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Welcome to Spirit AeroSystems **Benefits Enrollment!**

Information about Medicare Part D Creditable Coverage

If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see [Legal Notices](#) for more details.

This guide includes information about your [benefit options](#) and how to select the best benefits for your personal situation. Use this online guide to learn about our comprehensive, competitive benefits and to enroll for benefits that will best meet your needs.

Annual Enrollment

For information about 2011/2012 Annual Enrollment, including **what's new** and **when to enroll**, review the [Annual Enrollment](#) section of this guide, which is located under the [Important Benefits Info](#) tab.

New Hires

To learn about the 2011/2012 benefit programs available to you, including **when to enroll** and **who's eligible**, review this guide. The [New Hire](#) section, which is located under the [Important Benefits Info](#) tab, has important information that you should be aware of before enrolling.

Here's an overview of [how to use this guide](#).

[CLICK](#)

This benefit guide provides an overview of Spirit's benefits for eligible employees. Complete details of various plans in the program are found in the legal plan documents/Summary Plan Descriptions (SPDs) and insurance contracts that govern the plans. If there is a difference between this information and the documents and contracts, the documents and contracts will govern. Spirit reserves the right to amend the plan or any part of the plan at any time.

To view the Summary Plan Descriptions from the **Spirit Intranet**, under **Human Resources** on the left side of the screen, click on **myHR Home Page**. Then, under **Benefits** on the left side of the screen, click on **Summary Plan Descriptions (SPDs)**. Select the appropriate SPD.

SPEEA/WEU bargaining unit Employees
2011/2012

November 2011

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THERE ARE TWO WAYS YOU CAN USE THIS GUIDE:

1. Click on **the links** throughout this guide to skip to the information you're interested in, like a website.

Click on the "Navigation Tabs" to go to a specific part of the guide.

Use the links within the text of each section to access more information or link directly to an external website. You'll see these links as blue, bold text.

Use the search feature to find what you need.

OR

2. Read this guide page-by-page, like a printed document.

Click on "Previous" and "Next" at the bottom of each page to move forward or backward through the guide.

Print a page, section or the entire guide.

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Important Benefits Information for Annual Enrollment

Annual Enrollment is **May 2 - 13, 2011**. That means you must submit any benefit elections or changes online by **midnight Central time on May 13, 2011**. Telephone elections must be submitted by 5 p.m. Central time. Elections you make during Annual Enrollment will be effective from July 1, 2011 - June 30, 2012.

IMPORTANT THINGS TO KNOW ABOUT YOUR 2011/2012 BENEFITS

There are four things you should be aware of:

- 1.** No enrollment guide will be mailed to your home; this online guide is your source for enrollment information. To view your current coverages and costs, and to make changes for the 2011/2012 benefit year, access the [Spirit AeroSystems Benefits Center](#). Enter your Social Security number and PIN, **which has been reset to the last four digits of your Social Security number**. Once you log in, you will be required to change your PIN. If you've forgotten your PIN, click on **"Forgotten Pin? Click here to reset your PIN"** or call the Spirit AeroSystems Benefits Center at 1-877-459-3345.
- 2.** **Benefits Center call hours.** The Spirit AeroSystems Benefits Center will be available to take your elections and answer questions during the Annual Enrollment period **May 2 - 13**, by calling **1-877-459-3345** Monday through Friday, 8 a.m. to 5 p.m. Central time.
- 3.** **Confirmation of elections.** After the Annual Enrollment period has ended, you will receive a link to view your 2011/2012 elections online. A courtesy copy of your confirmation statement will also be mailed to your home. **Review your elections carefully** to be sure they reflect the plans and coverage levels you want. Those employees that actively made an election during Annual Enrollment will have from May 23 - 27 to make corrections by **calling** the Spirit AeroSystems Benefits Center at **1-877-459-3345**.
- 4.** There are a number of **changes** for the 2011/2012 plan year.

New Hire?

Are you a new hire and need enrollment and eligibility information? **New Hire and Who's Eligible** will help.

Questions?

If you have questions or need assistance with enrollment. . .

- Call the Spirit AeroSystems Benefits Center at **1-877-459-3345**

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2011/2012 Plan Updates and Reminders

Eligibility

- **Dependent coverage extended to age 26** — you and/or your spouse's/same-gender domestic partner's children will be eligible for medical coverage until the end of the month in which they turn age 26. You may be asked periodically to show proof of dependent eligibility.

Medical


- **Unlimited preventive care benefits** — there are no limits on preventive care services.
- **Eliminating the lifetime maximum on medical benefits** — there will no longer be a lifetime maximum limit on benefits in the Coordinated Care (Core) Plan and Consumer Directed (Enhanced) Plan.
- **Therapy changes** — inpatient and outpatient rehabilitation services, such as physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation will no longer have a per benefit year limitation. Rehabilitation services are covered only if they are expected to result in significant improvement in the covered person's condition. PHS will determine whether significant improvement has, or is likely to occur based upon the medical information received from the physician. Some exclusions apply.
- **Comprehensive hearing exams now covered** — preventive hearing exams are still covered every three benefit years; a comprehensive hearing exam is covered at the same level as any other benefit.

Do I Need to Enroll?

You only need to enroll if you're:

- **Making changes** to your benefit plans,
- **Adding or dropping dependents, or**
- **Going to contribute to the Health Care or Dependent Day Care Flexible Spending Accounts (FSAs).**

Your 2010/2011 FSA contribution elections will not carry over to the 2011/2012 benefit period. If no action is taken during Annual Enrollment, you will not be able to make changes during the May 23 - 27, 2011 correction period.

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Health Care FSA

- **Over-the-counter medications (except insulin/diabetic supplies and a few other items) are no longer eligible for Health Care FSA reimbursement** — unless you have a written prescription from your doctor.

Life and Disability Insurance

- **New vendor** — The Hartford; your coverage and premium will remain the same, unless you make changes during the enrollment period or have had a birthday in the past year that moves you to the next Life Insurance premium category.

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Important Benefits Information for New Hires

YOUR SPIRIT AEROSYSTEMS BENEFITS

As a Spirit AeroSystems employee, you have access to a wide variety of high-quality plans and programs to help meet your health, wealth, worklife, and career needs.

New Hire Enrollment Deadline

You must enroll within 30 days from your hire date. If you don't enroll within 30 days of your hire date, you will be automatically enrolled in employee-only coverage in the **PHS Consumer Directed (Enhanced) Plan** medical option with no dental plan coverage. Coverage is effective as of your hire date.

IMPORTANT THINGS TO KNOW ABOUT YOUR 2011/2012 BENEFITS

There are six things you should be aware of:

- 1. Enroll.** You can enroll online or by phone. To enroll online, log in to www.myspiritbenefits.mercerhrs.com and enter your SSN and your PIN. When you log in the first time, your PIN is the last four digits of your SSN. To enroll by phone, call the Spirit AeroSystems Benefits Center at 1-877-459-3345. The Benefits Center is available to take your elections and answer questions Monday through Friday, 8 a.m. to 5 p.m. Central time.
- 2. Confirmation statements mailed.** After enrollment, your confirmation statement will be mailed to your address on record. **Review the statement carefully** to be sure it reflects the plans and coverage levels you want. You will have 15 days from the date of the confirmation statement to make corrections by *calling* the Spirit AeroSystems Benefits Center at **1-877-459-3345**.
- 3. Monthly Contributions.** Spirit pays the majority of the premium costs for benefits. Your portion of the premiums will be deducted from the first and second paychecks of each month. In months with three pay periods, there will be no deduction taken from the third paycheck. Premiums for medical and dental benefits, plus the deduction for the flexible spending accounts, will be taken on a pre-tax basis. Supplemental benefit contributions, such as supplemental life insurance deductions, are taken on an after-tax basis.

No Pre-existing Condition Waiting Period

There is no pre-existing condition waiting period for health care coverage.

Questions?

If you have questions or need assistance with enrollment. . .

- Call the Spirit AeroSystems Benefits Center at **1-877-459-3345**

4. Covering a Spirit-employed spouse/child on a health and welfare benefit plan. If your spouse already works for Spirit, you may choose separate coverage or have coverage for the family through either you or your spouse.

- Two Spirit employees (spouses or parent/child) cannot be covered as an employee **and** as a dependent under each others' Medical, Dental, Supplemental Spouse Life, or Accidental Death and Dismemberment (AD&D) insurance.
- You or your spouse (but not both of you) can elect to cover eligible dependent children under Medical, Dental, and Child Life insurance.

5. Waiving Spirit health plans. If you waive Spirit's medical insurance as a new employee, you must do so within 30 days of your hire date. Otherwise, you will be automatically enrolled in employee-only coverage in the **PHS Consumer Directed (Enhanced) Plan** medical option with no dental plan coverage. Employees who waive coverage will be required to certify they have other coverage.

6. Preferred Health Systems or Aetna?

- Generally, if you live inside the Preferred Health Systems (PHS) Coordinated Care (Core) network service area, you're eligible for the PHS medical plan options.
- If you live outside the PHS Coordinated Care (Core) network service area, but within an Aetna network service area, you're eligible for the Aetna medical plan options.
- **The following is applicable to employees with a permanent address in Kansas or Oklahoma:** If you live within one of the network service areas, but work in the other network service area, you can either enroll in one of the medical plans relevant to where you live or where you work. This special provision is known as the "Live/Work" Rule, and can only be requested during your initial enrollment, Annual Enrollment or when you have a qualifying life event, by calling the Spirit AeroSystems Benefits Center.
- If you live outside both the PHS Coordinated Care (Core) network service area and any Aetna service area, you're eligible for the Aetna Out-of-Area Plan.

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Who's Eligible

You're able to participate in the health care plans if you're an active full-time or part-time employee and your regular work schedule is at least 19.1 hours per week.


DEPENDENTS

You may enroll your eligible dependents for coverage under the Company's health care plans if you're enrolled in the plan(s) as an employee. Eligible dependents under the health care plans include your eligible dependent children as well as your lawful spouse or your same-gender domestic partner. You will be required to certify you meet the criteria to add a common law spouse or same-gender domestic partner.

ELIGIBLE DEPENDENT CHILDREN INFORMATION

Eligible children are your or your spouse's/same-gender domestic partner's children to age 26 and include:

- children by birth;
- children by legal adoption (effective as of the date the child is placed for adoption);
- stepchildren who live with you and whom you claim as dependents on your federal income tax return;
- children of your spouse/same-gender domestic partner;
- foster children who have been placed with you by an authorized placement agency or by judgment, decree, or other order of the court, and whom you claim as dependents on your federal income tax return;
- children for whom you have legal guardianship or court-ordered custody, or have a pending application for legal custody or guardianship;

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- children who are related to you either directly or through marriage (e.g. grandchildren, nieces, nephews) who live with you and are dependent on you for more than 50% of their financial support;
- children whom the plan is required to cover under the terms of a Qualified Medical Child Support Order ("QMCSO");
- disabled dependent children age 26 or older, who are incapable of self-support as a result of any mental or physical condition that began before age 26 and were covered under your benefits prior to age 26, and whom you claim as dependents on your federal income tax return. To cover disabled dependent children, you must verify in writing that the disability occurred before age 26.

LIFE EVENTS

If you experience a qualifying life event, you can make benefit changes if you do so within 30 days of the event. Otherwise, you may not make any benefit changes or add/drop any dependents until the next Annual Enrollment period.

Qualifying life events include:

- Marriage, divorce or annulment
- Birth or adoption of a child
- Death of a spouse, same-gender domestic partner or other qualifying dependent
- Change of employment status for you, your spouse/same-gender domestic partner or dependent (such as starting or ending a job)
- Change in dependent's eligibility status (such as child reaching maximum eligible age limit)

For other qualifying life events, see the Summary Plan Description.

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Benefit Plans

Your Spirit health and welfare plans offer comprehensive coverage with choices and flexibility for you and your family, while balancing the need to keep cost increases to a minimum. But **managing health care costs takes a group effort**. For Spirit, managing cost means that we'll continue our role in evaluating the plans and negotiating with plan providers to get the best service, fees and quality for you.

What can you do to help manage your out-of-pocket costs? Use your health care plans wisely, and think about accessing and using your health care plans just like you would any other major expense in your life.

Spirit offers the following benefit plans:

- [CLICK](#) ■ **Medical, Prescription Drug and Vision Coverage**
- [CLICK](#) ■ **Plan Comparison Chart**
- [CLICK](#) ■ **Dental Coverage**
- [CLICK](#) ■ **Flexible Spending Accounts**
- [CLICK](#) ■ **Preventive/Wellness**
- [CLICK](#) ■ **Employee Assistance Program (EAP)**
- [CLICK](#) ■ **Life, Disability and Critical Illness**
- [CLICK](#) ■ **Wealth**
- [CLICK](#) ■ **Worklife**

You Can Help Reduce Health Care Costs

- Use **generic (tier 1 formulary) drugs** when appropriate and available.
- Receive a higher level of coverage by using **network providers and facilities**.
- Embrace a **healthy lifestyle**, which involves eating healthy, exercising and getting routine physical exams.
- Use the emergency room only for emergencies.

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Medical, Prescription Drugs and Vision

This section provides detailed information about your 2011/2012 medical plan options, including prescription drug and vision coverage. Each medical plan is administered by Preferred Health Systems (PHS).

MEDICAL PLAN OPTIONS

You may choose from two medical plans:

CLICK

- [The Coordinated Care \(Core\) Plan](#)

CLICK

- [The Consumer Directed \(Enhanced\) Plan](#)

Each plan has different components, including deductibles, coverage levels, available networks and copays for services. It's important to look at each plan and decide which best meets the needs of you and your family.

Prescription drug and vision coverage is automatically included with your medical coverage, regardless of which plan you choose.

See the [Medical Plan Comparison](#) for specific coverage and benefit levels.

The medical and prescription drug information in this guide refers to plans administered by PHS. If you are enrolled in an Aetna plan through the Live/Work Rule, please contact the [Spirit AeroSystems Benefits Center](#) for details about those plans.

Watch for ID Cards Once You're Newly Enrolled or Change Plans

If you need coverage before you receive your ID card, use your confirmation statement or online enrollment confirmation to show proof of coverage.

Retiree Medical

Spirit offers "access-only" Retiree Medical coverage for retirees who are age 55 or older with at least 10 years of service. This is a retiree-paid benefit.

PHS Network Providers

Find network providers, including Option 1 and Option 2 Primary Care Physicians at [PHS' website](#) to save on out-of-pocket expenses.

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NETWORK HOSPITALS

There are several hospitals in the Wichita area that are PHS network hospitals, which provide you with the highest benefit level when you need hospital services, including:

- Via Christi — St. Joseph, St. Francis and St. Teresa
- Kansas Heart Hospital
- Galichia Heart Hospital
- Kansas Medical Center
- Kansas Spine Hospital
- Kansas Surgery and Recovery Center
- Wesley Medical Center, LLC

For an up-to-date list of network hospitals, visit [PHS' website](#).

URGENT CARE

Urgent care is medical treatment that requires immediate attention for an illness or accident that is not an emergency. When you cannot see your provider immediately, but have an urgent medical need, visit one of the many [urgent care facilities](#) located throughout the Wichita area. Examples of urgent care medical situations include aches, pains and sprains.

Remember:

- Some plans may require a referral from your Primary Care Physician or the covering doctor, so please understand how your plan works.
- There is **no** coverage for non-emergent care received in a hospital emergency room.

Walgreens Take Care Clinics

We are pleased to announce Take Care Clinics are now included in the PHS provider network. For most services, a visit would be covered at the applicable copay or deductible/coinsurance. For more information, visit <http://takecarehealth.com/what-we-treat.aspx>.

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THE COORDINATED CARE (CORE) PLAN

You must choose a network Primary Care Physician (PCP) who will coordinate your care and refer you to specialists when necessary. You may use a specialist without a referral, but it will cost you more out-of-pocket. Benefits are paid at a higher level when you coordinate your care through your PCP; therefore you have lower out-of-pocket expenses.

Generally, PCP coordinated care is covered at 100% after a copay. Although all Option 1 and Option 2 PCPs are quality professionals, **if you select an Option 1 PCP, you'll pay a lower office visit copay.** Access [PHS' online directories](#) for a listing of Option 1 and Option 2 providers. **If you don't coordinate your care through your PCP, there is a deductible you must meet.** Refer to the [Medical Plan Comparison](#) for more information.

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THE CONSUMER DIRECTED (ENHANCED) PLAN

The Consumer Directed (Enhanced) Plan requires you to satisfy an annual deductible, rather than pay a copay each time you see a provider. Spirit helps you meet this annual deductible by setting dollars aside (pre-tax) in a Personal Care Account (PCA). When you visit the doctor or have a procedure done, the amount being applied to the deductible is automatically paid out of the PCA until all dollars are exhausted. You are responsible for the remaining balance.

This plan does **not require you to choose a Primary Care Physician (PCP)**. You have the freedom to go to any provider without a referral, but you'll receive a higher level of benefits when you use a network provider (90% after the in-network deductible) than when you use an out-of-network provider (60% after the out-of-network deductible). The percentage that you pay after the deductible is known as *coinsurance*. Once you reach the annual out-of-pocket maximum, the plan generally pays 100% of remaining eligible expenses. See the [Medical Plan Comparison](#) for more information.

Key Features of the Personal Care Account (PCA)

If you enroll in the Consumer Directed (Enhanced) Plan, Spirit will make a tax-free contribution to a PCA ranging from \$250 to \$750 each year, depending on your coverage level. This amount may be prorated depending on your hire date. Spirit's dollars are used first to help satisfy the deductible and coinsurance requirements. Any unused funds remaining in your PCA at the end of the year can be carried over (tax-free) to the next year.

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How the Enhanced Plan Works

If you're wondering how the Enhanced Plan works, here's a breakdown:

1.

Spirit contributes to your Personal Care Account (PCA) at the beginning of each plan year (between \$250 - \$750, depending on your coverage level)¹.

2.

When you visit the doctor or have medical procedures, you must **first satisfy the deductible** except for prescription drug, vision frames and lenses. In-network preventive care is covered at 100% with no deductible.

3.

Claims for these services are filed automatically against the dollars in your PCA which are used to help **pay your deductible and coinsurance**.

4.

After you meet your deductible, **the plan pays 90%** of eligible network charges and 60% of eligible out-of-network charges. You pay the remaining coinsurance².

5.

If you reach the out-of-pocket limit, eligible expenses are **covered at 100% for the rest of the benefit year** (not including prescription drug copays and vision care).

¹ If you're a new hire, this amount may be prorated depending on your hire date.

² Please note that out-of-network charges beyond the eligible amount will be balance-billed by the provider and may not be eligible.

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PRESCRIPTION DRUG COVERAGE

If you enroll in either of the medical plans, prescription drug coverage is automatically included with your plan. Your prescription drug provider offers you the convenience of **both retail and mail order prescriptions**. For prescriptions you need immediately, you should visit a **PHS network pharmacy**. For maintenance (long-term) drugs, you can typically save money by ordering your prescriptions through the mail order service.

Medco Mail Order Service or Preferred Direct Network Saves Time and Money on Prescription Drugs

You can receive savings when you fill your generic (tier 1 formulary) prescriptions through the **Preferred Direct Network** program. Pharmacies that participate in the program include Dillons, Damm Pharmacy, Derby Drug, Rose Hill Pharmacy and Homeland Pharmacy in Haysville. Here's an example of the savings:

PHS	Generic (Tier 1 Formulary) 30-day supply		Generic (Tier 1 Formulary) 90-day supply	
	Pharmacy in Preferred Direct Network	Other Contracting Pharmacy	Pharmacy in Preferred Direct Network	Medco Home Delivery Service
Coordinated Care (Core) Plan	\$5.00	\$8.00	\$10.00	\$16.00
Consumer Directed (Enhanced) Plan	\$7.00	\$10.00	\$17.00	\$25.00

VISION COVERAGE

Regardless of which PHS medical plan you enroll in, vision coverage is automatically included. For specific coverage details, see the **Medical Plan Comparison**.

Mail Order Prescriptions

Medco helps you save money on prescriptions. Here's how:

1. Visit www.phsystems.com
2. Click *Find a Drug*
3. Select *Mail Order Prescriptions Quick Link*
4. Create your unique log in using your PHS Member Number found on your PHS Member ID card
5. Enter your prescription number, and click *Continue*
6. Watch for your medication to arrive in the mail.

You can also pick up a 90-day supply of a generic (tier 1 formulary) prescription by using a participating network pharmacy in the Preferred Direct Pharmacy program.

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Medical, Prescription Drug and Vision Coverage Plan Comparison

The following Medical Plan Comparison shows your medical, prescription drug and vision benefits under each plan. Unless otherwise noted, the percentages are the amount *the plan will pay* for each service. For more details, see your Summary Plan Description.

PHS	Coordinated Care (Core)		Consumer Directed (Enhanced)	
	Primary Care Provider Option	Self-Referral Option ¹	Network	Out-of-Network ¹
Type of Plan	Coordinated Care Plan (CCP/POS)		Consumer Directed Health Plan (CDHP)	
Deductible				
Individual	None	\$600	\$1,000	\$2,000
Employee + spouse or child(ren) ²	None	\$1,200	\$1,750	\$3,500
Family ³	None	\$1,800	\$2,500	\$5,000
Personal Care Account				
Individual		None		\$250
Employee + spouse or child(ren)		None		\$500
Family		None		\$750
Out-of-Pocket Maximum You Pay Each Year⁴				
Individual	None	\$1,500	\$1,000	\$2,000
Employee + spouse or child(ren) ²	None	\$2,250	\$1,500	\$3,000
Family ³	None	\$3,000	\$2,000	\$4,000
Lifetime Maximum Benefit	Unlimited			
Preventive Care	100%	Not covered; certain well-woman and well-man preventive benefits are covered at 60% after deductible	100%	Not covered; certain well-woman and well-man preventive benefits are covered at 60% after deductible

¹ Subject to reasonable charges, as determined by the plan.

² At least two family members must contribute toward the deductible and out-of-pocket maximum.

³ At least three family members must contribute toward the deductible and out-of-pocket maximum.

⁴ The out-of-pocket maximum does not include deductibles and/or copays; network and out-of-network maximums accumulate separately.



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PHS	Coordinated Care (Core)		Consumer Directed (Enhanced)	
	Primary Care Provider Option	Self-Referral Option ¹	Network	Out-of-Network ¹
Office Visit	100% after \$15 copay for Option 1 providers 100% after \$20 copay for Option 2 providers	60% after deductible	90% after deductible	60% after deductible
Specialist Office Visit	100% after \$20 copay per visit	60% after deductible	90% after deductible	60% after deductible
Maternity				
Initial Visit	100% after \$20 copay	60% after deductible	90% after deductible	60% after deductible
Pre-Natal Visits after Initial Visit	100%	60% after deductible	90% after deductible	60% after deductible
Delivery/Hospital Services/Doctor Visits while in Hospital	100% after \$100 copay	60% after deductible	90% after deductible	60% after deductible
Post-Natal Visit	100%	60% after deductible	90% after deductible	60% after deductible
Outpatient Therapy —				
Occupational/Physical Therapy	100% after \$20 copay	60% after deductible	90% after deductible	60% after deductible
Speech Therapy	100% after \$20 copay	60% after deductible	90% after deductible	60% after deductible
Chiropractic	100% after \$20 copay	60% after deductible	90% after deductible	60% after deductible
Diagnostic Testing/X-Rays	100%	60% after deductible	90% after deductible	60% after deductible
Hospital				
Outpatient	100% after \$25 copay	60% after deductible	90% after deductible	60% after deductible
Inpatient	100% after \$100 copay per admission	60% after deductible	90% after deductible	60% after deductible

¹ Subject to reasonable charges, as determined by the plan.

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PHS	Coordinated Care (Core)		Consumer Directed (Enhanced)	
	Primary Care Provider Option	Self-Referral Option ¹	Network	Out-of-Network ¹
Emergency Room Care Contact the plan for information about <ul style="list-style-type: none"> Out-of-network facility benefits Coverage for non-emergency care 	100% after \$100 copay (waived if admitted)	<i>Outside the service area:</i> 100% after \$100 copay (waived if admitted)	90% after deductible	<i>Outside the service area:</i> 90% after deductible
Mental Health Treatment Inpatient	100% after \$100 copay per admission	60% after deductible	90% after deductible	60% after deductible
Outpatient (including intensive outpatient programs and partial day hospitalization; care must be coordinated through PHS)	\$20 Specialist or applicable PCP copay per visit. Services must be coordinated through PPK at 1-316-609-2541 or 1-866-338-4281 (outside Wichita)	60% after deductible	90% after deductible	60% after deductible
Smoking Cessation Prior authorization required for prescription drugs; contact the plan or the Spirit AeroSystems Benefits Center for more information	Tobacco cessation drugs, Chantix or bupropion are no charge for you and your covered dependents (age 18 and older) at a network pharmacy for up to six monthly fills per person			

¹ Subject to reasonable charges, as determined by the plan.

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PHS	Coordinated Care (Core)		Consumer Directed (Enhanced)	
	Primary Care Provider Option	Self-Referral Option ¹	Network	Out-of-Network ¹
Prescription Drugs <i>Retail (30-day supply)</i>		Member reimbursed at the allowed amount, minus the copay		Member reimbursed at the allowed amount, minus the copay
Generic (Tier 1 Formulary) (<i>mandatory</i>) Preferred Direct Network pharmacy All other pharmacies	\$5 copay \$8 copay		\$7 copay \$10 copay	
Formulary (Tier 2 Formulary)	\$15 copay ³		\$20 copay ³	
Non-Formulary (Tier 3 Non-Formulary)	\$30 copay ³		\$35 copay ³	
Mail Order (90-day supply)		Not covered		Not covered
Generic (Tier 1 Formulary) (<i>mandatory</i>) Preferred Direct Network pharmacy Mail Order	\$10 copay \$16 copay		\$17 copay \$25 copay	
Formulary (Tier 2 Formulary)	\$30 copay ³		\$50 copay ³	
Non-Formulary (Tier 3 Non-Formulary)	\$60 copay ³		\$85 copay ³	
Vision Coverage				
Eye exam (once per benefit year)	100% after \$20 copay	60% after deductible	100% after \$20 copay	60% after deductible
Lenses, frames or contacts (one pair of lenses/frames or contacts per benefit year)		\$82 frame allowance \$78 - \$215 lens allowance (depending on the type of lens) \$210 contact lens allowance (in lieu of lenses and frames)		
Hearing Coverage				
Hearing Exam	100% after \$20 copay	60% after deductible	90% after deductible	60% after deductible
Hearing Aid (per ear, every three years)	100% up to \$1,000	100% up to \$1,000	100% up to \$1,000	100% up to \$1,000

¹ Subject to reasonable charges, as determined by the plan.

³ If you purchase a brand name drug when a generic (tier 1 formulary) drug is available, you will pay the copay plus the cost difference between the two drugs.

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Dental Plan

Dental coverage is **available to you and any covered dependents at no cost** through the **Delta Dental Premier Plan**. This plan has a large network of providers, and has both network and out-of-network benefits. You are encouraged to **use network dental providers as you will pay less for services** than if you use out-of-network providers. To find a network provider, simply log on to [Delta Dental's website](#) or call **1-800-234-3375**.

DENTAL PLAN AT-A-GLANCE

The following chart shows your dental benefits under the Delta Dental Premier Plan. Unless otherwise noted, the percentages are the amount *the plan will pay* for each service^{1,2}.

	Delta Dental Premier Option	
	Network ²	Out-of-Network ^{1,2}
Deductible³	\$50 for individual \$150 for family	\$100 for individual \$300 for family
Annual Maximum	\$2,000 per person	
Preventive Services	100%	80%
Basic Services	80%	70%
Major Services	50%	50%
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	\$1,750	

¹ When you use a Delta Dental network dentist, the plan pays a percentage of the cost, up to the network fee scheduled amount. If you use an out-of-network dentist, the plan pays a percentage of the cost, up to the Maximum Plan Allowance (MPA). The MPA is the network pre-filed fee, his/her submitted fee or the Delta Dental participating dentist's maximum fee, whichever is lower.

² Certain services are not covered, including (but not limited to) services performed for the purpose of full mouth reconstruction (extensive treatment involving multiple crowns or units of fixed bridgework could be considered full mouth reconstruction); services not necessary and customary as determined by the standards of generally accepted dental practice; and temporary services and procedures. If you're not sure whether a particular treatment is covered, contact Delta Dental.

³ The network and out-of-network deductibles accumulate separately. At least three family members must contribute toward the family deductible.

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Flexible Spending Accounts

Pay less in taxes! Spirit offers you both a **Health Care and Dependent Day Care Flexible Spending Account (FSA)**. These accounts are a great way to reimburse yourself for health care or dependent day care expenses with tax-free money.

If you enroll in either of these accounts, you can pay eligible expenses with pre-tax money (money from your paycheck that is not subject to federal income tax, Social Security withholding, and, in most cases, state taxes). **This means you reduce your overall taxable income and pay less in taxes.**

Following are a few key features of FSA accounts:

- You have access to your Health Care FSA dollars anytime during the plan year — even before all of the money is in your account!
- Use a **debit card** to pay for eligible health care expenses up to your maximum annual election amount. If you prefer to submit paper claims and receipts, you can still do so by using [Express Claims](#).
- Plan your elections carefully! **Your unused contributions do not carry over from one year to the next.** This means **any unused funds left in your account after September 15 are forfeited.** You have until December 15 to submit paper claims incurred through September 15 for reimbursement.
- Be sure to **save your receipts!** The FSA administrator may request receipts or itemized statements (not the debit card receipts) to ensure expenses are eligible. If you don't submit the requested information, your debit card may be shut off and you may be required to repay the amount in question.

Want to learn more about FSAs?

- Check out [Your FSA At-a-Glance](#) for a list of eligible expenses.
- See [Saving Money with an FSA](#) for an example of how much money you could save by enrolling in one or both FSAs.

Health Care versus Dependent Day Care FSA?

The **Health Care FSA** is used to **pay eligible health care expenses for you and your dependents.** These include, but are not limited to, office visit copays, coinsurance and contact lenses.

The **Dependent Day Care FSA** is used to pay eligible day care expenses that allow you and your spouse to work. These include, but are not limited to, preschool, after-school care, nanny expenses, and in some cases, elder care if you are taking care of your elderly parents.

Need Help Deciding How Much to Contribute to Your FSA?

Check out the [FSA Estimator tool](#) on [PayFlex's website](#).

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Over-The-Counter Medications

Most over-the-counter (OTC) medications that are not prescribed by a physician are not eligible for reimbursement through your Health Care FSA. This includes items such as antacids, pain relievers, and allergy and cold medicines. However, if your doctor writes a prescription for an OTC medication, it will be eligible for reimbursement through your FSA.

The following OTC items are eligible for FSA reimbursement without a prescription:

- Band aids
- Birth control
- Braces and supports
- Contact lens solution and supplies
- Elastic bandages and wraps
- First aid supplies
- Insulin
- Reading glasses

Contact PayFlex for more information on eligible and ineligible expenses.

Your FSA At-a-Glance

	Health Care FSA	Dependent Day Care FSA
What to Use it for	Eligible medical, dental and vision expenses not paid for by insurance or a Personal Care Account (PCA)	Dependent day care expenses that allow you or your spouse to work
Examples of Eligible Expenses For a complete list of eligible expenses, refer to www.irs.gov/publications/p502	<ul style="list-style-type: none"> ■ Prescription drug copays ■ Physician office visit copays ■ Hospital and emergency room copays ■ Plan deductible and coinsurance amounts, as long as it is not reimbursed by the PCA (which is automatic) in the Enhanced Plan ■ Eye exams, eyeglasses and prescription sunglasses ■ Contact lenses and cleaning solutions ■ LASIK eye surgery ■ Orthodontics ■ Hearing exams, hearing aids and batteries 	<ul style="list-style-type: none"> ■ Day care expenses for children under the age of 13 ■ In-home care for an adult dependent who lives with you ■ Pre-school ■ After-school care ■ Nanny expenses
Annual Plan Year Contribution Limits	Up to \$4,500 per benefit year; minimum contribution is \$250 per benefit year	Up to \$5,000 per benefit year (\$2,500 if you're married and file taxes separately); minimum contribution is \$250 per benefit year
<ul style="list-style-type: none"> ■ The plan year runs from July 1 through June 30. ■ The "grace period" runs from July 1 to September 15 to "spend down dollars" from the previous plan year FSA. ■ The "run-out period" goes from September 15 to December 15 to file FSA claims for eligible expenses from the previous plan year. 		

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Saving Money with an FSA

Here's an example of how you can save money by contributing to a Health Care FSA: let's say you expect to have \$1,000 in eligible medical expenses that are not covered by any health plan or Personal Care Account (PCA). Let's also assume you normally pay approximately 25% in taxes. Look at what happens if you pay these eligible expenses through an FSA account:

	With an FSA	Without an FSA
Money I use to pay my health care expenses during the year	\$1,000	\$1,000
Taxes I pay on this money	\$0	\$250
Actual amount of money available to pay my health care expenses	\$1,000	\$750
Tax savings to me	\$250	\$0

Please note: This example also applies for eligible dependent care expenses.

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Preventive/Wellness Benefits

Access free or low-cost preventive care benefits, including:

- Mammograms
- Colonoscopies
- Well-child care
- Immunizations
- Routine exams

Under the medical plans, you and your eligible covered dependents receive 100% coverage with no deductible or copay in preventive care benefits. These benefits are subject to using **in-network** providers, if enrolled in the Enhanced Plan, or your PCP if enrolled in the Core Plan. You can use these benefits to get a routine physical or other wellness/preventive care. Spirit also offers wellness programs you may participate in, such as smoking cessation, flu shots, biometric screenings, and a Health Risk Assessment (HRA).

Health Risk Assessment (HRA)

Get an overall snapshot of your health! You'll have the opportunity to participate in a confidential on-line questionnaire, called a Health Risk Assessment (HRA), where you can answer simple questions about your lifestyle, review a summary of your health risks, and receive personalized tips on how to improve your health.

Healthy Spirit Wellness Program

Staying or becoming healthy is mutually beneficial for you and Spirit. That's why we encourage you to take advantage of the many resources in Spirit's Healthy Spirit wellness program:

Tobacco/smoking cessation is a benefit, administered by Preferred Health Systems, and offers tobacco cessation therapy and participation in a coaching program at no-cost to you. Some limits apply. To access information about the tobacco cessation program from the Spirit Intranet, click on **Healthy Spirit** under **Human Resources** on the left side of the screen. Then, click on the "**Want to quit smoking?**" link in the middle of the page.

Good News if You Want to Quit Smoking!

You and your covered dependents (age 18 or older) can obtain certain smoking cessation medications at **no cost** for up to six months of treatment.

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Flu shots, blood pressure checks and select health screenings are some of the health maintenance opportunities available to you.

Wellness/safety programs offer stretching and exercise injury prevention resources.

A Walking Club that includes *Walk at Work* events, keeping you active at work and at home.

Spirit's wellness web page that offers company, community and state health and wellness information. To access the wellness web page from the Spirit Intranet, click on **Healthy Spirit** under **Human Resources** on the left side of the screen.

Fitness Discounts at the Greater Wichita YMCA with access to any of the multiple YMCAs in the Wichita area and reciprocating benefits throughout the country. Easy bank draft deductions and month-to-month payment arrangements are available. Employee rates are \$21.03 per month. Family rates are \$33.23 per month. To sign up, visit a Wichita YMCA and bring your badge, voided check and first month's payment. If you are already a YMCA member, you can convert your current membership to the Spirit program. You'll need to show your Spirit badge when making this change.

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Your Employee Assistance Program (EAP)

Whether or not you're enrolled for medical coverage, Spirit provides all employees access to the Employee Assistance Program (EAP). The EAP offers practical solutions, online resources, confidential advice and support, and can help you with:

- Parenting, child care and elder care issues
- Family and relationship problems
- Legal and financial matters
- Health and wellness needs

For more information (Monday through Thursday, 8 a.m. - 4:30 p.m., and Friday, 8 a.m. - 2 p.m. Central time) contact your onsite counselor:

- By phone at 1-316-526-0311
- Address: Oliver & 31st St. South

24-Hour Crisis Hotline: 1-800-234-0630

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Life & Disability Plans

Spirit provides welfare coverage to protect your income if you become sick or injured and are unable to work or in the event of your death. Some are Company-paid while others are optional and you pay the full cost of coverage. These plans include:

Welfare Coverage	Paid By	Administered By	Benefit
Short-Term Disability (STD)	Company	The Hartford	80% of weekly base wage for weeks 2 - 13 60% of weekly base wage for weeks 14 - 26 <small>*The 26-week maximum STD benefit will be proportionately reduced by the period of time you are burning down ETO.</small>
Long-Term Disability	Company	The Hartford	40% of monthly base wage to a monthly maximum of \$5,000
Optional Long-Term Disability²	You	The Hartford	20% of monthly base wage to a monthly maximum of \$2,500
Basic Life¹	Company	The Hartford	1.25 times annual base wage to a maximum of \$500,000
Supplemental Life^{2,4}	You	The Hartford	1 to 5 times annual base wage; spouse coverage available at 50% or 100% of your basic life coverage; \$10,000 for each child; evidence of insurability may apply
Basic AD&D¹	Company	Chartis	2 times annual base wage; actual payment depends on the loss suffered
Supplemental AD&D³	You	Chartis	1 to 5 times annual base wage; spouse coverage available at 50% of your election; children's coverage at 10% of your election; actual payment depends on the loss suffered
Business Travel Accident (BTA)	Company	Chartis	2 times annual base wage; actual payment depends on the loss suffered
Critical Illness	Company	Boston Mutual	Face amount of \$15,000; children covered at 25% of the face value amount available to the employee

Your Life and Disability Coverage

If you don't enroll in Supplemental Life, Supplemental AD&D or Optional Long-Term Disability within 30 days of your hire date, you will be covered by all Company-paid employee benefits. However, you will not be enrolled in any supplemental benefits for you or your family and you may be required to provide Evidence of Insurability at a later date.

For more information about the plans, see your Summary Plan Description.

For more information about how to **enroll**, log on to www.myspiritbenefits.mercerhrs.com. Review the benefits you are eligible for, then enroll for coverage.

¹ Your Company-paid Basic Life and Basic Accidental Death & Dismemberment (AD&D) will go into effect the date of your hire, provided you are at work on that date. If not, it will go into effect on your first day worked.

² If you do not enroll in Supplemental Life or Optional Long-Term Disability insurance within the first 30 days of your hire date, you will be required to provide evidence of insurability upon enrolling at a later time.

³ If you do not enroll in Supplemental AD&D coverage within the first 30 days of your hire date, you may enroll in this benefit at a later "qualifying" time without having to provide evidence of insurability.

⁴ When you enroll in Supplemental Life as a new hire, you can elect up to the lesser of five times your annual base wage or \$500,000 without having to provide evidence of insurability. If your Supplemental Life election is less than five times your annual base wage or \$500,000, at each annual enrollment period thereafter, you can elect an additional 1 times your annual base wage without having to provide evidence of insurability, unless that amount exceeds \$500,000. If you do not enroll in Supplemental Life insurance within the first 30 days of employment (or when you become eligible), you will need to provide evidence of insurability when you enroll.

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Wealth

Spirit’s retirement program is designed to help you build personal wealth to help you prepare for your financial needs when you retire. Through the retirement program, you can enjoy tax advantages, convenient payroll deductions, and investment choices. And, Spirit makes contributions to your account, so your account can grow.

There are three important parts to your Retirement Savings 401(k) Plan (RSP) at Spirit:

- 1. You contribute.** You may make pre-tax, after-tax, and roll over contributions to the plan.
- 2. Spirit contributes.** For each pay period, the Company matches up to 75% of the first 8% that you contribute — for a total maximum 6% match.
- 3. Spirit makes an additional contribution.** The Company provides an additional contribution based on the age plus service calculation described below in the table. *Please note* that you must be employed by Spirit on December 31 and must have earned a year of vesting service (1,000 or more hours worked) for the calendar year to receive an additional contribution.

If Your Age + Earned Vesting Service Equals:	The Percentage of Company Additional Contributions You Receive Is:
Less than 60	1.5%
60–79	3.0%
80 or more	4.5%

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VESTING

You are always 100% vested in your contributions and the company’s matching contributions. You vest in Spirit’s *additional contribution* based on the schedule described below. *Please note* that a year of vesting service is earned for each calendar year you work at least 1,000 hours.

Years of Vesting Service	Percentage Vested
Less than 2 years	0%
At least 2 years but less than 3 years	25%
At least 3 years but less than 4 years	50%
At least 4 years but less than 5 years	75%
5 years or more	100%

What is *Vesting Service*?

You’re credited with one year of vesting service for every calendar year of service that you complete at least 1,000 hours with the Company.

MANAGING YOUR INVESTMENT

The RSP offers 16 investment fund options. **You decide how to invest your contributions and account balance.** You can invest them in one or more of the 16 available funds, in 1% increments. For example, if you want to invest in four funds, you could invest 50% in one fund, 20% in another fund, 15% in a fund, and the remaining 15% in a fourth fund. How your investments are split is your choice, as long as the investment elections total 100%. Your account balance will reflect investment gains or losses based on the performance of the investment funds you select.

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KEEPING TRACK OF YOUR ACCOUNT

There are two resources to help you stay aware of your account activity:

- 1. Account Statements.** You will receive quarterly account statements mailed to your address on record. To update your address, go to **myHR** and then to the “myInfo” tab. The statement will include your total balance, your investment election and the current value of each investment fund.
- 2. Online** at <https://myrsp.ingplans.com>. You can access your account information 24/7, including a summary of your account activity, fund information, and investment transaction history.

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PAY

At Spirit, your rewards are many, including excellent pay and benefits, earned time off, 12 paid holidays and much more. Here is some information about your pay and salary schedule:

- There are 26 pay periods per year
- Pay is distributed every other Thursday
- Yearly salary is determined by multiplying your base wage by 2,080 (hours worked).

HOW TO TRACK YOUR TIME

- Clock your time using the online CATS System
- Your manager approves your time on a weekly basis.

FLEX TIME

Spirit offers the benefit of flexing your time with management approval. For instance, if you miss work to attend an appointment, you can work additional hours within the same pay week to cover that time away from work.

HOLIDAYS

The company provides twelve scheduled, paid **holidays per year**. This includes the shutdown between the Christmas and New Year's holidays.

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2011 Holidays

	Day of Week	Date of Observance
New Year's Day	Monday	January 3, 2011
Memorial Day	Monday	May 30, 2011
Independence Day	Monday	July 4, 2011
Labor Day	Monday	September 5, 2011
Thanksgiving Day	Thursday	November 24, 2011
Day following Thanksgiving	Friday	November 25, 2011
Winter Break	Friday	December 23, 2011
Winter Break	Monday	December 26, 2011
Winter Break	Tuesday	December 27, 2011
Winter Break	Wednesday	December 28, 2011
Winter Break	Thursday	December 29, 2011
Winter Break	Friday	December 30, 2011

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2012 Holidays

	Day of Week	Date of Observance
New Year's Day	Monday	January 2, 2012
Memorial Day	Monday	May 28, 2012
Independence Day	Wednesday	July 4, 2012
Labor Day	Monday	September 3, 2012
Thanksgiving Day	Thursday	November 22, 2012
Day following Thanksgiving	Friday	November 23, 2012
Winter Break	Monday	December 24, 2012
Winter Break	Tuesday	December 25, 2012
Winter Break	Wednesday	December 26, 2012
Winter Break	Thursday	December 27, 2012
Winter Break	Friday	December 28, 2012
Winter Break	Monday	December 31, 2012

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EARNED TIME OFF (ETO)

Spirit understands the importance of a good “Work/Life” balance. Earned Time Off (ETO) allows you the opportunity to “re-charge, re-connect and re-balance” your life, as well as provides you time to recoup from illnesses while receiving pay.

Employees accrue Earned Time Off upon employment based on the following schedule:

Complete Years of Service	Earned Time Off Days	Earned Time Off Hours
0 – 4	16	128
5 – 9	18	144
10 – 11	21	168
12 – 13	22	176
14 – 15	23	184
16 – 17	24	192
18+	25	200

How To Determine My ETO Balance

You can find your ETO balance in two ways:

- On your bi-weekly paycheck
- Go to **myHR**, then to the “Timekeeping & Pay” tab

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Using My ETO

- ETO can be recorded in increments of one-tenth of an hour (e.g. 2.4).
- At no time can an employee's ETO balance exceed two years' worth of accrual, based on [the schedule](#). **For example**, a person with seven years of service cannot have more than 36 days/288 hours in his or her account. Excess accrual cannot be realized except for an annual redemption of up to 5 days/40 hours at 100% of current wage. This redemption will be available upon the employee's anniversary date with the company. The request must be made within two weeks of your "Service Date." "Service Date" is often the same as hire date. Contact the **HR Service Center** at 316-523-4556 for confirmation of Service Date.

Notifying My Manager

Except in cases of illness, employees should notify their manager within a reasonable time frame and gain concurrence prior to taking ETO.

TUITION REIMBURSEMENT PROGRAM

Spirit strongly supports continuing education for its employees through the Tuition Reimbursement Program. Here's how the Tuition Reimbursement Program works:

- Participants apply for pre-approval of their class(es) through the Tuition Reimbursement Program Office.
- Participants pay for educational expenses to the school.
- Participant completes class(es) with a sufficient grade.
- Participant submits grade, completion report and paid receipts for qualified expenses.
- Spirit reimburses participant, up to annual limits, upon submittal of a sufficient grade/completion report with the paid receipts for qualified expenses.

For more information, contact the HR Service Center at 316-523-4556.

Vacation Pay in Lieu:

An engineer may choose to be paid, upon written request, for a total of up to five earned time off days in any calendar year. An engineer may request on two occasions during the year: (1) on his/her service date, and (2) one other time during the calendar year at the engineer's discretion.

Ready to Enroll?

Enrolling for your benefits is easy. Keep in mind that unless you experience a [qualifying life event](#), **this is your only opportunity to make or change elections (including adding or dropping dependents) until the next Annual Enrollment period in Spring 2012.**

Follow these three simple steps:

1. Review Annual Enrollment

To review your current coverage, log in to www.myspiritbenefits.mercerhrs.com and enter your Social Security number and PIN, **which has been reset to the last four digits of your Social Security number.** Once you log in, you will be required to change your PIN. If you've forgotten your PIN, click on **"Forgotten PIN? Click here to reset your PIN"** or call the Spirit AeroSystems Benefits Center at **1-877-459-3345**. Once you are logged in, click on the **Health and Welfare** tab, then on **View my Current Coverage**.

New Hires

Review the benefits within this guide. If you have questions, call the Spirit AeroSystems Benefits Center at **1-877-459-3345**.

2. Enroll

You must enroll for your 2011/2012 benefits within 30 days of your hire date or during the Annual Enrollment period (May 2 - 13, 2011). You can enroll online or by phone.

Considering Waiving Medical Coverage?

If you have other medical coverage available to you, such as through your spouse's plan, carefully evaluate your medical plan options to determine which offers the most value for you and your family at the most reasonable cost. If you decide to waive coverage through Spirit, **you'll be required to certify that you're enrolled in coverage through another medical plan.**

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Online (available 24 hours a day, seven days a week)

Log in to www.myspiritbenefits.mercerhrs.com and enter your Social Security number and PIN. The first time you log in, your PIN is the last four digits of your Social Security number. If you've forgotten your PIN, click on **"Forgotten PIN? Click Here to reset your PIN"** or call the Spirit AeroSystems Benefits Center at **1-877-459-3345** to have your PIN reset.

- Follow the instructions to **enroll for coverage** (at the end of your online enrollment, you can review your selections before finalizing and saving them).
- When you're sure you've enrolled in the benefits you want, click on the **"Submit My Elections"** button in the upper right side of the screen. Your elections will then be saved.
- Once you save your elections, you'll receive an **online confirmation number** on the screen and you can print an online confirmation statement for your records. You will also receive one in the mail.

Don't Forget to Name Your Beneficiaries

Be sure to complete your beneficiary designations for your life insurance coverages during enrollment.

[CLICK](#)

By phone at 1-877-459-3345 (available Monday through Friday, 8 a.m. to 5 p.m. Central time).

3. Check Your Confirmation Statement

Shortly after you enroll, a printed confirmation of your benefit elections will be sent to your address on record. **Review the statement carefully** to be sure it reflects the plans and coverage levels you want.

If you actively made an election change during Annual Enrollment, **you will have from May 23 - 27 to make corrections** by contacting the Spirit AeroSystems Benefits Center at 1-877-459-3345.

If you're a new hire, **you will have 15 days from the date of your confirmation statement to make changes or corrections** by contacting the Spirit AeroSystems Benefits Center at 1-877-459-3345.

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QUESTIONS? OR NEED HELP?

The Spirit AeroSystems Benefits Center is available by phone at **1-877-459-3345**.
(Monday through Friday, 8 a.m. to 5 p.m. Central time)

ENROLL BY PHONE

Call the Spirit AeroSystems Benefits Center at **1-877-459-3345, option 2** and enter your Social Security number and PIN. The first time you enter a PIN, use the last four digits of your Social Security number. If you forgot your PIN, you can hit the pound key (#), and have it re-set by the Spirit AeroSystems Benefits Center. The Spirit AeroSystems Benefits Center Representative will review your elections with you over the phone before your elections will be saved. Later, you will receive a confirmation statement in the mail.

Remember, the Spirit AeroSystems Benefits Center representatives are available Monday through Friday, 8 a.m. to 5 p.m. Central time.

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This guide contains important information about your benefit options. If you have questions, please contact the organizations listed below or refer to your Summary Plan Descriptions.

For Information About	Contact	By Phone	By Web
How to enroll	Spirit AeroSystems Benefits Center	1-877-459-3345	www.myspiritbenefits.mercerhrs.com
Medical plans, including prescription drug and vision coverage, the Personal Care Account (PCA) and how to find a provider	Preferred Health Systems	1-316-609-2559 1-800-693-3643	www.phsystems.com
Dental plan, including how to find a provider	Delta Dental	1-316-264-4511 1-800-234-3375	www.deltadentalks.com
Accidental Death & Dismemberment and Business Travel Accident coverage	Chartis	1-800-551-0824	www.chartisinsurance.com
Life and Disability coverage	The Hartford	Disability Claims: 1-877-707-3593, Option 1 Life Insurance Claims: 1-877-707-3593, Option 2	www.thehartfordatwork.com
Critical Illness coverage	Boston Mutual	Customer Service: 1-877-624-2249 Claims Service: 1-800-669-2668	NA
Flexible Spending Accounts	PayFlex or Spirit AeroSystems Benefits Center	1-800-284-4885 1-877-459-3345	www.payflex.com www.myspiritbenefits.mercerhrs.com
Spirit Retirement & Savings Plan	ING	1-877-459-3345	https://myrsp.ingplans.com
HR Service Center		1-316-523-4556	https://myhr.web.spiritaero.com/HRSC.asp

Urgent Care Locations in Wichita

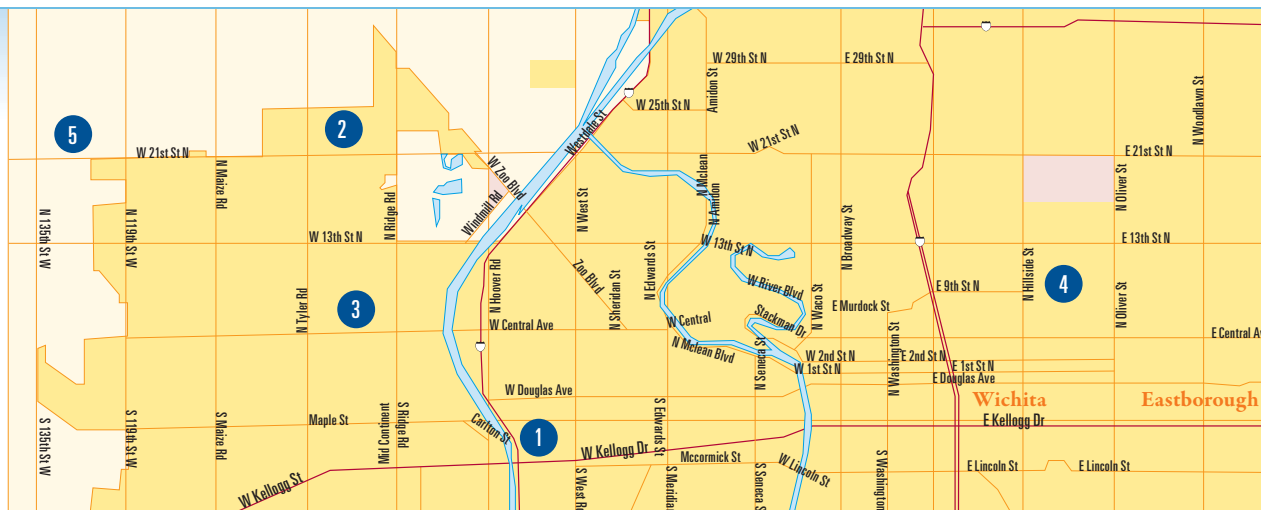
LOCATIONS¹

URGENT CARE FACILITIES

- | | | |
|--|---|--|
| <p>1 Immediate Medical Care
4722 W. Kellogg Dr.
Wichita, KS 67209
316.440.2565
www.immediatecarewichita.com
Mon. - Sat. 9 a.m. - 7 p.m.
Sun. 1 - 6 p.m.</p> | <p>2 PMA Immediate Care
8444 W. 21st St.
Wichita, KS 67205
316.721.9500
www.via-christi.org
Sat. - Sun. noon - 5 p.m.</p> | <p>3 West Wichita Minor Emergency
8200 W. Central
Wichita, KS 67212
316.721.4910
www.wfpfa.com
Mon. - Fri. 8 a.m. - 8 p.m.
Sat. - Sun. noon - 6 p.m.</p> |
| <p>4 Wichita Clinic Immediate Care East
3311 E. Murdock
Wichita, KS 67208
316.689.9107
www.wichitaclinic.com
Mon. - Fri. 8 a.m. - 8 p.m.
Sat. 9 a.m. - 6 p.m.
Sun. noon - 6 p.m.</p> | <p>5 Wichita Clinic Immediate Care West
13213 W. 21st St. N.
Wichita, KS 67235
316.946.1789
www.wichitaclinic.com
Mon. - Fri. 5 a.m. - 8 p.m.
Sat. 9 a.m. - 5 p.m.
Sun. noon - 5 p.m.</p> | |

Take Care Clinics in Walgreens

710 N. West St.
9525 E. 21st St. N.
5505 E. Harry St.
555 Maize Road N.
3770 N. Woodlawn St.
333 W. 13th St. N.
866.TAKE.CARE (866.825.3227)
www.takecarehealth.com
Mon. - Fri. 8 a.m. - 7:30 p.m.
Sat. 9:30 a.m. - 5 p.m.
Sun. 9:30 a.m. - 5 p.m.



URGENT CARE

An urgent care situation — such as migraines and cold/flu symptoms — is not an immediate threat to your health, but it needs prompt medical attention. Medical conditions that are not an emergency should be treated by your family physician or at a contracting urgent care center. Doctors are available 24 hours a day to help you get the care you and your family need. Their after-hours message will instruct you on how to reach them. **In most cases, care for non-Emergency Medical Conditions is not covered when received in a hospital emergency room.**

www.phsystems.com

Try the Take Care Clinics in Walgreens!

Take Care Clinics in Walgreens offer a variety of services, including these benefits for patients 18 months and older:

- Walk-in appointments
- Most services require an urgent care copay
- Referrals aren't required

For more information, please visit <http://takecarehealth.com/what-we-treat.aspx>.

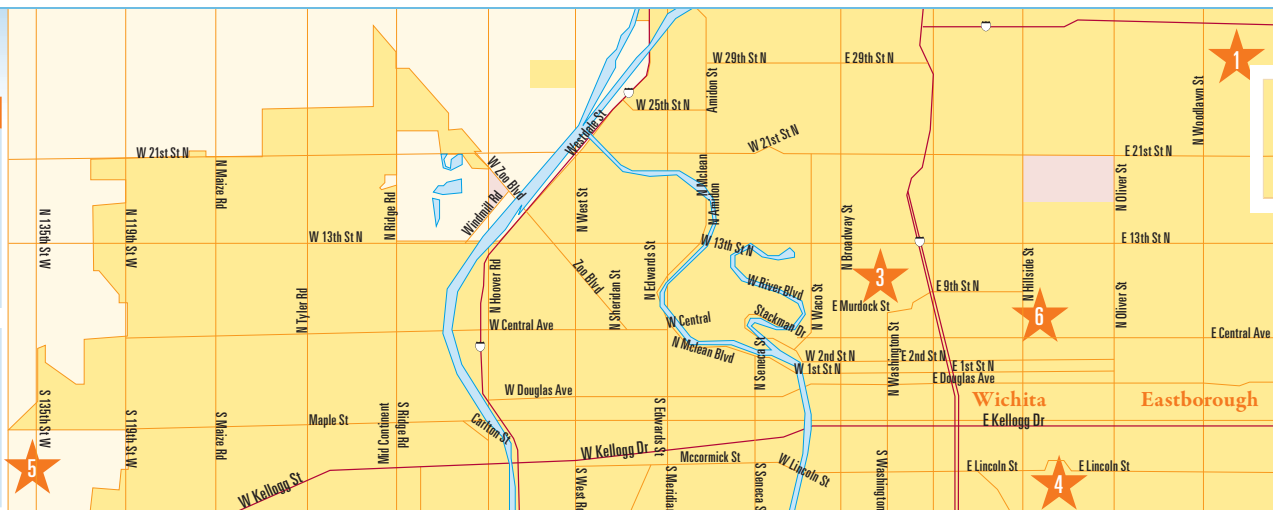
¹ Contracting facilities are subject to change. Contact PHS for confirmation before seeking care.

Emergent Care Locations in Wichita

LOCATIONS¹

EMERGENT CARE FACILITIES

- | | | |
|--|---|--|
| <p>1 Galichia Heart Hospital
2610 N. Woodlawn
Wichita, KS 67220
316.858.2610
www.ghhospital.com</p> | <p>2 Kansas Medical Center
1124 W. 21st St.
Andover, KS 67002
316.300.4000
www.ksmedcenter.com</p> | <p>3 Via Christi Regional Medical Center – St. Francis
929 N. St. Francis
Wichita, KS 67214
316.268.5000
www.via-christi.org</p> |
| <p>4 Via Christi Regional Medical Center – St. Joseph
3600 E. Harry St.
Wichita, KS 67218
316.685.1111
www.via-christi.org</p> | <p>5 Via Christi Hospital – St. Teresa
14800 W. St. Teresa
Wichita, KS 67235
316.796.7000
www.via-christi.org</p> | <p>6 Wesley Medical Center, LLC
550 N. Hillside
Wichita, KS 67214
316.962.2000
www.wesleymc.com</p> |



EMERGENT CARE

If you have an Emergency Medical Condition such as difficulty breathing, suspected heart attack, uncontrolled bleeding, unconsciousness or severe burns, try to use a **contracting** emergency room. If you choose to go to a non- contracting emergency room, your coverage may be limited. Please remember, **Wesley Medical Center and Wesley West Emergency & Diagnostic Center** are **not** Contracting Providers and your out-of-pocket costs could be substantial.

www.phsystems.com

Please call specific locations for hours of operation and holiday schedules. For urgent and emergent care outside Wichita, refer to the Provider Directory.

Health insurance plans underwritten by: Preferred Plus of Kansas. Preferred Health Systems Insurance Company

¹ Contracting facilities are subject to change. Contact PHS for confirmation before seeking care.

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WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this plan. Deductibles and coinsurance for each plan can be found [here](#).

If you would like more information on WHCRA benefits, call your Plan Administrator at 1-800-693-3643.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

IMPORTANT NOTICE FROM SPIRIT AEROSYSTEMS ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Spirit AeroSystems medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2011. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2011 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully. It has information about prescription drug coverage with Spirit AeroSystems and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Spirit AeroSystems prescription drug plans listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2011. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Coordinated Care (Core)
- Consumer Directed (Enhanced)

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Spirit AeroSystems coverage, Medicare will be your only payer.

You should know that if you waive or leave coverage with Spirit AeroSystems and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Spirit AeroSystems coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit [Medicare's website](#) for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit [SSA online](#) or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Preferred Health Systems (PHS)
8535 E. 21st Street North
Wichita, KS 67206
316-609-2559 or 1-800-693-3643
www.phsystems.com

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SPECIAL ENROLLMENT RIGHTS

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Notice of Special Enrollment for Dependents Up to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in a Spirit AeroSystems health plan unless they have other employer-provided coverage.

Notice of Special Enrollment for Individuals Who Reached Spirit AeroSystems Benefit Plan's Lifetime Limit

The lifetime limit on the dollar value of benefits under the Spirit AeroSystems Medical Plans no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan.

Notice of Your Rights for Selecting Primary Care Physicians and OB/GYNs Primary Care Physicians

The Spirit AeroSystems Coordinated Care (Core) Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

Until you make this designation, PHS or Aetna designates one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Spirit AeroSystems Benefits Center at 1-877-459-3345.

OB/GYN visits

You do not need prior authorization from Spirit AeroSystems, Preferred Health Systems or Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Spirit AeroSystems Benefits Center at 1-877-459-3345.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

Beginning April 1, 2009, Spirit will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities, you will have 60 days — instead of 30 — from the date of the Medicaid/CHIP eligibility change to request enrollment in the Spirit AeroSystems group health plan. Note that this new 60-day extension does not apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

To request special enrollment or obtain more information, contact Spirit AeroSystems Benefits Center.

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Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2011. You should contact your state for further information on eligibility —

KANSAS — Medicaid	NORTH CAROLINA — Medicaid	OKLAHOMA — Medicaid
Website: https://www.khpa.ks.gov	Website: http://www.nc.gov	Website: http://www.insureoklahoma.org
Phone: 800-792-4884	Phone: 919-855-4100	Phone: 1-888-365-3742

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

or

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

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Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

Spirit AeroSystems Health Information Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans:

- Coordinated Care (Core)
- Consumer Directed (Enhanced)
- Open Access (Premier)
- Employee Assistance Program

The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Spirit AeroSystems as an employer — that's the way the HIPAA rules work. Different policies may apply to other Spirit AeroSystems programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care

between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share your health information with physicians who are treating you.*

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*
- **Health care operations** include activities by this Plan (and, in limited circumstances, other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs.*

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes. The Plan may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, as permitted by law.

How the Plan may share your health information with Spirit AeroSystems

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Spirit AeroSystems for plan administration purposes. Spirit AeroSystems may need your health information to administer benefits under the Plan. Spirit AeroSystems agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Certain departments of Spirit AeroSystems (and employees of those departments) will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Spirit AeroSystems, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Spirit AeroSystems if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Spirit AeroSystems information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Spirit AeroSystems cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Spirit AeroSystems from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects

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Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates

HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule
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Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Effective February 17, 2010, an entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid for the item or service, in full out of pocket.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Effective February 17, 2010, you may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an “accounting of disclosures.” You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request, but not earlier than April 14, 2003 (the general effective date of the HIPAA privacy rules). You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a “limited data set” (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on April 14, 2003. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint, it must be in writing and addressed to the Benefits Manager at Spirit AeroSystems, Inc., P.O. Box 780008, Wichita, KS 67278-0008.

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For more information on the Plan's privacy policies or your rights under HIPAA, contact the Benefits Manager at Spirit AeroSystems, Inc., P.O. Box 780008, Wichita, KS 67278-0008.

ADDITIONAL CONTACTS

The following is a list of key persons or offices you may need to contact to exercise your rights under the HIPAA privacy rule for different benefit plans offered by Spirit AeroSystems:

	Restricted disclosures	Confidential communications	Access to or copies of your health information	Amendment of your health information	Accounting of disclosures
PHS Medical Plans			Lisa Foos Manager, Regulatory Compliance Phone: 316-609-2564 Fax: 316-609-2346 Email: lfoos@phsystems.com		
Dental Dental of Kansas			Michael J. Herbert Chief Financial Officer Delta Dental of Kansas, Inc. 1619 N Waterfront Parkway P.O. Box 789769 Wichita, KS 67278-9769 Phone/Fax: 316-462-3330 Email: mherbert@deltadentalks.com		
Vision Service Plan			VSP Customer Service P.O. Box 997100 Sacramento, CA 95899 Phone: 800-877-7195 Fax: 916-463-9090 Email: imember@vsp.com		

	Restricted disclosures	Confidential communications	Access to or copies of your health information	Amendment of your health information	Accounting of disclosures
Chartis Accidental Death & Dismemberment and Business Travel Accident Plans	Claims Vicki Bichel, CPCU, AIC, PLA Assistant Vice President Accident & Health Division 17200 W. 119 Street Olathe, KS 66061 Phone: 913-495-3289 Fax: 866-241-1891 Email: vicki.bichel@chartisinsurance.com				Stephanie Dejoie Accounting Manager 100 Connell Berkley Heights, NJ 07922 Phone: 908-679-3932 Fax: 866-668-9968 Email: stephanie.dejoie@chartisinsurance.com
	Underwriting Karen McLaughlin Regional Underwriting Manager Accident & Health Division 300 S. Riverside Plaza, Suite 2100 Chicago, IL 60606 Phone: 312-930-5393 Fax: 312-930-5589 Email: karen.mclaughlin2@chartisinsurance.com				

November 2011

This Enrollment Guide represents a summary of the health and welfare coverage available to you as an eligible employee of Spirit AeroSystems, Inc. Every effort has been made to provide an accurate summary of the terms of the plans. However, if there is a conflict between this information and the official plan documents or insurance contracts, the official plan documents and insurance contracts will control. In addition, the Company reserves the right to change, amend, modify or terminate the plans in whole or in part at any time. This information does not constitute an offer of continued employment with the Company.