SUMMARY OF MATERIAL MODIFICATIONS FOR THE
US AIRWAYS, INC. HEALTH BENEFIT PLAN
EIN/PN: 53-0218143/501

Section 104 of the Employee Retirement Income Security Act of 1974 ("ERISA") directs the administrator of an ERISA-covered plan to furnish to participants (and beneficiaries receiving benefits under the plan) a summary of any material modifications to the plan (the "SMM") within 210 days following the plan year in which the change was adopted. This summary describes certain changes to the US Airways, Inc. Health Benefit Plan (the "Plan"). This SMM modifies the Summary Plan Description (the "SPD"), revised as of January 1, 2013. You should keep this SMM with the SPD you previously received for future reference.

The following changes to the SPD are **effective January 1, 2014**, unless otherwise indicated:

ABOUT YOUR PARTICIPATION – ACTIVE EMPLOYEES (SPD, Pages 1-14)

Eligibility for YOU (SPD, Page 1)

Effective January 1, 2014, replace the first bullet with the following:

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

- An active, full-time or part-time employee of the US Airways, Inc. with a work base in the United States, but excluding (i) a pilot listed on the Pilots System Seniority List that is domiciled in Phoenix, Arizona and (ii) any temporary, on-call or seasonal employees; or

Eligibility for Your Dependents (SPD, Pages 2-3)

Effective January 1, 2014, replace this section in its entirety with the following:

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

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

- Your children who are age 26 and under at any time in a calendar year. However, for Plan years beginning before January 1, 2014, adult dependent children (dependent children age 19 through age 26), are not eligible for coverage under the Plan if they are eligible to enroll in health coverage sponsored by the adult dependent's employer;

- The children of your Spouse or domestic partner who are age 26 and under at any time in a calendar year, even if you do not elect coverage for your domestic partner. However, for Plan years beginning before January 1, 2014, adult dependent children (dependent children age 19 through age 26), are not eligible for coverage under the Plan if they are eligible to enroll in health coverage sponsored by the adult dependent's employer; a6nd

- The unmarried children of you, your Spouse or your domestic partner following the calendar year in which they attain age 26 who are not self-supporting because of a permanent physical, or mental disability and are dependent upon you, as defined by the Internal Revenue Code for income tax purposes, provided that such children were physically or mentally disabled and covered by the Plan on the day before the end of the calendar year in which they attained age 26. Any child who satisfies these conditions will continue to be eligible for coverage as long as the disability remains. The Plan Administrator may require documentation

that confirms such child's ongoing disability. "Disability" for dependent eligibility purposes will have the meaning used by the Internal Revenue Service for income tax purposes.

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

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

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

Domestic Partners (SPD, Page 3)

Effective September 16, 2013, clarify that a domestic partner may not be married to a participant by replacing the second bullet under the definition of domestic partner with the following:

- Not married to anyone, and has dissolved any prior marriages through death or divorce.

Domestic Partners (SPD, Page 4)

Effective September 16, 2013, delete the first bullet designating a marriage certificate as a category of documentation to validate a domestic partnership.

If You and Your Spouse (or Domestic Partner) Both Work for the Company (SPD, Page 5)

This clarification, effective January 1, 2013, replaces the title and introduction with the following:

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

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

Paying for Coverage for Domestic Partners and Their Children (SPD, Pages 7-8)

This section is amended, effective September 16, 2013, to clarify the treatment of same-sex Spouses under federal law and the laws of certain states for purposes of state income tax by adding a paragraph to the end of this section, as follows.

A same-sex Spouse will be treated as a Spouse for federal income tax purposes, which means that an active employee may pay for such coverage with pre-tax dollars, and no income will be imputed to an employee or retiree for that coverage or treated as taxable for federal tax purposes. However, state tax treatment of coverage provided to same-sex Spouses may differ. Where required, the Company will impute the value of coverage for a same-sex Spouse to the employee or retiree for state tax purposes.

If You Go to Work for Another Employer (SPD, Page14)

Effective for plan years on or after January 1, 2014, group health plans may no longer impose pre-existing condition exclusions. Therefore, the paragraphs under the title "If you Go to Work for Another Employer," which primarily describe certain rules relating to the pre-existing condition exclusion are deleted in their entirety.

Medical Services Covered Under the Plan (SPD, Page 33)

Gender Reassignment Benefit (GRB)

For information on Company policies about transgender issues, refer to the Employee Handbook located on Wings.
The Gender Reassignment Benefit (GRB) provides coverage due to Gender Identity Disorder under the US Airways Inc. Health Benefit Plan, US Airways Inc. Health Options Plan and US Airways Inc. Health Care Plan for PHX based Pilots effective 1/1/2014.
This benefit is available to active employees and retirees. This benefit is not available to spouses, Company-recognized Domestic Partners and other eligible dependents.
The GRB **only** offers benefits on an in-network basis.
The GRB offers a $75,000 surgical benefit and a $10,000 travel reimbursement for the entire time the employee/retiree is covered under a US Airways Inc. or American Airlines Group medical Option.

- If you change Network/Claims Administrators, any balances incurred as a member under your previous Network/Claims Administrator will carry over to your new Network/Claims Administrator
- If you receive the GRB while covered under a US Airways sponsored medical option and later become covered under an American Airlines sponsored medical option, then the amount of benefits provided are deducted from your available GRB under the American Airlines sponsored medical benefit.

Preauthorization for the GRB

You must have approval from the Network/Claims Administrator both at the time you begin your treatment and at the time you are admitted for surgery.

Failure to obtain preauthorization both at the time you begin treatment and at the time you are admitted for surgery will result in denial of your claims.

Each Network/Claims Administrator has board certified providers and facilities available in-network.

GRB Coverage

The Plan pays the following benefits in-network:

- Continuous hormone replacement (hormones of the desired gender), including laboratory testing to monitor the safety of continuous hormone therapy.
- Evaluation and diagnosis by a psychological professional and psychotherapy, as set forth in standard treatment protocols.
- Genital revision surgery and bilateral mastectomy or bilateral augmentation mammoplasty, as applicable to the desired gender.
- Any co-insurance or co-payments amounts for in-network medical visits and prescription drugs do not accumulate toward the $75,000.
- Prescription drugs and mental health treatment associated with the GRB are considered under the medical option's behavioral and mental health and prescription drug provisions; subject to applicable provisions, limitations and exclusions.

Surgical Benefit In-Network

Surgical benefits are limited to one bilateral mastectomy or bilateral augmentation mammoplasty, and one genital revision surgery for the entire time the employee/retiree is covered under the Standard Option as an active employee or the Retiree Standard Medical Option.
Subsequent surgical revisions, modifications or reversals are excluded from coverage.

Consideration for benefits is guided by the most current standards of care as published by the World Professional Association for Transgender Health (WPATH) and by the provisions, limitations and exclusions as set forth by the medical options.

Travel Reimbursement

Gender reassignment surgery is performed at limited locations in the United States, and most patients will need to travel outside their immediate home area.
If travel is required for surgery because it is not offered in your immediate home area, travel to an in-network surgery provider and lodging expenses will be reimbursed up to a maximum of $10,000, regardless of your Network/Claims Administrator, even if you change administrators.
To be eligible for reimbursement, travel must be:

- over 100 miles away from your home
- be by air, rail, bus or car
- to an in-network provider within the 48 contiguous United States

The $10,000 covers you and one caretaker to travel with you for in-network surgery only.
Lodging expenses for you and your caretaker include: hotel or motel room, car rental, tips and cost of meals while you are not hospitalized. Your caretaker's meals while you are hospitalized are included.
Itemized receipts will be required by your Network/Claims Administrator. Contact your Network/Claims Administrator for instructions on receiving reimbursement for your expenses.

YOUR VOLUNTARY LONG-TERM CARE PLAN (SPD, Page 65)

This plan is closed to new entrants effective September 30, 2013.

RETIREE HEALTH COVERAGE (SPD, Pages 68-73)

Making Changes After Retirement (SPD, Pages 69-70)

This clarification, effective January 1, 2013, replaces the second item in the *In the Event of* column with the following:

You (if you Retired Prior to March 1, 2005 and retain access to post-65 benefits) or your Spouse attaining age 65 *Coverage Effective Date is the first of the month following attainment of age 65*	▪ May change coverage option. ▪ May not increase coverage level. ▪ May decrease or drop coverage at any time.

ADDITIONAL RULES THAT APPLY TO YOUR PLAN (SPD, Pages 74-79)

Subrogation and Reimbursement (SPD, Pages 74-76)

Effective January 1, 2014, replace this section with the following:

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 Plan has the right to subrogate 100% of the benefits paid or to be paid on your behalf.

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. The Plan has the right to 100% reimbursement in a lump sum and has the right to recover interest on the amount paid by the Plan because of the actions of a 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 the Plan is not

responsible for your attorney's fees, expenses and costs. The Plan is not subject to any state laws or equitable doctrines, including but not limited to the so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine." which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs,.

- 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 doctrine or state law shall limit or defeat 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.

QUALIFYING EVENTS FOR CONTIUATION COVERAGE UNDER FEDERAL LAW (COBRA) (SPD, Pages 80-84)

Continuation of Coverage for Retirees (SPD, Page 84)

This clarification, effective January 1, 2013, replaces sentence two with the following:

However, the Spouse or Dependent of a Retiree who is covered under the Access Plan at the date of the Retiree's retirement may incur a subsequent Qualifying Event when there is a divorce or death of the retiree, or when an eligible Dependent ceases to be eligible for benefits under the Plan, for example, when he or she attains age 26, **but only if the Qualifying Event occurs while the retiree remains eligible for coverage under the Access Plan (ie, prior to the retiree turning age 65).**

HOW TO CONTACT YOUR CLAIMS ADMINISTRATORS/CLAIMS FIDUCIARIES (SPD, Page 91)

Effective January 1, 2014, replace the MetLife contact information with the following:

MetLife (dental benefits)	1-888-651-9127	www.metlife.com/mybenefits

PLAN ADMINISTRATION (SPD, Pages 92-96)

Organizations Providing Administrative Services under the Plan (SPD, Page 94)

Effective January 1, 2014, replace the MetLife contact information with the following:

Dental	MetLife Insurance Company P.O. Box 981282 El Paso, TX 79998-1282 1-888-651-9127 http://www.metlife.com/mybenefits

Glossary (SPD, Page 103)

Effective September 16, 2013, the definition of spouse is replaced in its entirety with the following:

Spouse - For the purpose of this Plan, a Spouse is defined as a person who is married to an enrolled employee or retiree under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction such marriage, as evidenced by a valid marriage certificate.

For Additional Information

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