IMPORTANT INFORMATION ABOUT THE PLAN

The Plan provisions contained in this booklet apply to the ITT Salaried Dental Plan (“the Plan”) as of July 1, 2008, administered by Metropolitan Life Insurance Company (“MetLife”). This booklet is an integral part of the Summary Plan Description (“SPD”) for the Plan as it describes your Dental Plan benefits. The full SPD required under the Employee Retirement Income Security Act of 1974 (ERISA) is this booklet, along with the ITT Salaried Medical Plan and Salaried Dental Plan General Plan Terms (“General Plan Terms”) booklet.

This booklet provides you with specific information about the benefits available under this Plan, explains how to file and appeal claims and provides other important information.

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

Claims under the Plan are administered by MetLife. The Plan, however, is self insured, meaning ITT pays the majority of the costs directly, and you pay the employee portion.

The General Plan Terms is a separate booklet, but is referenced here as needed.

We encourage you to read this booklet and the General Plan Terms booklet 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 Plan provides coverage for your dental 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 Plan and pay for those services from other resources.

Please note: 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.
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HIGHLIGHTS OF YOUR DENTAL BENEFITS

The ITT Salaried Dental Plan ("the Plan") helps make dental care more affordable for you and your eligible dependents by covering a portion of your dental expenses.

The Plan is structured as a preferred provider organization plan (a “PPO”) that offers you the option of receiving dental care from any provider you choose.

The PPO offers discounted fees if you use a dental provider who participates in the PPO network. Under the Plan, you and your covered family members have the choice to visit any dental provider you want and receive benefits.

Regardless of whether you visit a dental provider in the network or outside of the network, the deductibles and coinsurance percentages will be the same. However, because of network discounts, your costs will generally be lower if you choose a dental provider who participates in the network. In addition, your annual maximum benefit and your maximum orthodontia benefit will be greater if you use a network dental provider.

**Dental Plan at a Glance**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Calendar Year Deductible</td>
<td>$50 per person</td>
<td>$150 maximum per family</td>
</tr>
<tr>
<td>Diagnostic and Preventive Care* — oral exams and cleanings (two times per calendar year), x-rays (once every five years)</td>
<td>100%, no deductible</td>
<td></td>
</tr>
<tr>
<td>Basic Care — fillings, extractions and root canals</td>
<td>80%, after deductible</td>
<td></td>
</tr>
<tr>
<td>Major Care — crowns, bridgework and dentures</td>
<td>50%, after deductible</td>
<td></td>
</tr>
<tr>
<td>Orthodontia**</td>
<td>50%, up to $2,000 per lifetime</td>
<td>50%, up to $1,500 per lifetime</td>
</tr>
<tr>
<td>Annual Maximum Benefit**</td>
<td>$1,500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

* Sealants for children under age 19 are also covered if the sealants are on molars. Sealants on all other teeth are not covered. Full mouth x-rays are limited to once every five calendar years. Bitewing x-rays are covered (two sets in any calendar year up to age 19; one set per year thereafter). Fluoride treatments are covered for children up to age 14—one treatment per calendar year. Brush biopsies are covered once every two years.

** In-network and out-of-network orthodontia maximum benefits and Annual Maximum Benefits are integrated; they are not cumulative (see page 10 for details).
Special Dental Enrollment Periods

There is an enrollment period for the Plan every two years, for coverage effective January 1, 2011, January 1, 2013 and following. This means that when you enroll in the Plan or waive coverage during the enrollment period, you are making your election for two years. You will not be able to make any changes to your Plan election unless you have a qualified change in status and make your new election within 31 days of the qualified status change. (See “Changing Your Election” in the General Plan Terms for more information.)

If you are a new employee, you are making your election for the period between your date of hire and the next dental enrollment period.

For example, if as an existing employee, you waived coverage in the fall of 2008, that waiver is in effect for 2009 and 2010 and you will not be eligible for dental benefits again until January 1, 2011. This rule also applies to any election you make regarding dependent coverage for each individual dependent. A newly hired employee has the opportunity to elect dental coverage during their first 31 days of employment, and then going forward the above timelines apply.
HOW THE PLAN WORKS

The Plan pays benefits for covered services regardless of the dental provider you see for care. However, MetLife offers a network of dental providers that offer dental services at reduced costs.

The MetLife Preferred Dentist Program (“PDP”) is a Preferred Provider Organization (“PPO”), which means you choose the dentist of your choice at the time of treatment. You do not have to select a primary dentist, there is no ID card to show and there are no referrals needed for specialty care.

If you choose to receive care from a network dental provider:

- Services are provided at discounted network rates.
- Your annual maximum benefit and your maximum orthodontia benefit will be greater.
- You do not have to file claim forms; network dentists will file claims for you directly with the Claim Administrator.

Finding a Network Provider

To get a list of network dental providers in your area, you can access the MetLife Dental PPO directory online at www.metlife.com/dental. You can also call MetLife at 1-866-665-1467. Representatives are available Monday through Friday, 8 a.m. to 11 p.m., Eastern time.

MetLife’s Concern for Quality Providers

To participate in the network, dental providers must go through the MetLife Dental PDP credentialing process. Participating dental providers must provide or demonstrate:

- Current, valid license to practice in the state
- Certificate(s) verifying specialty training
- Acceptable malpractice coverage and malpractice claims history
- Compliance with professional standards on sterilization techniques, infection control, etc.
Reasonable and Customary (R&C) Limits

R&C limits are based on the range of fees charged by dental providers with comparable training and experience for the same or similar service in the area where you get care. When you receive care out-of-network, the Plan pays benefits based on R&C limits. If your expenses are higher than the R&C limit, you are responsible for paying the additional amount. Since network providers pre-negotiate discounted fees, R&C limits do not apply when you use network providers for covered services. R&C limits are determined by the Claim Administrator.

The Deductible

Each year, you must meet a $50 individual deductible ($150 per family) before the Plan begins to pay benefits for covered basic and major care expenses. The deductible does not apply to diagnostic and preventive care or orthodontia.

If you are covering yourself and more than two dependents under the Plan, you can begin to receive benefits from the Plan once the total covered expenses for all individuals equals the $150 family deductible, even if no one person has met the individual deductible. (No one family member’s expenses over $50 can be used to satisfy the family deductible.)

An Example: Meeting the Family Deductible

Your family could meet the family deductible with the expenses listed below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>$50</td>
</tr>
<tr>
<td>Your spouse</td>
<td>+ $40</td>
</tr>
<tr>
<td>Your son</td>
<td>+ $30</td>
</tr>
<tr>
<td>Your daughter</td>
<td>+ $30</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>= $150</td>
</tr>
</tbody>
</table>

January 1, 2010
Predetermination of Benefits

You can protect yourself from unexpected out-of-pocket dental expenses by requesting a predetermination review from the Claim Administrator before your dental provider starts any extensive treatment. A predetermination review will tell you exactly what the Plan will and will not cover, and whether an out-of-network provider’s charges will fall within the Plan’s R&C guidelines, before you receive services.

To request a predetermination review, you or your dentist should submit a treatment plan to the Claim Administrator. The treatment plan should be completed by your dental provider and include a description of the proposed treatment and expected charges.

Your dental provider may want to suggest several different treatment options on the treatment plan. If multiple treatment options are listed on the treatment plan, an allowable amount will be indicated for each procedure. Of course, only expenses for one treatment option will be covered, and only up to the Plan maximums for that calendar year.

Benefits for all services will be based on the materials and method of treatment which cost the least, and which meet generally accepted dental standards, as determined by the Claim Administrator.
COVERED EXPENSES

Diagnostic and Preventive Care

The Plan pays 100% of the covered charges for diagnostic and preventive care, and you do not have to meet the deductible before the Plan will pay for these expenses.

Diagnostic and preventive care includes:
- Oral exams
- Routine x-rays
- Routine cleanings (prophylaxis)
- Fluoride treatments for children under age 14
- Molar sealants for children under age 19
- Emergency dental care
- Space maintainers (non-orthodontic) (up to age 14).

When Receiving In-Network Care

The Plan has a PPO feature. If you receive in-network services, be sure your dental provider knows that the Plan is MetLife’s Preferred Dentist Program (“PDP”), not another type of managed dental plan.

Remember

All out-of-network charges are subject to R&C limits as determined by the Claim Administrator.

The Plan covers oral exams and cleanings two times per calendar year for each covered individual.

Full mouth x-rays, including panorex x-rays, are covered once every five calendar years. Bitewing x-rays are covered twice each calendar year up to age 19 and once each calendar year, thereafter.
Basic Care

The Plan pays 80% of the covered charges for the following basic care expenses after you meet the deductible:

- Fillings (other than gold)—composite fillings are covered on anterior teeth and molars; amalgam fillings are covered on all other teeth
- Extractions
- Root canals
- Treatment for gum disease (periodontics)—including periodontic maintenance treatments (see page 13)
- Oral surgery
- Denture or bridgework repair
- Rebasing and relining of dentures that are more than six months old (not more than one time in any 36-month period)
- General anesthesia with oral surgical procedures covered under the Plan when necessary based on generally accepted standards of dental care as determined by the Claim Administrator.

Major Care

The Plan pays 50% of the covered charges for the following major care expenses after you meet the deductible:

- Inlays, onlays, gold fillings, crowns, laminates, veneers, cast restoration and other laboratory fabricated restorations
- Full or partial dentures and fixed bridgework including initial installations, alterations and replacements
- Dental implants and related expenses, such as surgery, bridgework and dentures.
- Scaling and root planings, up to two per quadrant every 24 months
- Replacement of any prosthetic appliance, crown, inlay or onlay restoration, laminate, veneer, cast restoration, other laboratory fabricated restoration, fixed bridge or bruxism appliance with an 84 month replacement limit.
Inlays, Onlays and Crowns

Installation of inlays, onlays, crowns, laminates, veneers and other laboratory fabricated restoration are covered when due to decay or traumatic injury to the tooth and the tooth cannot be restored with a routine filling material. Replacement inlays, onlays and crowns are covered if the existing prosthesis is at least five years old and unserviceable.

Dentures and Fixed Bridgework

Expenses are covered for initial installations and additions to existing dentures or bridgework.

Replacement of dentures or fixed bridgework is covered if the replacement is more than five years after the installation of dentures being replaced.

Remember

You may want to request a predetermination review and consider R&C limits and the Plan’s maximum benefits (see page 10) before your dentist begins any extensive treatment.

Orthodontia

The Plan pays 50% of the covered charges for orthodontic treatment and appliances.

A course of orthodontic treatment begins when the first brace (appliance) is installed and ends when the last brace (appliance) is removed.

How Orthodontia Benefits Are Calculated

Orthodontia benefits are calculated over the course of treatment, as follows:

- Your dental provider completed a treatment plan indicating the expected length of treatment and total fee, which includes any charges for services rendered before the first brace is installed.

- Twenty-five percent of the total fee (but not more than the R&C limit or the orthodontia lifetime maximum) is paid as a benefit when the first brace is installed.

- The balance of the orthodontia lifetime maximum is prorated over the estimated duration of the treatment and payments are made quarterly.

- You are reimbursed 50% of each of these covered charges, until the orthodontia lifetime maximum benefit (see page 11) is reached.
The total benefit paid over the course of the treatment plan will never exceed 50% of the total cost up to the orthodontia lifetime maximum whether in- or out-of-network.

If you are receiving care from an out-of-network provider, you must submit a claim in order to be reimbursed.

**Important Note**

Benefits for all services will be based on the materials and method of treatment which cost the least, and which meet generally accepted dental standards, as determined by the Claim Administrator.

### An Example: Advantages of Using Network Dental Providers

The following example illustrates some of the advantages of using an in-network dental provider who charges discounted fees.

Suppose that you have met the deductible for the year and now you need to have some root canal work done. This is basic care, so the Plan will cover 80% of the cost of care. Let’s assume that the out-of-network dentist charges $700 and the network dentist has agreed to a charge of $500 for the same service, as shown in the following table:

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered charges</td>
<td>$500</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance percentage</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>The Plan pays</td>
<td>$400</td>
<td>$560</td>
</tr>
<tr>
<td>Total you pay</td>
<td>$100</td>
<td>$140</td>
</tr>
</tbody>
</table>

As you can see, you would save $40 by visiting a dentist in the network, since network dentists charge discounted fees. This example assumes that the $700 charged by the out-of-network dentist was within R&C limits. If the charge had been over the R&C limit, your out-of-pocket costs for using the out-of-network dentist would be more. R&C limits do not apply when you use network dental providers for covered services.
PLAN LIMITATIONS

Maximum Benefits

*Annual Maximum Benefit*

For each covered person, the Plan will pay an annual maximum benefit for eligible dental expenses. The annual maximum benefit is:

- $1,500 for in-network services
- $1,000 for out-of-network services.

In-network and out-of-network annual maximum benefits are not cumulative. In other words, you cannot receive $1,500 for in-network services and then an additional $1,000 for out-of-network services.

| Service                          | Amount         | Benefit paid/denied due to
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Extractions (in-network)</td>
<td>$300</td>
<td></td>
</tr>
<tr>
<td>Bridgework (out-of-network)</td>
<td>$700</td>
<td></td>
</tr>
<tr>
<td>Total benefits paid (in- and out-of-network)</td>
<td>$1,000</td>
<td></td>
</tr>
<tr>
<td>Additional extractions (in-network)</td>
<td>$300 benefit paid</td>
<td></td>
</tr>
<tr>
<td>Additional extractions (out-of-network)</td>
<td>$400</td>
<td>benefit denied due to being over the annual maximum allowable for out-of-network</td>
</tr>
</tbody>
</table>

As you can see, you have received $1,000 from the Plan for in- and out-of-network services. Once you receive $1,000 of benefits in a calendar year for any combination of in-network and out-of-network services, you can receive up to an additional $500 of benefits provided that the services are received from a network provider. Additional out-of-network services for that calendar year will not be covered. Therefore, the order in which you receive services can affect your annual maximum benefit.
**Maximum Benefit for Orthodontia Services**

The maximum lifetime benefit for orthodontia services, or the “orthodontia lifetime maximum” is:

- $2,000 for services received in-network
- $1,500 for services received out-of-network.

In-network and out-of-network maximum orthodontia benefits are not cumulative. In other words, you cannot receive $2,000 for in-network services and then an additional $1,500 for out-of-network services.

The maximum benefit for orthodontia services does not apply toward the annual maximum benefit; it is a separate benefit and orthodontia has a separate lifetime maximum.

**When Dental Expenses Are Incurred**

It is important to understand when a dental expense is considered to be incurred under the Plan. For most services, an expense is incurred when the service is performed. For the following services, the expense is considered to be incurred:

- When the impression is taken and/or abutment teeth are fully prepared, in the case of dentures or fixed bridgework
- When preparation of the tooth is begun, in the case of crown work, inlays or onlays
- When work on the tooth is begun, in the case of root canal therapy
- When the first brace (appliance) is installed, in the case of orthodontia.

**Expenses Not Covered**

The following dental expenses are not covered by the Plan:

- Expenses not recommended and approved by a dentist legally licensed to practice dentistry
- Expenses for services by other than approved classifications of providers (approved classifications include dentists licensed or certified by the state in which the services are provided and acting within the scope of that license or certificate)
- Expenses for services provided by a relative (a relative means you or your spouse, your spouse’s parents, grandparents, grandchildren, a child, a
brother or sister or any of the following in-laws: sister, brother, son, daughter, grandparent or grandchild)

- Expenses above what are R&C, as determined by the Claim Administrator
- Expenses above those which are determined to be above the least costly materials and method of treatment and/or which do not meet generally accepted dental standards, as determined by the Claim Administrator
- Expenses for injuries or illnesses that would be covered under any Workers’ Compensation or similar law, whether or not such coverage is in effect
- Expenses for any service, supply or treatment that is not necessary for the diagnosis or treatment of the patient’s condition. (No service, supply or treatment will be considered necessary if it is experimental. The Claim Administrator will determine what is necessary for the treatment of an injury or illness.)
- Expenses for unnecessary repetition of tests or services, as determined by the Claim Administrator
- Expenses in connection with cosmetic dental work
- Expenses for services, supplies and treatment provided or covered under any government plan or law, including state and local governments, entities or agencies
- Expenses that are deemed to be medical services (i.e., accidental injury, removal of tumors)
- Expenses for any loss caused or contributed by war or act of war (declared or not), including any expenses incurred for injuries sustained while in the armed forces of any country engaged in war or other armed conflict
- Expenses reimbursed directly by any employer or potential employer
- Expenses neither you nor any other covered person has a legal obligation to pay
- Expenses incurred in a Veteran’s Administration Hospital for a covered person with a military service related injury or illness
- Expenses received from a dental department maintained by any employer, a mutual benefit association, labor union, trustee or similar group
- Expenses for injury or illness sustained as a result of doing any work for pay or profit
- Expenses for preventive procedures other than as provided under the “Diagnostic and Preventive Care” section
- Expenses for any court-ordered charges that would not otherwise be covered under this Plan
- Expenses in excess of the stated Plan limits
- Expenses for the treatment of Temporomandibular Joint Dysfunction (TMJ)
- Expenses for prescription drugs
- Expenses for periodontic maintenance except as described below:
  - Periodontic maintenance performed at least three months after active periodontic treatment
  - Only four periodontic maintenance treatments in any calendar year period (this limit of four cleanings includes all routine and periodic maintenance cleanings)
- Expenses for filing claims
- Expenses for any scalings and root planings in excess of two per quadrant every 24 months
- Expenses for services that are experimental procedures or treatment methods not approved by the American Dental Association or the applicable dental specialty society
- Expenses for the replacement of any prosthetic appliance, crown, inlay or onlay restoration, laminate, veneer, cast restoration, other laboratory fabricated restoration, fixed bridge or bruxism appliance in excess of the 84 month replacement limit
- Expenses for dental splinting—bite registrations, precision or semi-precision attachments
- Expenses in connection with oral hygiene, plaque control programs, home fluorides or dietary instructions
- Expenses to replace lost or stolen dentures, bridgework or other appliances
- Expenses for duplication of x-rays or records.
COORDINATION OF BENEFITS (COB)

General COB Rules

If you or a covered dependent incur expenses that are also covered under another plan, benefit payments will be coordinated between plans. One plan will be primary and the other will be secondary. The primary plan is the plan that will pay benefits first.

When your ITT coverage is secondary, the total reimbursement from the two plans cannot exceed what the ITT Plan would have paid if it had been the only coverage.

The Plan coordinates with any plan that provides dental benefits. Typical plans include those sponsored by other employers (for example, your spouse’s employer’s plan). They could also include automobile “no-fault” or “fault” insurance plans, hospital indemnity plans, HMOs and other pre-payment plans, Medicare supplemental plans, blanket or franchise coverage; labor management trustee plans, union welfare plans and employer/employee organization plans.

The following additional rules apply to COB:

- If a plan does not have a provision for coordination of benefits, that plan is always considered primary.

- In determining the order of benefits payable, if none of the stated rules apply, then the plan that has covered you longest will be considered primary.

- Any benefits payable include those that you could have collected, but for which you chose not to apply.

- The ITT Plan determines coordination of benefits in accordance with generally accepted insurance industry practices (these practices are subject to periodic revision).

In administering COB, the Claim Administrator has the right to make determinations regarding certain payments, as described below:

- To recover any payment that has been paid in excess of the proper amount

- To reimburse any other plan when they paid in error

- To obtain or release any information pertaining to the processing of your claim
To determine who is primary in each instance while considering the ITT Plan and the other plans providing coverage.

**No-Fault Auto Coverage**

If you or an eligible dependent are involved in a motor vehicle accident, payment for dental services will be coordinated between the ITT Plan and your auto insurance carrier, as follows:

- Whether or not your auto coverage has a coordination of benefits provision, your auto insurance carrier is primary.
- The ITT Plan will be secondary to your no-fault auto insurance. The ITT Plan will reject auto accident-related claims received without proof of primary payment by the auto insurer.

It is important that you discuss this with your auto insurance company.

**For You and Your Spouse**

If you are covered by another dental plan, the ITT Plan coordinates benefits with the other plan.

The ITT Plan is the primary plan when you are the patient. If your spouse has other dental coverage, your spouse’s plan will pay first if your spouse is the patient and second, if you are the patient.

If you have two employer-provided coverages, the plan that covers you as an active employee is primary and the plan that covers you as a retiree or laid-off employee is secondary.

**For Your Covered Children**

If your child is covered by both the ITT Plan and your spouse’s plan, the decision about which plan pays first is determined by the “birthday rule.” This means the ITT Plan pays first if your birthday (month/day) comes before your spouse’s in the calendar year.

If your child is covered as a dependent under this Plan and you and the other parent are divorced or separated, benefits are determined as follows:

- Benefits under the plan of the parent who has custody will be determined first.
- Benefits under the plan of the spouse of the parent with custody (the stepparent) are determined next.
Benefits under the plan of the parent not having custody will be determined last.

However, if there is a court decree that establishes financial responsibility for your covered child, the benefits under the plan of the parent with this responsibility will be determined first.

If you and the child’s other parent share joint custody, without stating that one parent has financial responsibility, benefits will be determined in accordance with the standard “birthday rule.”
EXTENDED BENEFITS WHEN COVERAGE TERMINATES

If you or a dependent began dental treatment, including orthodontic treatment, before coverage terminated, benefits for the unfinished covered dental expense will be payable if the dental expense is considered to have been incurred before coverage terminated. (See page 11 for information about when an expense is incurred.) Under no circumstances will benefits be payable for any services performed more than three months after coverage is terminated.
HOW TO FILE OR APPEAL A CLAIM

If you stay in-network for dental treatment, you do not need to file any claim forms. Network providers file claims for you directly with the Claim Administrator.

If you go out-of-network, a claim form must be submitted in order for you to be reimbursed for your dental expenses. Claim forms are available from your Human Resources representative. To file a claim, you should send the bill and completed claim form to:

MetLife
Group Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

All claims should be submitted promptly. Claims must be submitted to the Claim Administrator within two years after the expense is incurred.

After a claim is submitted, you will receive an Explanation of Benefits (EOB) that will provide information about the charge submitted, the amount covered and the amount paid by the Plan. All claim determinations are made by the Claim Administrator in accordance with generally accepted practices.

The Plan requires information regarding other health insurance coverage for you and any of your eligible dependents. The Claim Administrator will periodically request other coverage information from you. This request may occur in connection with a submitted claim. If so, you will be advised that the other coverage information (including an explanation of benefits from the other administrator or insurer) is required before the submitted claim will be processed for payment.

When you file a claim under the ITT Salaried Dental Plan, benefits are generally paid as soon as possible. However, in rare instances, the claim may receive what’s called an “adverse benefit determination,” which is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit. Often, a claim may receive an adverse benefit determination simply because you haven’t provided sufficient information.

Health services and benefits must be medically necessary to be covered under the Plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested and the type of health plan. Medical necessity determinations are made on either an urgent care, pre-service, post-service or concurrent care basis, as described in this section.
About Benefit Determination

For **urgent care and pre-service claims**, the Claim Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- **Urgent care** — 72 hours after receipt of a claim that is initiated for urgent care (a decision can be provided to you verbally, as long as a written or electronic notification is provided to you within three days after the verbal notification)

- **Pre-service care** — 15 days after receipt of a claim that is initiated before the service has been provided.

For **post-service claims**, the Claim Administrator will notify you of an adverse benefit determination (i.e., any denial, reduction or termination of a benefit, or a failure to provide or make a payment) within 30 days after receipt of a claim.

The notification will be provided either in writing or electronically and will include:

- The specific reason(s) for the adverse benefit determination

- References to the specific Plan provisions on which the benefit determination is based

- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary

- A description of the Plan’s appeal procedures and time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination

- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request

- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request

- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim.
For urgent care claims, if you fail to provide the Claim Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claim Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The Claim Administrator’s receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For pre- and post-service claims, a 15-day extension may be allowed, provided that the Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claim Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your failure or your provider’s failure to submit necessary information, the Plan’s time frame for making a benefit determination is stopped from the date the Claim Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan’s procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be verbal, unless you or your authorized representative request written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, and
- Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.
If you have questions about any health-care claim you submitted or if you submitted a claim and did not receive a response, please contact the Claim Administrator.

### Urgent Care Claims

Urgent care claims are those which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient’s health or ability to regain maximum function, or
- In the opinion of a physician with knowledge of the patient’s medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient’s medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

### Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. Your request for review or reconsideration must be made in writing (except in the case of an urgent care claim) to the office where the claim was originally submitted within 180 days after you receive notice of an adverse benefit determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, information is treated as relevant to your claim if it:

— was relied upon in making the benefit determination
— was submitted, considered or generated in the course of making the benefit determination, regardless of whether the document, record or other information was relied upon in making the benefit determination
— demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
— constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether the statement was relied upon in making the benefit determination

A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination

A review that does not defer to the initial adverse benefit determination and that is conducted by someone other than the individual who made the adverse determination, nor that person’s subordinate

Require the individual(s) reviewing the appeal to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was not consulted in connection with the initial adverse benefit determination, nor the subordinate. This applies if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment

The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision

In the case of a claim for urgent care, an expedited review process in which:

— you may submit a request (verbally or in writing) for an expedited appeal of an adverse benefit determination, and
— all necessary information, including the Plan’s benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method.

It is mandated that a decision be reached within:

January 1, 2010
■ 72 hours after receipt of your request for review of an urgent care claim

■ 15 days after receipt of your request for review of a claim initiated before the service has been provided

■ 30 days after receipt of your request for review of a claim initiated after the service has been provided.

The Claim Administrator will notify you of any adverse benefit determination, including:

■ The specific reason(s) for the adverse benefit determination

■ References to the specific Plan provisions on which the benefit determination is based

■ A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim

■ A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA

■ Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination or a statement that a copy of this information will be provided free of charge to you upon request

■ If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claim Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Please note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

Further Appeal

If you are still dissatisfied with the benefit determination, you may submit your written request to the office where the claim was originally submitted for further review within 60 days after you receive the decision, together with any additional information you have in support of your request. In addition, you should also send a copy of your request to the Claim Administrator at the following address:

MetLife
Group Dental Claims
P.O. Box 14589
Lexington, KY 40512-4589

A decision on this review of your claim will be given to you in writing, explaining the reasons for the decision, with reference to the applicable provisions of the Plan. It is mandated that this decision be reached within:

- 72 hours after receipt of your request for review of an urgent care claim
- 15 days after receipt of your request for review of a claim initiated before the service has been provided
30 days after receipt of your request for review of a claim initiated after the service has been provided.

The Claim Administrator will notify you of any adverse benefit determination, including:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such will be provided free of charge upon request.

You must use and exhaust this Plan’s administrative claims and appeals procedure before bringing a suit in either state or Federal court. Similarly, failure to follow the Plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.
TERMS YOU NEED TO KNOW

It is important that you have a basic understanding of a few key terms that have special meaning in the Plan. These terms are defined in this section.

Coinsurance Percentage — The percentage of covered charges paid by the Plan.

Covered Charges — Eligible charges to which the coinsurance percentage and deductible apply. Covered charges include charges not in excess of Reasonable and Customary (R&C) limits, and charges for services considered to be necessary for care of teeth.

Deductible — The amount you pay each year for covered dental services before the Plan begins to pay benefits. You only have to satisfy one deductible for in-network and out-of-network care. Once the deductible is met, covered dental expenses (either in- or out-of-network) are not subject to any further deductible for the rest of that calendar year.

Dental Provider — Licensed dental professionals, such as dentists, orthodontists and periodontists, who provide dental services.

Necessary or Necessity — “Necessary” or “necessity,” when used in connection with a treatment, service or supply, means that the treatment, service or supply is consistent with and recognized by dentists as currently accepted practice in the diagnosis and treatment of a dental condition, and is generally considered by dentists to be the most appropriate level of service, supply, treatment or device to provide safe and adequate care for a given dental condition.

In order to determine if a treatment meets the definition, the Claim Administrator may use, but is not limited to, assessments and publications issued by medical organizations and professionals or by government agencies which assess new, unestablished or changed methods of dental treatment and technologies.

Services provided by a dentist or physician are determined by the Claim Administrator to be medically/dentally necessary if they are:

- Required for the diagnosis and/or treatment of the particular dental condition or disease
- Consistent with the symptoms or diagnosis and treatment of the dental condition or disease
- Commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease
The most fitting level of service which can be safely given to the patient.

A diagnosis, treatment and service with respect to a dental condition or disease is not medically/dentally necessary if made, prescribed or delivered solely for the convenience of the patient or provider.

**Reasonable and Customary (R&C)**—A charge which is usually made by a large majority of dentists and other providers of services within the locality where the service is rendered. It also means a charge commonly made based on the complexity of the service or treatment and the severity of the condition or injury. The term “locality” means a geographic region, determined by the Claim Administrator, that is large enough to obtain a cross section of R&C charges. You are responsible for any portion of your expenses that exceeds R&C charges. R&C limits do not apply when you use network providers for covered services. All R&C limits are determined by the Claim Administrator.
OTHER INFORMATION YOU SHOULD KNOW

This information about the administration of the Plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about the Plan.

The ITT Salaried Dental Plan is an employee welfare benefit plan that provides dental benefits. Prior to July 1, 2006, the name of the Plan was the “ITT Industries Salaried Dental Plan.”

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.

Coverage

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

Employer Identification Number

13-5158950

Plan Number

597

Claim Administrator

MetLife
Group Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

MetLife is the Claim Administrator for the Plan. MetLife provides claim processing and related services to the Plan. Benefits under the Plan are not guaranteed by MetLife or by any third party.
Plan Sponsor and Plan Administrator

The name, address and telephone number of the Plan Sponsor and Plan Administrator are:

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

ITT Corporation
4 West Red Oak Lane
White Plains, NY 10604
(914) 641-2000

ITT Corporation
1133 Westchester Avenue
White Plains, NY 10604
(914) 641-2000

Agent for Service of Legal Process

The name, address and telephone number of the agent for service of legal process on the Plan and the Plan Administrator are:

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

Corporate Secretary
ITT Corporation
4 West Red Oak Lane
White Plains, NY 10604
(914) 641-2000

Corporate Secretary
ITT Corporation
1133 Westchester Avenue
White Plains, NY 10604
(914) 641-2000

The name and address of the agent for service of legal process on MetLife are either a local office of MetLife or the supervisory official of the Insurance Department in the state in which the employee resides.

Plan Year

The fiscal records for the Plan are kept on a Plan year basis ending on December 31 of each year.

The Plan’s Future

The Company expects to continue the Plan, 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 by action of the Company. Any such action would be taken in writing and maintained with the records of the Plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction or elimination of benefits or other features of the Plan to the extent permitted by law.
In addition, the Plan will not pay benefits, including extended benefits, for any expenses after the Plan is terminated or amended to terminate a class of covered persons—if, for example, your employer ceases to be a participating employer.

**Right of Recovery**

If, for some reason, a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person, entity or agency who received it.

If benefits are paid which exceed the benefits you or your covered dependents are entitled to, the Claim Administrator will:

- Request that the overpayment be returned and/or
- Reduce future benefits by the amount of the overpayment.

**Subrogation/Right of Reimbursement**

If you or your covered dependents suffer an illness or injury because of an act or omission of a third party and covered expenses are incurred as a result, then the following provisions apply:

- If you or your covered dependents subsequently recover damages from the third party, the Plan will be entitled to reimbursement of any such benefits paid by the Plan (reimbursement will be the lesser of the amount of benefits paid by the Plan, or the amount of damages recovered, less any reasonable legal fees and costs associated with the recovery).

- If you or your covered dependents do not initiate any legal action for the recovery of those expenses from the third party within a reasonable time frame, the Plan will be subrogated to any rights you or your covered dependents may have against the third party and may, at its option, bring legal action to recover any payments made by it in connection with the illness or injury.

“Third party” means any person or entity other than the Plan or the covered person whose act or omission caused a covered person to suffer an illness or injury for which you or your covered dependents incur expenses covered under the Plan.

In return for the advancement of benefits by the Plan under this provision, you and your dependents must acknowledge in writing your obligation to cooperate with and assist the Plan’s exercise of its rights under this provision and your agreement to repay duplicate payments made under the Plan.
How Benefits Can Be Forfeited or Delayed

Benefits can be forfeited or delayed under certain situations. Most of these circumstances are described in the previous sections. However, benefit payments also may be forfeited or delayed if:

- You (or your beneficiary) do not properly file an application for benefits within the time periods required;
- You do not furnish information required by MetLife to complete or verify your claim;
- Your current address is not on file with the Company or with the Claim Administrator.

You should know that benefits are not payable for expenses that dependents may have after they become ineligible due to age, marriage or divorce.
Compliance with the Law

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

The benefits for which you are covered are set forth in the Plan booklet which is incorporated and is part of the Plan document. Coverage takes effect only if you are eligible for it, you elect it and you make contributions for it, as required.

Benefits payable under your dental coverage for covered services may be assigned by you to the provider who performed the service.

This booklet takes the place of any prior one issued describing this coverage. This coverage takes effect only for persons who become and stay covered under the Plan.

Notice of Claim — Claims for benefits must be submitted to the Claim Administrator on the appropriate claim forms as soon as possible, but no later than two years after the date on which the expense is incurred.

Legal Actions — No one may sue for payment of claim less than 60 days after due proof of claim is furnished or more than two years after the date proof of claim is required by the Plan.

Payment of the benefits described in this Plan will be made on the basis of your submission of proof that a charge, fee or expense has been incurred.

No Guarantee of Employment

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

As provided in all ITT benefit plans, the terms and conditions of the Plan document will govern and while ITT expects to continue the Plan, it reserves the right to change or discontinue the Plan at any time with respect to some or all participants.