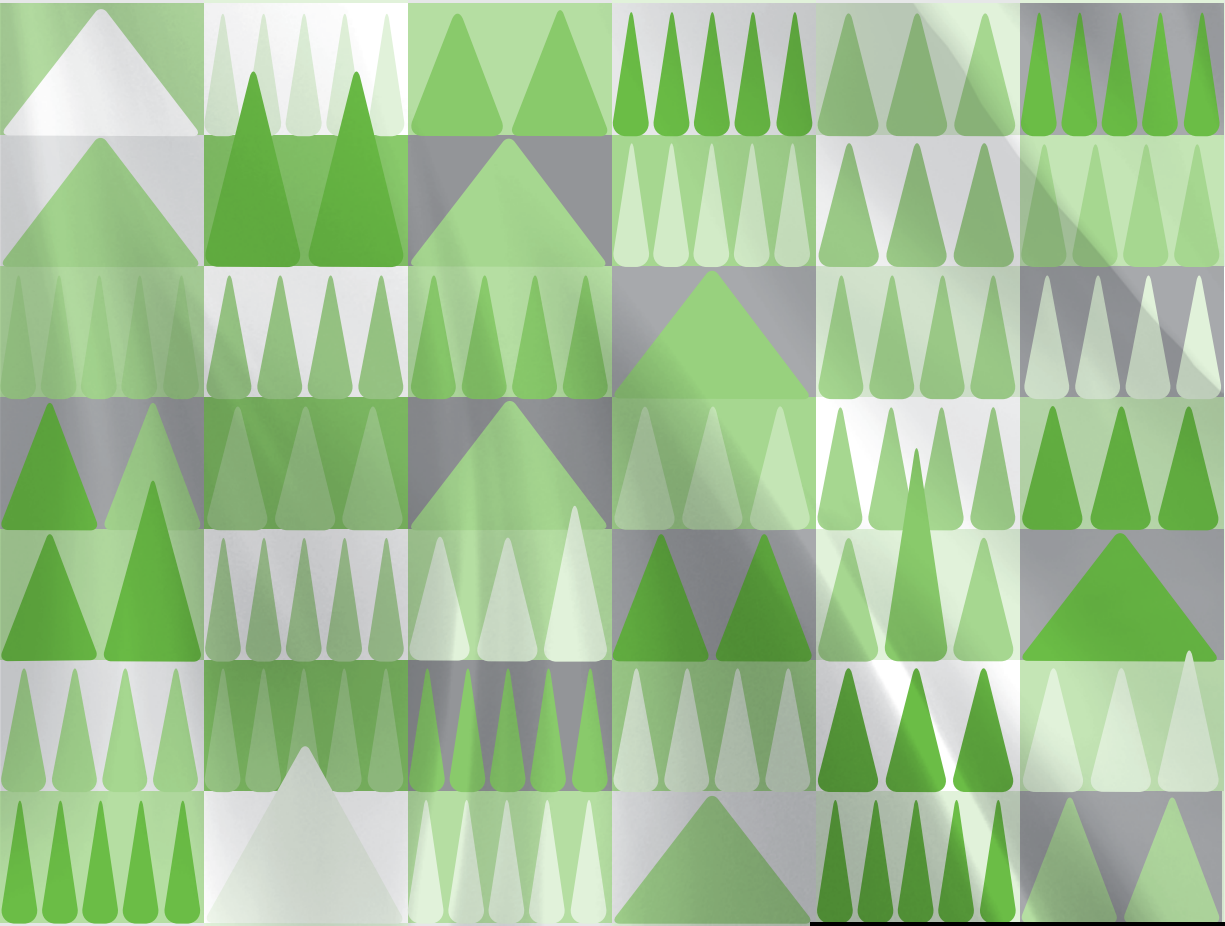


Medicare Supplemental Benefits Plan – Administered by UMR



INTERNATIONAL  PAPER

## Medicare Supplemental Benefits Plan

Administered by  
UMR (formerly Fiserv Health)



# Medicare Supplemental Benefits Plan

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## Medicare Supplemental Benefits Plan

### Medicare Supplemental Benefits Plan

#### Who Is Eligible

You and your covered dependents are eligible for coverage under the Medicare Supplemental Benefits Plan (the Plan) if you meet the eligibility requirements in the Appendix and you are eligible for Medicare, except during the first 30 months of Medicare entitlement based on end stage renal disease (ESRD).

Family members not eligible for Medicare may continue to receive medical coverage through the company-sponsored medical plans offered to active employees and to non-Medicare-eligible retirees. Any covered person who is eligible for Medicare as a result of ESRD also will receive medical coverage through the company medical plans offered to active employees and to non-Medicare-eligible retirees during the first 30 months of Medicare entitlement due to ESRD.

#### Eligible Dependents

Dependents eligible for coverage include:

- Your spouse (husband or wife to whom you are legally married);
- Your domestic partner (Effective January 1, 2009. See the section entitled Domestic Partners on the next page.);
- 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 claim 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 claim administrator, and proof of creditable coverage within 31 days following the child's eligibility date under the Plan; and
- 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 (as outlined below), 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 or your spouse's federal income tax return.

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

## Medicare Supplemental Benefits Plan

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

### Domestic Partners

International Paper will offer post-retirement medical coverage to the domestic partners of employees who retire or who begin receiving company-sponsored LTD benefits on or after January 1, 2009, and current retirees and LTD recipients who acquire a domestic partner on or after January 1, 2009. The retiree/LTD recipient must pay the full cost of the domestic partner coverage with no company subsidy; therefore, there will be no imputed or taxable income associated with this benefit.

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 retiree 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 as outlined above.

## How to Enroll

### Enrolling Your New Dependents

If you acquire a new dependent — for example, if you get married or have a child — and you want to enroll your new dependent, your newly acquired dependent will become covered provided you contact the Retiree Service Center (RSC) within 31 days of the event. Coverage will begin on the date you acquire the new dependent.

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.

## Medicare Supplemental Benefits Plan

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 RSC 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 any of the plans offered through the company.

### **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.

### **Special Enrollment Periods**

#### *Loss of Other Coverage*

If you or your eligible dependents 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 dependents 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.

### **How Medicare Works**

In general, when you reach age 65, you become eligible for Medicare. You or your eligible dependents also may become eligible for Medicare 24 months after qualifying for Social Security disability benefits. Once you are eligible for Medicare you may continue medical coverage through the Medicare Supplemental Benefits Plan, provided you make the required contributions. The Plan helps cover eligible expenses not fully reimbursed by Medicare Parts A and B such as:

- Medicare Part A and Part B deductibles;
- Daily coinsurance amounts under Medicare Part A;
- Coinsurance amounts under Medicare Part B; and
- Medically necessary private duty nursing services by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.). Custodial care is not covered.

The Plan always calculates benefits based on the assumption that you are enrolled in Medicare Parts A and B, even if you are not enrolled in both parts. In order to receive the maximum benefits of both plans, you should enroll in both Medicare Parts A and B.

Medicare Part A, also called Hospital Insurance, helps pay for medically necessary inpatient hospital services after the Medicare Part A deductible has been met. Medicare Part B helps pay for physicians' services, outpatient hospital services, outpatient therapy and rehabilitation services, diagnostic and ambulance services, medical equipment and other services and supplies not covered by Medicare Part A. Medicare Part B generally pays 80 percent of allowed charges after the Medicare Part B deductible has been met.

## Medicare Supplemental Benefits Plan

The Medicare-allowed charge is the maximum charge Medicare allows for a covered service. The allowed charge is often less than what physicians and suppliers charge for their services, and it cannot be greater than the actual charge. Providers that accept Medicare assignment limit their fees to Medicare's allowed charge. When providers do not accept assignment, Medicare's allowed charge is reduced by five percent.

Please refer to the charts entitled How the Medicare Supplemental Benefits Plan Coordinates With Medicare Part A and Part B in this summary plan description (SPD) to see how Medicare and this Plan pay benefits.

**Important Note** – Although Medicare usually does not cover health care expenses incurred outside of the United States, this Plan will provide coverage for these expenses as long as:

- You remain a resident of the US;
- You have been traveling outside of the US for 90 days or less; and
- Your expenses were incurred or your hospital confinement began within 90 days of your most recent departure from the US.

Expenses will be reimbursed according to the provisions of the Company's Comprehensive Medical Plan except that the following provisions of the Medicare Supplemental Benefits Plan will continue to apply:

- Deductible;
- Out-of-pocket maximum; and
- Retail and mail-order prescription drug program copayments.

If you expect your travel outside of the US to continue beyond 90 days, you should consider other sources of medical coverage for the period beginning with the 91st day. Details regarding the level of coverage offered under the Company's Comprehensive Medical Plan are available by calling the RSC at 1-888-ESC-2YOU (372-2968).

## How the Plan Works

The Plan is designed to complement Medicare benefits for hospital and other medical expenses and to provide added protection in the event of large expenses not fully reimbursed by Medicare Parts A and B.

The Plan also includes coverage for outpatient prescription drugs, which are not covered by Medicare. You may purchase prescription drugs at a participating pharmacy through the Retail Prescription Drug Program or through the mail by using Medco By Mail. See the sections entitled Retail Prescription Drug Program and Medco By Mail for details on prescription drug coverage.

**Important Note** – If you enroll in International Paper's COBRA medical program when otherwise eligible for International Paper's post-retirement medical plan, you forfeit your right to enroll in any International Paper post-retirement medical plan.

### Coordination With Medicare Part A Benefits

For hospitalizations covered by Medicare Part A, after you meet your plan deductible, the Plan pays 80 percent of the Part A hospital deductible and Part A coinsurance amounts subject to your out-of-pocket maximum. Once you have met your out-of-pocket maximum, the Plan pays 100 percent of the Part A hospital deductible and Part A coinsurance amounts.

### Coordination With Medicare Part B Benefits

For medical services and supplies covered by Medicare Part B, the amount recognized by the Plan as a covered expense is limited to the Medicare-allowed amount. If Medicare does not consider a charge to be a covered expense, that charge will not be covered by this Plan (with the exception of medically necessary private duty nursing services by an R.N. or L.P.N.). Expenses above the Medicare-allowed charge will not be applied to your deductible or out-of-pocket maximum.

## Medicare Supplemental Benefits Plan

After you meet your plan deductible, the Plan pays 80 percent of covered expenses, minus the amount already reimbursed by Medicare Part B, up to your out-of-pocket maximum. Once you reach your out-of-pocket maximum, the Plan pays 100 percent of covered expenses, minus the amount already reimbursed by Medicare Part B (with the exception of mental health and substance abuse treatment which continue to be reimbursed at 80 percent).

**Important Note** – The Plan pays the difference between the amount that would be paid by the Plan in the absence of Medicare, and the actual amount paid by Medicare. If the amount paid by Medicare is equal to or greater than the Plan’s calculated payment, the Plan pays nothing, and the Medicare coinsurance would then be applied to the out-of-pocket maximum.

### Medicare Prescription Drug Coverage

The federal government offers Medicare Prescription Drug Coverage (Medicare Part D) to everyone who is eligible for Medicare. Participation in the program is voluntary, and those who choose it will pay a monthly premium for the coverage. Premiums vary depending on the plan the participant chooses and where they live. Enrollment and coverage are through private companies, such as health care insurance companies.

Despite the availability of this new coverage, International Paper continues to offer prescription drug benefits through the Medicare Supplemental Benefits Plan. Also, each year International Paper issues a “Creditable Prescription Drug Coverage Notice” which states, among other things, that the Prescription Drug Coverage you have through International Paper, is on average, at least as good as the new Medicare Prescription Drug Coverage.

It is important to note that you cannot participate in both the Medicare Supplemental Benefits Plan and Medicare Prescription Drug Coverage. Any Medicare-eligible retiree, spouse or dependent who chooses to enroll in Medicare Prescription Drug

Coverage will no longer be eligible for medical and prescription drug coverage under the Medicare Supplemental Benefits Plan and will not be able to enroll in the Plan in the future.

### Deductible and Out-of-Pocket Maximum

Once you or a covered dependent becomes eligible for Medicare, deductibles and out-of-pocket maximums work differently from the way they work under the company medical plans offered to active employees and non-Medicare-eligible retirees.

- You must now meet an individual deductible and individual out-of-pocket maximum each calendar year;
- Medical expenses applied to your deductible and/or out-of-pocket maximum can no longer be used to satisfy the family deductible and/or out-of-pocket maximum.
- In the year you become eligible for Medicare, any of your expenses applied to your individual pre-Medicare deductible and out-of-pocket maximum will be credited toward your deductible and out-of-pocket maximum under the Medicare Supplemental Benefits Plan.
- In the year you become eligible for Medicare, any expenses other members of your family have that were used to meet your pre-Medicare deductible and out-of-pocket maximum cannot be used to satisfy your individual deductible and out-of-pocket maximum under the Medicare Supplemental Benefits Plan.

Prescription drug copayments and mental health care and substance abuse treatment coinsurance amounts are not applied toward the out-of-pocket maximum.

**Important Note** – The Medicare Supplemental Benefits Plan is administered by UMR. If your pre-Medicare plan was with one of International Paper’s other vendors, please provide UMR with proof of year-to-date deductibles and out-of-pocket amounts such as an explanation of benefits.

## Medicare Supplemental Benefits Plan

### **Lifetime Maximum**

After you or one of your covered dependents becomes eligible for Medicare, the Plan provides up to \$1,500,000 in lifetime maximum benefits (or the remaining lifetime maximum under your company-sponsored pre-Medicare coverage, if less) for each covered person. Unlike the company-sponsored pre-Medicare coverage, the Medicare Supplemental Benefits Plan does not provide for the restoration of any portion of the lifetime maximum benefit.

### **Retail Prescription Drug Program**

The Retail Prescription Drug Program allows you to meet your prescription drug needs with increased convenience at a reduced cost.

The Program is available to you and your covered dependents from the effective date of coverage under the Plan.

#### *Network Pharmacies*

Under the Medco Retail Pharmacy Network Program, you will receive two prescription drug cards. When you or your covered dependents need a prescription filled, simply present the drug card along with the physician's prescription to any participating pharmacy. You can receive up to a 30-day supply of medication from a participating pharmacy.

When prescriptions for you or your covered dependents are filled at a pharmacy that participates in the Medco Retail Pharmacy Network Program, you will pay a copayment for generic or brand-name medication. Refer to the Appendix for the copayment amounts for generic and brand-name medication. You also will be asked to sign a form acknowledging receipt of the medication.

The majority of national pharmacy chains and independent pharmacies participate in the Medco Retail Pharmacy Network Program. If you have questions about which pharmacies are in the Medco Retail Pharmacy Network Program, call Medco customer service or visit their website (see Appendix).

#### *Out-of-Network Pharmacies*

If prescriptions for you or your covered dependents are filled at a pharmacy that does not participate in the Medco Retail Pharmacy Network Program, you will pay the full price charged by the pharmacy for the prescription. To receive reimbursement for medication purchased from an out-of-network pharmacy, you will need to submit a claim form to Medco. The Program will reimburse the allowable amount for the medication purchased, less the applicable copayment.

For additional information or to obtain claim forms, call Medco customer service or visit their website.

### **Maintenance Medication**

If a prescription is for maintenance medication and you or your covered dependents need to begin taking the maintenance medication right away, have the physician complete two prescriptions — one to be filled immediately at a Medco network pharmacy for up to a 30-day supply and the other for a 90-day supply to be submitted to Medco By Mail.

Participants who have access to the Savannah Employee Family Medical Center (EFMC) may purchase up to a 90-day supply of maintenance medications at the EFMC pharmacy.

## Medicare Supplemental Benefits Plan

### Medco By Mail

If you or your covered dependents take medication on a long-term and regular basis, after the first fill of medication at a retail pharmacy, you must use Medco By Mail in order to receive coverage. Medco By Mail provides a convenient, less expensive way for you to order these medications and have them delivered directly to your home.

Medco By Mail is available to you and your covered dependents from the effective date of coverage under the Plan.

You may order up to a 90-day supply of medication from Medco By Mail. You will pay a copayment for each prescription or refill. Refer to the Appendix for the copayment amounts for generic and brand-name medication.

To order medication through Medco By Mail, submit the following to Medco:

- The original prescription from your physician;
- A completed, signed Medco By Mail order form; and
- The applicable copayment as listed in the Appendix.

For additional information or to obtain a Medco By Mail order form, call Medco customer service or visit their website. You can order refills of maintenance medications by mail, telephone, or the Internet.

**Important Notes** – The copayment amounts under the Retail Prescription Drug Program and Medco By Mail do not apply toward the deductible or out-of-pocket maximum under the Plan. In addition, amounts not reimbursed under the programs are not eligible for reimbursement under the Plan.

Prescription drug coverage under the Medco Retail Prescription Drug Program and Medco By Mail is subject to the rules and restrictions of the Medco contract.

Drugs that are not approved by the U.S. Food and Drug Administration to be lawfully marketed for a proposed use, or are considered to be experimental, educational, investigative, unproved or obsolete, are not eligible for reimbursement under the Plan.

### Should you purchase a brand-name or a generic drug under the Medco Prescription Drug Program?

It's your and your physician's choice, but if you choose to purchase a brand-name drug instead of the generic equivalent, and the prescribing physician has not indicated in writing that you must take the brand-name drug, you will pay the brand-name copayment *plus* the difference between the cost of the brand-name drug and the cost of the generic equivalent.

## Medicare Supplemental Benefits Plan

### Additional Health Care Expenses

This section addresses coverage under the Plan for the following:

- Health care expenses incurred outside of the United States;
- Expenses for private duty nursing; and
- Expenses for inpatient hospitalizations and skilled nursing facilities that exceed Medicare's benefit limits.

These expenses, if not eligible for reimbursement under Medicare due to exclusions (for health care expenses incurred outside of the U.S. and for private duty nursing expenses) or limitations (for inpatient hospitalizations and skilled nursing facilities) and if determined to be medically necessary and within usual and customary guidelines, will be considered eligible expenses under the Plan subject to the deductible, 80 percent coinsurance paid by the Plan, and out-of-pocket maximum.

### Usual and Customary Allowance

The Plan bases reimbursement for these services on the usual and customary allowance. The usual and customary allowance is the lower of:

- The usual charge by most physicians or other providers in the same or similar geographic area for the same or similar medical service or supply; or
- The actual charge by the physician or other provider for the medical service or supply.

**Usual and Customary Allowance** – the basis on which the charge for a medical service or supply 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 under the Plan nor will it apply toward your deductible or out-of-pocket maximum.

### Requirement of Medical Necessity

Benefits for services and supplies are payable if they are determined by the Plan's claims administrator to be medically necessary in terms of generally accepted medical standards. Care or treatment is deemed "medically necessary" if it meets *all* of the following conditions.

- It is appropriate given the symptoms and is consistent with the diagnosis.
- It is provided for the diagnosis or direct care and treatment of your medical condition.
- It is rendered in accordance with generally accepted medical practice and professionally recognized standards.
- It is not provided primarily for the convenience and/or comfort of you, your family, your physician or another provider of services.
- It is not regarded generally as experimental, educational, investigative, unproved or obsolete.
- It is specifically allowed by the licensing statutes that apply to the provider who renders the service.
- It is performed in the least costly setting or manner required by your medical condition.

A "setting" may be your home, a physician's office, a participating ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. As your medical condition changes, the setting you need also may change.

## Medicare Supplemental Benefits Plan

### How the Medicare Supplemental Benefits Plan Coordinates With Medicare Parts A and B

The following charts show how the Plan coordinates benefit payments with Medicare Parts A and B.

#### Hospitalization

*First 60 Days*

**Medicare Pays** All but the Medicare Part A hospital deductible

**Plan Pays** 80 percent of the Medicare hospital deductible, after you meet the plan deductible, up to your out-of-pocket maximum; then the Plan covers 100 percent of Medicare hospital deductible

**You Pay** Balance

*61st – 90th day*

**Medicare Pays** All but your daily coinsurance amount

**Plan Pays** 80 percent of the daily Medicare coinsurance amount, up to your out-of-pocket maximum; then the Plan covers 100 percent of daily Medicare coinsurance amount

**You Pay** Balance

*Beyond 90th day when using Medicare's 60-day Lifetime Reserve*

**Medicare Pays** All but your daily coinsurance amount

**Plan Pays** 80 percent of the daily Medicare coinsurance amount, up to your out-of-pocket maximum; then the Plan covers 100 percent of daily Medicare coinsurance amount

**You Pay** Balance

*Beyond 90th day after using all of Medicare's 60-Day Lifetime Reserve*

**Medicare Pays** Nothing

**Plan Pays** 80 percent of Medicare-covered expenses, up to your out-of-pocket maximum; then the Plan covers eligible expenses at 100 percent

**You Pay** Balance

#### Medical Expenses

The Plan helps pay for expenses associated with certain covered services such as physicians' visits, outpatient hospital care and outpatient physical therapy.

**Medicare Pays** 80 percent of Medicare-allowed charge, after you pay the annual Medicare Part B deductible.

**Plan Pays** The difference between the amount that would be paid by the Plan in the absence of Medicare, and the actual amount paid by Medicare. If the amount paid by Medicare is greater than the Plan's calculated payment, the Plan pays nothing.

**You Pay** Balance, including expenses above Medicare's allowed charge if you use a provider who does not accept Medicare assignment. (**Note:** Expenses above Medicare's allowed charge will not be applied to your deductible or out-of-pocket maximum.)



## Medicare Supplemental Benefits Plan

### Example 2: Reimbursement of Physicians' Fees

Physicians' fees are covered by Medicare Part B, up to Medicare's allowed charge. The Plan also covers physicians' charges up to the Medicare-allowed charge. Here is an example of how the Plan pays for the services of physicians who accept Medicare assignment (and limits fees to the Medicare-allowed charge).

	<b>Physician Accepts Medicare Assignment</b>
<b>Medicare Part B Pays</b>	
Physicians' fees	\$2,600
Medicare-allowed charge	2,600
2009 Part B deductible	(135)
Amount covered by Medicare	2,465
Medicare coinsurance	x 80%
<b>Medicare Part B Pays</b>	<b>\$1,972</b>

<b>Plan Pays</b>	
Covered physicians' fees (Medicare-allowed charge)	\$2,600
Plan deductible	(500)
	2,100
Plan coinsurance	x 80%
Plan benefit before Medicare coordination	1,680
Amount paid by Medicare Part B	1,972
<b>Plan Pays</b>	<b>\$ 0</b>

<b>You Pay</b>	
Physicians' fees	\$2,600
Amount paid by Medicare Part B	(1,972)
Amount paid by the Plan	(0)
<b>You Pay (including plan deductible)</b>	<b>\$ 628</b>

### Example 3: Reimbursement of Physicians' Fees if Deductible and Out-of-Pocket Maximum Have Been Met

If you have already met the deductibles for Medicare Part B and the Plan and have reached the Plan's out-of-pocket maximum, then the plan coinsurance increases from 80 percent to 100 percent.

	<b>Physician Accepts Medicare Assignment</b>
<b>Medicare Part B Pays</b>	
Physicians' fees	\$2,600
Medicare-allowed charge	2,600
Medicare coinsurance (Medicare deductible already met)	x 80%
<b>Medicare Part B Pays</b>	<b>\$2,080</b>

<b>Plan Pays</b>	
Covered physicians' fees (Medicare-allowed charge)	\$2,600
Plan benefit before Medicare coordination	2,600
Amount paid by Medicare Part B	(2,080)
<b>Plan Pays</b>	<b>\$ 520</b>

<b>You Pay</b>	
Physicians' fees	\$2,600
Amount paid by Medicare Part B	(2,080)
Amount paid by the Plan	(520)
<b>You Pay</b>	<b>\$ 0</b>

**Important Note** – Fees above Medicare's allowed charge for a physician who does not accept assignment are not applied toward the deductible or out-of-pocket maximum.

## Medicare Supplemental Benefits Plan

### Example 4: Prescription Drug Costs

The following are examples of two commonly prescribed drugs. As you can see, your copayment can be substantially less than the full retail cost of a 90-day supply of the medications.

<b>Zocor 20mg (cholesterol reducing medication)</b>	
Average cost for a 90-day supply	\$360.84
Your copayment (brand-name)	– 120.00
<b>Plan Pays</b>	<b>\$ 240.84</b>

<b>Meloxicam 15mg (arthritis medication)</b>	
Average cost for a 90-day supply	\$ 155.54
Your copayment (generic)	– 20.00
<b>Plan Pays</b>	<b>\$ 135.54</b>

### Filing Claims

To receive Supplemental Benefits, you must first file a claim for Medicare reimbursement. Medicare will send you an Explanation of Benefits (EOB) form. Then you must send the Medicare EOB form, together with copies of all bills, to the Plan's claims administrator.

Your claim will be processed as soon as the Plan's claims administrator receives the proof needed to support your claim. If any benefits have been denied, you will receive an explanation. See the section entitled General Administration of the Plan.

### Assignment of Benefits

Benefits due under the Plan will be paid directly to the hospital or the individual performing the service unless the provider of services indicates on the claim form that payment has been received. If so, payment will be made to you.

### When Coverage Ends

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 surviving spouse remarries or is covered, or becomes covered, under another group medical plan, coverage ends for the spouse and any covered dependent children when that event occurs.
- If you or your eligible dependents choose to enroll in Medicare Prescription Drug Coverage, coverage under the Plan will terminate and cannot be reinstated.
- The company terminates the Plan.

## Medicare Supplemental Benefits Plan

### Survivor Coverage

In the event of your death while you are actively employed by the company, medical coverage will be available for your surviving spouse, domestic partner and other eligible dependents as outlined in this section.

- If you were eligible for retirement under the Retirement Plan of International Paper Company or otherwise eligible for International Paper post-retirement medical coverage at the time of your death, and your eligible dependents were covered under an International Paper medical plan at the time of your death, your eligible dependents may continue their coverage under one of the International Paper medical plans offered to retirees by paying the applicable retiree contributions.
- If you were eligible for retirement under the Retirement Plan of International Paper Company or otherwise eligible for International Paper post-retirement medical coverage at the time of your death, and your eligible dependents were not covered under an International Paper medical plan at the time of your death, your eligible dependents may elect coverage at a later date under one of the International Paper medical plans offered to retirees if they experience a Loss of Other Coverage as outlined in the Special Enrollment Periods section. Your eligible dependents must enroll for coverage within 31 days of the Loss of Other Coverage, and they must pay the applicable retiree contributions.

Whether or not you were eligible for company sponsored, post-retirement medical coverage at the time of your death, coverage under the Plan may be continued for your eligible dependents as outlined in the section entitled COBRA — Continuation of Coverage.

In the event of your death, the company will notify your covered dependents how to continue medical coverage.

**Important Note** – If you enroll in International Paper’s COBRA medical program when otherwise eligible for International Paper’s post-retirement medical program, you forfeit your right to enroll in any International Paper post-retirement medical plan.

### Right to Certificate of Creditable Coverage

When your coverage under this Plan ends, the Plan is required to provide a written certification of how long your coverage was in effect. The purpose of this Certificate of Creditable Coverage is to help you obtain coverage under another group health plan or an individual insurance policy.

You will be sent a Certificate of Creditable Coverage automatically at the time your coverage ends and, if elected, again when continuation of coverage under COBRA ends. You also may request a Certificate of Creditable Coverage from the Plan’s claims administrator at any time within the 24-month period after your Plan coverage ends.

## Medicare Supplemental Benefits Plan

### Coverage After You Retire

If you are eligible to commence benefits under the company's Retirement Plan on the date you terminate employment with the company, or if you are not a participant in the company's Retirement Plan but are at least age 55 and have at least 10 years of service with the company when you terminate employment, you may elect retiree medical coverage for yourself and your eligible dependents who are covered on your retirement date. You may enroll yourself and your covered eligible dependents at the time of your retirement or at a later date for events outlined in the section entitled Special Enrollment Periods. After retirement, if you experience an event listed under Special Enrollment Periods, you must contact the Retiree Service Center (RSC) within 31 days from the date of the event to enroll for coverage. If you do not enroll within 31 days of the event, you will not be allowed to add coverage for yourself and/or your dependent(s) at a later date.

Medical coverage during retirement for persons not entitled to Medicare will be the same as coverage for active employees.

Any changes made to the active employee plan generally also apply to retiree coverage. You will be notified by the RSC when any changes occur that affect your retiree coverage.

IP also offers post-retirement medical coverage to the domestic partners of employees who retire or who begin receiving company-sponsored LTD benefits on or after January 1, 2009, and current retirees and LTD recipients who acquire a domestic partner on or after January 1, 2009. The retiree/LTD recipient must pay the full cost of the domestic partner coverage with no company subsidy; therefore, there will be no imputed or taxable income associated with this benefit.

All retiree medical coverage under this Plan will end on the day before you become eligible for Medicare, unless your Medicare eligibility is due to end stage renal disease (ESRD). If you are eligible for Medicare, you may be able to elect coverage under the company-sponsored Medicare Supplemental Benefits Plan.

When your coverage ends because of your eligibility for Medicare, except in cases of ESRD, your covered dependents may continue coverage under the retiree medical portion of the medical plans offered at your facility unless any of the following occur:

- If your dependents cease to be eligible dependents as defined in the Plan, coverage will end on the last day of the month in which they become ineligible.
- If your dependents become eligible for Medicare, unless Medicare eligibility is due to ESRD, coverage under this Plan will end on the day before they become eligible for Medicare.
- If you fail to make timely payment of any required retiree medical contributions, coverage will end on the last day of the month for which you have paid.

In the event of your death while you are covered as a retiree under the Plan, medical coverage may be available for your surviving spouse, domestic partner and other covered eligible dependents under one of the International Paper medical plans offered to retirees.

- If your eligible dependents were covered under an International Paper post-retirement medical plan at the time of your death, your eligible dependents may continue their coverage under one of the International Paper medical plans offered to retirees by paying the applicable retiree contributions.

## Medicare Supplemental Benefits Plan

- If your eligible dependents were not covered under an International Paper post-retirement medical plan at the time of your death, your eligible dependents may elect coverage at a later date under one of the International Paper medical plans offered to retirees if they experience a Loss of Other Coverage as outlined in the Special Enrollment Periods section. Your eligible dependents must enroll for coverage within 31 days of the Loss of Other Coverage, and they must pay the applicable retiree contributions.

If your eligible dependent marries or remarries, is covered under another group medical plan at the time of your death, or becomes covered under another group medical plan following your death, coverage under the Plan ends and cannot be reinstated.

You must make monthly payments to the company in accordance with the established retiree medical rates for both yourself and your covered eligible dependents. Benefits will be subject to the terms and conditions of the plan document. The RSC can provide additional information regarding retiree medical coverage.

**Important Note** – If you enroll in International Paper’s COBRA medical program when otherwise eligible for International Paper’s post-retirement medical program, you forfeit your right to enroll in any International Paper post-retirement medical plan.

### 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 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 medical 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 medical coverage under the Plan would be terminated may continue medical coverage under the Plan for up to 36 months. Also, your covered children may continue medical coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the Plan.

## Medicare Supplemental Benefits 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.

The law requires that continuation of coverage rights similar to those described previously may apply to retirees, spouses and dependents if the company commences a Chapter 11 bankruptcy proceeding.

### **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 medical 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 medical coverage. In the event of your death, the company will notify your covered dependents how to continue medical coverage.

## Medicare Supplemental Benefits Plan

### **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.

### **Cost**

#### *Continuing Coverage*

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

### *Additional Cost Requirements for Continuation of 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 for all family members participating in the same coverage option as the disabled individual; and
- 102 percent for any family members participating in a different coverage option than the disabled individual;

except as provided below.

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 for all family members participating in the same coverage option as the disabled individual; and
- the 102 percent rate for any family members in a different coverage option than the disabled individual.

### **Coverage During the Continuation Period**

If coverage under the Plan is changed, the same changes will be provided to individuals on COBRA continuation.

## Medicare Supplemental Benefits Plan

### 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 medical or 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.
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare.)
- 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 and retirees.

Contact the RSC 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 Retiree Service Center (RSC).

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

#### 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.

## Medicare Supplemental Benefits 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 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 Plan. The address of the claims administrator is:

UMR  
Medical Claim 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 plan participants annually and is also available from the RSC.

Retiree Service Center  
P.O. Box 7870  
Ocala, Florida 34478-7870  
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 a benefit 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 which 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 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 out-of-pocket 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

## Medicare Supplemental Benefits Plan

### 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

## Medicare Supplemental Benefits Plan

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. 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.

## Medicare Supplemental Benefits Plan

### 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);
- 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;

## Medicare Supplemental Benefits Plan

- 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 Health Plan Coverage**

You may continue health 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.

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

You may reduce or eliminate exclusionary periods of coverage for pre-existing conditions under a group medical 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.

## Medicare Supplemental Benefits 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.

## Medicare Supplemental Benefits 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.

## Medicare Supplemental Benefits 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.

## Medicare Supplemental Benefits 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

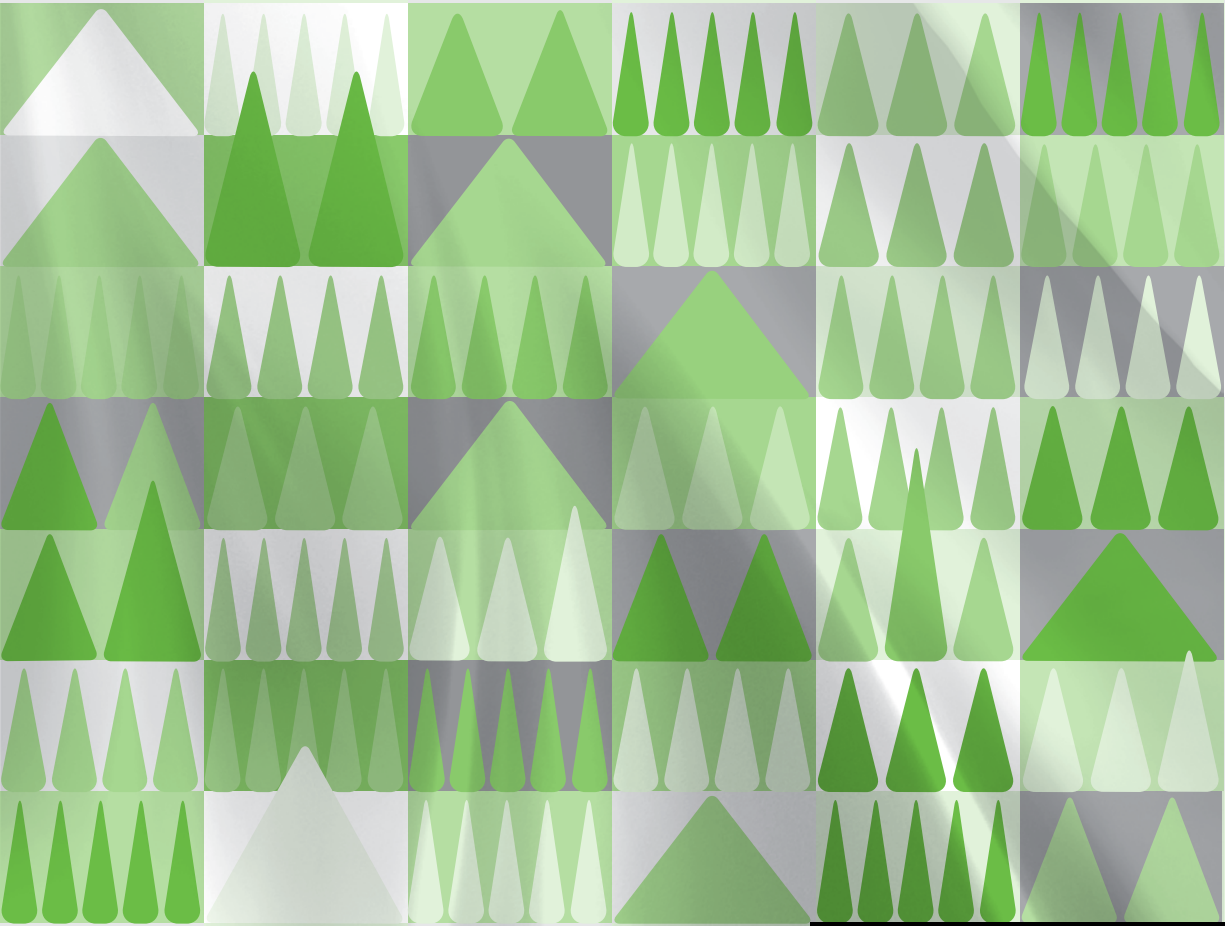
Requests to access, amend or restrict Protected Health Information, to obtain an authorization form or to obtain further information should be directed to:

Retiree Service Center  
P.O. Box 7870  
Ocala, Florida 34478-7870  
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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International Paper  
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## Medicare Supplemental Benefits Plan Appendix

This Appendix is effective January 1, 2009.

### Eligibility

These provisions apply to you if you are eligible for International Paper Retiree Medical Coverage or receiving company-sponsored Long-Term Disability Benefits and you are eligible for Medicare.

### Calendar Year Deductible

- Individual: \$500

### Calendar Year Out-of-Pocket Maximum (Includes Deductible)

- Individual: \$2,000

### Medco Network Retail Pharmacy Prescription Drug Copayments

For 30-day supply of new or refilled prescriptions	Per Prescription
Generic	\$10
Brand-name drug on Medco's preferred formulary or brand-name drug without a formulary equivalent	\$30
Brand-name drug not on Medco's preferred formulary but with a formulary equivalent	\$60

### Medco By Mail Prescription Drug Copayments

For 90-day supply of new or refilled prescriptions	Per Prescription
Generic	\$20
Brand-name drug on Medco's preferred formulary or brand-name drug without a formulary equivalent	\$60
Brand-name drug not on Medco's preferred formulary but with a formulary equivalent	\$120

*The above amounts may change in future years.*

### Where Can I Find More Information?

UMR (formerly Fiserv Health)

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

Medco Prescription Drug Program

1-800-309-5564      [www.medco.com](http://www.medco.com)

Retiree Service Center

P.O. Box 7870

Ocala, Florida 34478-7870

1-888-ESC-2YOU (1-888-372-2968)