Cummins Inc. Flexible Spending Account Plan (FSA)

Health and Dependent Care Accounts

PLAN YEAR JANUARY 1 – DECEMBER 31

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The following terms are used throughout the Plan Document as having definitions. In this section, you will find the definitions for these terms to help clarify their meaning and to provide information to better help you understand the provisions of your benefit plans.

Dictionary terms

Actively at work

Present and capable of carrying out the normal assigned job duties at Cummins Inc. If you are absent from work due to an approved health-related short-term disability leave, FMLA leave or regularly scheduled vacation, you will be considered actively at work.

Annual open enrollment

(annual enrollment, open enrollment)

The period of time each year designated by the Company when you may generally make changes to your benefit elections, if allowed by the Plan.

You must enroll in the Plan in order to have coverage. You may choose coverage for yourself and your dependents within 31 days from your date of hire or within 31 days of the date your first become eligible for coverage.

If you do not enroll within this 31-day period, or if you waive coverage and later decide you want to add this coverage, you may enroll during the next open enrollment period. If you experience a Qualifying Life Event, you may make your election within 31 days of the event.

Any changes you request during open enrollment will become effective January 1st of the following plan year and will remain in effect for the entire calendar year, unless you have a Qualifying Life Event, or your coverage otherwise ends.

Change in status

(also see qualifying life event, status change, qualified change in family status)

An event that changes your benefit eligibility, like getting married or having a child. You can make certain changes to your benefit elections that are consistent with the change.

COBRA

(Consolidated Omnibus Budget Reconciliation Act)

Federal law that lets certain people covered by a group health plan temporarily to extend coverage when their coverage would otherwise end by paying the applicable premium.

Common-law spouse

A person you marry without a civil or ecclesiastical ceremony. This is usually based on your living together continuously as husband and wife for an extended period of time. Time limits vary by state.

Company

The association or organization you work for and that provides your benefit program. Cummins Inc. and its affiliates and subsidiaries such as Fleetguard, Nelson, Power Generation, etc.

Dependent

A family member who is eligible for coverage under the Plan as described in the Eligibility section.

Dependent care expenses

Amounts paid for household and dependent care services necessary for gainful employment under the standards established by federal law and the Code of Federal Regulations and summarized in IRS Publication 503 ("Child and Dependent Care Expenses") for the most recent tax year.

Domestic partner

Someone of the opposite sex or same sex under the following criteria:

- You have had a single, dedicated relationship with and shared the same permanent residence for at least six months
- Is not married to another person or part of another domestic partner relationship and is 18 years of age or older
- Employee and domestic partner are mutually responsible for each others' common welfare
- Employee and domestic partner intended for their relationship to be permanent
- Employee and domestic partner share the same living quarters and share a permanent address
- Are not related to one another so closely as to preclude marriage under applicable state law

Effective date

The date your coverage begins under the Plan-generally your hire date, provided you are actively at work. If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to active work

Eligible benefit or benefits

The following qualified benefits permitted under Section 125(f) of the IRS Code and other benefits permitted under the regulations there under. These statutory benefits shall include:

- Reimbursement of medical expenses, but only to the extent not reimbursable through insurance; and
- Reimbursement of dependent care costs, but only to the extent not reimbursable through insurance.

Employee

A person the Company hires to do a job or activities that are controlled by the Company.

ERISA

Employee Retirement Income Security Act of 1974, as amended, and corresponding provisions of future laws.

Full-time

Employees who are scheduled to work for the Company for the full work week

Health insurance

Any policy or program of health benefits coverage maintained by the sponsor with a third-party carrier or administrator.

Medical expenses

Amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Medical expenses shall include expenses for routine and extraordinary physical, mental and dental examinations, surgery, psychiatric care, hospitalization, drugs and medicines, vision care, therapeutic, orthopedic, and prosthetic aids and devices, transportation primarily for and essential to medical care as that term is used in Section 105(b) of the Internal Revenue Code, and as summarized in IRS Publication 502 (“Medical and Dental Expenses”) for the most recent tax year.

Medically necessary or medical necessity

Services or supplies received for the treatment of an illness or injury or other health condition or that is medically appropriate for your age or sex as a preventive measure for an asymptomatic patient that is determined to be:

- Appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards
- Not chiefly Custodial in nature

- Not Experimental/Investigative or unproven
- Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment and as to institutional care, cannot be provided in any other setting, such as a Physician's office or the Outpatient department of a Hospital, without adversely affecting the patient's condition
- Not provided only as a convenience to you, your physician or another provider or person

The fact that any particular physician may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment medically necessary.

Mentally or physically disabled

A mental or physical condition that renders a person incapable of performing one or more duties of that person's regular occupation.

Participant

An employee who meets the requirements as stated under “Eligibility”.

Plan

The Flexible Spending Account Plan set forth in this document or as amended from time to time.

Plan administrator

The Plan Administrator administers the Plan and is a named fiduciary of the Plan within the meaning of ERISA. The Plan Administrator has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. FlexBen Corporation currently is the Administrator for purposes of determining the benefits payable under the Plan (Claims Administrator). If Cummins changes Claims Administrators, it will notify all plan participants. Cummins Inc. is the Plan Administrator for all other purposes

Plan year

The 12-month period, or policy or fiscal year on which the Plan's records are kept. Cummins Inc. benefits plans generally use the calendar year, January 1 through December 31.

Pre-tax

(before-tax)

Contributions taken from your paycheck before applicable federal, state, local and other taxes are withheld.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order that meets all of the following criteria:

- Is issued by a court pursuant to a domestic relations law or community property law
- Creates or recognizes the right of an alternate recipient to receive benefits under a parent's employer's group health plan
- Includes certain information relating to the participant and alternate recipient

Qualifying event

(change in status, qualifying life event)

An event recognized by Section 125 of the IRS tax code that entitles you to make a change in election. Examples of events include leaving the Company; a reduction in hours; your death, divorce or legal separation; your eligibility for Medicare; a dependent child's loss of dependent status; or loss of coverage due to your filing for bankruptcy.

Regular employee

An exempt or non-exempt employee who works on an ongoing basis instead of a temporary basis.

Reimburse

When you are paid back for money you spend on approved expenses

Salaried employees

Employees who receive fixed compensation paid regularly for work or services, regardless of the number of hours worked each week. These employees may also be referred to as "exempt" from overtime

Section 125

A section of the Internal Revenue Code that allows you to pay for certain benefits with pretax dollars, and regulates enrollment and eligibility requirements for these benefits.

Summary Plan Description (SPD)

Summary Plan Description is a description of your benefit coverage. This booklet is both your SPD and your plan document for this Plan.

Spouse

Your husband or wife, married to you in a civil or ecclesiastical ceremony. If your state of residence recognizes common-law marriage, such a person may also qualify as your spouse for benefits.

Termination date

The last day you are scheduled to work. Some plan document sections may also refer to a coverage or benefits termination date, which may be different from your last day of work or your termination of employment date.

Preface

This plan document provides a concise description of the Cummins Inc. Flexible Spending Account Plan available for you. Every attempt has been made to make it non-technical and understandable. This document is the "Summary Plan Description" (SPD) of the Plan required by the federal law known as ERISA. It is also the official plan document. This Plan supersedes any previous plan documents and any provision or practice not consistent with this Plan.

Benefits are determined under the terms of the Plan in effect at the time you become eligible for the benefits in question. Cummins Inc. reserves the right to suspend, modify, or terminate these benefits at any time to the extent permitted by law.

If you have a question regarding the Plan, please contact the CBS Benefits Contact Center at (877) 377-4357, Monday - Friday from 7:00 – 6:00 CST.

Introduction

The Flexible Spending Accounts (FSA) program allows employees the opportunity to pay out-of-pocket health and dependent care expenses with tax-free dollars.

Benefits of FSA

- You can increase take-home pay by reducing the amount you pay in taxes;
- You have the opportunity to make choices based on your individual and family needs;
- Participation provides an incentive to budget money for your family health and/or dependent care expenses; and
- You have the satisfaction of knowing you have tax-free money set aside to reimburse you for expenses not covered, or not covered in full, by your existing benefit plan.

Plan Design

Tax legislation and Internal Revenue Service (IRS) interpretations make it possible for Cummins Inc. to offer flexible spending accounts to its employees. These accounts permit employees to take advantage of setting money aside on a pre-tax basis to pay for unreimbursed health and dependent care expenses. That means employees do not have to pay federal, state[1] or Social Security taxes on money they deposit in flexible spending account programs administered in accordance with Section 125 of the IRS code.

With FSA, employees can set aside tax-free dollars in special accounts to pay out-of-pocket expenses they now pay with after-tax dollars.

FSA provides access to two types of accounts:

- Health Care Account
- Dependent Care Account

Employees may choose to enroll in either, both, or neither account based on their family's needs.

FSA works much like a direct deposit checking account. Employees decide how much to deposit in each account to cover expenses they anticipate incurring during the plan year. The money is automatically deducted from an employee's check each pay period before taxes are deducted. When out-of-pocket expenses are incurred, employees can draw against their FSA to get reimbursed with their own money,

[1] Pennsylvania and New Jersey do not recognize the exclusion of state income tax.

tax-free. Employees' deposits in FSA are never taxed, not when deposits are made, or when reimbursements are received, nor when income tax returns are filed.

Health Care Account

Employees may deposit up to $2,500 in a Health Care Account for the plan year. The Health Care Account covers eligible expenses incurred during the plan year that are not reimbursed or paid for by existing health insurance programs.

If you use the Health Care Account to get reimbursed for eligible expenses, you cannot take a tax deduction for the same expenses. Refer to "Eligible Expenses" for a list of those expenses that qualify for reimbursement under the Health Care Account.

Dependent Care Account

Employees may deposit up to $5,000 in a Dependent Care Account. The IRS limits the amount employees may deposit in the dependent account each year. The maximum annual amount employees may set aside is the lesser of:

- $5,000 if single or married filing jointly;
- $2,500 if married filing separately; or
- The employee's or spouse's income, whichever is lower.

The Dependent Care Account allows employees to use tax-free dollars to pay for dependent care expenses that make it possible for you and your spouse (if you're married) to work. The expenses must be for the well-being and protection of a qualified dependent.

In addition, an individual may participate in the Dependent Care Account if he or she has an eligible dependent and meets one of the following requirements:

- The individual is a single parent;
- The individual has a working spouse;
- The spouse is a full-time student for at least five months during the year while an employee is working;
- The spouse is disabled and unable to provide for his or her own care; or
- The individual is a divorced or legally separated parent who has child custody most of the time – even though the other parent may claim the dependent for tax purposes.

It is important to note that these are the same expenses considered eligible for the federal child credit. If you choose to be reimbursed for child care expenses through the dependent care account, you cannot also take advantage of the federal child care tax credit.

Refer to "Eligible Expenses" for a list of those expenses that qualify for reimbursement under the Dependent Care Account.

Eligibility

Eligible Employees

You are eligible to participate in the FSA if you are an active, full-time regular employee or you are on a Company approved leave of absence.

For the Health Care Account, you may be eligible to continue your participation in the FSA if you are receiving compensation through a disability plan or a paid leave policy.

Eligible dependents

You may use the FSA to reimburse eligible expenses for yourself, your spouse, or your eligible tax dependents. This section attempts to provide you with the rules published by the IRS, but if you have any doubts about a specific person after reading this section, please consult the IRS or your personal tax advisor.

Note - although Cummins Inc. general policy is to provide benefits to the domestic partners of our employees as though the domestic partner were a spouse, the FSA plan is driven entirely by the laws and regulations around U.S. federal income taxes which do not automatically recognize domestic partners as tax dependents. You may be able to claim a domestic partner's health expenses under FSA, if the domestic partner qualifies as a tax dependent under IRS rules.

According to the IRS, you may save for and claim reimbursement from your Health Care Flexible Spending Account for eligible expenses in the tax year for yourself, your spouse, a qualifying child, or qualifying relative if:

- They are claimed or could be claimed as an exemption on your federal income tax return, as long as no one else is claiming that person as a dependent on their tax return for that year;
- Your spouse was your spouse either at the time the spouse received the services or at the time you paid for those medical services.
- A child is your son, daughter, stepchild, foster child, brother, sister, stepbrother, stepsister, or a descendent of any of them (e.g., your nephew, niece, grandchild); and
    - is a US citizen or US national resident; or
    - is your adopted child or a child placed with you for adoption, and
    - Is under 19 years of age or under 24 and a full-time student or is permanently disabled, and
- They lived with you for at least half of the tax year as a member of your household
- They did not provide over one-half of his or her own support for the tax year.

Medical expenses for children of divorced or separated parents are also eligible for FSA savings:

- A child of divorced or separated parents can have medical expenses claimed by both parents to the extent that each parent actually paid that child's expenses, even if the other parent claims the child's exemption and even if the child lives with the other parent more than half the year.
- The child must have received over one-half of his or her support from one or both of the parents.
- The child must have lived over one-half of the year with one or the other parent.
- The parents must be legally divorced or legally separated by decree for this category to apply.

Medical expenses for qualifying relatives may also be eligible. A qualifying relative is a person:

- Who is your:
    - Son, daughter, stepchild, foster child or a descendent of any of these (e.g., your grandchild); or
    - Brother, sister, or a son or daughter of your sibling, or your father, mother, or an ancestor or sibling of either of them (e.g., your grandparent, your aunt or uncle); or
    - Stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; or
    - Any other person (not your spouse) who lived with you all year as a member of your household if your relationship does not violate local law, and
- Who is not a qualifying child (described above), and
- For whom you provided over half the support for the tax year in question.

An eligible dependent for the Dependent Care Account must meet the following:

- Is a child under age 13 in your custody whom you claim as a dependent on your tax return;
- Is a spouse who is physically or mentally incapable of self-care and who lived with your more than half the tax year;
- Is a person, such as a child age 13 or older, parent, sibling, in-law, or domestic partner who is physically or mentally incapable of self-care, who lived with your more than half the tax year, and whom you claim as a dependent on your tax return (or whom you could claim except that he or she filed a joint return, or received more than $3,200 in gross income for the tax year).

Enrollment

Enrolling in an FSA

To participate in an FSA, you must complete an enrollment form to elect to reduce your pay by the amount of your estimated health or dependent care expenses up to the maximum allowed for the coming plan year. The appropriate Flexible Spending Account(s) will be established in which the amounts you contribute each pay period will be credited.

The election you make when you join will remain in effect for that plan year. Then, prior to each new plan year, you will have the opportunity to re-enroll and make a new election if you wish to participate. If you do not re-enroll, your elected pay reduction will end at the end of the FSA plan year.

If you are a newly hired employee, you have 31 days from your date of hire to enroll in the Health Care and/or Dependent Care Flexible Spending Account(s). If you miss your deadline, the IRS requires that you wait until the next annual open enrollment period to participate in an FSA, unless you have a qualifying life event.

If you have a qualifying life event or other cause for a change in election, you will have 31 days to make changes to your election. Refer to the “Changes in election” section for more information.

When participation begins

If you enroll in an FSA during open enrollment (usually in October), your participation in the FSA plan will become effective on January 1 of the following year.

If you have a qualified change in family status or other cause for a change in election and become eligible and enroll in a FSA within 31 days of the status/life event, your FSA plan will become effective the date of the status/life event. Your contributions to your FSA will begin in the next available pay cycle after your enrollment.

If you enroll in a FSA as a new employee within 31 days after your hire date, your participation will start on your first day of work and your contributions will begin in the next available pay cycle after your enrollment.

Making changes

You may change your participation in the FSA if you have certain types of qualifying life events; otherwise you may only make changes during open enrollment. After a qualifying life event, you can increase, decrease, or stop your contributions to the extent that such a change is considered consistent with the specific type of life event.

Changes in election

If you have a qualifying life event, you may be able to change your existing FSA election or enroll for the first time if you previously waived participation. Any change in election due to a qualifying life event must be consistent with the qualifying life event. You must make changes to your coverage within 31 days of your qualifying life event.

The following is a list of events that are considered to be a qualifying life event and for which you may be able to make a change in your FSA election if that change meets the IRS' rule of consistency between the event and the change you wish to make:

- A change in legal marital status such as marriage, death of spouse, divorce, annulment or legal separation (that is separation from your spouse under a court decree of separate maintenance)
- A change in the number of an employee's dependents such as birth, death, adoption, placement for adoption or placement of a foster child or the issuance of a court order or legal decree requiring coverage of a dependent child, or a dependent's ceasing to satisfy eligibility requirements for coverage;
- A change in employment status for the employee, the employee's spouse, or the employee's tax dependent including a termination or commencement of employment, a strike or lockout, a commencement of or return from unpaid leave of absence, an end to or significant change in the benefit plan available to you or your spouse or dependent, or a change in worksite.
- A change in employment status for you or your spouse/domestic partner that affects your eligibility for benefits;

Changes you make after a qualifying life event become effective the date of the life event. Election changes must be made within 31 days of the life event. Note that the changes allowed mid-year by the IRS for Health Care FSA and Dependent Care FSA are limited and subject to the "rule of consistency." There will be circumstances where an employee is allowed to make a change to the level of health care coverage under the medical plan (such as going from family to single) but not be allowed to make an FSA election change.

To enroll in the FSA or find out if you may make changes to your contributions, please contact the CBS Benefits Contact Center at (877) 377-4357.

Eligible expenses

Health Care Account

Expenses that qualify for reimbursement under the Health Care Account must meet the following requirements:

- The expenses must not be covered by a health or dental plan or a spouse's plan.
- The expenses must be included in the IRS list of eligible tax deductible expenses. For the complete listing of eligible health care expenses, refer to IRS Publication 502. To get a copy of IRS Publication 502, visit the IRS website at www.irs.gov or call at 1-800-829-3676.
- The expenses must be incurred by the participant or his or her eligible dependents (spouse and any children) within the plan year.

Examples of eligible expenses

The following are examples of health care expenses which qualify for reimbursement:

- Medical and dental plan deductibles (the amount paid for each covered person before the plans begin paying benefits);
- Medical and dental plan coinsurance (the percentage of expenses paid after the deductible is satisfied);
- Medical co-payments (dollar amounts paid for office visits and emergency visits not covered under existing plans);
- Prescription drug co-payments;
- Expenses that exceed health and dental plans maximum coverage;
- Treatment of allergies not covered by a health plan;
- Vision care, including exams, glasses, and contact lenses;
- LASIK eye surgery;
- Orthodontia expenses for children and adults;
- Weight loss and smoking cessation programs if they are considered “medically necessary”; and

Examples of ineligible expenses

The following are examples of health care expenses which do not qualify for reimbursement:

- Health insurance premiums;
- Medicare part B Premiums;
- Prescription drugs for cosmetic purposes, weight loss or lifestyle enhancements;
- Marriage or family couseling;
- Custodial care in an institution;
- Health club dues;
- Over the counter medications, unless physician prescribed; and
- Over-the-counter items such as amounts paid for toiletries (e.g. toothpaste), cosmetics (e.g. face creams), and other sundry items, vitamins, herbal remedies, and supplements taken to promote general health and well being.

Dependent Care Account

Examples of eligible expenses

The following are examples of dependent care expenses which qualify for reimbursement (for the complete listing of eligible dependent care expenses, refer to IRS Publication 503):

- Care which is provided inside or outside the home by anyone other than a spouse, a dependent claimed on his or her income tax return, or a child under age 19;
- Care which is provided in a day care center or a child care center (If the center cares for more than six children, it must comply with state and local regulations);
- Care which is provided by a housekeeper whose services include, in part, providing care for an eligble dependent; and
- Care which is provided by a nurse or home health care agency for care for your spouse or legal dependent who is physically or mentally incapable if self-care.

To get a copy of IRS Publication 503, visit the IRS website at www.irs.gov or call at 1-800-829-3676.

Examples of ineligible expenses

The following are examples of dependent care expenses which do not qualify for reimbursement:

- Expenses for food, clothing, education, or entertainment, unless they are incidental and cannot be easily separated from the cost of dependent care;
- Transportation to and from the place where dependent care services are provided;
- Schooling in the first grade or beyond;
- Nursing home expenses;
- Payments made to a spouse or to any person declared as a dependent for income tax purposes; and
- Search fees for a dependent care provider.

Filing a claim

Claims

All health care claims will be automatically submitted to the FSA administrator, by the Medical Plan administrator, for reimbursement, unless the claim is related to:

- Any accident diagnosis;
- Vision correction expenses such as eyeglasses and contacts;
- Coordination of benefits with a spouse's medical plan; or
- Adjusted claims

In these cases, you will need to collect the receipts for your eligible health care expenses and submit them to the FSA administrator.

Manual claims

After an eligible expense has been paid (or when the service has been provided, in the case of a health care claim), a claim may be submitted for reimbursement from the FSA account. Claims must be for services that were performed during the current plan year and while an individual is a participant in the Plan including making contributions to the Plan. In addition, if an individual enrolls in the Plan during the year (for example, an individual is hired in the middle of the year and enrolls within the 31-day period), the individual will only be able to file claims for services received after the effective date. An individual must complete a Health or Dependent Care Reimbursement claim form, attach all required documentation, and submit the claim to the FSA administrator.

Deadline for filing claims

Claims may be submitted for reimbursement at any time. An individual has until March 31 of the current calendar year to file claims for expenses incurred during the previous calendar year. Any deposits from the previous calendar year that remain in the account on April 1 must be forfeited under IRS regulations. This is sometimes referred to as the "use it or lose it rule."

If an individual terminates employment, the individual has until the annual claim filing deadline to submit claims for reimbursement of expenses incurred prior to termination. An individual may continue participation in the Health Care Account on an after-tax basis by electing COBRA continuation coverage. An individual may not continue participation in the Dependent Care Account following termination.

Required documentation

Health Care Account

To file a claim for reimbursement from the Health Care Account, an individual must submit evidence of a qualified expense. Examples of proper claim documentation include:

- A document referencing the date of service, provider, amount billed and paid, and the type of service;
- A cancelled check accompanied by a third party statement as verification of the incurred health expense;
- An Explanation of Benefits (EOB) statement received from a medical or dental insurance plan; or
- For qualified over-the-counter (OTC) purchases, you must submit evidence of purchase date and the specific medicine, drug, and/or device name.

Submit the completed form with copies of supporting documentation by fax (preferred method) to 1-888-347-5212.

As an alternative, the completed claim form and documentation can be mailed to:

Anthem Blue Cross Blue Shield
P.O. Box 660165
Dallas, TX 75266

Dependent Care Account

When submitting a claim, the claim must show the name, Social Security Number or federal tax ID number of the care provider and reimbursement amount. The Social Security and federal tax ID numbers are not necessary if the care provider is a tax-exempt group, such as a church or if the care is provided outside of the United States by a foreign citizen. The dependent's name, relationship to the employee, age and dates of service should also be provided. Appropriate receipts, invoices, or other documents should be included. Otherwise, the care provider may record this information on the claim form along with his or her signature.

Submit the completed form with copies of supporting documentation by fax (preferred method) to 1-888-347-5212.

As an alternative, the completed claim form and documentation can be mailed to:

Anthem Blue Cross Blue Shield
P.O. Box 660165
Dallas, TX 57266

Amount of reimbursement

There is no minimum amount for requests for reimbursement.

Health Care Account

Employees may be reimbursed for eligible expenses incurred on or after the first day of the plan year up to the total amount elected for the current plan year. If the amount of a Health Care Account claim exceeds the current reimbursement account balance, the claim will be paid up to the total amount an individual will deposit for the current year. If this results in a temporary negative account balance, deposits for the remainder of the year will be used to repay the negative balance.

Dependent Care Account

Unlike reimbursement protocols for the Health Care Account which enable an individual to receive reimbursement up to the full amount for the year regardless of the amount deposited, the maximum reimbursable amount for dependent care cannot exceed an individual's current account balance. Claims exceeding the employee's balance will be paid only up to the balance amount. Additional reimbursements will be made as money accrues in the Dependent Care Account. You do not need to file the same claim again.

Reimbursements relating to a spouse or dependent child added as a result of a change in family status apply only to services received during the new coverage period for the covered individual.

If a claim is denied

If you have followed the appropriate submission procedures as outlined in this booklet and your request for reimbursement is denied, it is the Claim Administrator's duty to notify you within 90 days of receiving your request that no reimbursement is due. This notification will indicate the specific reasons for the denial, including references to Plan provisions that apply and a request for any additional information that may be necessary to process your reimbursement request. You will have 60 days from the notification of denial to appeal by writing to the Claim Administrator.

The Claim Administrator will review your appeal and give a ruling no later than 60 days after your request has been received. In special cases, the Claim Administrator has up to 120 days to rule on your appeal. You will be notified if such an extension is necessary.

The result of the review will be sent to you in writing, specifying the reasons for the final decision and references to plan provisions on which the decision was based.

Restrictions

IRS restrictions and tax considerations

This Flexible Spending Account Plan is offered on the basis of a current understanding of the provisions of the Internal Revenue Code. Since the current rules are subject to change, the Plan may be amended or discontinued if regulations or changes in the law make it advisable to do.

This document describes our Flexible Spending Account Plan. Any determination to qualification of an expense under a Flexible Spending Account is subject to review by the Internal Revenue Service (IRS). Should the IRS take a position contrary to that applied under the Plan, the Plan will act according to the IRS position. Anyone wishing to appeal that decision must obtain their own legal counsel.

Forfeiture of benefits

Before making your elections, carefully estimate the amount you want to contribute to the Flexible Spending Account(s). You may only use the money in your account to pay for expenses you incur during the same calendar year. Any money remaining in your account, after you have applied for reimbursement for the year, is forfeited and cannot be returned for any reason. You will have until March 31 of next year to request reimbursement for expenses incurred during the current plan year. This "use or lose it" rule makes it very important to estimate carefully before deciding to contribute.

Transfers

You may not transfer money from one account to the other, even in the case of a life event. For example, you cannot use money from the Health Care FSA to pay for dependent care expenses.

Re-enrollment

The IRS requires that employees make new elections for each and every plan year. If you do not make a new election during the open enrollment period, your participation in the flexible spending account will end as of the beginning of the new plan year.

Consult a tax advisor

The IRS permits a participant to take a federal tax credit on his or her annual income tax return for dependent care expenses. However, the amount deposited to the Dependent Care Account will reduce, dollar-for-dollar, the amount used toward the federal tax credit.

For some individuals, the tax savings is greater if they pay for dependent care expenses through the reimbursement account. For others, it is greater if they take a tax credit on their annual income tax returns.

For more information about the federal income tax credit, an individual can call the IRS at (800) 829-3676 and ask for publication #503 Child and Dependent Care Expenses and for publication #596 Earned Income Credit. Publication #503 provides a list of eligible and ineligible expenses for both the tax credit and reimbursement account.

Individuals are encouraged to consult a credible tax advisor if there are any questions about whether the reimbursement account or tax credit is more advantageous.

Social Security taxes

Pre-tax contributions to your Flexible Spending Account(s) will not be taxed for Social Security and as a result, could result in a slightly lower Social Security benefit for you or your family at retirement. Most employees should find, however, that the tax savings they receive under the Flexible Spending Account Plan will be greater than any Social Security benefit reduction that might result.

Termination and continuation

Change in employment status

If you retire, terminate employment, or take a non-FMLA leave of absence, your participation in the Plan will end as of your last day paid. This means that your contribution will stop on that day and only expenses incurred on or before that date will be reimbursable. You may submit reimbursement requests for these expenses up to the annual claim filing deadline after your employment status changes.

For example, if you terminate on April 1, you would have until March 31 of the following year to submit reimbursement requests for expenses incurred between January 1 and April 1 prior to your termination.

If you leave the Company or are otherwise eligible to continue medical benefits under the Federal COBRA Law, you may continue contributing to your Health Care Account. However, since your payments are not deducted from wages, they will not provide you with tax advantages associated with pre-tax payroll deductions. But, COBRA allows you to continue to make after-tax contributions to your account, and also submit reimbursement requests for claims incurred after your employment has ended (during your COBRA coverage period).

An individual may not continue participation in the Dependent Care Account following termination. Continuing contributions through COBRA is not available for the Dependent Care Account.

If you return to work

If you return to work within the same plan year, you will automatically participate as of the first day of your return to work. If you return to work in a subsequent plan year, you will be treated as a new hire for Plan purposes and may elect to participate by submitting a completed enrollment form within your 31 day enrollment period.

Administrative information

The information presented in this summary plan document is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA).

This Plan supersedes and replaces any past plans or summaries and any verbal or written representations or practices inconsistent with the Plan. Contact the CBS Benefits Contact Center for a copy of the plan document. The CBS Benefits Contact Center can be reached by calling (877) 377-4357, Monday - Friday from 7:00 – 6:00 CST.

Administrative and ERISA Information

Future of the Plan

The future of the Plan and future benefits depend upon the future of Cummins Inc. Cummins Inc. hopes to continue providing benefits and every effort has been made to foresee and provide for future benefits. However, Cummins Inc. reserves the right to change, suspend temporarily or terminate the Plan as necessary. The Benefits/Pension Policy Committee of Cummins Inc. shall make any such change by adoption of the appropriate resolutions.

Modifications

This SPD shall be subject to amendment, modification, and termination in accordance with any of its provisions by Cummins Inc., or by mutual agreement between FlexBen Corporation and Cummins Inc. without the consent or concurrence of any participant. By electing benefits under the Plan or accepting the plan benefits, all participants legally capable of contracting and the legal representatives of all participants incapable of contracting agree to all terms, conditions, and provisions hereof.

No Guarantee of Employment

Establishment of the Plan will in no way enlarge or diminish your employment rights, nor will it guarantee your employment with Cummins Inc.

Non-Discrimination Requirement

The Plan Administrator may in its sole and absolute discretion take any actions that it deems appropriate to assure compliance with all applicable non-discrimination requirements and all applicable limitations on benefits provided to key employees or highly-compensated employees. These actions may include without limitation the modification of elections by key employees and highly-compensated employees with or without their consent.

Confidentiality Policy

Privacy of Protected Health Information

Purpose

This Section permits the Company to receive Protected Health Information from the Plan or a Business Associate in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations. The Section is effective April 1, 2003.

Company's Certification of Compliance

The Company will certify that this section has been incorporated into the plan documents and that the Company agrees to abide by the provisions of this section. Neither the Plan nor any business associate

will disclose protected health information to the Company until the Company has provided the certification.

Disclosures to the Company

The Plan's disclosures of protected health information to the Company will be limited to the following:

- The Plan or any Business Associate will disclose protected health information to the Company to permit the Company to carry out administration functions for the Plan consistent with the requirements of HIPAA. Any disclosure to and use by the Company of protected health information will be subject to and consistent with the provisions of this Section.
- The Plan or any business associate will not disclose protected health information to the Company unless the disclosure is explained in the Notice of Privacy Practices distributed to participants in the Plan.
- The Plan or any business associate will not disclose protected health information to the Company for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company.

Restrictions on the Company's Use and Disclosure of Protected Health Information

The Company's use and disclosure of protected health information will be limited as follows:

- The Company will not use or further disclose protected health information, except as permitted or required by the plan documents, as amended, or as required by law.
- The Company will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the restrictions and conditions of the plan documents, including this section, with respect to the protected health information.
- The Company will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company.
- The Company will report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of the inconsistent use or disclosure.
- The Company will make protected health information available to the individual who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.
- The Company will make an individual's protected health information available for amendment, and will incorporate any amendments to the individual's protected health information, in accordance with 45 Code of Federal Regulations § 164.526.
- The Company will keep track of disclosures it may make of protected health information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
- The Company will make its internal practices, books, and records, relating to its use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Parts 160-64.
- If feasible, the Company will return or destroy all protected health information, in any form, received from the Plan, and the Company will not retain copies of the information after the information is no longer needed for the purpose for which the disclosure was made. If returning or destroying the

information is not feasible, the Company will limit the use or disclosure of the information to those purposes that make the return or destruction infeasible.

Adequate Separation Between the Plan and other Company Functions

To permit the Company to carry out its responsibilities for administration of the Plan, the following employees or classes of employees or other workforce members under the Company's control may be given access to protected health information received from the Plan or a business associate and they are as follows: CBS Call Center Staff, CBS Benefits Staff, Benefits Strategy, IT Staff assisting with Health Plan Data Transmission.

This list includes every employee or class of employees or other workforce members under the Company's control who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

The employees, classes of employees or other workforce members identified above will have access to protected health information only to perform the plan administration functions that the Company provides for the Plan. These people will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Company, for any use or disclosure of protected health information that violates the provisions of this section. The Company will promptly report any violation to the Plan, as required by this section. The Company will also cooperate with the Plan to correct the violation, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the violation, and to mitigate any deleterious effect of the violation on the individual whose privacy rights may have been compromised by the violation.

This policy sets forth guidelines regarding a participant's right to access and amend information in the Administrator's and/or employer's possession. The policy specifically addresses when a release, signed by a participant, is required before information may be disclosed by the Administrator and/or employer to parties such as a participant's provider, spouse or other family members. The policy includes the following key points:

- Subscribers may sign a consent form to allow the release of any information or records concerning claims, conditions, or treatments of you, your spouse, and/or your dependents enrolled under the Plan for routine uses. Routine uses of participant information include but are not limited to: payment of claims, health care operations, plan administration, quality improvement, utilization review, coordination of benefits, subrogation, audits, health promotion, disease management and prevention programs and other uses stated specifically in the enrollment materials. By enrolling, you also agreed and consented to the recording and/or monitoring of any telephone conversation between you and the Administrator;
- Participants have the right to approve the release of information for non-routine uses of data. In certain circumstances, the Administrator may obtain a specific release form before information is disclosed;
- For participants unable to give consent, the Administrator will obtain a copy of the guardianship papers or power of attorney before releasing confidential information to the participant's representative;
- Participants have the right to access their medical records and to request that the Administrator restrict others access to their confidential information;
- The Administrator takes reasonable precautions to protect participant information and maintain privacy in all settings. The Administrator contracts with practitioners and providers explicitly state expectations about the confidentiality of participant information and records; and

- The Administrator may provide certain information, upon request, to employers or their representatives without specific consent. In certain circumstances, the Administrator may request that you sign a specific release form before information is disclosed. If information is released, the Administrator advises the employer that it must be kept confidential to the extent necessary or as otherwise provided by law, and that it should not be used for unlawful purposes.

Also note that any person or entity having information about an illness or injury for which benefits are claimed may give the Administrator or anyone acting on the Administrator's and/or employer's behalf any information about the illness or injury. The Administrator may provide any person or entity any information about an illness or injury upon its request, if it is providing similar benefits. Benefits will not be payable where sufficient information cannot be obtained to properly process a claim. You waive any and all privileges with respect to such information.

The Administrator's Customer Service Area may release information to you or your spouse concerning a claim for benefits, or your coverage under the Plan. If you do NOT want the Administrator to release such information to anyone but yourself, you must notify the Administrator in writing. Your spouse or any dependent child over age 18 must also notify the Administrator, in writing if they do not wish such information regarding their claims or coverage released to you by Customer Service. However, the Explanation of Benefit forms will contain information on all claims for benefits under your coverage, and will be sent to the person in whose name the coverage is held (except as prohibited by law).

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to participants regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Administrator's business activities.

- The Administrator may collect personal information about a participant from persons or entities other than the participant;
- The Administrator may disclose participant information to persons or entities outside of the Administrator and employer without participant authorization in certain circumstances;
- A participant has a right of access and correction with respect to all personal information collected by the Administrator; and
- The Administrator takes reasonable precautions to protect participant information in its possession, including the use of restricted computer access.

A participant may request a more detailed notice regarding the types of personal information that may be collected by the Plan and the types of disclosures and the circumstances under which such disclosures may be made without prior authorization by submitting a written request to customer services.

ERISA rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA entitles you to:

- examine, at the Plan Administrator's office and other specified locations, including work sites and union halls, if applicable, without charge, all plan documents governing the Plan. These documents may include insurance contracts, collective bargaining agreements and the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- obtain, after sending a written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and

copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. You may be asked to pay a fee for the copies.

- receive a written summary of the Plan's annual financial report. The Plan Administrator is required by law to provide each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties on the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the best interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack of decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and a fee if, for example, it finds your claim is frivolous.

If you have any questions about your Plan, contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Plan sponsor

Cummins Inc.
500 Jackson Street
Columbus, IN 47201
Phone: (812) 377-5000

Plan name

Cummins Inc. and associates employee group Flexible Spending Account Plan

Plan administrator

Anthem Blue Cross Blue Shield
P.O. Box 660165
Dallas, TX 75266
Phone: 1-866-251-1779

Employer Identification Number (EIN)

The EIN is 35-0257090.

Plan number

The plan number is 510.

Plan year

The plan year is January 1 through December 31.

Source of Contributions to the Plan

This Plan is funded by employee pretax contributions.

Agent for services of legal process

Cummins, Inc.
Attn: General Counsel
Post Office Box 3005
500 Jackson Street
Columbus, IN 47201
Phone: (812) 377-5000

Claims administrator

Anthem Blue Cross Blue Shield
P.O. Box 660165
Dallas, TX 75266
Phone: 1-866-251-1779

Contacts

For appealing a claim

Claims Appeals
P.O. Box 224604
Dallas, TX 75222-4604

For claim forms

Anthem Blue Cross Blue Shield
P.O. Box 660165
Dallas, TX 75266
Phone: 1-866-251-1779

For COBRA coverage

CBS Benefits Contact Center
2931 Elm Hill Pike
Nashville, TN 37214
Phone: (877) 377-4357

For a copy of the plan document

CBS Benefits Contact Center
2931 Elm Hill Pike
Nashville, TN 37214
Phone: (877) 377-4357

For sending a completed claim

Anthem Blue Cross Blue Shield
P.O. Box 660165
Dallas, TX 75266
Fax: 888-347-5212