About the ITT Salaried Medical Plan and Salaried Dental Plan General Plan Terms

The ITT Salaried Medical and Salaried Dental Plan General Plan Terms (“General Plan Terms”) apply to the Medical Plan and the Dental Plan (the “Plan” or “Plans” or the “Health Plan” or “Health Plans”) available for salaried employees at your location and are an integral part of your Plan booklet, Plan summary, and/or other Plan information. The General Plan Terms booklet and the individual Plan booklets describing your Health Plan benefits (for example, the plan certificate for a Plan) together form the full Summary Plan Description (“SPD”) required under the Employee Retirement Income Security Act of 1974 (ERISA).

This General Plan Terms booklet provides you with specific information about:

- Enrolling
- Eligibility requirements for you and your dependents, and
- Information about what happens if you terminate employment, become disabled or retire.

Also included is information about your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and ERISA.

Every use of “you” or “your” in the General Plan Terms and in the Plan material refers to each covered individual and each of his or her covered dependents unless the context specifically indicates otherwise. If you have any questions on this, contact your Human Resources representative.

Details of the Plan that provides health coverage for you can be found in the individual Plan booklets. We encourage you to read this General Plan Terms booklet and the separate Medical Plan and Dental Plan booklets carefully and share them with your family members. If you have any questions about your benefits, please contact your Human Resources representative.

Remember, of course, that the final decisions about all your health care are personal ones—to be made after discussions with your health care provider. While the ITT Health Plans provides coverage for your health care expenses, it does not make any determination about whether you should obtain any service. That decision is between you and your health care provider, and is solely up to you. You are always free to decide to choose services that are not covered under the Plans and pay for those services from other resources.

January 1, 2011
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ELIGIBILITY

You are eligible to participate in the ITT Salaried Medical Plan and the ITT Salaried Dental Plan offered at your location as part of the ITT Salaried Benefit plans if you are a regular full-time salaried employee who is on a U.S. payroll and you are employed by ITT Corporation (“ITT”) or a designated division, subsidiary, affiliate or unit that is participating in the Plan. You may also be eligible for the Health Plans if you are a regularly scheduled part-time employee who is on a U.S. payroll of a participating ITT company and are regularly scheduled to work at least 20 hours per week year round.

Contact your Human Resources representative for more information about your eligibility for the Health Plans and your employer’s participation in the Plan.

You are not eligible to participate in the Health Plans if:

- The terms and conditions of your employment are determined by a collective bargaining agreement with the Company that does not make this Plan applicable to you
- You are classified by the Company as a consultant, independent contractor, or are in any relationship that the Company characterizes as other than an employment relationship
- You are a leased employee
- You are paid on an hourly basis and, under the Company’s employment classification practices, are considered an hourly employee for purposes of the Company’s employee benefit plans.

Eligible Dependents

If you enroll yourself in the Health Plans, you may also elect coverage for your eligible dependents. Eligible dependents include:

- Your spouse (unless you are divorced or legally separated)
- Your domestic partner who meets the definition of an eligible domestic partner under the ITT Salaried Employee Benefit plans*
- Your biological children, legally adopted children, or step children up to age 26, regardless of the following:
  - Financial dependency upon the employee (or any other person)
  - Residency with the employee (or any other person)
- Student status
- Employment status
- Marital status
- Any combination of these factors
  - This definition also includes children for whom you have assumed permanent legal and physical custody pursuant to a valid State Court order
  - If you are in the process of adopting a child, the child is eligible for coverage when placed with you for the purpose of adoption
  - Unmarried dependent children beyond age 26 who become incapable of self-support due to physical or mental impairment while covered under the Plan. (You must notify your Human Resources representative of the child's incapacity at least 31 days prior to the child attaining the limiting age. Proof of continuing incapacity may be required by the Claim Administrator or its designee. Coverage continued under this provision is subject to all other provisions of the Plan.)
  - Your domestic partner’s children if they meet the Plan’s definition of eligible child as described here.*

For more information about domestic partner eligibility, contact your Human Resources representative for the required “Affidavit of Domestic Partnership” and the “ITT Domestic Partner Eligibility Information” documents.

* For more information about domestic partner eligibility, contact your Human Resources representative for the required “Affidavit of Domestic Partnership” and the “ITT Domestic Partner Eligibility Information” documents.
HOW TO ENROLL

You have 31 days from the date you are hired or first become eligible for the Plan to enroll for health coverage. If you are a current employee, you can enroll for health coverage during the enrollment period.

When you elect your health benefits, you have the option to choose one of the following levels of coverage:

- Employee only
- Employee plus one dependent
- Employee plus two or more dependents
- No coverage.

If you enroll within 31 days after you first become eligible, coverage begins on the date you first became eligible. If you do not enroll within this 31-day period, you will be considered to have waived coverage.

Documentation evidencing the eligibility of your dependents may be required.

Cost of Coverage

You and ITT share the cost of health coverage, with ITT contributing a large portion of the cost. Your Human Resources representative can provide you with a contribution schedule for the Health Plans. Contributions and the methodology for determining those contributions are subject to review and change by the Company.

Your contributions are automatically deducted from your paycheck as before-tax dollars. This means that you do not pay Federal income or Social Security taxes—and, in most cases, state or local income taxes—on the amount deducted from your paycheck to pay for health coverage. However, because of this special tax treatment, you can only change your election during an enrollment period—to be effective on January 1—unless you have a qualified status change, and provided you are permitted to make a change according to the Plan terms.

Special rules apply to contributions for coverage for domestic partner benefits in accordance with IRS rules. Refer to the “ITT Domestic Partner Eligibility Information” document for these rules.
Changes in Mental Health and Substance Abuse Benefits

In accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, effective January 1, 2010, copays, coinsurance, deductibles, out-of-pocket maximums and treatment limits will be the same for mental health and substance abuse benefits as for medical/surgical benefits.
CHANGING YOUR ELECTION

You can only change your election during a non-enrollment period in the year if you have a qualified status change that affects your eligibility for coverage, such as:

- Change in your legal marital status (marriage, divorce, death of spouse or legal separation)
- Change in your domestic partner status (i.e., an individual meets or fails to meet the domestic partner criteria)
- Change in the number of your dependents (through birth, adoption, placement for adoption or death)
- Your dependent is no longer eligible as a dependent under the Plan
- Commencement or termination of employment by you, your spouse or domestic partner or your eligible dependent(s)
- Change in work schedule by you, your spouse or domestic partner or your eligible dependent(s) resulting in an individual’s becoming (or ceasing to be) eligible under the Health Plans
- Change in residence or work site for you, your spouse or domestic partner or your eligible dependent(s). (The change must affect your eligibility for health coverage.)

Other permissible changes include the following:

- Changes required by a court or administrative order that affects coverage for a child, including a Qualified Medical Child Support Order (QMSCO) resulting from a divorce, legal separation, annulment or change in legal custody that requires health coverage for your child. If the order directs you to cover the child, you may enroll the child (and yourself) in the Health Plans providing that the child meets the Plan’s eligibility requirements. If the order directs someone other than you to cover the child, you may drop health coverage for the child, but only if the other health coverage is actually provided. See the “Qualified Medical Child Support Order (QMCSO)” section on page 35 for further details.
- Significant changes in cost or coverage for yourself or your covered dependent
- Employer contributions cease for coverage that you, your spouse or domestic partner, or your eligible dependent(s) have under another plan
- COBRA continuation period under another plan ends for you, your spouse or domestic partner, or your eligible dependent(s)

- Changes due to entitlement (or loss of entitlement) to Medicare or Medicaid. If you, your spouse or domestic partner, or a covered dependent becomes entitled to (becomes enrolled in) Medicare or Medicaid, you may drop or reduce health coverage for that individual. If you, your spouse or domestic partner or a dependent loses entitlement to Medicare or Medicaid, you may enroll or increase health coverage for that individual (and yourself) in the Plan.

- Changes consistent with taking leave under the Family and Medical Leave Act (FMLA). If you take leave under the FMLA, you may revoke your election under the Health Plans and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA. See the “Continuation of Coverage While on a Family and Medical Leave (FMLA)” section on page 12 for further details.

If you have a qualified status change or other permissible change, you must make a new election **within 31 days of the date of change** by contacting your Human Resources representative. The new election must be consistent with the status change; your Human Resources representative can provide information on the new elections you can make based on your status change. **If you do not make the change within the 31-day period, you cannot make any changes until the next enrollment period (unless you have another qualified status or other permissible change).**

These qualified status changes and the other permissible changes are consistent with the requirements for special enrollment periods under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If regulations or changes in law differ from the above, those regulations or changes will govern.
WHEN COVERAGE ENDS

Your coverage and that of your dependents generally ends when any of the following events occur:

- Your employment terminates, including retirement
- You cease to be an eligible employee
- You stop making required contributions
- You choose to be covered under another health program offered through the Company
- Your severance payments end
- The Plan terminates.

Coverage for your dependents will also end:

- For your spouse, if you divorce or become legally separated
- If your dependent child ceases to be eligible because of age
- For your domestic partner and your domestic partner’s child(ren), if your domestic partner no longer meets the definition of an eligible domestic partner under ITT Salaried Employee Benefit plans
- If your domestic partner’s dependent child ceases to be eligible because of age
- If you stop making required contributions on behalf of your eligible dependents.

In each of the above cases, coverage under the Health Plans ends at the end of the month in which the event occurs. However, you and/or your dependents may be eligible to elect to continue coverage under the Federally-mandated continuation option (COBRA) described on pages 18 – 27. The maximum continuation periods are shown on the chart on page 19.

Coverage for you and your dependents will also terminate on the date your employer ceases to be a participating employer under the Health Plans.
Certificate of Creditable Coverage

When you are no longer covered under the Health Plans, a certificate will be provided in accordance with HIPAA. The certificate identifies the names of you and/or your dependents who had health coverage, and the period of time you and/or they were covered under the Health Plans.

Always keep a copy of your HIPAA certificate for your records—you may need to present the certificate to your new employer at the time you are enrolling for health benefits under the new employer’s plan, especially if you or your dependents have a preexisting condition that would limit coverage under your new employer’s plan.
BENEFITS COVERAGE WHILE ON APPROVED UNPAID LEAVE OF LESS THAN SIX MONTHS

If you are on an approved unpaid leave of absence of less than six months, including approved leaves under the Family and Medical Leave Act (FMLA), your health coverage will remain in effect. (See the following section for more information on FMLA.) You are responsible for paying the employee portion of the cost of this coverage for the duration of your leave. If you choose not to maintain your health coverage during the leave, your coverage will cease at the end of the month in which your leave commences, provided you make the election within 31 days of the date your leave begins.

When you return from an approved leave, you will be able to maintain or reinstate your benefits under the Health Plans, but only in accordance with the elections you had in effect prior to taking your leave, unless you were eligible and chose to make new benefit elections during an enrollment period or due to a qualified status or other permissible change (see page 8).

When coverage ends because your leave ends, or if you fail to return to work after the leave, you may be eligible for health coverage continuation under COBRA as described on pages 18 – 27.

Continuation of Coverage While on a Family and Medical Leave

Under the Federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected health coverage during this time. The previous section details the options available to you if you choose to continue your coverage during your leave or to suspend your coverage during your leave.

If you are eligible, under FMLA, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition
- For a qualifying exigency arising because your spouse, child or parent is on active duty or call to active duty in the Armed Forces in support of a contingency operation
For the care of a covered servicemember with a serious injury or illness incurred in the line of duty on active duty, if you are the spouse, a parent, child or next of kin of the covered servicemember.

If you are eligible, under FMLA, you may take up to 26 weeks of unpaid leave in a 12-month period to care for a family member who is a covered military service member with a serious injury or illness incurred in the line of duty, while on active duty. Leave may not be approved for the same disability for more than one 26-week period.

In addition, if you (or a family member) are a member of the National Guard or Reserves on active duty, you may take job-protected FMLA leave for up to 12 weeks to manage personal affairs with respect to qualifying exigencies for yourself or a family member. Qualifying exigencies are defined as:

- Short-notice deployment
- Military events and related activities
- Child care and school activities
- Financial and legal arrangements
- Counseling
- Rest and recuperation
- Post-deployment activities
- Additional activities where ITT and you agree to the leave.

Depending on the state you live in, the number of weeks of unpaid leave available to you for family and medical reasons may vary, based on state law requirements.
CONTINUATION OF COVERAGE FOR EMPLOYEES IN THE UNIFORMED SERVICES

The following information is provided pursuant to Federal requirements. For specific information about coverage during military leaves of absence, contact your Human Resources representative.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your health coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of 24 months after the leave begins or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA (see page 18). Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your health coverage while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.
In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days.

- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days.

- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.
IF YOU BECOME TOTALLY DISABLED

If you become totally disabled while an active employee, coverage for you and your dependents is available if you remain disabled, assuming you continue making the required contributions. You are considered totally disabled if:

- For the first 18 months, you are unable to perform the duties of your own occupation
- After 18 months, you are unable to engage in any substantial gainful employment for which you are reasonably fitted by education, training or experience.

You will not be considered totally disabled during any period in which you are gainfully employed in any occupation, except for approved rehabilitative employment. All determinations of disability will be made by the Plan Administrator or a third party designated by the Plan Administrator to make these determinations.

If you meet the above criteria for disability, you will be considered a disabled former employee under this Plan. If you fail to meet these criteria, your coverage and eligibility to participate will end.

Contributions for health coverage are the same as those required for active employees and are based on your salary at the time you became disabled. Contributions are subject to periodic change. In addition, contributions for disabled former employees are made on an after-tax basis. If you do not make the required contributions, your coverage and eligibility to participate in the Plan will end.

Coverage for disabled former employees is subject to all Health Plans provisions, including amendments, termination of eligibility and termination of the Health Plans.
IF YOU DIE

If you die while you are an active employee or a disabled former employee, and while you and your dependents are covered under the Plan, coverage for your covered dependents will be continued until the end of the third month following the month in which your death occurred—at no cost to your dependents.

At the end of the three-month period, your covered dependents may elect health coverage under the Federally-mandated continuation option (Consolidated Omnibus Budget Reconciliation Act of 1985, called “COBRA”).

However, if you were eligible for retiree health coverage under the ITT Salaried Retiree Health Plans at the time of death, your eligible dependents may elect health coverage beyond the three-month period described here. This includes eligible dependents of deceased active employees and disabled former employees who would have been eligible for retiree health coverage at the time of death. Coverage is not available beyond the date the dependents no longer meet the definition of “eligible dependents,” nor may any new dependents be added. Contributions for coverage are required and all coverage is subject to the terms and conditions of the Retiree Health Plans. Further details may be obtained from your Human Resources representative.
CONTINUATION OF COVERAGE

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. It generally explains COBRA continuation coverage, when it may become available to you and your covered spouse and dependent children, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 called “COBRA”. COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to your spouse and dependent children who are covered under the Plan when they would otherwise lose such coverage.

What is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when you would otherwise lose such coverage because of a life event known as a “qualifying event” (see chart below for a complete list). After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Additionally, a child who is born to or adopted or placed for adoption with you (the covered employee) during the COBRA continuation coverage period is also considered a qualified beneficiary, provided that you elected COBRA continuation coverage for yourself. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described later in this notice.
## COBRA Qualifying Events

### An overview

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<td>Your spouse loses coverage because you and your spouse legally separate or divorce</td>
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<tr>
<td>Your child loses coverage because the child no longer qualifies as an eligible dependent</td>
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</tr>
<tr>
<td>You lose coverage because you become entitled to Medicare</td>
<td>N/A</td>
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* 36-month period is counted from the date the employee becomes entitled to Medicare.

For information about COBRA coverage for your domestic partner and/or your domestic partner’s eligible dependents, contact your Human Resources representative.

### Detailed list

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
Your employment ends for any reason other than your gross misconduct.

If you are the **spouse of an employee**, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies
- Your spouse’s hours of employment are reduced
- Your spouse’s employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your **dependent children** will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies
- The parent-employee’s hours of employment are reduced
- The parent-employee’s employment ends for any reason other than his or her gross misconduct
- The parent-employee becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (Part A, Part B, or both)
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

Note that “lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. For example, any increase in the premium or contribution that must be paid by you (or your covered spouse or dependent children) for coverage under the Plan that results from the occurrence of a qualifying event is a loss of coverage.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to ITT, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse,
and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. For this purpose, “loss of coverage” also means any substantial elimination of retiree health coverage within one year before or after the date the bankruptcy proceeding commences, for a covered employee who had retired on or before the date of the substantial elimination of group health plan coverage.

How to Elect COBRA

If you or your covered dependents lose coverage as a result of a qualifying event, you will be notified by mail of your COBRA election rights. COBRA must be elected within 60 days of the later of the following dates:

- The date you and/or your covered spouse and dependent children would lose coverage under the Plan as a result of a qualifying event, or
- The date you are sent notice of eligibility to continue coverage, (through a “COBRA Continuation Coverage Election Notice” also called the “COBRA Election Notice”).

You or your covered dependents are responsible for notifying your Human Resources representative within 60 days of a divorce, legal separation, or a child reaching the age at which coverage ends, so that COBRA can be offered and election rights can be mailed to you or your dependents.

Initially, you or your covered dependents are entitled to elect COBRA coverage under the same plan and coverage elections as in effect on the date of the qualifying event. While on COBRA, you or your covered dependents also may add family members to coverage, subject to any legal requirements and any provisions applicable to active employees.

How COBRA Continuation Coverage Is Provided

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a “COBRA Continuation Coverage Election Notice”) to you and or your qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If coverage under the Plan is changed for active employees, the same changes will be provided to individuals receiving COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections during the annual enrollment
periods, if a change in status occurs, or at other times under the Plan to the same extent that: similarly situated non-COBRA employees or retirees may do so.

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is your termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage you, your covered spouse and your dependent children generally lasts for only up to a total of 18 months.

When the qualifying event is your death, your becoming entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both), or your divorce or legal separation, COBRA continuation coverage for the employee's spouse and/or dependent children (but not the employee) lasts for up to a total of 36 months. Also, your dependent children are entitled to COBRA continuation coverage for up to 36 months after losing eligibility as a dependent child under the terms of the Plan.

When the qualifying event is the bankruptcy of ITT, retiree health coverage under the Plan for you and your covered spouse and dependent children may be continued for the rest of your (the retiree’s) life. After your death (including if you have already died when the bankruptcy proceeding commences), your surviving spouse and children may continue retiree health coverage for an additional 36 months after your death.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. With regards to the 11-month disability extension of COBRA continuation coverage, the cost of coverage for the 19th through 29th months of coverage is: 1) 150% of the cost of group health plan coverage for all family members participating in the same coverage option as the disabled individual, and 2) 102% for any family members participating in a different coverage option than the disabled individual, except as provided in the next sentence. If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the qualified beneficiary is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th months), then the cost of coverage for the 19th through 36th months of coverage is: 1) the 150% rate
for all family members participating in the same coverage option as the disabled qualified beneficiary, and 2) the 102% rate for any family members in a different coverage option than the disabled qualified beneficiary.

**Premium Due Dates:** If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Health Plans. Payment is considered made on the date it is sent to the Health Plans.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The premium due date and exact amount due for each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you elect COBRA continuation coverage, but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under the Health Plans, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

**When COBRA Ends**

COBRA coverage ends before the end of the maximum continuation period as soon as one of the following occurs:

- The applicable 18, 29 or 36-month COBRA continuation coverage period ends
- You (or any qualified beneficiary in your family) after electing COBRA, first become covered under another group health plan not offered by ITT, provided the plan does not have a legally valid preexisting condition exclusion or limitation affecting the covered person
- You (or any qualified beneficiary in your family) after electing COBRA, become entitled to Medicare (covered dependents who are not entitled to Medicare can continue coverage under COBRA until the maximum continuation period is reached)
You (or your dependent) fail to make timely premium payments or contributions as required

In the case of extended COBRA continuation coverage due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA continuation coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.

For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation coverage, the date your COBRA continuation coverage period ends unless a second qualifying event has occurred.

ITT no longer provides health benefits to its employees.

When COBRA Can Be Extended

Disability

If you (or your covered dependent) are disabled, as determined by the Social Security Administration, an additional 11 months of COBRA coverage (up to the 29-month maximum) for disability applies when all of the following conditions are met:

- The COBRA qualifying event was a termination of employment or reduction in hours
- The Claim Administrator determines that the covered person is disabled
- You or your eligible dependent is disabled on or before your termination of employment or reduction in hours, or during the first 60 days of COBRA coverage.

If you (or a covered dependent) are disabled, COBRA premiums for months 19–29 generally are based on ITT’s full cost per covered person set at the beginning of the year, plus 50%.

To qualify for this disability extension, you must notify the Plan Administrator in writing of the person’s disability status BOTH:

1) within 60 days after the latest of:
   a. the date of the disability determination by the SSA,
   b. the date on which the qualifying event occurs,
c. the date on which you lose (or would lose) coverage under the plan, or
d. the date on which you are informed of both the responsibility to provide
this notice and the Plan’s procedures for providing such notice to the Plan
Administrator, AND

2) before the original 18-month COBRA continuation coverage period ends. Also,
if Social Security determines that the qualified beneficiary is no longer disabled,
you are required to notify the Plan Administrator [in writing] within 30 days
after this determination. If these procedures are not followed or if the notice
is not provided in writing to the Plan Administrator within the required
period, you will not receive a disability extension of COBRA continuation
coverage.

If a second qualifying event occurs during the 29-month COBRA disability period,
each qualified beneficiary (whether or not disabled) may further extend COBRA
coverage for an additional seven months—for a total of 36 months of COBRA
coverage from the date employment terminated or hours were reduced.

**Eligibility for Medicare**

If you become entitled to Medicare within 18 months prior to termination of
employment (or reduction in hours), your spouse and/or dependent children are
eligible for COBRA continuation coverage for up to 36 months, measured from the
date you became entitled to Medicare. For example, if you become entitled to
Medicare on June 1, 2010, and you terminate your employment on August 1, 2010,
your spouse and/or dependent children will be eligible for up to 36 months of
COBRA continuation, measured from June 1, 2010, which is the date you became
entitled to Medicare.

If a second qualifying event occurs during an 18-month continuation period, your
covered dependents are eligible to continue coverage for no more than 36 months
from the date of the first qualifying event.

The continuation of coverage option is intended to comply with Public Law 99-272
Title X and any related legislation. If regulations or changes in the law differ from
the above, those regulations or changes will govern.

**Second Qualifying Event**

If your spouse and/or dependent children experience a second qualifying event while
receiving the initial 18 months of COBRA continuation coverage, your spouse and
dependent children (but not you) can get up to 18 additional months of COBRA
continuation coverage, for a maximum of 36 months, if timely [written] notice of
the second qualifying event is given to the Plan. This extension may be available to
your spouse and any dependent children receiving COBRA continuation coverage if one of the following events occurs and would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred:

- you die, become entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both), or get divorced or legally separated, or
- if the dependent child stops being eligible under the Plan as a dependent child.

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required 60-day period, you will not receive an extension of COBRA continuation coverage due to a second qualifying event.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.

Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator, for your records.

Plan Contact Information

Please contact your Human Resources representative at your location for information about your ITT Health Plans. Retirees need to contact the ITT Benefits Center, at 1-866-488-4889.

California State-Mandated Continued Coverage After COBRA

California law contains a provision that extends continuation coverage after COBRA ends. This applies only to insured or HMO contracts that are issued, delivered, amended, or renewed in California.

California COBRA provides for an additional 18 months of continuation coverage (not to exceed 36 months from the original qualifying event) for employees, spouses and dependents who elect COBRA but are entitled to less than 36 months of
COBRA. It applies only for qualified beneficiaries who begin their COBRA coverage on or after January 1, 2003, and who have exhausted 18 months of COBRA coverage. The cost for this “after COBRA” coverage is 110% of the applicable rate under the group health plan. Premiums must be remitted to the insurer or HMO, not to the employer.

If you are eligible for this coverage, the insurer will provide additional details if you have a qualifying event.
IF YOU RETIRE

You are eligible for retiree coverage if you meet both of the conditions described below when you stop working:

- You are eligible to retire under the ITT Salaried Retirement Plan (“Salaried Retirement Plan”). To be eligible to retire, you must be:
  - Age 65, or
  - At least age 55 with at least 10 or more years of Eligibility Service, or
  - At least age 50, and your age plus Eligibility Service equals 80 (“Rule of 80”). The Rule of 80 does not apply if you were first hired by ITT on or after January 1, 2000, and also does not apply to employees of companies acquired by ITT after February 1, 1999, regardless of the employee’s original date of hire with that company.

- You were eligible to participate in the ITT Salaried Health Plans for the 10 years immediately preceding retirement. Rehired employees may also meet this requirement if:
  - Your period of service after your break in employment is longer than the length of the actual break, and
  - You were eligible to participate in the ITT Salaried Health Plans for the 10 years of employment immediately preceding retirement.

The following also counts toward this requirement:

- Eligibility for the former ITT Corporation Salaried Health Plans prior to December 19, 1995, and

- Eligibility under the ITT Industries Health Plans from December 19, 1995 to June 30, 2006, and

- Eligibility to participate in a health plan offered by a participating division, subsidiary or unit of ITT to salaried employees at that unit while the unit was part of ITT, and

- Eligibility for participation in the ITT Salaried Health Plans during a severance payment period.

Any period of time during which you are eligible for COBRA coverage, as described on pages 18 – 27, does NOT count toward this eligibility requirement. This applies to COBRA coverage under the ITT Salaried Medical Plan, the ITT Salaried Dental
Plan, the former ITT Corporation Salaried Medical and Dental Plan prior to December 19, 1995, the ITT Industries Salaried Medical Plan and the ITT Industries Salaried Dental Plan from December 19, 1995 to June 30, 2006, or a health plan offered by a participating division, subsidiary or unit of ITT.

If you retire before, on or after you reach age 65 and you are eligible to receive benefits (as described here), you can enroll in dental coverage through MetLife immediately upon your retirement. If you waive coverage at retirement and instead elect COBRA coverage, you will be able to apply for retiree dental coverage by notifying MetLife within 60 calendar days of the termination of your COBRA coverage. However, if you decline coverage at retirement and do not elect COBRA coverage, you will not be able to elect dental coverage at a later date. Details of retiree coverage are described in the ITT Salaried Retiree Health Plans booklet.

**Cost of Retiree Coverage**

If you are eligible for retiree coverage, contributions are required. Contributions for all retirees and the methodology for determining those contributions are subject to periodic review and change by the Company. In addition, the cost of the retiree plan is based on the experience for retirees. It is not the same as the cost for active employees.

**If You Were Hired Prior to January 1, 2000**

Employees who were hired prior to January 1, 2000, and who are eligible for retiree coverage, contribute a percentage of the monthly cost of the Plan with the percentage based on their full years of Eligibility Service under the Salaried Retirement Plan in accordance with the following chart:

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<tr>
<th>Years of Service at Retirement</th>
<th>Retiree’s Share of Cost</th>
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<tr>
<td>10</td>
<td>50%</td>
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<thead>
<tr>
<th>Years of Service at Retirement</th>
<th>Retiree’s Share of Cost</th>
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<td>18</td>
<td>34%</td>
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<td>24</td>
<td>22</td>
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<td>25 or more</td>
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</table>
Special eligibility and contribution rules may apply if you work or worked at a company that was acquired by ITT prior to January 1, 2000. For more information, contact your Human Resources representative.

The cost-sharing percentage is fixed at retirement. Each year, your actual contributions will be adjusted up or down to reflect the premium rate in effect at that time.

In addition, Company contributions will be limited or “capped” with respect to employees who retire after January 1, 1993. The Company’s contribution will not increase beyond the cap and any additional amounts over the cap will be paid by the retirees. The retiree’s cost-sharing percentage will be applied to the capped amount, and the retiree will pay the full amount of the cost above the cap.

**If You Were Hired on or After January 1, 2000**

Employees who are first hired on or after January 1, 2000, and who are eligible for retiree coverage, can choose to participate in the Retiree Health Plans by paying the full monthly cost of the Retiree Health Plans. This also applies to any employee who was employed at a company acquired by ITT on or after January 1, 2000, and who is eligible for retiree coverage, regardless of the employee’s original date of hire with that company.
HOW TO FILE OR APPEAL A CLAIM

Information about how to file or appeal a claim is included in the individual Health Plans booklet or other Plan material.
OTHER INFORMATION YOU SHOULD KNOW

The Health Plans are group health plans that provide health benefits.

Coverage

The benefits provided under the Plans are subject to the terms and conditions of the Plan documents.

Employer Identification Number and Plan Number

The Employer Identification Number (EIN) and the Plan Number can be found in the individual Health Plans booklet or other Plan material.

Plan Year

The Plan year can be found in the individual Health Plans booklet or other Plan material.

Claim Administrator

The Claim Administrator is shown in the individual Health Plans booklet or other Plan material, and is the entity designated to process claims and provide other services.

COBRA Administrator

The COBRA Administrator for ITT Health Plans is:

SHPS Continuation Services
P.O. Box 34240
Louisville, KY 40232
1-800-778-8133

Your Human Resource representative will advise you if the COBRA Administrator differs for any of the Health Plans offered by your ITT company.

Use of the Term “Company”

The term “Company” as used in this booklet, means ITT Corporation and its participating divisions, subsidiaries, affiliates and units. From December 19, 1995 through June 30, 2006, the term “Company” referred to ITT Industries, Inc. and its participating divisions, subsidiaries, affiliates and units.
Plan Administrator

The Plan Administrator is shown in the individual Health Plans booklet or other Plan material.

Agent for Service of Legal Process

The Agent for Service of Legal Process for the Health Plans and the Plan Administrator are:

Prior July 1, 2008: Effective July 1, 2008:

Corporate Secretary Corporate Secretary
ITT Corporation ITT Corporation
4 West Red Oak Lane 1133 Westchester Avenue
White Plains, New York 10604 White Plains, NY 10604
914-641-2000 914-641-2000

The Agent for Service of Legal Process for the Claim Administrator is shown in the individual Health Plans booklets or other Plan material.

Plan Funding

The ITT Salaried Health Plans are self-insured plans. Benefits from the Health Plans are paid from employee contributions and, as applicable, from the general assets of the Company, as needed. However, certain health maintenance organizations (HMOs or DMOs) and certain other health plans offered by ITT are fully insured plans, which means the insurers assume financial responsibility and adjudication of paying claims. Additional information on the insured status of the Plan can be found in the Health Plans booklets or other Plan material.

Organizations Providing Insurance and/or Administrative Services

The organization that provides insurance and/or administrative services is shown in the Health Plan booklets or other Plan material. Information on how to contact that organization is also shown.

The Plan’s Future

The Company expects to continue the Health Plans, but it reserves the right to make changes for active employees, disabled former employees and/or retired employees, and their eligible dependents, including changing the amounts of active employee, disabled former employee and/or retiree contributions or discontinuing the Plan at any time.
In addition, the Health Plans will not pay benefits, including extended benefits, for any expenses incurred after the Health Plans are terminated or amended to terminate a class of covered persons if, for example, your employer ceases to be a participating employer.

Limitation on Assignment

Information about Plan provisions related to assignment of benefits can be found in the Health Plans booklets or other Plan material.

Right of Recovery

Information about Plan provisions when a benefit is paid that is larger than the amount allowed by the Plan can be found in the Health Plans booklets or other Plan material.

Subrogation/Right of Reimbursement

Information about Plan provisions when you (or a covered dependent) suffer an illness or injury that causes you to incur covered expenses due to an act or omission of a third party can be found in the Health Plans booklets or other Plan material.

Compliance With the Law

The terms of the Health Plans and the administration of the Health Plans comply with all applicable laws and regulations. If changes in law or regulations require that changes be made to the Health Plans, those changes in law or regulations will govern.

Circumstances That May Result in Denial, Loss or Forfeiture of Benefits

Under certain circumstances, Health Plan benefits may be denied or reduced from those generally described in the Health Plans booklets or other Plan material. Please read the Health Plans booklet or other Plan material for limitations and exclusions that may apply.

Coordination of Benefits

In situations where you have other primary coverage, the Health Plans have a provision to ensure that payments from all of your group Health Plans do not exceed the amount the Health Plans would pay if it or they was or were your only coverage. The rules relating to how benefits are coordinated can be found in the Health Plans booklets or other Plan material.
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Health Plans will comply with all the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or judgment from a court or administrative body directing a plan to cover a child of a participant for benefits under a company’s health care plans. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child’s representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan’s procedure for determining if the order is valid.

Coverage under the Health Plans pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact your Human Resources representative.

If you, the employee, are required to provide coverage for a child under the terms of a QMCSO, the child will be eligible for coverage under the Health Plans in the same manner as any other eligible dependent. If that child does not meet the definition of eligible dependent, you will not be able to provide coverage under the Health Plans for that child. A full description of the procedures governing a QMCSO may be obtained from the Plan Administrator.
YOUR RIGHTS UNDER ERISA

As a participant in the ITT Salaried Medical Plan and/or the ITT Salaried Dental Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plans and Benefits

- Examine, without charge, at the office of the Plan Administrator and other specified locations, such as worksites, all documents governing the Plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plans, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each member with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue group health coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Group Health Plans, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

If a claim for a Plan 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 steps you can take to enforce these rights. (See “How to File or Appeal a Claim” on page 31). For instance, if you request a copy of Plan documents or the latest annual report from the Plans and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in state or Federal court, but only after you have exhausted the Plan’s claims and appeals procedure as described in the Health Plans booklets. In addition, if you disagree with the Plan’s decision concerning the status of a qualified medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse a 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 a Federal court. The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits
Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-EBSA, logging on to www.dol.gov/ebsa, or contacting the EBSA field office nearest you.

**Plan Document**

This booklet, combined with the individual Health Plans booklets that together form a Summary Plan Description, is intended to help you understand the main features of the ITT Health Plans. It should not be considered a substitute for the Plan documents. The complete terms of the coverage are set forth in the Plan documents issued by the Claim Administrator for each Plan and are subject to amendment. If any questions arise that are not covered in this booklet or the Plan booklets, or if this booklet and the Plan materials appear to conflict with the Plan documents, the text of the Plan documents will determine how questions will be resolved.

**No Guarantee of Employment**

Your participation or eligibility for benefits under the Health Plans described in this booklet is no guarantee of continued employment with ITT.

**Right to Change or Discontinue at Any Time**

As provided in all ITT benefit plans, the terms and conditions of the Plan documents will govern and while ITT expects to continue the Health Plans indefinitely, it reserves the right to change or discontinue the Plans at any time with respect to some or all participants.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We (the ITT Corporation Group Health Plan) use personal health information of Plan participants as part of our normal operations and Plan administration. To protect your privacy, Federal law sets rules about what we can do with your personal health information and gives you certain rights.

Note: If you are covered by an insured health option under the ITT Corporation Group Health Plan (also referred to in this notice as the “Plan”), you will also receive a separate notice from your insurer or HMO.

This notice explains:

- How your personal health information (called “Protected Health Information”) may be used, and
- What rights you have regarding this information.

How the ITT Corporation Group Health Plan May Use Your Information

We are permitted by law to use and disclose your Protected Health Information in certain ways without your authorization:

For treatment. We may use and disclose your Protected Health Information to coordinate or manage health care services you receive from providers. For example, so that your treatment and care are appropriate, your physician may use your information to consult with a specialist regarding your condition.

For payment. We may use and disclose your Protected Health Information to determine plan eligibility and responsibility for coverage and benefits. For example, to make sure that you receive the correct benefits and claims are paid accurately, we may use your information when we confer with other health plans to resolve a coordination of benefits issue. We may also use your Protected Health Information for utilization review activities.

For health care operations. We may use your Protected Health Information in several ways, including Plan administration, quality assessment and improvement, and vendor review. Your information could be used to ensure quality and efficient Plan operations, for example, to assist in the evaluation of a vendor who supports us. We also may contact you with appointment reminders or to provide information 

January 1, 2011
about treatment alternatives or other health-related benefits and services available under the Plan.

We may also disclose your Protected Health Information to ITT Corporation (the Plan Sponsor) in connection with these activities or for purposes related to your enrollment or disenrollment in the Plan. If you are covered under an insured health plan, the insurer also may disclose Protected Health Information to the Plan sponsor in connection with any of these activities.

Other Permitted Uses and Disclosures

Federal regulations allow us to use and disclose your Protected Health Information, without your authorization, in accordance with law, for several additional purposes, including:

- Public health
- Reporting and notification of abuse, neglect or domestic violence
- Oversight activities of a health oversight agency
- Judicial and administrative proceedings
- To law enforcement officials
- To a coroner or medical examiner
- To certain organ, eye or tissue donation programs
- To avert a serious threat to health or safety
- Specialized government functions (e.g., military and veterans’ activities, national security and intelligence, Federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- Research, as long as certain privacy-related standards are satisfied
- Workers’ compensation or similar programs established by law that provide benefits for work-related injuries or illness
- Other purposes required by law, provided that the use or disclosure complies with, and is limited to, the relevant requirements of such law.
In Special Situations

We may disclose your Protected Health Information to a family member, relative, close personal friend, or any other person whom you identify, when that information is directly relevant to the person’s involvement with your care or payment related to your care.

We also may use your Protected Health Information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what, in our judgment, is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person’s involvement with your health care.

We will make other uses and disclosures only after you authorize them in writing. You may revoke your authorization in writing at any time.

Your Rights Regarding Protected Health Information

You have the right to:

- Inspect and copy your Protected Health Information
- Request that inaccurate information be amended or corrected
- Receive a paper copy of this notice, even if you agreed to receive it electronically
- Receive an accounting of certain disclosures of your Protected Health Information made by us.

However, you are not entitled to an accounting of several types of disclosures including, but not limited to:

- Disclosures made for payment, treatment or health care operations
- Disclosures you authorized in writing
- Disclosures made before April 14, 2003.

Right to Request Restrictions

You may ask us to restrict how we use and disclose your Protected Health Information as we carry out payment, treatment, or health care operations. You may also ask us to restrict disclosures to your family members, relatives, friends, or other...
persons you identify who are involved in your care or payment for your care. However, we are not required to agree to these requests.

**Right to Request Confidential Communications**

You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have Protected Health Information sent by mail or to an address other than your home.

*For more information about exercising these rights, contact the ITT Corporation Group Health Plan Privacy Office, listed below.*

**Complaints**

If you believe that your privacy rights have been violated, you may file a written complaint without fear of reprisal. Direct your complaint to the ITT Corporation Group Health Plan Privacy Office, listed below under “Contacting Us,” or to a Regional Office of the Office of Civil Rights, U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

**About This Notice**

We are required to provide you this notice regarding our privacy policies and procedures, and to abide by the terms of this notice, as it may be updated from time to time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information we maintain. If we change this notice, you will receive a new notice.

**Contacting Us**

You may exercise the rights described in this notice by contacting the ITT Corporation Group Health Plan Privacy Office identified below, which will provide you with additional information. For more details, please see the following page.
You can contact the ITT Corporation Group Health Plan Privacy Office through the Human Resources department for your ITT Corporation employer or by directing your inquiry to:

Effective July 1, 2008:

ITT Corporation Group
Health Plan Privacy Office
c/o ITT Corporation
1133 Westchester Avenue
White Plains, NY 10604
Telephone: 914-641-2000

This address may also be used for filing complaints.