;
- equipment and supplies — for example, abdominal supports, air conditioner where necessary for relief from an allergy or for relieving difficulty in breathing, arches, autoette, back supports, contact lenses, elastic hosiery, eyeglasses, fluoridation unit in home, heating devices, invalid chair, orthopedic shoes, rental of medical equipment, sacroiliac belt, truss;
- medicine such as prescription drugs, vitamins, tonics (prescribed by a Doctor);
- medical treatments — for example, acupuncture, diathermy, healing services, hydrotherapy, sex therapy, sterilization, vasectomy, whirlpool baths (prescribed by a Doctor);
- miscellaneous items: birth control pills or items prescribed by your Doctor, Braille books, hair

transplant operation, physical examinations, seeing eye dog and its maintenance, special school costs for physically and mentally disabled children;

• other medical, dental and vision expenses, including contact lens solution, that are not paid for by a health care plan in which you participate. These are referred to as "exclusions," "excluded expenses," or "non-covered expenses;" and

• over-the-counter drugs and medications obtained with a prescription, or insulin.

If you have questions about what types of eligible expenses can be paid for through your HCSA, contact the flexible benefit Claims Administrator.

Income Tax Deduction For Health Care Expenses

If you use the HCSA to be reimbursed for a health care expense, you cannot claim that same expense as an income tax deduction.

The IRS allows a tax deduction on your income tax return for qualifying health care expenses for which you are not reimbursed by any insurance plan. In order to be eligible to claim health care expenses as a deduction on your income tax return, your expenses must be more than 10% of your adjusted gross income if you are under age 65 (7.5% if you are age 65 or over). For example, if you are under age 65 and your adjusted gross income for the year is $30,000, you would be able to deduct only the unreimbursed health care expenses that exceed $3,000 (10 % of $30,000) for the year.

For more information regarding income tax deductions for health care expenses, see **IRS Publication 502, Medical and Dental Expenses**, which can be down-loaded from the IRS website at www.irs.gov.

Ineligible Health Care Expenses

Expenses that are not eligible for reimbursement include, but are not limited to, the following. Expenses for:

- anti-baldness drugs
- cosmetic surgery
- treatment related to cosmetic surgery
- dental procedures/ supplies to whiten teeth
- diaper service
- donations to volunteer ambulance companies
- household help
- premiums paid for health care coverage
- toothpaste, cosmetics and toiletries
- funeral and burial
- health club dues
- over-the-counter drugs and medications obtained without a prescription

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End of Section VII

About Voluntary Benefit Plans

The Company has arrangements to provide you and your eligible dependents with additional insurance coverage that are completely portable. A complete description of the benefits under each program are in the Appendix of this Section VIII.

Appendix A

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.

Eligibility

For more eligibility details about coverage for you and your eligible dependents, please refer to the "Who Participates in this Plan" section on page 19 of the SPD. Domestic partners are not eligible.

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 "Introduction to Your Plan Benefits" section of this SPD, under "Claims Administrators", 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.

Appendix B

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.

Eligibility

For more eligibility details about coverage for you and your eligible dependents, please refer to the "Who Participates in this Plan" section on page 19 of the SPD. Domestic partners are not eligible.

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 "Introduction to Your Plan Benefits" section of this SPD, under "Claims Administrators", 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.

Appendix C

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.

Eligibility

For more eligibility details about coverage for you and your eligible dependents, please refer to the "Who Participates in this Plan" section on page 19 of the SPD. Domestic partners are not eligible.

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 "Introduction to Your Plan Benefits" section of this SPD, under "Claims Administrators", 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.

End of Section VIII and conclusion of Health Care SPD