US AIRWAYS, INC.
HEALTH OPTIONS PLAN

Effective January 1, 2012

TABLE OF CONTENTS

ARTICLE VI
FUNDING

ARTICLE VII
AMENDMENT AND TERMINATION

ARTICLE VIII
MISCELLANEOUS

ARTICLE IX
PRIVACY

ARTICLE X
SECURITY

US AIRWAYS, INC.
HEALTH OPTIONS PLAN

Effective January 1, 2012, US Airways, Inc. ("Company") establishes this group health plan, known as the Health Options Plan ("Plan") for the purpose of providing medical, prescription drug, behavioral health and chemical dependency benefits to employees of the Company and their eligible dependents.

ARTICLE I
DEFINITIONS

Whenever used in the Plan, the following terms, when capitalized, have the respective meanings set forth below unless otherwise expressly provided.

1.1 "Effective Date" of this Amendment and Restatement means January 1, 2012.

1.2 Plan Definitions

As used herein, the following words and phrases have the meanings hereinafter set forth, unless a different meaning is plainly required by the context:

"Administrator" means the Company or such other person or organization as may be appointed from time to time by the Company to supervise the administration of the Plan.

"Claims Administrator" means the individual or entity with which the Company has entered into claims administration agreements to process benefit claims.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended from time to time, and any regulations issued thereunder.

"Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to a section of the Code shall include such section and any comparable section or sections of any further legislation that amends, supplements or supersedes such section.

"Company" means US Airways, Inc., a Delaware corporation, and any successor thereto.

"Dependent" means any of the following:

(a) the spouse, or registered Domestic Partner, of an Employee;

(b) the children of an Employee, or their registered Domestic Partner up to age 26;

(c) the unmarried children age 26 and over of an Employee, or their registered Domestic Partner, who are not self-supporting because of a permanent physical, or mental disability and are dependent upon the Employee, as defined by the Code for income tax purposes, and provided the child became disabled when covered as a Dependent under this Plan.

For purposes of this definition of Dependent, the "spouse" of an Employee means the lawful wife of a male Employee, or the lawful husband of a female Employee, provided that such marriage has been licensed by a governmental authority, and "children" of an Employee, or his or her registered Domestic Partner, mean:

(1) natural children;

(2) legally adopted children, children placed with an Employee, or their registered Domestic Partner for adoption;

(3) stepchildren of the Employee, or their registered Domestic Partner; or

(4) other children not described in (1) through (3) above, who are permanently residing in the household of the Employee or registered Domestic Partner, and being supported by the Employee or registered Domestic Partner, provided the Employee or registered Domestic Partner is the legal guardian and such legal guardianship has been permanently granted.

"Domestic Partner" means the unmarried partner of the same gender of an Employee, who is:

(a) at least 18 years of age;

(b) competent to contract at the time such domestic partnership is registered;

(c) not legally married to anyone other than the Employee, and has dissolved any prior marriages through death or divorce;

(d) not related to the Employee by a degree of closeness that would prohibit legal marriage in the state or domicile of residence;

(e) the sole domestic partner of the Employee;

(f) sharing the same household with the Employee as his or her primary place of residence for the last six (6) months, except for absence due to education, healthcare, work or military service;

(g) responsible for the common welfare and financial obligations of the Employee, and vice versa;

(h) registered as a domestic partner with the Company by submitting any forms required to be executed as determined by the Company; and

(i) has provided proof of the domestic partnership, as is also required of the Employee, by submitting the requisite documentation as determined by the Company.

"Employee" means any active, full-time or part-time employee of the Employer, with a work base in the United States, but excluding any temporary, on-call or seasonal employees. An Employee shall not include any individual who: has a work base outside of the United States; is a resident of a country other than the United States and who is covered by a health plan sponsored by any governmental authority of such country; is not classified by the Employer, in its discretion, as an employee under Section 3121(d) of the Code (including, but not limited to, an individual classified by the Employer as an independent contractor and/or a non—employee consultant); or is classified by the Employer, in its discretion, as an employee of an entity other than the Employer, even if the classification by the Employer is determined to be erroneous, or is retroactively revised. In the event the classification of an individual who is excluded from the definition of Employee under the preceding sentence is determined to be erroneous or is retroactively revised, the individual shll nonetheless continue to be excluded from the definition of Employee 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.

"Employer" means the Company.

"Enrollment Period" means the period of time designated by the Company prior to each Plan Year during which Employees may elect to enroll for benefits under the Plan on behalf of themselves and their Dependents, or the period of time designated by the Company with respect to which Employees who become eligible to participate in the Plan during the Plan Year may enroll for benefits under the Plan.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to a section of ERISA includes such section and any comparable section or sections of any future legislation that amends, supplements, or supersedes such section.

"Participant" means: (i) any Employee, and their eligible Dependent(s), who satisfies the eligibility requirements and enrolls in the Plan in accordance with the procedures set forth in Article II; and (ii) any former Employees of the Company who elect coverage under the Plan solely for purposes of electing and receiving continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) in accordance with the procedures set forth in Article II.

"Plan" means the US Airways, Inc. Health Options Plan, as amended from time to time.

"Plan Year" means the 12 consecutive month period ending December 31, 2012 and each 12 consecutive month period thereafter.

1.3 Interpretation

Where appropriate, wherever used herein, the masculine pronoun shall include the feminine, the singular shall include the plural, and the plural shall include the singular.

1.4 Incorporation. The written instrument under which the Plan is established and maintained, as required by Section 402(a) of ERISA, shall include this Plan document, together with (i) all provisions of any summary plan description for the Plan that set forth terms and conditions of the Plan, as amended from time to time, and any supplements thereto, and (ii) all other documents (each, if any) that set forth the terms and conditions of the Plan, as may be amended from time to time. Any amendment to the documents described in (i) and (ii) will constitute automatically an amendment to the Plan. The terms and conditions, including any limitations or restrictions, of the documents described in (i) and (ii) are incorporated by reference in this document and constitute a part of the Plan.

ARTICLE II
ELIGIBILITY

2.1 Eligibility to Participate

Each Employee shall be eligible to participate in the Plan in accordance with the following provisions:

(a) **General Rule.** An Employee is eligible to participate in the Plan on the later of January 1, 2012 or the date of hire, except as otherwise specified in this Section.

(b) **Phoenix-Based Pilots and Flight Attendants.** Phoenix-based pilots and flight attendants are eligible to participate in the Plan on the later of January 1, 2012 or the first of the month following 90 days from the date of hire.

(c) **Former Employee.** A former Employee is eligible for coverage under the Plan solely for purposes of electing and receiving continuation coverage pursuant to COBRA and only if such former Employee was eligible for coverage under the Plan as active Employee the day before his or her separation from service.

Each Dependent shall be eligible to participate in the Plan at such time as the Employee becomes a Participant in the Plan.

2.2 Enrollment as a Participant

Each Employee or Dependent eligible to participate in the Plan shall become a Participant in the Plan upon enrollment in one of the programs offered under the Plan in accordance with the procedures prescribed by the Administrator and described in Article III.

2.3 Termination of Participation

An Employee and the Employee's Dependents shall cease to be Participants in the Plan and all benefits provided under this Plan shall cease upon the earliest of:

(a) the date upon which a Participant ceases to be an Employee;

(b) the date upon which a Participant ceases to make contributions required under this Plan;

(c) the date as of which the Participant revokes his election to enroll in any of the medical programs offered under the Plan as provided in Section 3.4; or

(d) the effective date of the Participant's election not to re-enroll in any of the medical programs offered under the Plan;

provided, however, that an Employee who is on a Company-approved leave of absence or furlough from the Company shall continue to be eligible to receive coverage under the Plan during the period prescribed by the Company policy, unless (a), (b) or (d) above cause a prior

termination coverage. In addition, a Dependent shall cease to be a Participant in the Plan and all benefits provided under this Plan shall cease upon the date he ceases to be a Dependent. Notwithstanding the foregoing, Employees and Dependents who cease to be Participants in the Plan shall be eligible for COBRA continuation coverage as provided in Section 4.8 of the Plan.

2.4 Resumption of Participation

If an Employee who terminated employment with the Company is reemployed as an Employee, or an Employee who was on furlough or a Company-approved leave of absence and previously waived or elected out of coverage from the Company is re-called or returned to work, such Employee shall again become eligible to participate in the Plan on the date the Employee is reemployed, recalled or returned to work. If such Employee is reemployed, recalled, or returned to work during the same Plan Year in which the Employee was terminated, furloughed or took leave, such Employee's prior enrollment election shall be reinstated for the balance of such Plan Year. If such Employee is reemployed, recalled, or returned to work during a subsequent Plan Year, such Employee may make a new enrollment election for such Plan Year in accordance with the provisions of Section 3.1 of the Plan.

An Employee who ceased required contributions under the Plan may resume such required contributions at any time during the Plan Year in which such contributions ceased, provided he is in active employment with his Employer. Such Employee shall again become a Participant in the Plan and his prior enrollment election shall be reinstated as of the date he or she resumes required contributions under the Plan; provided, however, that coverage under the Plan will be effective only for those periods for which the Employee makes required contributions. An Employee who ceased required contributions under the Plan may re-enroll in the Plan for any subsequent Plan Year in accordance with the provisions of Section 3.1 of the Plan, provided he is in active employment with his Employer.

Except as provided in Section 3.4, an Employee who revokes his election to enroll or who elects not to re-enroll in any of the medical programs offered under the Plan will not be eligible to enroll in the Plan until the next Enrollment Period..

ARTICLE III
ENROLLMENT PROCEDURES

3.1 In General

(a) Each Employee eligible to participate in the Plan may make an annual election to enroll in one of the medical programs offered under the Plan during the Enrollment Period for the Plan Year. The Enrollment Period dates will be determined annually and announced by the Company. Each Employee who becomes eligible to enroll in the Plan part way through a Plan Year shall elect whether to enroll in one of the medical and/or dental programs offered under the Plan for the balance of such Plan Year during the Enrollment Period prescribed by the Company. An eligible Employee who fails to make a proper enrollment election under the Plan will not receive coverage under the Plan and will not be eligible to enroll in the Plan until the next Enrollment Period, unless such Employee is eligible for an election change as described in Section 3.4.

(b) Each Employee who is inactive shall make an election to modify or revoke his enrollment in the medical programs offered under the Plan at the time such inactive status commences. An Employee who is inactive and fails to make an election under the Plan at the time such inactive status commences shall be deemed to have elected to continue his enrollment in the medical program in which he was enrolled at the time that his inactive status commenced. If an Employee who is inactive was not enrolled for coverage, or elects to waive coverage at the time that his inactive status commenced, such Employee may not elect coverage under the Plan until he returns to active employment with the Employer. An "inactive" Employee is an Employee who is on a Company-approved leave from employment with his Employer, or who is on furlough.

3.2 Forms and Procedures

The Company shall prescribe the enrollment procedures and may prescribe deadlines and other procedures for filing enrollment elections.

3.3 Revocation of Enrollment Election

Once an eligible Employee under Plan Section 3.1(a) has enrolled in one of the medical programs offered under the Plan or elected not to enroll in the Plan, that enrollment election cannot be revoked or modified during the Plan Year except as provided in Section 3.4 of the Plan.

Once an eligible inactive Employee under Plan Section 3.1(b) has elected to continue enrollment in the Plan or elected not to continue his enrollment in the Plan, that enrollment election cannot

be modified or revoked until such Employee returns to active status with the Employer except as provided in Section 3.4 of the Plan.

3.4 Election Changes

An enrollment election made by an eligible Employee may be revoked and a new enrollment election made after the beginning of the Plan Year for the balance of the Plan Year if both the revocation and the election are on account of and consistent with a change in status event described in this Section 3.4.

(a) *Change in Status.*

(i) Change in legal marital status including marriage, death of a spouse, divorce and annulment;

(ii) Change in the number of dependents, including birth, death, adoption, and placement for adoption;

(iii) Change in employment status, or the employment status of an Employee's spouse (or Domestic Partner) or Dependent, including termination or commencement of employment, strike or lockout, furlough, commencement of or return from an unpaid leave of absence, and a change from full-time to part-time status, or vice versa (a change in employment status that does not change the number of hours worked does not constitute a change in status);

(iv) Change which causes a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance; and

(v) Change in place of residence, or the place of residence of an Employee's spouse (or Domestic Partner) or Dependent.

(b) *Other Events.*

(i) An Employee or Dependent who is not enrolled under the Plan and declined coverage under the Plan because of coverage under another group health plan or individual coverage loses such coverage;

(ii) A judgment, decree, or order resulting form a divorce, legal separation, annulment, or change in legal custody that requires an Employee or an Employee's (former) spouse to provide health coverage to a Dependent child;

(iii) An Employee or an Employee's spouse (or Domestic Partner) or Dependent becomes entitled or loses entitlement to Medicare or Medicaid coverage; and

(iv) A significant curtailment of coverage resulting in the complete loss of coverage, including the elimination of a benefit option, or losing all coverage due to an overall lifetime limit or annual limitation.

ARTICLE IV
BENEFITS

4.1 Programs Offered Under the Plan

The following programs are offered under the Plan:

(a) Medical;

(b) Prescription Drug; and

(c) Mental Health and Chemical Dependency.

Enrollment in the medical program includes coverage under the prescription drug and mental health and chemical dependency programs. Employees must enroll their Dependents and Domestic Partners in the same programs in which the Employee is enrolled.

4.2 Benefits

Benefits under the Plan shall be provided in accordance with the terms of the program in which the Participant enrolls. The benefits under the medical, prescription drug, and mental health and chemical dependency programs are set forth in the Summary Plan Description for the Plan, which is incorporated by reference as described in Section 1.4.

4.3 Adjustment of Benefits

Benefits paid by the Plan shall be adjusted to reflect benefits paid by other plans so that the total amount of benefits paid to any Participant for any type of coverage shall not exceed the largest benefit payable under any single plan for such type of coverage. For this purpose, the term "other plans" includes, without limitation, policies and organizations that provide medical, hospitalization, surgical, and disability benefits, government programs, group insurance programs and on-fault automobile insurance.

4.4 Coordination Rules

In determining whether benefits payable under the Plan will be adjusted as provided in Section 4.3, the following rules for coordination with other plans will be applied. These rules are described in greater detail in the summary plan description for the Plan:

(a) A plan with no rules for coordination of benefits with other plans will be deemed to pay its benefits before a plan that contains such rules.

(b) A plan that covers a person other than as a dependent will be deemed to pay its benefits before a plan that covers a person as a dependent.

(c) Except in the case of a dependent child whose parents are separated or divorced, the plan that covers a person as a dependent of a participant whose birthday comes earlier in the calendar year will be deemed to pay its benefits before a plan that covers that person as a dependent of a participant whose birthday comes later in the calendar year. If both participants have the same birthday, the plan that covered one of the participants the longer will be deemed to pay its benefits first.

(d) In the case of a dependent child of separated or divorced parents:

If a court decree established financial responsibility for the medical, dental or other health care expenses for the child, the plan that covers the child as a dependent of the parent with the financial responsibility will be deemed to pay its benefit before any other plan that covers the child as a dependent child. Otherwise benefits for the dependent child will be deemed to be paid in this order:

(i) First, form the plan of the parent with custody of the child;

(ii) Then, from the plan of the spouse of the parent with the custody of child; and

(iii) Finally, from the plan of the parent not having custody of the child.

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child will be deemed to follow the rules in Paragraph (c).

(e) If a person is receiving continuation coverage under this Plan and is also covered under another plan, the following shall be the order of benefit determination:

(i) first, the benefits of a plan covering the person as an employee (or as the person's dependent); and

(ii) second, the benefits under the continuation coverage.

If the other group health plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(f) Provided the other plan has this rule, a plan that covers a person as an employee who is neither laid off nor retired (or covers that employee's dependent) will be deemed to pay its benefits before a plan that covers a laid off or retired employee (or covers that employee's dependent).

(g) If none of the above rules apply, a plan that has covered the person longer will be deemed to pay its benefits before a plan that has covered the person for a shorter term.

(h) If the preceding rules do not determine the order of benefits, expenses will be

shared equally between the plans. However, this Plan will not pay more than it would have paid had it been the primary plan.

The Plan may release or obtain from other plans any data needed to carry out these provisions or those of other plans. Claimants shall furnish such data upon request.

4.5 Coordination with Medicare

When a Participant or his Dependent is eligible for Medicare, this Plan will pay first for:

(a) an active Employee who is age 65 or over;

(b) an active Employee's Dependent age 65 and over;

(c) an active Employee's disabled Dependent under age 65; or

(d) the first 30-month period of treatment for end stage renal disease received by any Participant, beginning with the first month in which the Participant becomes entitled to Medicare or, if earlier, the first month that the Participant would have been entitled to Medicare had an application been filed for such benefits.

In situations other than the above, this Plan will pay second to Medicare when a Participant becomes eligible for Medicare, even if such Participant does not file an application for Medicare benefits.

4.6 Subrogation

Unless otherwise specified in an applicable insurance policy, this Section applies if another party is, or may be considered, liable for a Participant's injury, sickness, or other condition (including insurance carriers who are so financially liable).

(a) If this Section applies, the Plan will not cover either the reasonable value of the services to treat such an injury, sickness or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded. The Plan may, however, advance moneys or provide care for such an injury, sickness or other condition, and, if so, in consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Participant against any party liable for the Participant's injury, sickness, or other condition, or is or may be liable for the payment for the medical treatment of such injury, sickness or other condition (including any insurance carrier), in the amount of benefits advanced or provided by the Plan to the Participant. The Plan may assert this right independently of the Participant. This right includes, but is not limited to, the Participant's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners

or otherwise), workers' compensation coverage, or other insurance, as well as the Participant's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Participant, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion. If such moneys are advanced, as described in this Section, the Participant shall be considered the constructive trustee over these funds, and failure to hold such funds in trust will be deemed a breach of the Participant's fiduciary duty to the Plan.

(b) The Participant is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

(c) If the Participant enters into litigation or settlement negotiations regarding the obligations of other parties, the Participant must not prejudice, in any way, the subrogation rights of the Plan under this Section. If the Participant fails to cooperate as provided herein, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the amount of benefits advanced under this Section to the extent not recovered by the Plan.

(d) The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Participant shall be borne solely by the Participant.

4.7 Benefit Overpayments

The Plan shall have the right to recover from any Participant or former Participant the amount of any benefits paid by this Plan (i) for expenses incurred on behalf of a Participant which were not paid by the Participant and were not legally required to be paid by the Participant; (ii) which exceeded the amount of benefits payable under the Plan; or (iii) for expenses which were recovered from or paid by a source other than this Plan, as described above in Section 4.6. If the Participant or former Participant, or any other person or organization, does not repay to the Plan the amount of payment owed to the Plan in a lump sum within 30 days of receiving notice of such amount owing to the Plan, then notwithstanding any provision herein to the contrary and without limiting any other remedies available to the Plan, the Plan may reduce the amount of any benefits that become payable thereafter to or in respect of such Participant under the Plan to recover the amount of such benefits owed to the Plan.

4.8 COBRA Continuation of Coverage

If any benefit provided under this Plan that is subject to continuation coverage under Section 4980B of the Code becomes unavailable as the result of any qualifying event (as defined therein) each qualified beneficiary (as defined therein) shall be eligible to elect COBRA continuation coverage (as defined therein) under the Plan for the applicable period descried in Section 4980B of the Code. A qualified beneficiary (as defined therein) may elect COBRA continuation coverage under the Plan during the sixty (60) day period beginning on the later of the date his coverage terminates or the date he receives notice of his right to COBRA continuation coverage under the Plan; provided, however, that the qualified beneficiary shall be required to pay the applicable premium provided under Section 4980B of the Code.

4.9 Family and Medical Leave

In accordance with federal law, eligible Employees may take up to twelve weeks of Family and Medical Leave for any of the following:

(a) To care for a Dependent child following the birth, adoption, or placement or adoption or foster care of such child;

(b) To care for a seriously ill child, parent or spouse; or

(c) To recover from a serious illness.

If such Employee is a Participant in the Plan, the medical coverage in effect prior to the Family and Medical Leave for such Participant and his eligible Dependents shall continue, provided such Employee pays any applicable premiums, and returns to work at the end of the Family and Medical Leave. If the Employee does not return to work, the Company may require such Employee to reimburse the Company-paid portion of any premiums during the Family and Medical Leave.

ARTICLE V
ADMINISTRATION

5.1 Authority of the Company

The Company shall be the "administrator" for purposes of ERISA, and shall be responsible for the administration of the Plan. In addition to the power and authorities expressly conferred upon it in the Plan, the Administrator shall have all such powers and authorities as may be necessary to carry out provisions of the Plan, including but not limited to the power and authority:

(a) to control and manage the operation and administration of the Plan;

(b) to interpret and construe the provisions of the Plan and the summary plan description for the Plan, and all other Plan documents, in its sole and complete discretion, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) to make benefit determinations in its sole and complete discretion;

(d) to determine all questions relating to eligibility for benefits in its sole and complete discretion; and

(e) to resolve any disputes arising under the Plan.

The Company may employ such attorneys, agents, accountants and consultants as it may deem necessary or advisable to assist in carrying out its duties hereunder. The Company shall be the "named fiduciary" as that term is defined in Section 402(a)(2) of ERISA. The Company may, in writing, designate a person or persons other than the Company to carry out any of the powers, authority or responsibilities for the operation and administration of the Plan which are retained by it or granted to it by this Article, including, without limitation, the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claims, and the discretion to decide matters of fact and interpret Plan provisions. Upon such designation and acceptance, the Administrator shall have no liability for the acts or omissions of any such designee. All allocations and delegations of fiduciary responsibility shall be terminable upon such notice as the Administrator in its discretion deems reasonable and prudent, under the circumstances.

5.2 Actions of the Company

Any act authorized, permitted or required to be taken under the Plan by the Company and which has not been delegated in accordance with Section 5.1 of the Plan, may be taken by the appropriate officer of the Human Resources Department of the Company.

5.3 Examination of Records

The Company shall make available to each Participant such records under the Plan as pertain to the Participant as required or permitted by law, for examination at reasonable times during normal business hours.

5.4 Reliance on Data

In administering the Plan, the Company will be entitled to the extent permitted by the law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the Plan or by accountants, counsel or other experts employed or engaged by the Company.

5.5 Claims Review Procedure

If a Participant or any other individual (hereinafter referred to as the "Claimant") believes that he has been wrongfully denied benefits under this Plan, such claimant must follow the procedures as set forth herein. A claim for benefits must be submitted as required by the particular benefit program. No Claimant shall be entitled to benefits unless the Administrator (or its delegate, such as an administrator deciding claims under this Plan) determines in its discretion that the Claimant is entitled to benefits. The following claims procedures shall apply:

(a) *Initial Determination.* The Administrator shall notify a Claimant of the Plan's benefit determination as follows:

(1) Post-Service Claims. The Administrator shall notify the Claimant of the Plan's benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information and the period for making the benefit determination shall be tolled from the date on which the notice of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

(2) Pre-Service Claims. The Administrator shall notify the Claimant of the Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by

the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information and the period for making the benefit determination shall be tolled from the date on which the notice of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

(3) Urgent Care Claims. The Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information. In the case of such a failure, the Administrator shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of: (A) the Plan's receipt of the specified information, or (B) the end of the period afforded the Claimant to provide the specified additional information.

(4) Concurrent Care Claims. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable timeframes for pre-service, urgent care or post-service claims.

(b) *Notice of Denial.* If the claim is denied in whole or in part, the Claimant will receive a written notice setting forth, in a manner calculated to be understood by the Claimant: (a) the specific reason or reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a description of any

additional material or information needed from the Claimant in connection with the claim and the reason such material or information is needed; (d) an explanation of the claims review procedures and the applicable time limits, including a statement concerning the Claimant's right to bring a civil action under ERISA § 502(a)(1)(B) following an adverse determination on review; (e) a statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request); (f) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request); and (g) if the claim is an urgent care claim, a description of the expedited review process applicable to such claims. Additionally, the written notice will also include (a) information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount, if applicable; (b) the denial code and its meaning; (c) a description of the Plan's standard for denying the claim; (d) information regarding available internal and external appeals, including how to initiate an appeal; and (e) the availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with internal and external appeals processes.

In the case of an urgent care claim, the notice of the benefit determination may be made orally, provided that a written notification is furnished to the Claimant not later than three days after the oral notification.

(c) *Right to Request Review: Internal ERISA Appeal.* Except for urgent claims, a Claimant will be entitled to two levels of appeal of any initial claims denial. For urgent claims, a Claimant will be entitled to one level of appeal under an expedited timeframe. The Claimant must make a written request for review to the Administrator within 180 days of the initial denial of the claim. If a written request for review is not made within such 180 day period, the Claimant shall forfeit his or her right to review. If the denial is upheld on the first level of appeal, the Claimant will have 30 calendar days to file a second request for appeal. For non-urgent claims, the Claimant is required to complete a second level of appeal before submitting a request for external Review or a claim in court. The Claimant's written request for review may (but is not required to) include issues, comments, documents, and other records the Claimant wants considered in the review. All the information the Claimant submits will be taken into account on review, even if it was not reviewed as part of the initial decision. No deference will be given to the initial decision. The Claimant may ask to examine or receive free copies of all pertinent Plan documents, records, and other information relevant to the claim by asking the Administrator. Additionally, the Plan will provide the Claimant with any new or additional evidence or rationale considered in connection with the claim sufficiently in advance of the appeals determination date to give the Claimant a reasonable opportunity to respond.

The Claimant will be given the identity of medical or vocational experts if requested, whose advice was obtained by the Plan in connection with the Claimant's initial claim denial, if any, even if their advice was not relied upon in making the initial decision. Where an adverse determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan will consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide the Claimant's appeal. The Administrator may, in its discretion, hold one or more hearings. The Claimant may, at the Claimant's own expense, have an attorney or other representative act on the Claimant's behalf, but the Administrator requires a written authorization. The Administrator reserves the right to delegate its authority to make decisions.

In the case of an urgent care claim, the Claimant may provide a request for an expedited appeal of an adverse benefit determination either orally or in writing and all necessary information, including the Plan's benefit determination on review, shall be transmitted by telephone, facsimile, or other available similarly expeditious method.

(d) *Decision Upon Review: Internal ERISA Appeal.* The Administrator shall notify a Claimant of the Plan's benefit determination on review as follows:

(1) Post-Service Claims. The Administrator shall notify the Claimant of the Plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than 60 days after receipt by the Plan of the Claimant's request for review of the adverse determination.

(2) Pre-Service Claims. The Administrator shall notify the Claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Plan of the Claimant's request for review of the adverse determination.

(3) Urgent Care Claims. The Administrator shall notify the Claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt by the Plan of the Claimant's request for review of the adverse determination.

(4) Concurrent Care Claims. The Administrator shall notify the Claimant of the Plan's decision to reduce or terminate an initially-approved course of treatment before the proposed reduction or termination takes place. The Administrator shall decide the appeal of a denied request to extend a concurrent care decision in the

appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

(e) *Notice of Denial of Internal ERISA Appeal.* If the decision on the ERISA appeal is denied, the Claimant will receive a written notice setting forth, in a manner calculated to be understood by the Claimant: (a) the specific reason or reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits; (d) a statement explaining the voluntary appeal procedures offered by the Plan and the Claimant's right to bring a civil action under ERISA § 502(a)(1)(B); (e) a statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request); and (f) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request). Additionally, the written notice also will include: (a) information sufficient to identify the claim involved, including the date of service, and health care provider, claim amount, if applicable; (b) the denial code and its meaning; (c) a description of the Plan's standards for denying a claim; (d) information regarding availability of internal and external appeals, including how to initiate an appeal; and (e)the availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals processes.

Notification of denial of the ERISA appeal of an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

(f) *External Appeal Process.* If a Claimant's internal appeal for benefits under the Plan is denied, the Claimant may choose to further appeal the claim pursuant to independent external review process established under the Patient Protection and Affordable Care Act. The external appeal will be conducted by an independent review organization not affiliated with the Plan. The independent review organization may overturn the Plan's decision, and the independent review organization's decision will be binding on the Plan. A Claimant must file a claim for external review within four (4) months of the date the Claimant receives the internal appeal denial notice. Filing a request for external review will not affect a Claimant's ability to bring a legal claim in court. When a Claimant files a request for external review, the Claimant will be required to authorize release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

5.6 Indemnification

In addition to whatever rights of indemnification any member of the board of directors or any employee of the Employer who is acting within the scope of his employment and who is acting on behalf of the Employer pursuant to any power, authority or responsibility of the Company under Section 5.1 of the Plan may be entitled under the articles of incorporation of the Employer, under any provisions of law, or under any other agreement, the Employer shall satisfy any liability actually and reasonably incurred by any such person, including expenses, attorneys' fees, judgments, fines, and amounts paid in settlement (other than amounts paid in settlement not approved by the Company), in connection with any threatened, pending or completed action, suit or proceeding which is related to the exercising or failure to exercise by such person of any of the powers, authority, or responsibilities of the Employer under the Plan, or reasonably believed by such person to be exercised in connection therewith, unless the same is judicially determined to be the result of such person's gross negligence or willful misconduct.

ARTICLE VI
FUNDING

6.1 Funding Benefits

Benefits under the Plan shall be paid from the general assets of the Employer, provided through a group contract with an insurance carrier or health maintenance organization as determined by the Company and/or provided through a trust established by the Employer. The Company shall have the sole right to select the trustee, insurance company and/or health maintenance organization and to remove the trustee, insurance company and/or health maintenance organization and select a successor and to determine the form and terms of all applicable agreements and contracts. To the extent provided by the Employer's corporate policy, the Employer may require contributions from Participants. In the event any benefit is to be provided, in whole or in part, through a group contract with one or more insurance companies and/or health maintenance organizations, the Employer shall remit to such insurance companies and/or health maintenance organizations as premium payments its contributions and any Participant contributions in respect of such benefits, as appropriate.

6.2 No Liability for Benefits

Notwithstanding any other provision of the Plan, neither the Employer nor the Plan shall have any liability to provide any benefit that is to be provided through any insurance contract or health maintenance organization contract in the event that such benefit is not paid or otherwise provided by the issuer of such contract.

ARTICLE VII
AMENDMENT AND TERMINATION

7.1 Amendment

The Company may at any time, and from time to time, amend the Plan by written instrument executed by an officer of the Company. This reservation of the right to amend benefits applies to benefits for current Employees and their Dependents and also to retired or terminated employees and their survivors or Dependents. Nothing in this document or other communication from the Company shall be deemed to create or imply a continuing obligation by the Company to provide or fund benefits to current Employees or their Dependents or survivors, or retired or terminated Employees or their Dependents or survivors.

7.2 Termination

The Company reserves the right to terminate the Plan at any time. On or after the effective date of the termination, no further benefits hereunder shall be payable to or on behalf of any Participant as to whom such termination applies.

ARTICLE VIII
MISCELLANEOUS

8.1 No Commitment to Employment

Nothing herein shall be construed as a commitment or agreement upon the part of any person to continue his employment with the Employer, and nothing herein contained shall be construed as a commitment on the part of the Employer to continue the employment or rate of compensation of any person for any period, and all employees of the Employer shall remain subject to discharge to the same extent as if the Plan had never been put into effect.

8.2 Claims

The provisions of the Plan in no event shall be construed as giving any employee or any other person, firm, or corporation, any legal or equitable right as against the Employer, its officers, employees, or trustees, except such rights as are provided in accordance with the terms and provisions of the Plan.

8.3 No Precedent

Except as otherwise specifically provided, no action taken in accordance with the provisions of the Plan by the Administrator or the Employer shall be construed or relied upon as a precedent for similar action under similar circumstances.

8.4 Expenses

To the extent they are not paid by the Company, the Plan may pay any reasonable expenses incident to the administration of the Plan, including the compensation of legal counsel, advisors, other technical or clerical assistance as may be required, the payment of any bond or security, and any other expenses incidental to the operation of the Plan that the Administrator determines, in its sole discretion, are proper. The Company may advance amounts properly chargeable to the Plan and then obtain reimbursement from the Plan for these advances (without interest).

8.5 Governing Law

Except as may be governed under ERISA or other federal law, the provisions of the Plan shall be governed by and construed in accordance with the laws of the Commonwealth of Virginia. The invalidity or illegality of any provision of the Plan shall not affect the validity or legality of any other part hereof. The rights of eligible persons under the Plan are legally enforceable.

8.6 Severability

If a provision of the Plan is held illegal or invalid, the illegality or invalidity does not affect the remaining parts of the Plan and the Plan must be construed and enforced as if the illegal or invalid provision had not been included in the Plan.

8.7 No Vested Right to Benefits

No Participant or person claiming through such Participant shall have any right to, or interest in, any benefits provided under the Plan upon termination of his employment, retirement, termination of Plan participation, or otherwise, except as specifically provided under the Plan.

ARTICLE IX
PRIVACY

9.1 Purpose

The privacy standards for individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rule"), 45 C.F.R. Parts 160 and 164, requires that group health plans amend their plan documents to establish the permitted and required uses and disclosures of protected health information. This Article is intended to meet such requirement as set forth under § 164.504(f) of the Privacy Rule.

9.2 Definitions

For purposes of this Article, the following terms have the following meanings, as defined in the Standards for Privacy of Individually Identifiable Health Information.

"Authorization" shall mean an individual's written permission for the use or disclosure of his or her protected health information for activities that are not payment or health care operations.

"Business associate" shall mean an entity or person who performs or assists in performing a function or activity on behalf of the Plan involving the use or disclosure of protected health information.

"Health care operations" shall mean the following types of activities to the extent that they are related to administering the Plan: (i) conducting or arranging for legal services, auditing functions, or medical review; (ii) underwriting and premium rating; (iii) reviewing health plan performance; (iv) business planning and development; (v) business management and general administrative activities; and (vi) conducting quality assessment and improvement activities.

"Individual" shall mean the person who is the subject of the protected health information.

"Payment" shall mean an activity undertaken by the Plan to determine or fulfill responsibilities for providing benefits under the Plan or to obtain or provide reimbursement for health care. Payment activities include (i) billing, claims management, collection activities, obtaining payment under a contact for reinsurance (including stop-loss insurance and excess loss insurance), and related health care data processing; (ii) review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; (iii) eligibility and coverage determinations including coordination of benefits and adjudication or subrogation of health benefit claims; (iv) utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services; (v) risk adjusting based on enrollee status and demographic characteristics.

"Plan sponsor" shall mean US Airways, Inc. in its role as Administrator of the Plan.

"Protected health information" shall mean information that is created or received by the Plan and relates to the past, present, or 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; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information about persons living or deceased wither in electronic, printed or spoken form.

"Secretary" shall mean the Secretary of the Department of Health and Human Services.

9.3 Use and Disclosure of Protected Health Information

(a) Uses and disclosures related to payment and health care operations. The Plan and its business associates may use or disclose an individual's protected health information for activities related to payment or health care operations without such individual's authorization.

(b) Required disclosures. The Plan may use or disclose an individual's protected health information to other persons or organizations without such individual's authorization under the following circumstances:

(i) *Disclosures for Public Health Activities.*

(1) Public Health Authorities: The Plan may disclose protected health information to public health authorities who need the information to prevent or control disease, injury, or disability or handle situations where children are abused or neglected.

(2) Food and Drug Administration (FDA): The Plan may disclose protected health information when there are problems with a product that is regulated by the FDA.

(3) Communicable Diseases: The Plan may disclose protected health information to a person who has been exposed to a communicable disease or may be at risk of spreading or contracting a disease or condition.

(4) Employment-Related Situations: The Plan may disclose protected health information to an employer when the employer is allowed by law to have that information for work-related reasons. The Plan may also disclose protected health information for workers' compensation programs.

(ii) *Disclosures for Judicial or Administrative Proceedings.* The Plan may disclose protected health information in a court or other type of legal proceeding if it is requested through a legal process, such as a court order or a subpoena.

(iii) *Disclosures for Health Care Oversight.* The Plan may disclose protected health information so the government agencies can monitor or oversee the health care system and government benefit programs and be sure that certain health care entities are following regulatory programs or civil rights laws as required.

(iv) *Disclosures About Victims of Abuse, Neglect, or Domestic Violence.* The Plan may disclose protected health information to appropriate authorities if there is reason to believe that a person has been a victim of abuse, neglect, or domestic violence.

(v) *Disclosures for Law Enforcement Purposes.* The Plan may disclose protected health information to law enforcement if it is required by law; if needed to help identify or locate a suspect, fugitive, material witness, or missing person; if it is about an individual who is or is suspected to be the victim of a crime; if there is reason to believe that a death may have resulted form criminal conduct; or if there is reason to believe that the information is evidence that criminal conduct occurred on the Company's premises.

(vi) *Uses or Disclosures to Avert Serious Threat to Health or Safety.* The Plan may use or disclose protected health information to appropriate persons or authorities if the Plan has reason to believe it is needed to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

(vii) *Uses or Disclosures in Situations Involving Decedents.* The Plan may use or disclose protected health information to coroners, medical examiners, or funeral directors so that they can carry out their responsibilities.

(viii) *Uses or Disclosures Related to Organ Donation.* The Plan may use or disclose protected health information to organizations involved in organ donation or organ transplants.

(ix) *Uses or Disclosures Relating to Research.* The Plan may use or disclose protected health information for research purposes if the privacy of the information will be protected in the research.

(x) *Uses or Disclosures Related to Specialized Government Funcitons.* The Plan may use or disclose protected health information to the federal government for military purposes and activities, national security and intelligence, or so it can provide protective services to the U.S. President or other official persons.

(xi) *Uses or Disclosures for Law Enforcement Custodial Situations.* The Plan may use or disclose protected health information about a person in a prison or other law enforcement custody situation for health, safety, and security reasons.

(c) Uses and disclosures Requiring Authorization. In any other situation that is not set forth under Sections 9.3(a) or (b) above, the Plan must obtain an authorization from an individual before using or disclosing such individual's protected health information.

(d) Other uses and disclosures. An individual's protected health information may be disclosed to the Plan Sponsor for purposes of administering the Plan.

9.4 Obligations of the Plan Sponsor

The Plan Sponsor agrees:

(a) Not to use or further disclose an individual's protected health information other than as permitted or required by the Plan or as required under the Privacy Rule;

(b) To ensure that any agents, including subcontractors, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(c) Not to use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(d) To report to the Plan any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) To make protected health information available for access in accordance with § 164.524 of the Privacy Rule and its implementing regulations;

(f) To make protected health information available for amendment and incorporate any amendments to protected health information in accordance with § 164.526 of the Privacy Rule and its implementing regulations;

(g) To make available the information required to provide an accounting of disclosures in accordance with § 164.528 of the Privacy Rule and its implementing regulations;

(h) To make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the

Secretary for purposes of determining compliance by the Plan with the Privacy Rule and its implementing regulations; and

(i) To, if feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

9.5 Adequate Separation between the Plan and Plan Sponsor

In order to ensure that there is adequate separation between the Plan and the Plan Sponsor in accordance with § 164.504(f) of the Privacy Rule, the following classes of employees of the Company under the control of the Plan Sponsor may be given access to protected health information received from the Plan or business associate servicing the Plan: Benefits Administration, Benefits Strategy & Design; Payroll; Finance; and Legal (collectively referred to as the "Workforce").

(a) The Workforce shall be the only class of employees who may receive protected health information relating to payment, health care operations, or other matters pertaining to the Plan in the ordinary course of business.

(b) The Workforce shall have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

(c) The Workforce shall be subject to disciplinary action and sanctions, up to and including termination of employment or affiliation with the Plan Sponsor for any use or disclosure of protected health information in noncompliance with the provisions of the Plan. The Plan Sponsor shall impose appropriate disciplinary action or sanctions on each member of the Workforce causing the noncompliance and will work to mitigate any deleterious effect of the noncompliance on any individual whose protected health information is the subject of such noncompliance.

ARTICLE X
SECURITY

10.1 Safeguarding Electronic Information

To comply with the Security Standards and Implementation Specifications issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Security Rule"), the Company will reasonably and appropriately safeguard electronic protected health information created, received, maintained or transmitted to or by the Company on behalf of the Plan.

10.2 Implementation Standards

The Company will take the following action to implement the HIPAA Security Rule:

(a) 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;

(b) Ensure that the adequate separation required by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom the Company provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which the Company becomes aware.

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EXECUTED, at Tempe, Arizona this 15th day of December, 2011.

US AIRWAYS, INC.

By: _____

Elise Eberwein
Executive Vice President,
People & Communications