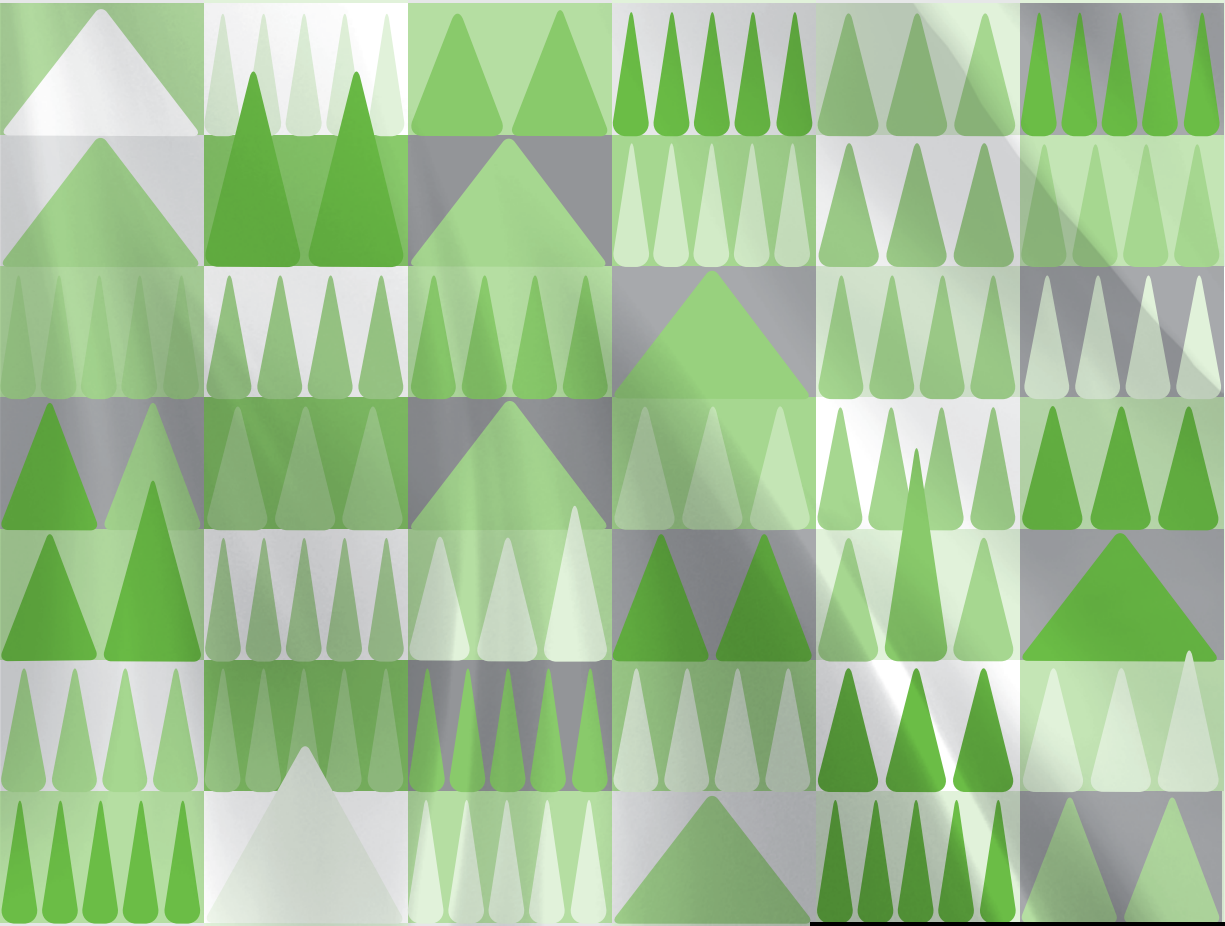


Dental Plan – Administered by UMR



INTERNATIONAL  PAPER

## Dental Plan

Administered by  
UMR (formerly Fiserv Health)



# Dental Plan

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## Dental Plan

### Dental Plan

The company sponsors a Dental Plan (the Plan) which provides a broad range of coverage for dental expenses for you and your covered dependents. The Plan stresses regular preventive care by providing 100 percent coverage for diagnostic and preventive dental treatment, thus encouraging you to identify and treat minor dental problems before they become serious. After you reach an annual deductible, the Plan also provides benefits for basic restorative, major restorative and orthodontic services.

The Plan includes the following features:

- You and the company share in the cost of the Plan;
- Reimbursement at the rate of 100 percent of the usual and customary allowance with no deductible required for diagnostic and preventive services such as routine examinations and cleaning of teeth;
- An annual individual deductible and an annual family maximum deductible;
- Reimbursement at the rate of 80 percent of the usual and customary allowance after an annual deductible for basic restorative services such as fillings, extractions and root canals;
- Reimbursement at the rate of 50 percent of the usual and customary allowance after an annual deductible for major restorative services such as installation of bridges and dentures;
- Benefits up to \$1,500 for each covered individual each calendar year for combined diagnostic, preventive, basic restorative and major restorative services; and
- Reimbursement at the rate of 50 percent of the usual and customary allowance after an annual deductible for orthodontic care, with benefits up to a lifetime maximum of \$1,500 for each covered individual.

The provisions of the Plan, including deductibles, benefit maximums, rates of reimbursement and employee contribution amounts, are subject to change. Refer to the Appendix for deductibles and benefit maximums.

### Who Is Eligible

If you are an eligible employee of International Paper as shown in the Appendix, you and your eligible dependents may enroll in the Plan on your effective date of coverage.

Individuals eligible for coverage include:

- You (the employee);
- Your spouse (husband or wife to whom you are legally married);
- Your domestic partner;
- Your unmarried dependent children under age 19;
- Your unmarried dependent children age 19 to age 25 if full-time students enrolled in and attending an accredited secondary school, college, university or school of nursing;
- Your unmarried dependent children who are physically or mentally incapable of self-support and who become disabled prior to reaching age 19. For a child to remain eligible, you will be required to provide proof of disability, satisfactory to the Plan's claims administrator, within 31 days of the child's 19th birthday. You may be required to provide documentation periodically to confirm continuing eligibility;
- Your dependent child age 19 to age 25 who meets the Plan's student status requirements, and becomes disabled. For the child to remain eligible, you must provide proof of disability, satisfactory to the Plan's claims administrator, within 31 days following the date that the child's coverage otherwise would terminate due to the loss of student status or the attainment of age 25, whichever occurs first. If an eligible child who is not disabled reaches age 19 and does not retain full-time student status, coverage terminates and cannot be reinstated due to disability alone;
- Your newly eligible dependent child age 19 to age 25 who does not meet the Plan's student status requirements, but the dependent child is replacing prior coverage (as defined under HIPAA) provided to him/her as either a dependent child or a dependent disabled adult child. For the child to remain eligible, you must provide proof of disability, satisfactory to the Plan's claims administrator, and proof of creditable coverage within 31 days following the child's eligibility date under the Plan;
- Your newly eligible dependent child age 25 or older who is replacing prior coverage (as defined under HIPAA) provided to him/her as a dependent disabled adult child. For the child to remain eligible, you must provide proof of disability, satisfactory to the Plan's claims administrator, and proof of creditable coverage within 31 days following the child's eligibility date under the Plan; and

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- Any child of a participant who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). Refer to the section entitled Qualified Medical Child Support Order for additional information.

Children, including the children of your domestic partner, are considered your dependents if they reside with you and are your natural children, stepchildren, legally adopted children, children placed with you for adoption or children for whom you are legal guardian (unless either of the natural parents also resides with the guardian) or if they do not reside in your home, but are dependent on you for more than one-half of their support during the calendar year, as defined by the Internal Revenue Code, by qualifying in the current year for dependency tax status on your, your spouse's or your domestic partner's federal income tax return.

Dependents in the armed services of any country are not eligible for coverage.

The dependent children of the employee's domestic partner also are eligible for benefit coverage, where applicable, if they meet the same relationship and dependency requirements with regard to the employee's domestic partner as those for an employee and the employee's dependent children.

A dependent who is covered under a company-sponsored plan as an employee is not eligible for coverage as your dependent.

### Domestic Partners

Domestic partners are two adults of the same or opposite sex who are not married or related by blood but who have lived together continuously for at least one year and plan to do so indefinitely. In addition, domestic partners are mutually responsible for their common welfare, reside at the same address and maintain no other domestic partner relationships or marriage.

Each employee and domestic partner will be asked to affirm the following by electronic or paper affidavit.

- They are at least 18 years old (or the age of consent), and they are mentally competent to consent to contract.
- They are each other's sole domestic partner and intend to remain so indefinitely.

- They share a close personal relationship, and they are responsible for each other's common welfare.
- They are not married to anyone nor have they had another domestic partner within the prior 12 months.
- They are not related by blood closer than would bar marriage in their state of residence.
- They have jointly shared the same regular and permanent residence for at least one year immediately preceding the date of the affidavit and intend to do so indefinitely.
- They are jointly financially responsible for basic living expenses including the cost of food, shelter and the other expenses of maintaining a household.

Proof of joint financial responsibility may be required and will include:

- Joint mortgage or lease;
- Designation of the domestic partner as the primary beneficiary for life insurance or retirement benefits;
- Designation of the domestic partner as the primary beneficiary in the other person's will;
- Durable power of attorney for health care or financial management;
- Joint ownership of a vehicle, a joint checking account, or a joint credit account; and
- A relationship or cohabitation contract which obligates each person to provide support for the other.

Proof may not be required at the time of enrollment, but it may be required subsequently as part of a routine audit.

**Important Note** – Any reference in the summary plan description to an employee's spouse also refers to an employee's domestic partner.

### Qualified Medical Child Support Order

This Plan will comply with the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or a judgment from a court or administrative body directing the Plan to cover a child of a participant under the Plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's

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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 Plan pursuant to a QMCSO will not become effective until the plan administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Employee Service Center (ESC).

### How to Enroll

To enroll in the Plan, contact the ESC. If you enroll, coverage begins on the effective date of coverage indicated in the Appendix.

#### Initial Enrollment Period

To enroll yourself or your eligible dependents, you must enroll within 31 days of your effective date of coverage. If you do not enroll at this time, you may enroll during annual enrollment, a special enrollment period or if you have a change in status.

As a new employee you may enroll yourself and your eligible dependents in the company-sponsored dental plan. Enrollment must be completed within 31 days of your effective date of coverage. During the next regular enrollment period, you will have the option of changing coverage for yourself and your eligible dependents.

Your eligible dependent children can be covered under the Plan even if coverage is available for them under the plan of the other parent's employer. If your eligible dependent children are covered under the plans of both parents, the coordination of benefits provision will apply. Refer to the section entitled Coordination of Benefits for details.

#### Enrolling Your New Dependents

If you have employee only coverage and acquire a new dependent — for example, if you get married or have a child — and you want to change to family coverage, your newly acquired dependent will become covered provided you contact the ESC within 31 days of the event. Coverage will begin on the date you acquire the new dependent.

If you have family coverage and acquire a new dependent, your newly acquired dependent can be covered from the date of the event (marriage, birth, adoption, placement for adoption or establishment of legal guardianship) provided you contact the ESC before the end of the year in which the event occurs. You may be required to submit documentation to the ESC to add your newly acquired dependent before claims will be processed.

You may be required to provide documentation supporting the eligibility of your covered dependents. Documentation may be required for all dependents when you first enroll them for coverage and thereafter when dependents are added for coverage.

In addition, documentation may be required on a periodic basis to confirm continuing eligibility. For example, documentation may be required to show that your enrolled dependent children over age 19 are still full-time students or that an enrolled child continues to be disabled.

Examples of acceptable documentation include birth certificates, marriage licenses, letters from school registrars, letters from treating physicians and court decrees.

The ESC will review the documentation you provide and will verify dependent eligibility. If proper documentation proving eligibility of your dependents is not provided, they cannot be covered under the company Plan.

**Important Note** – If you and your spouse or domestic partner both work for the company and are both eligible for dental coverage, you may each enroll for dental coverage as an employee or one of you may waive your coverage as an employee and choose to be covered as a dependent under your spouse's plan. Your eligible dependent children may be enrolled as either your dependents or your spouse's dependents, but not both.

#### Annual Enrollment Period

Once each year, during the designated annual enrollment period, you will have the opportunity to:

- Add coverage for yourself and/or any eligible dependent(s) under the Plan; or
- Waive coverage for yourself and/or any covered dependent(s).

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The decision you make must be made prior to the beginning of the plan year, and your plan choice cannot be changed until the next year's enrollment period. There are specific circumstances under which you may change your health care coverage choice midyear. These circumstances are outlined in the Change in Status section and in the Special Enrollment Periods section.

### Change in Status

Although your election of coverage under the Plan generally cannot be changed until the annual enrollment period, you may revoke your prior election and make a new election midyear if you have a change in status as described in this section. If you wish to make a midyear change of election, you must report the occurrence of your change in status by contacting the ESC within 31 days of the event. If you do not contact the ESC by the deadline, you will have to wait until the next annual enrollment period (or until you have another change in status) to change your coverage.

#### *Specified Events*

You may revoke your election and make a new election, within the required 31-day period, for the remaining portion of the plan year only if the change in status results in you, your spouse or your eligible dependent gaining or losing eligibility for coverage under this Plan or a health plan of your spouse's or dependent's employer, AND your election change corresponds with that gain or loss of coverage.

The specified events that qualify as changes in status are:

- Events that change your (the employee's) legal marital status, including marriage, the death of your spouse, divorce, legal separation or annulment;
- Events that change the number of your dependents, including birth, adoption, placement for adoption or the death of a dependent;
- Termination or commencement of employment by you, your spouse or your dependent, if the termination or gain of employment results in a loss or gain of eligibility for other group health care coverage;

- Reduction or increase in hours of employment by you, your spouse or your dependent, including a switch between part-time and full-time, a strike or lockout, or commencement of or return from an unpaid leave of absence;
- Your dependent satisfies or ceases to satisfy the requirements for unmarried dependents, including attainment of age, change in student status or any similar circumstances previously defined under this Plan; or
- You, your spouse or your dependent has a change in the place of residence or work.

#### *Judgment, Decree or Order*

If you present proof of a divorce, legal separation, annulment or change in legal custody (including a QMCSO) to the plan administrator, you may make a related change in your election to cancel coverage for your spouse or dependent. For a QMCSO you may change your election to cover the child if the QMCSO requires coverage under this Plan, or you may cancel coverage for the child under this Plan if the QMCSO requires your former spouse to provide coverage.

#### *Significant Cost or Coverage Changes*

If an independent third-party provider increases the cost of coverage significantly, stops providing coverage or significantly curtails coverage during the plan year, you may either:

- Change your contributions correspondingly; or
- Revoke your election and choose other dental coverage offered by the company for the remainder of the plan year.

#### *Special Enrollment Rights*

You may revoke your election and make a new election corresponding with the special enrollment rights described in the section entitled Special Enrollment Periods.

### Change in Job Status

If your job status is changed to one not covered by this booklet, you will become eligible in accordance with the benefits applicable to your new job.

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### Special Enrollment Periods

#### *Loss of Other Coverage*

If you or your eligible dependent(s) declined coverage under this Plan because you or they had other coverage and you and/or your dependent(s) lose the other coverage due to one of the following reasons, you have 31 days to enroll yourself and/or your eligible dependent(s) in this Plan.

- Eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis or termination for cause).
- The employer contributions toward the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.

#### *Acquiring a New Dependent*

You may enroll your new spouse and stepchildren or children for whom you are legal guardian, if any, within 31 days of your marriage. You may enroll a newborn child, a child who is newly adopted or placed for adoption or a child for whom you are legal guardian within 31 days of the birth, adoption, placement for adoption or establishment of legal guardianship. If you are not enrolled in the Plan, you must do so when you enroll any of these dependents. If your spouse is not enrolled in the Plan, you may enroll him or her in the Plan when you enroll a child due to birth, adoption, placement for adoption or establishment of legal guardianship. Coverage will begin the date you acquire the new dependent(s) provided they are enrolled within 31 days of the event.

To enroll during a special enrollment period, you must contact the ESC, enroll within 31 days of the event and provide acceptable documentation of the event(s) allowing enrollment.

### Health Care Contributions (Active Employees)

The company contributes a portion of the cost of health care coverage for you and your covered eligible dependents. Your portion of the cost of coverage is paid on a tax-free basis unless domestic partner coverage is included. By enrolling in the Plan, you are authorizing the company to reduce your pay by the amount of your contribution for coverage.

Amounts withheld on a tax-free basis from your current pay are not subject to:

- Social Security and Medicare taxes (FICA);
- Federal income taxes; and
- State and local income taxes (except in limited cases).

These tax-free contribution amounts are not reported as taxable income on your W-2 form. By paying for your health care coverage on a tax-free basis, you will see an increase in your take-home pay. At the end of the year, your tax liability may be reduced.

**Important Note** – Future Social Security retirement benefits may be reduced slightly because tax-free health care contributions may reduce the amount on which you and the company pay Social Security taxes.

### Government Restrictions

There are certain Internal Revenue Service (IRS) rules you need to understand regarding tax-free health care contributions.

#### *Plan Year Decisions (January 1 through December 31)*

The decision you make about plan coverage paid for with tax-free health care contributions must be made prior to the beginning of the plan year, unless you are first eligible to participate at a later date. Your tax-free health care coverage choice cannot be changed until the next annual enrollment period unless you have a change in status as described in the Change in Status section or qualify for special enrollment as described in the Special Enrollment Periods section. International Paper requires domestic partner coverage to follow the same plan year decision rules outlined in this section.

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### Domestic Partner Coverage

The IRS does not recognize domestic partners and the children of a domestic partner. If an active employee's dependent coverage includes a domestic partner or the children of a domestic partner, the employee's contribution toward family coverage must be paid on an after-tax basis, and the company's contribution must be considered imputed income to the employee and taxed at the supplemental tax rate. The employee's contribution toward his or her own coverage will be paid on a pre-tax basis.

For more information on health care contributions, refer to the booklet entitled Health Care and Dependent Day Care Tax-Free Plan or contact the ESC.

### How the Plan Works

#### Usual and Customary Allowance

The Plan provides benefits based on the usual and customary allowance for the dental services that you receive. The usual and customary allowance is determined by the Plan's claims administrator. The usual and customary allowance is the lower of:

- The usual charge by most dentists in the same or similar geographic area for the same or similar dental service or supply; or
- The actual charge by the dentist for the dental service or supply.

**Usual and Customary Allowance** – the basis on which the charge for a dental service is covered, considering the usual charge for the service or supply in a geographic area, and the nature of the condition.

If a charge exceeds what the Plan's claims administrator determines to be the usual and customary allowance, the excess portion will not be covered by the Plan nor will it apply toward your deductible. You may contact a representative of the Plan's claims administrator at 1-800-343-2737 to find out whether the provider's fees are within the usual and customary allowance.

If you expect that your dental expenses will be more than \$200, you should ask your dentist to submit a request for pre-treatment review. Please refer to the section entitled Pre-Treatment Review for additional information.

### Deductible

The Plan requires that each covered individual meet an annual individual deductible amount before the Plan will begin to pay benefits for basic restorative, major restorative and orthodontic dental services. There is no deductible required for diagnostic and preventive dental services.

There are two types of deductibles — individual and family. The maximum family deductible in a calendar year is twice the individual deductible. The maximum family deductible in a calendar year is reached either when two family members each meet the individual deductible or when the combined deductibles of all family members reach the maximum family deductible amount. After a family's maximum annual deductible is reached, no additional deductibles will be required of family members for the rest of that year.

Refer to the Appendix for the individual and family deductible amounts.

**Deductible** – the amount you pay for certain covered dental expenses each calendar year before the Plan starts to provide benefits. The deductible does not include any charges you incur for services that are not covered by the Plan. Amounts above the usual and customary allowance will not apply toward your deductible.

### Maximum Benefit

The Plan provides up to \$1,500 in combined diagnostic, preventive and restorative benefits for each covered individual in a calendar year. In addition, the Plan provides up to a lifetime maximum of \$1,500 in benefits for orthodontic services for each covered individual.

### Alternate Benefits

Many dental conditions can be treated in more than one way. This Plan has an alternate benefits provision that determines the amount that this Plan will pay for covered treatments. If a patient chooses a more expensive treatment that is needed to correct a dental condition according to accepted standards of dental practice, the payment will be based on the cost of the treatment which provides professionally satisfactory results at the more cost-effective level.

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For example, if a regular amalgam (silver) filling is sufficient to restore a tooth, but the patient and the dentist decide to use a resin (white) filling, the Plan will base its payment on the usual and customary allowance for the amalgam filling. The patient will be responsible for paying the difference in cost.

### Commencement of Dental Services

If a dental service is recommended or considered necessary, but is not performed until a later date, the dental service will be considered to begin on the date the service actually is performed. Crowns and full or partial dentures will be considered to have been performed on the date the crown or denture is seated. If a dental service such as orthodontics is started prior to coverage under the Plan, you will be reimbursed for only that part of the service performed after the date your coverage becomes effective.

### Covered Expenses

The Plan provides benefits for four types of dental services. After you meet the deductible, the usual and customary allowance for each type of dental service is reimbursed at the following rates:

Dental Service	Rate
Diagnostic and preventive	100 percent (no deductible required)
Basic restorative	80 percent
Major restorative	50 percent
Orthodontic	50 percent

### Diagnostic and Preventive Services

The Plan reimburses 100 percent of the usual and customary allowance for covered diagnostic and preventive dental services, up to the combined annual maximum benefit of \$1,500 for each covered individual. There is no deductible required for these services.

Diagnostic and preventive dental services include:

- Routine examinations and the cleaning and scaling of teeth twice each calendar year;
- Fluoride treatments for your dependent children under age 19 once each calendar year;
- Space maintainers for your dependent children under age 19;
- Diagnostic X-rays (bite-wing X-rays covered twice each calendar year and full-mouth X-rays covered once every three years);
- Emergency treatment for temporary relief of pain; and
- Sealants for your dependent children under the age of 14 for permanent molars, excluding wisdom teeth. This benefit is limited to a one-time application per tooth. To be sealed, teeth cannot have previous restorations and must be free of cavities.

### Basic Restorative Services

The Plan reimburses 80 percent of the usual and customary allowance after your annual deductible has been reached for basic restorative services, up to the combined annual maximum benefit of \$1,500 for each covered individual.

Basic restorative dental services include:

- Oral surgery, including extractions;
- Fillings, including amalgam, silicate, acrylic, synthetic porcelain and composite restorations to restore diseased or accidentally broken teeth;
- General anesthesia, when medically necessary and administered in connection with oral or dental surgery;
- Scaling and root planing prior to periodontal work;
- Treatment of gum disease (periodontia);
- Occlusal guards, limited to one every five years;
- Treatment of diseases within a tooth, such as root canal therapy (endodontics);
- Adjusting, relining or rebasing dentures more than 6 months after installation of an initial or replacement denture, but not more than once in any 36 consecutive months;
- Repairing or recementing crowns, inlays, onlays, bridgework or dentures more than 6 months after installation; and
- Injectable antibiotic drugs, when administered by the attending dentist.

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### Major Restorative Services

The Plan reimburses 50 percent of the usual and customary allowance after your annual deductible has been reached for major restorative services, up to the combined annual maximum benefit of \$1,500 for each covered individual.

Major restorative dental services include:

- Inlays, onlays, gold fillings and initial or replacement crown restorations five or more years after initial placement;
- Restorations to restore severely decayed, diseased or accidentally broken teeth when the tooth cannot be restored with the type of fillings described under Basic Restorative Services;
- Services to replace one or more teeth except wisdom teeth;
- Initial placement of fixed bridgework, including inlays and crowns as supports;
- Partial or full removable dentures and any adjustments during the 6-month period following placement;
- Replacement of, or additions to, existing bridgework or dentures when the service is required to replace teeth extracted after the existing denture or bridgework is placed. Replacement is allowed if:
  - The existing denture or bridgework cannot be made serviceable and at least five years have elapsed prior to its replacement; or
  - The existing denture is an immediate temporary denture, cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial placement; and
- Surgical placement of a dental implant. Replacement is allowed if the existing implant cannot be made serviceable and at least five years have elapsed prior to its replacement.

### Orthodontic Services

The Plan reimburses 50 percent of the usual and customary allowance after your annual deductible has been met for orthodontic diagnosis and treatment, up to a lifetime maximum benefit of \$1,500 for each covered individual. Orthodontics includes braces and other appliances for the purpose of straightening teeth.

### Pre-Treatment Review

Pre-treatment review is a voluntary procedure that enables you to know, before any treatment is performed, the benefits allowed for dental services that are expected to exceed \$200. By using this voluntary procedure, you will know how much of the expense will be reimbursed and how much your out-of-pocket expenses will be.

**Pre-Treatment Review** – the review by the Plan's claims administrator of a dentist's statement describing a planned dental treatment and the anticipated charges.

Whenever you expect your dental expenses will be more than \$200, your dentist should fill out the regular dental claim form indicating the proposed dental services and anticipated charges and submit the form to the Plan's claims administrator.

The Plan's claims administrator will determine the benefits allowed, taking into consideration alternative procedures or services that may be more appropriate for treatment, and return the form to your dentist. The form will indicate the amount covered for each procedure recommended by the dentist or the allowance for the alternative treatment, whichever is considered more professionally appropriate. You and your dentist will then know exactly what portion of the expenses will be covered by the Plan.

Once the treatment has been completed, your dentist must fill in the date each service was performed and resubmit the claim form to the Plan's claims administrator for payment.

### Expenses Not Covered

Like most plans, the Plan does not cover all expenses. The Plan does not cover expenses for:

- Sealants for individuals ages 14 and over, oral hygiene and dietary instruction or a plaque control program;
- Services that are cosmetic in nature, including charges for personalization or characterization of dentures;
- Dental treatment before coverage is in effect or after it has been canceled;
- Dental appliances or restoration, other than full dentures, when the primary purpose is to alter

## Dental Plan

vertical dimension, stabilize periodontally involved teeth or restore occlusion;

- Replacement of a bridge, crown, denture or implant within five years following the date of its original placement;
- Charges for failure to keep dental appointments;
- Assistance in completing claim forms;
- Replacement of lost, missing or stolen orthodontic appliances and prosthetic devices including, but not limited to, dentures and partials;
- Charges made by someone other than a dentist or licensed hygienist;
- Precision or semiprecision attachments, bite registration or splinting;
- Charges for treatment for injuries incurred by individuals engaged in an act of war, whether declared or undeclared;
- Services provided by a member of the immediate family of the employee or of the employee's spouse;
- Services provided at no cost or when payment is received as a result of legal action or settlement;
- Services, supplies or methods of treatment that are considered to be experimental, investigative or obsolete;
- Temporomandibular joint disorder (TMJ) services determined to be medical in nature regardless of whether or not you are enrolled in the International Paper Medical Plan;
- Services for which you are eligible to receive benefits under workers' compensation or occupational disease laws;
- Services provided in publicly financed institutions at no cost to the patient or services available without cost under state, federal or other governmental law, including Medicare;
- Services or supplies furnished by or for the U.S. government or any other government, unless payment is legally required;
- Charges for services in excess of the usual and customary allowance;
- Services or supplies which are not medically necessary;
- Charges you legally are not required to pay;
- Charges that would not have been made if Plan coverage did not exist;
- Charges for which benefits are payable under any group medical expense policy; or

- Any bodily injury, sickness or disease occurring while participating in or in consequence of having participated in committing or attempting a crime (felony or misdemeanor).

### Other Provisions of Dental Coverage

Here are some other things you need to know about how the Plan works.

#### Coordination of Benefits

Benefits payable from this Plan will take into account benefits or reimbursements received from another group plan, no-fault and uninsured or underinsured motorist automobile insurance required by law or through settlement of a lawsuit.

Coordinating plan benefits with those from other sources also occurs when this Plan is the secondary plan and the claim is for your enrolled dependent who has primary coverage from another source.

If you receive benefits or reimbursements from one or more of the sources named above, the benefits from this Plan will be limited to an amount that, when added to benefits payable from other sources, will not exceed what would have been paid by this Plan if no other coverage had existed. If the benefits from other sources equal or exceed what this Plan would have paid, no additional benefits are payable from this Plan. This method is called maintenance of benefits. Maintenance of benefits provides that the cumulative benefits received by you or your dependent will be at least equal to, but not greater than, the benefits provided by this Plan.

**Coordination of Benefits** – the administrative procedure that considers the order of payment of benefits under this Plan and any other group medical or dental plans, no-fault and uninsured or underinsured motorist automobile insurance or legal settlement from which you or a dependent is eligible to receive benefits.

**Maintenance of Benefits** – the administrative procedure that ensures that the cumulative benefits received by you or your dependent will be at least equal to, but not greater than, the benefits provided by this Plan.

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The following provisions regarding order of payment do not apply to benefits you are eligible to receive from personal coverage you have purchased other than no-fault and uninsured or underinsured motorist automobile insurance required by law.

If you or your covered dependents are covered by more than one group dental plan, the coordination of benefits provision applies. The following rules are applied in the order listed to determine which plan provides benefits first.

1. The plan without a coordination of benefits provision (or a nonduplication provision) will determine its benefits first.
2. The plan under which the patient is covered as an employee or retiree will determine its benefits before a plan under which he or she is covered as a dependent.
3. The plan covering the patient as a dependent child of parents not separated or divorced will be determined based on the parents' birthdays. The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that has covered the parent longer pays first. The plan that has covered the other parent for a shorter time pays second. This is called the birthday rule. A person's year of birth is not relevant in applying this rule.
4. When the patient is a dependent child of parents separated or divorced, the birthday rule does not apply. Instead:
  - The plan of the parent with custody pays first;
  - The plan of the spouse of the parent with custody (the stepparent) pays next;
  - The plan of the parent without custody pays third; and
  - The plan of the spouse of the noncustodial parent pays last.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obligated to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided before that entity has actual knowledge, this "court decree rule" is not applicable during the remainder of the plan year or policy year.

5. The plan covering the person as an employee (or as a dependent of an employee) who is neither laid off nor retired pays first and the plan covering the person who is laid off or retired is second. If the other plan does not have this rule, this rule is ignored. (Note that coverage provided to an individual as a retired worker and as a dependent of an actively working spouse is determined under the second rule in this list, not under this rule.)
6. If an individual who is covered under COBRA or state continuation of coverage is also covered under another plan, the plan covering the person as an employee or retiree pays first and the continuation coverage pays second. If the other plan does not agree because it does not have this rule, this rule is ignored.
7. The plan that has covered the patient for the longer period of time will determine its benefits first.
8. If the preceding rules do not establish the order of payment, then the allowable expenses will be shared equally between the plans, but this Plan will not pay more than it would have paid if it were to pay first.

Failure to disclose coverage under another group dental plan constitutes falsifying a record and is a crime.

### **Subrogation and Reimbursement of Claims**

If the Plan pays benefits for dental expenses which are the legal responsibility of another person or organization because of an accident or because of other circumstances, the Plan is subrogated to your and your covered dependents' rights of recovery and shall be entitled to reimbursement of the total amount of the benefit payments which the Plan makes to, or on behalf of, you or your covered dependents. Subrogation permits the Plan to assume your/your covered dependents' place for purposes of recovering damages from third parties that are legally responsible to you/your covered dependents. Reimbursement allows the Plan to recover from you/your covered dependents amounts you/your covered dependents receive from a third party.

By accepting benefits under the Plan, you and your covered dependents agree to execute and deliver such instruments and papers as may be required and whatever else is needed to secure the Plan's rights including, but not limited to, an assignment of claims and/or reimbursement agreement. You and your covered dependents are further obligated to avoid doing anything that would prejudice the Plan's right of subrogation or reimbursement.

## Dental Plan

The Plan shall be considered to have an equitable lien on any payments you or your covered dependents receive from a third party or a third party's insurance company or amounts paid from no-fault, uninsured or underinsured motorist automobile insurance, regardless of whether such payment is made as a result of settlement, compromise, award, judgment, verdict or other means (collectively referred to as "Third Party Payments"). This provision does not apply to any other personal insurance coverage purchased by you or your covered dependents. The Plan has the authority to take whatever actions it deems necessary to impose a constructive trust on Third Party Payments. If a lawsuit is filed, the Plan may also record a notice of payment of benefits, which shall constitute a lien on any judgment or recovery.

You and/or your covered dependents agree to reimburse the Plan immediately out of any Third Party Payments which you/they receive (whether or not the moneys are designated as payment for health care expenses or for pain or suffering or otherwise) and authorize the Plan to suspend further benefit payments and set off benefits already paid against future benefits until the reimbursement is completed. The Plan's right to reimbursement will apply even if you and/or your covered dependents have not been made whole for the loss. The Plan's right of recovery shall be in first priority to the extent of any and all benefits paid. The Plan will not pay, offset any recovery or in any way be responsible for any fees or costs associated with any claim or lawsuit, including but not limited to attorneys' fees, unless the plan administrator consents in writing.

You and/or your covered dependents assign to the Plan (and understand and agree that the Plan is subrogated to) a portion of your/their claim against the other person or organization which is equal to the total amount paid by the Plan. In addition, you and your covered dependents agree to cooperate in good faith with the Plan in bringing suit in your/their name or otherwise pursuing the collection of the claim. The Plan also reserves the right to independently pursue and recover paid benefits. The cost of collection and litigation shall be part of any subrogation claim pursued by the Plan.

## Coverage During Leaves of Absence

### Salary Continuance

If you are temporarily absent because of an illness or accident, you and your covered eligible dependents may continue dental coverage during the period of your disability, up to the maximum duration under the Salary Continuance Plan, provided you pay the active employee contributions. Otherwise, you and your covered eligible dependents may continue dental coverage as outlined in the section entitled COBRA — Continuation of Coverage.

### Long-Term Disability (Employees with Salaried Benefits – IP and xpedx)

If you become totally disabled and receive benefits under a company-sponsored long-term disability plan, you and your covered eligible dependents may continue coverage as outlined in the section entitled COBRA — Continuation of Coverage.

### Temporary Layoff – Hourly Employees Only

If you are temporarily laid off, you and your covered eligible dependents may continue dental coverage for two full months following the month the layoff occurred provided you pay the active employee contributions. If at the end of this two-month period you have not been re-employed, you may continue dental coverage as outlined in the section entitled COBRA — Continuation of Coverage. The COBRA coverage period will run concurrently with the two-month coverage period outlined above.

**Important Note** – For the purpose of administering the Plan, the term "temporarily laid off" will apply only in instances where the occupation or operation has been temporarily suspended or curtailed due to lack of market, power or other conditions. Such suspension or curtailment is intended to be temporary and both the employees concerned and the company are in agreement that employment will be resumed when the occupation resumes normal operation. This rule will not apply to employees who are laid off because the occupation or operation in which they were employed has been discontinued or completed.

## Dental Plan

### **Disability – Employees with Hourly Benefits (IP hourly represented, IP hourly non-represented and xpedx hourly represented)**

If you are unable to perform your job as a result of an occupational or nonoccupational illness or injury and are under the regular care of a physician licensed to practice medicine, you and your covered eligible dependents may continue dental coverage during your period of disability for up to 12 months following the date your disability began provided you continue to pay the required active employee contributions.

Once this coverage period ends, you may elect to continue coverage as outlined in the COBRA — Continuation of Coverage section of this document. The 12-month period, or any portion thereof, is not considered a part of your COBRA period.

### **FMLA Leave**

#### *Paid Leave*

If you are on paid FMLA leave, you and your covered eligible dependents may continue dental coverage during your paid leave. Active employee contributions will continue to be deducted from your paycheck.

#### *Unpaid Leave*

If you are on unpaid FMLA leave, you may either continue or cancel coverage. To continue coverage, you must pay the required monthly active employee contribution on an after-tax basis by check or money order to the company.

If you elect not to continue coverage during an unpaid FMLA leave or your coverage lapses due to failure to pay the required contributions, you may reinstate your coverage (or make new elections if you have a change in status) when you return from your unpaid FMLA leave. You must contact the ESC within 31 days of your return to work in order to reinstate your coverage (or make new elections if you have a change in status).

Coverage will be reinstated without any waiting period, except for that which would have been applicable had you not taken an FMLA leave.

### **Military Leave of Absence**

If you are required to serve in the Armed Forces, you may continue dental coverage for up to 12 weeks under the terms listed for an unpaid FMLA leave. Following the 12-week period, you and your covered eligible dependents may continue dental coverage as outlined in the section entitled COBRA — Continuation of Coverage.

Reinstatement following your military leave is in accordance with the terms listed for an unpaid FMLA leave. You must contact the ESC within 31 days of your return from military leave in order to reinstate your coverage (or make new elections if you have a change in status).

### **Other Leaves of Absence**

If you are granted a leave of absence from the company for reasons other than temporary layoff, disability, FMLA leave or military service, you and your covered eligible dependents may continue dental coverage as outlined in the section entitled COBRA — Continuation of Coverage.

Contact the ESC for details.

### **Termination of Coverage**

Coverage under the Plan will end for any of the following reasons.

- If you stop making the required contributions for coverage for yourself or your dependents, coverage will end on the last day of the month covered by your last contribution.
- If your dependent ceases to be an eligible dependent as defined in the Plan, coverage will end on the last day of the month in which that event occurs.
- If your employment with the company terminates, coverage for you and your dependents will end on the last day of the month in which your employment ends.
- In the event of your death while you are actively employed by the company, coverage for your spouse and other eligible dependents will end on the last day of the month in which your death occurs.
- If you retire, coverage under the Plan for you and your covered dependents will end on the last day of the month preceding your retirement.
- The company terminates the Plan.

## Dental Plan

### Extension of Benefits

You and your covered eligible dependents will receive no reimbursement for expenses incurred after coverage terminates except for those otherwise eligible expenses incurred for work in progress that is completed within two months of the date your coverage ends. However, charges incurred for orthodontia and periodontia after termination will not be reimbursed under the Plan.

### Converting to an Individual Policy

There are no conversion rights under the Plan. You cannot convert your coverage to an individual policy for either yourself or a dependent if your employment terminates or your dependent is no longer eligible for coverage.

Under certain circumstances your coverage may be continued as outlined in the section entitled COBRA — Continuation of Coverage.

### How to File a Claim

In order to receive benefits from the Plan, you and your health care provider must fill out the appropriate claim forms. The ESC has claim forms and can assist you in filling them out. Remember, you may file a claim form for a pre-treatment review whenever you anticipate dental charges may exceed \$200.

It is important for you to keep an accurate record of bills for all dental expenses. You may submit your original bills with a claim form, including the following information:

- Name of the patient;
- Name of the covered employee;
- Social Security number of the covered employee;
- Name of the company (International Paper);
- Date the service was rendered;
- American Dental Association code; and
- Charge.

In order for claims to be considered for payment, they must be submitted and received by the Plan's claims administrator within 15 months of the date they were incurred.

If you have a question about a claim payment, you may call the toll-free number shown on the claim form.

### Assignment of Benefits

Once your claim is received and processed by the Plan's claims administrator, an explanation of benefits (EOB) will be sent to you. This EOB will identify which charges are covered and for what amounts, to whom the checks were sent and any amount you are responsible for paying.

Benefits will be paid directly to you or will be assigned to your dentist if you complete the authorization section of the claim form.

### COBRA — Continuation of Coverage

Under a federal law commonly known as COBRA, you, your spouse and dependent children may elect to temporarily continue coverage under this Plan in certain instances where coverage otherwise would be reduced or terminated. Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your spouse and your dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

### Qualifying Events

If your employment terminates for any reason other than your gross misconduct or if your hours worked are reduced so that your Plan coverage terminates, you, your covered spouse and dependent children may continue coverage under the Plan for up to 18 months.

If you (the employee) should die, become legally separated or divorced or become entitled to Medicare, your covered dependents whose coverage under the Plan would be terminated may continue coverage under the Plan for up to 36 months. Also, your covered children may continue coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the Plan.

## Dental Plan

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked.

- If your dependent(s) experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
- If you (the employee) became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (your termination of employment or reduction in hours worked) happens within 18 months, your dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.
- If you or your dependent is disabled (as determined by the Social Security Administration) on the date of termination of employment or reduction in work hours or at any time during the first 60 days of COBRA continuation coverage due to such event, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). To qualify for this disability extension, the company must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the company within 30 days after this determination.

**Important Note** – If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a spouse or dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

### **Giving Notice That a COBRA Event Has Occurred**

To qualify for COBRA continuation upon legal separation, divorce or loss of a child's dependent status under the Plan, you or one of your dependents MUST notify the company of the legal separation, divorce or loss of dependent status within 60 days of the later of the date of the event or the date the individual would lose coverage under the Plan. Your covered dependents then will be provided with instructions for continuing coverage. Individuals already on COBRA continuation must notify the company within these deadlines if a legal separation, divorce or loss of a child's dependent status occurs that would extend the period of COBRA coverage for your spouse or dependent child(ren).

For other qualifying events (if your employment ends, your hours are reduced, or you become entitled to Medicare), you and your covered dependents will be provided with instructions for continuing coverage. In the event of your death, the company will notify your covered dependents how to continue coverage.

### **Electing and Paying for COBRA Continuation Coverage**

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered dependent(s) would lose coverage as a result of the qualifying event; or
- The date the company notifies you and/or your covered dependent(s) of your right to choose to continue coverage as a result of the qualifying event.

### **Premium Due Date**

If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation, but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day for which timely payment was made and cannot be reinstated.

## Dental Plan

### Cost

#### *Continuing Active Coverage*

The cost of COBRA coverage is 102 percent of the full cost of Plan coverage.

#### *Additional Cost Requirements for Continuation of Active Coverage*

The cost of coverage for the 19th through 29th months of coverage under the disability extension is 150 percent of the full cost of coverage.

If a second qualifying event occurs during the first 18 months of coverage, the 102 percent rate applies to the full 36 months even if the individual 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 rate for the 19th through 36th months of the COBRA continuation period is the 150 percent rate.

### Coverage During the Continuation Period

If coverage under the Plan is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment period, when a change in status occurs, or at other times under the Plan to the same extent that active employees may do so.

### When COBRA Continuation Coverage Ends

COBRA continuation of coverage for any person will end when the first of the following occurs:

- The applicable continuation period ends.
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected or any subsequent premium is not paid within 30 days after it is due.
- After the date COBRA is elected, the qualified beneficiary first becomes covered under another group dental plan (as an employee or otherwise) that does not contain an exclusion or limitation affecting the person's pre-existing condition, or the other plan's pre-existing condition limit or exclusion does not apply or is satisfied because of Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules.

- In the case of the 11-month extended coverage period 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 coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued.
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.
- The company terminates all group medical or dental coverage for all employees.

Contact the ESC for further details on COBRA coverage or if you or your spouse has an address change.

## General Administration of the Plan

This booklet is the summary plan description as required by the Employee Retirement Income Security Act of 1974, as amended (ERISA) and pertains to the applicable employees as defined in the section entitled Who Is Eligible. This booklet also serves as the portion of the official plan document governing covered benefits.

If there is any conflict between the information in this summary and the provisions of the plan document, the plan document always will control. If you have questions about any of the information in this booklet, contact the ESC.

This section will explain more about how the Plan is administered and your legal rights under ERISA.

### Plan Sponsor

The benefit plan described in this booklet is sponsored by:

International Paper Company  
6400 Poplar Avenue  
Memphis, TN 38197  
901-419-9000

## Dental Plan

### Plan Administrator

The administration of the Plan is the responsibility of the plan administrator, who is:

Senior Vice President – Human Resources  
c/o Employee Benefits Department  
International Paper Company  
6400 Poplar Avenue  
Memphis, TN 38197  
901-419-9000

The plan administrator has the authority, responsibility and discretion to determine all questions of eligibility and status and has the right to interpret the provisions of the Plan.

### Administrative Information

This Plan is a welfare plan that provides health care benefits. The Plan has been assigned the number 752 and is called officially the International Paper Company Group Health and Welfare Plan. The plan year ends on December 31 of each year.

The Dental Plan is self-funded. All benefits are provided directly by International Paper and administered by UMR. UMR reviews claims for benefits and authorizes payment in accordance with the terms of the Dental Plan. The address of the claims administrator is:

UMR  
Dental Claims Services  
P. O. Box 30541  
Salt Lake City, Utah 84130-0541  
Toll-free: 1-800-343-2737  
Website: [www.umar.com](http://www.umar.com)

You and the company share in the cost of the Plan. Information about premiums is provided to employees during annual enrollment and is available from the ESC.

Employee Service Center  
P.O. Box 563989  
Charlotte, NC 28256-3989  
1-888-ESC-2YOU (1-888-372-2968)

### Employer Identification Number

In addition to the plan number assigned to the Plan, the IRS has assigned the employer identification number **13-0872805** to International Paper. If you need to correspond with a governmental agency about the Plan, use this number along with the plan name and the company name.

### Administration of Health and Welfare Plans

The Plan is managed by the benefits department at the corporate headquarters in Memphis, Tennessee, under the supervision of the plan administrator. Benefits are subject to the provisions of the Plan.

The plan administrator has discretion to interpret and administer the provisions of the Plan and to decide any claims or disputes that may arise under the Plan. The decision of the plan administrator with respect to any such matters shall be final and binding on both the company and the members of the Plan. The plan administrator is responsible for ensuring that accurate records are maintained, that all reports and disclosures are made as required by law and that benefits are paid as authorized.

### Amendment and Termination

The company will continue to review the Plan to determine if additional changes are needed to address the rapidly changing health care industry.

The company reserves the right to modify, amend, suspend or terminate the Plan, subject to collective bargaining (if applicable), at any time, including, but not limited to, the right to make changes in the terms of the Plan and the amount of employee contributions, deductibles and maximums. You will be notified of any important changes.

### Plan Trustee

Mellon Bank, N.A., has been appointed as trustee to hold all health care participant contributions. The trustee maintains the trust for the exclusive benefit of plan participants and their beneficiaries. The address of the trustee is:

Mellon Bank, N.A.  
One Mellon Bank Center  
Pittsburgh, PA 15258-0001

### Claim Review

#### Right to File Claim

Every participant, former participant, retired participant, or beneficiary of a participant or former participant shall be entitled to file with the claims administrator a claim for benefits under the Plan. The claim is required to be in writing. For purposes of this section, any action required or authorized to be taken by the claimant may be taken by a representative authorized in writing by the claimant to represent him.

#### Defective Pre-Service Claims

If a claimant has attempted to file a pre-service claim under the Plan (including an urgent care claim), but has not properly followed the Plan's procedures for doing so, the claims administrator shall notify the claimant of the failure and of the proper procedures for filing a pre-service claim. Such notification shall be given, orally or in writing, no later than five days after the initial attempt to file a claim (or 24 hours in the case of an urgent care claim). A claimant will be considered to have attempted to file a pre-service claim if he has communicated with the Plan's claims administrator, and has named a specific medical condition, symptom, treatment, service, or product for which the claimant is seeking approval.

#### Time for Decision on a Claim

If a claimant has submitted a claim for benefits, the claims administrator shall notify the claimant of its decision in accordance with the rules described below:

1. Urgent Care Claims – In the case of an urgent care claim, the claims administrator shall notify the claimant of any determination on the claim (whether favorable or unfavorable) as soon as possible, but not later than 72 hours after the claims administrator receives the claim. If the claimant does not provide sufficient information to determine whether benefits are payable under the Plan, the claims administrator shall notify the claimant as soon as possible, but no later than 24 hours after receipt of the claim. The claimant shall be afforded at least 48 hours to provide the necessary information. The claims administrator shall notify the claimant of its determination (whether favorable or unfavorable) as soon as possible, but no later than 48 hours after the claims administrator receives the additional information required (or, if earlier, the date by which the additional

information was required to be submitted). If the claims administrator denies the claim, the claimant will be notified of the denial as described below. The initial notice of denial of an urgent care claim may be provided orally, provided that written notification is provided to the claimant within three days after the oral notification.

2. Concurrent Care Decisions – This section applies if the claimant has already received approval for an ongoing course of treatment to be provided over a period of time or a specified number of treatments.
  - Reduction/Termination in Course of Treatment – Any decision to reduce or terminate a previously-approved course of treatment (unless the Plan is being terminated altogether) will be considered a denial of a claim for benefits. The claims administrator shall provide sufficient advance written notice of the reduction or termination to allow the claimant to obtain a review of the decision before the course of treatment is reduced or eliminated. The notice will be provided as described below.
  - Requesting an Extension on a Course of Treatment – A claimant may request an extension of a course of treatment beyond the initial period of time or number of treatments for which the claimant previously received approval. If such request involves urgent care, the claimant must make such request at least 24 hours prior to the expiration of the previously-approved course of treatment, and the claims administrator shall notify the claimant in writing of the decision whether to extend the course of treatment as soon as possible, but no later than 24 hours after its receipt of the request. If the request does not involve urgent care, the claim will be treated as a pre-service claim, as described below. If the claims administrator denies a request to extend a course of treatment, it shall provide the claimant with notice as described below.
3. Pre-Service Claims – With respect to a pre-service claim, the claims administrator shall provide notice of a denial within a reasonable period appropriate to the medical circumstances, but no later than 15 days after its receipt of the claim. If special circumstances require a 15-day extension of time to review the claim, the claims administrator shall notify the claimant of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 15-day period.

## Dental Plan

The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve these issues. If additional information is required from the claimant, the claimant will be afforded at least 45 days to provide such information. The deadline for making a decision on the claim will then be extended for 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

4. Post-Service Claims – With respect to a post-service claim, the claims administrator shall notify the claimant of a denial no later than 30 days after its receipt of the claim. If special circumstances require a 15-day extension of time to review the claim, the claims administrator shall notify the claimant of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 30-day period. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from the claimant, the claimant shall be afforded at least 45 days to provide such information. The 15-day extension for making a decision on the claim will be extended for an additional 45 days or, if shorter, for the length of time it takes the claimant to provide the additional information.

### Notification of Denial

A written notice of claim denial will contain the following:

- The specific reason or reasons for denial;
- A reference to specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to perfect the claim, with an explanation of why the material or information is necessary;
- An explanation of the claims review procedure and the time limits applicable to such procedure, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following a denial upon the second appeal of the claim;
- If any internal rule, guideline, protocol, or other similar criteria was relied upon in denying the claim, an explanation of such criteria or a statement that such criteria

will be provided to the claimant free of charge, upon request; and

- If the denial is based on medical necessity or experimental treatment or a similar limitation, an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided to the claimant free of charge, upon request.

### Right to Review

A claimant may request review at any time within 180 days following the date the claimant received written notice of the denial. A failure to file a request for review within 180 days will constitute a waiver of the claimant's right to request a review of the denial of the claim.

### Review Procedures

The claimant must request a review in writing to the claims administrator and must state the claimant's name and address, the fact that the claimant is disputing the denial of a claim, the date of the initial notice of denial, the reason(s) for disputing the denial, and any other information as the claims administrator may reasonably require in order to make a determination upon review of the claim. However, if the claimant is requesting a review of an urgent care claim, the claimant may also request a review orally, and all communications between the claimant and the claims administrator may be done by telephone, facsimile, or other similar method.

During the review process, the claims administrator shall:

- Provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- Permit the claimant to submit written comments, documents, records and other information relating to the claim;
- Provide a review that takes into account all comments, documents, records, and other information submitted, without regard to whether such information was submitted or considered in the initial determination;
- Provide a review that does not afford deference to the initial claim determination and that is conducted by a Plan fiduciary other than the person who conducted the initial claim determination (or a subordinate of that person);

## Dental Plan

- If the decision is based on a medical judgment, consult with a health care professional with experience in the appropriate field;
- Provide the claimant, upon request, with the identity of those medical experts whose advice was obtained in connection with the claim; and
- Ensure that any health care professional consulted during the review is someone other than the person consulted in the initial claim determination (or a subordinate of that person).

### Time for Decision on Review

1. Urgent Care Claims – With respect to an urgent care claim, the claims administrator shall notify the claimant of the decision on review (whether favorable or unfavorable) as soon as possible, taking into account medical exigencies, but no later than 72 hours after receipt of the request for review. If the claims administrator denies the claim, the claimant will be provided notice as described below.
2. Pre-Service Claims – With respect to a pre-service claim, the claims administrator shall notify the claimant of the decision on review (whether favorable or unfavorable) within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review. If the claims administrator denies the claim, the claimant will be provided notice as described below.
3. Post-Service Claims – With respect to a post-service claim, the claims administrator shall notify the claimant of the decision on review (whether favorable or unfavorable) no later than 60 days after receipt of the written request for review. If the claims administrator denies the claim, the claimant will be provided notice as described below.

### Notification of Determination on Review

If the claims administrator denies a claim upon review, in whole or in part, the written notice shall contain the following information:

- The specific reason for the decision and specific reference to the provisions of the Plan on which the decision is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits;

- A statement describing the mandatory appeal procedures offered by the Plan and explaining the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial upon the second appeal of a claim;
- If any internal rule, guideline, protocol, or other similar criteria was relied upon in denying the claim, an explanation of such criteria or a statement that such criteria will be provided to the claimant free of charge, upon request; and
- If the denial is based on medical necessity or experimental treatment or a similar limitation, an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided to the claimant free of charge, upon request.

### Second Review – Mandatory Appeal

If your claim is denied upon review, you may request a mandatory appeal by sending a written request for review to the plan administrator at the corporate headquarters in Memphis, Tennessee, within 60 days of the denial. Your written request should state the reasons why you believe the claim should not have been denied. The plan administrator will review your written request, the administrative record previously reviewed by the Plan's claims administrator and any additional documentation submitted by you with your written request. You will be notified of the plan administrator's decision in writing within 60 days from the receipt of the request for review.

If your claim is denied at the second appeal, you have the right to bring a civil action under Section 502(a) of ERISA. You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. You may contact the Department of Labor and your state insurance regulatory agency to find out what options may be available to you.

### Agent for Service of Legal Process

Any legal process against the Plan, in the event of an unresolved dispute over benefit plan provisions, should be served on the plan administrator.

### Your ERISA Rights

As a participant in the International Paper Company Group Health and Welfare Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to the following.

#### Receive Information About Your Plan and Benefits

- You may examine, without charge, at the plan administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.
- You may receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

#### Continue Group Dental Plan Coverage

You may continue dental care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan 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 on the rules governing your COBRA continuation rights.

#### Reduction or Elimination of Exclusionary Periods of Coverage

You may reduce or eliminate exclusionary periods of coverage for pre-existing conditions under a group dental plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage (free of charge) from your group medical plan or medical insurance issuer when you lose coverage under a plan, you become entitled to elect COBRA continuation coverage, or your COBRA continuation coverage ceases.

### Prudent Actions 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 employee benefit plan. The people who operate your plan, 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 welfare benefit or exercising your rights under ERISA.

#### Enforce Your Rights

If your claim for a welfare 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 the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you 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.

## Dental Plan

### Assistance with Your Questions

If you have any questions about your plan, 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 offices of the Employee Benefits Security Administration, 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### Contributions to the Plan

Each year, the company determines the amount that it will contribute for the cost of health care coverage for you and your covered eligible dependents. You are responsible for contributing the remainder of the cost of your coverage. The amount that the company contributes is subject to change, and the company will notify you annually as to your portion of the cost of coverage.

### Notice on Privacy of Health Information

*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.*

The plan in which you participate is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a federal law, to protect the privacy of your individual health information maintained by the Plan ("Protected Health Information"). In addition, you have certain rights relating to such Protected Health Information. The HIPAA privacy protection and rights described in this notice also apply to your dependents participating in the Plan.

### Use and Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations

The Plan is permitted to use and disclose your Protected Health Information, without your authorization, for treatment, payment, and health care operations purposes.

For treatment purposes, such use and disclosure may take place in providing, coordinating, or managing health care and its related services by one or more of your providers, such as when your primary care physician consults with a specialist regarding your condition.

For payment purposes, such use and disclosure may take place when your health care provider submits health information to the Plan's claim administrator for payment. The Plan may also use and disclose health information in conferring with other health plans to resolve a coordination of benefits issue, assisting in making eligibility and coverage determinations, or for utilization review activities.

For health care operations purposes, such use and disclosure may take place in a number of ways involving plan administration, including quality assessment, vendor review, and underwriting activities.

## Dental Plan

### **Use and Disclosure of Protected Health Information for Involvement in Your Care and for Notification Purposes**

The Plan may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, your Protected Health Information that is directly relevant to such person's involvement with your health care or payment related to your health care.

In addition, the Plan may use or disclose your Protected Health Information to notify a member of your family, your personal representative, or another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death.

If you are incapacitated, if there is an emergency, or if you otherwise do not have the opportunity to agree to or object to this use or disclosure, the Plan will determine what is in your best interest and will use or disclose only the information that is directly relevant to the person's or agency's involvement with your health care.

### **Use and Disclosure of Protected Health Information for Other Reasons**

The Plan may be permitted or required to use or disclose Protected Health Information for certain other reasons, without your authorization, such as when required by law or for public health purposes. These reasons are specified in the HIPAA regulations, and include the following:

- Disclosures to an appropriate government authority regarding victims of abuse, neglect or domestic violence,
- To a health oversight agency for oversight activities authorized by law,
- In connection with judicial and administrative proceedings,
- To a law enforcement official for law enforcement purposes,
- To a coroner, medical examiner, or funeral director,
- To cadaveric organ, eye or tissue donation programs,
- For research purposes, as long as certain privacy-related standards are satisfied,
- To avert a serious threat to health or safety,
- For 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), and
- For workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

In addition, your health information can be used to provide you information about treatment alternatives or other health-related benefits and services available under the Plan.

## Dental Plan

### **Use and Disclosure of Protected Health Information to International Paper**

The Plan may disclose your Protected Health Information to International Paper as the plan sponsor in connection with the operation and administration of the Plan.

International Paper has designated a limited number of employees who are the only ones permitted to access and use your Protected Health Information for certain Plan functions, including the determination of claim appeals, the audit of payments under the Plan and the reconciliation of plan utilization and cost.

When appropriate, the Plan may share two types of Protected Health Information with other International Paper employees:

- Enrollment/disenrollment data – information on whether you participate in the health plan or whether you have enrolled or disenrolled from a Plan option (e.g., HMO), and
- Summary health information – summaries of claims from which names and other identifying information have been removed.

### **Authorization to Use or Disclose Protected Health Information**

Other uses and disclosures of your Protected Health Information will be made only with your written authorization. Authorizations are voluntary, require the filing of an authorization form and may be revoked by you in writing at any time to stop any future uses and disclosures. You may request the authorization, for example, to direct the Plan to release your health information as medical evidence in your filing of a disability claim, or the Plan may request that you make an authorization, for example, for a claims research project involving International Paper's employees.

### **Individual Rights Relating to Protected Health Information**

You have the right to request the following with respect to your Protected Health Information: (i) inspection and copying; (ii) amendment or correction; (iii) an accounting of disclosures of this information by the Plan, excluding disclosures made for payment, treatment or health care operations, or disclosures made pursuant to your written authorization. All requests must be made in writing, and you will receive a response to your request, including specific reasons if your request is denied, in whole or in part.

You may request the Plan restrict uses and disclosures of your Protected Health Information for treatment, payment, and health care operations. You may also request the Plan restrict uses and disclosures to family members, relatives, or other persons who may be involved in your health care or payment for your health care. For example, you may want to restrict the physician providing a second medical opinion from consulting with your treating physician or you may want to restrict disclosures to family members in the case of divorce. The Plan will consider your request but is not required to agree to your request for restriction. Any restriction agreed to by the Plan will not apply if the use or disclosure is necessary to provide you with emergency treatment. Further, the Plan generally will not agree to restrictions on disclosures relating to treatment, payment and health care operations. All requests for restriction must be made in writing, and you will receive a response to your request.

You have the right to request in writing that you receive your Protected Health Information by alternative means or at an alternative location and the Plan will accommodate reasonable requests if the normal method of communication could endanger you.

You have the right to obtain a paper copy of this notice at any time, upon request.

## Dental Plan

### Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the HelpLine at 1-800-443-6308. You may also send a written complaint to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. International Paper may not retaliate against you for filing a complaint.

### Additional Information

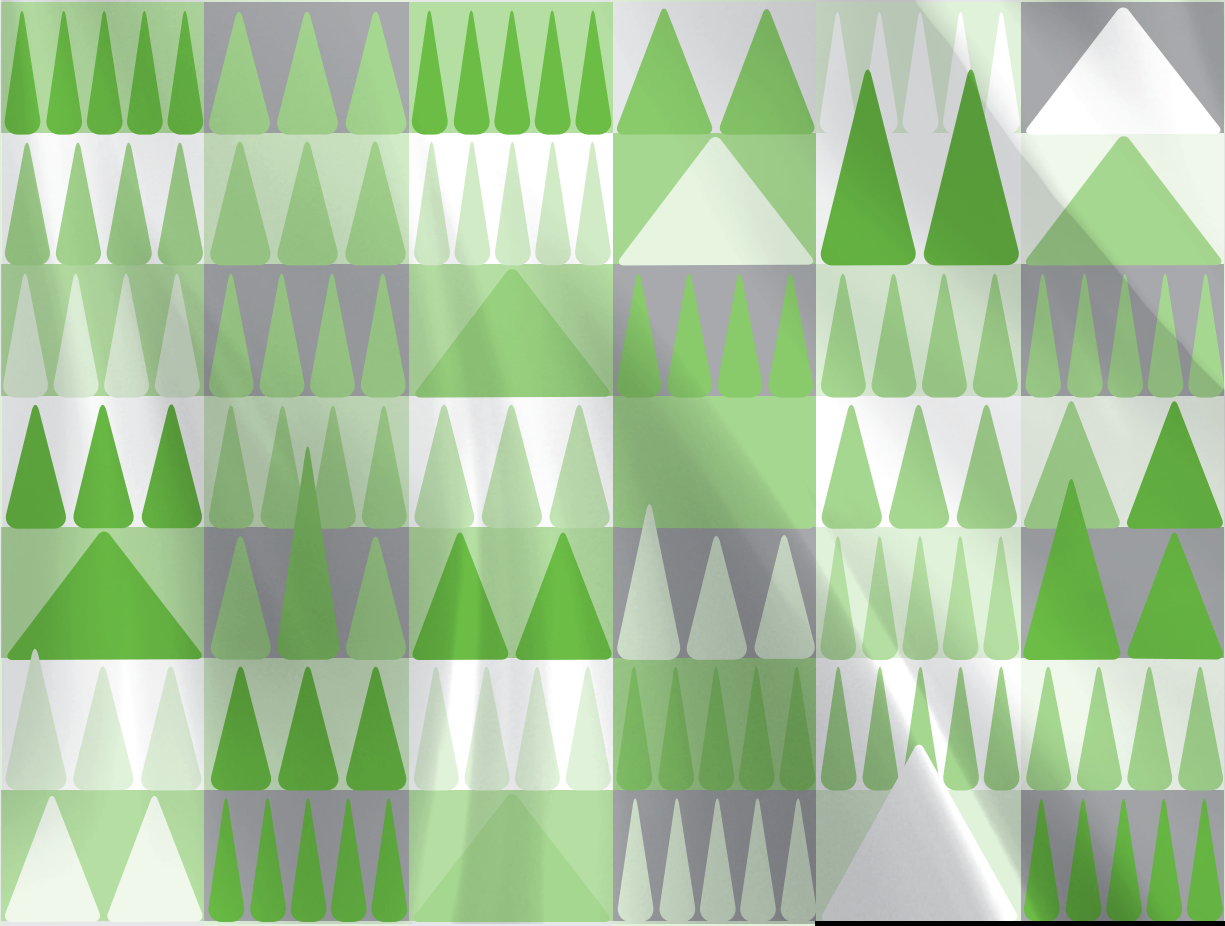
Requests to access, amend or restrict Protected Health Information, to obtain an authorization form or to obtain further information should be directed to:

Employee Service Center  
P.O. Box 563989  
Charlotte, NC 28256-3989  
1-888-ESC-2YOU (1-888-372-2968)

The Plan may charge you for requested copies of your health information or for summaries of such information.

The Plan reserves the right to change its privacy policies at any time. Before any significant change is made, you will receive a new notice by mail.

The Plan is required by law to protect individual health information about you, to provide this notice about its information practices, and to follow the information practices described in this notice.



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## Dental Plan Appendix

This Appendix is effective January 1, 2009.

### Who Is Eligible

All regular, active full-time employees who are represented in collective bargaining and who participate in the company's Benefits Architecture program or core dental plan.

### Effective Date of Coverage

First day of the month following one month of continuous employment

### Where Can I Find More Information?

UMR (formerly Fiserv Health)  
1-800-343-2737      [www.umar.com](http://www.umar.com)

### Deductibles

Diagnostic and Preventive Services	None
Basic Restorative, Major Restorative and Orthodontic Services	Individual: \$50 Family: \$100

### Maximum Benefits

Diagnostic, Preventive and Restorative Services Individual Annual Maximum	\$1,500
Orthodontic Services Individual Lifetime Maximum	\$1,500

### Reimbursement at 100 Percent Without Satisfying the Deductible

Diagnostic and Preventive Services

### Reimbursement at 80 Percent After Satisfying the Deductible

Basic Restorative Services

### Reimbursement at 50 Percent After Satisfying the Deductible

Major Restorative Services  
Orthodontic Services

### Reinstatement of Coverage

If your employment terminates and you are rehired within one year, coverage for you and your eligible dependents can be reinstated without serving the eligibility waiting period. Reinstatement of coverage will be effective on the day you return to work, provided you make application for coverage within 31 days after the date of re-employment. If you do not make application within this 31-day period, you may enroll during annual enrollment, a special enrollment period or if you have a change in status as outlined in the section entitled How to Enroll.

If your employment terminates and you are rehired after one year, you will be considered a new employee and will be required to serve the waiting period before you are eligible to enroll for coverage.

If you are eligible for recall rights as outlined in the applicable collective bargaining agreement and you return to regular full-time employment, coverage for you and your eligible dependents can be reinstated without serving the eligibility waiting period. Reinstatement of coverage will be effective on the day you return to work, provided you make application for coverage within 31 days after the date of your re-employment. If you do not make application within this 31-day period, you may enroll during annual enrollment, a special enrollment period or if you have a change in status as outlined in the section entitled How to Enroll.

### Collective Bargaining Agreements

The Plan is maintained under a collective bargaining agreement. A copy of such agreement may be obtained by participants upon written request to the plan administrator and is available for examination by participants at various work locations.