Employee Assistance Program
Administered by Magellan Health
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Employee Assistance Program

International Paper provides the Employee Assistance Program under which you, your eligible dependents and other members of your household can secure professional counseling services to help deal with behavioral or medical problems or concerns that might adversely affect work performance. This program offers services in addition to any group medical plan sponsored by International Paper. The program is administered by Magellan Health.

Features of the Program

The program is:

- Confidential;
- Available 24 hours a day, seven days a week;
- Based on voluntary participation;
- Available to you, your eligible dependents and other members of your household; and
- Free of charge.

Services, which are offered by appointment in an off-site counselor’s office, include:

- Assessment;
- Counseling;
- Consultation;
- Referral if needed; and
- Follow-up.

Who Is Eligible

You, your eligible dependents and other members of your household are enrolled automatically in the Employee Assistance Program. The company pays the entire cost of the program. There is no paperwork for you to complete to enroll.

How the Program Works

Initial Evaluation Sessions

International Paper has made arrangements with Magellan Health to provide services under the Employee Assistance Program. In turn, Magellan Health has made arrangements with professional counseling organizations staffed by licensed professionals to provide services under the program to individual participants. These service providers vary from location to location. The names of local service providers can be obtained by contacting Magellan Health.

Magellan Health and the service providers have agreed to provide confidential professional assessment, initial counseling and referral services to you, your eligible dependents and other members of your household. There will be no charge for up to six professional evaluation and counseling meetings per person per year with a participating service provider.

Continuing Counseling

If services beyond those provided under the program are recommended, Magellan Health will help refer you to appropriate professionals, such as social workers or psychologists. You will be responsible for the cost of these additional services.

Your group medical plan may provide coverage for part of the cost of such continuing services. Please refer to the Summary Plan Description for your International Paper group medical plan for additional information regarding coverage.

Confidentiality and Nature of Counseling

Participation in the program by you, your eligible dependents and other members of your household is voluntary and confidential. In accordance with client confidentiality laws, service providers will not reveal to anyone your contact with them or disclose any individual information to anyone without your written consent. However, providers may have a legal obligation to disclose to appropriate authorities situations involving potential harm to others or to yourself.

The service providers have exclusive control over the substance of the counseling services provided under the program as well as the direction and guidance of the professionals who provide the counseling services.

The service providers under the program are independent contractors. Service providers and persons hired by the service provider to perform services under the program are not employees or agents of International Paper.
**Employee Assistance Program**

### How to Use the Program

You, your eligible dependents and other members of your household may begin voluntary participation in the program and take advantage of the free confidential consultation services by contacting Magellan Health.

**How to Contact Magellan Health**

- EAP Toll-Free Number: 1-800-891-4329
- Self-Screening and Audio Library Access: 1-866-391-6734

You may call Magellan Health directly for information and to schedule an appointment. Inform Magellan Health of your status as an eligible employee or as an eligible dependent or household member under the International Paper Employee Assistance Program.

Magellan Health will arrange an appointment for you or your eligible dependents or household members near your home or office.

### Examples of Covered Services

A wide variety of problems can have a negative effect on personal well-being and job performance. The program may be of assistance in the following areas:

**Family**

- Problems with children
- Family or household member conflicts
- Serious illness of family or household member
- Aging parents

**Marital**

- Divorce adjustment
- Resolving conflicts

**Work-related**

- Interpersonal problems
- Job dissatisfaction

**Substance abuse (alcohol or drug)**

- Work performance
- Relationships
- Family life
- Health

**Emotional**

- Stress
- Anxiety
- Depression
- Lack of emotional self-control
- Unresolved anger

**Physical**

- Alternate treatment referrals
- Need for specialty physician
- Stress-related illness
Coverage During Leaves of Absence

Salary Continuance

If you are temporarily absent because of an illness or accident, coverage under the program for you, your eligible dependents and other members of your household will continue during the period of your disability, up to the maximum duration under the Salary Continuance Plan. Otherwise, coverage for you and your covered eligible dependents will continue as outlined in the section entitled COBRA — Continuation of Coverage.

Long-Term Disability – Employees with Salaried Benefits

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

Temporary Layoff – Hourly Employees and Employees with Salaried Benefits

If you are temporarily laid off, coverage under the program for you, your eligible dependents and other members of your household will continue for two full months following the month the layoff occurred. If at the end of this two-month period you have not been reemployed, coverage under the program will continue 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 program, 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.

Disability – Employees with Hourly Benefits

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, coverage under the program for you, your eligible dependents and other members of your household will continue during your period of disability for up to 12 months following the date your disability began. Once this coverage period ends, coverage under the program will continue as outlined in the section entitled COBRA — Continuation of Coverage.

FMLA Leave

If you are on paid or unpaid FMLA leave, coverage under the program for you, your eligible dependents and other members of your household will continue.

Military Leave of Absence

If you are required to serve in the Armed Forces, coverage under the program for you, your eligible dependents and other members of your household will continue for up to 12 weeks. Following the 12-week period, coverage under the program for you and your eligible dependents will continue as outlined in the section entitled COBRA — Continuation of Coverage.

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, coverage under the program for you and your eligible dependents will continue as outlined in the section entitled COBRA — Continuation of Coverage.

Contact the Employee Service Center (ESC) for details.
Termination of Coverage

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

- If your dependent ceases to be an eligible dependent, coverage will end on the last day of the month in which that event occurs.
- If your household member ceases to live with you, coverage for the household member will end on the last day of the month in which you and the individual last lived in the same household.
- If your employment with the company terminates, coverage for you and your dependents and household members 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 and household members will end on the last day of the month in which your death occurs.
- If you retire, coverage under the program for you and your covered dependents and household members will end on the last day of the month preceding your retirement.
- The company terminates the program.

Converting to an Individual Policy

There are no conversion rights under the program. Under certain circumstances your coverage will be continued as outlined in the section entitled COBRA — Continuation of Coverage.

COBRA — Continuation of Coverage

Under a federal law commonly known as COBRA, coverage under the program for you and your covered dependents may continue temporarily in certain instances where coverage otherwise would be terminated. Individuals entitled to COBRA continuation (qualified beneficiaries) are you and your eligible dependents 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. Your household members are not entitled to COBRA continuation because household members who are not your dependents as defined in the group medical plan are not qualified beneficiaries.

Qualifying Events

If your employment terminates for any reason other than your gross misconduct, coverage under the program for you and your covered dependents will continue for up to 18 months.

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

Certain events will extend the 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, coverage under the program for your covered dependents will be extended for an additional 18 months (for a total of 36 months from the original qualifying event).
- If you (the employee) become entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost) and then a second qualifying event (your termination of employment or reduction in hours worked) happens within 18 months, coverage under the program for your covered dependents will continue under COBRA for 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 at any time during the first 60 days of COBRA continuation coverage due to such event, COBRA continuation coverage under the program for each qualified beneficiary (whether or not disabled) will be extended for an additional 11 months (for a total of 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.
Employee Assistance Program

Important Note – If a second qualifying event occurs at any time during this 29-month disability continuation period, then coverage under the program for each qualified beneficiary who is a spouse or dependent child (whether or not disabled) will be extended for seven more months, for a total of 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 program, 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 program. COBRA continuation coverage then will be provided automatically for your covered eligible dependents. 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, domestic partner or dependent child (ren).

Electing and Paying for COBRA Continuation Coverage

COBRA continuation coverage for the International Paper Employee Assistance Program is automatic for eligible participants. The company pays the full cost of the COBRA continuation coverage.

Coverage During the Continuation Period

If coverage under the program is changed for active employees, the same changes will be provided to individuals on COBRA continuation.

When COBRA Continuation Coverage Ends

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

- After the date COBRA coverage begins, the qualified beneficiary first becomes covered under another group Employee Assistance Program (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 preexisting 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 Employee Assistance Program coverage for all employees.

Contact the ESC for further details on COBRA coverage.

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 Employee Assistance Program (“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 and Communications
c/o Global Compensation and 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 Plan is self-funded. All benefits are provided directly by International Paper and administered by Magellan Health. Magellan Health reviews claims for benefits and authorizes payment in accordance with the terms of the Plan. The address of the claims administrator is:

Magellan Health
14100 Magellan Plaza
Maryland Heights, MO 63043
1-800-891-4329

The company pays the entire cost of the Plan.

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 Global Compensation and 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.

Claim Review

Right to File Claim

Magellan Health pays EAP counselors directly. You do not have to file EAP claims. There are no copays, coinsurance, or deductibles. You should not make any payment to a provider for EAP services. You should not make any agreement with an EAP counselor to pay the counselor for EAP sessions. However, you will be responsible to pay for services that you obtain without having Magellan Health open an EAP case with a particular EAP counselor.
Defective Pre-Service Claims

If a claimant has attempted to file a pre-service claim under the Plan, 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. 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 – EAP services do not include urgent care services. Therefore, if Magellan Health determines that you need urgent care, Magellan Health will make an appropriate referral to your benefit plan and/or emergency resources in the community. Magellan Health does not make determinations relating to urgent care under the Employee Assistance Program.

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. 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:

- Information sufficient to identify the claim (including the date of service, health care provider, and claim amount, if applicable) and a statement describing the claimant’s opportunity to request applicable diagnosis and treatment codes and the corresponding meaning of those codes;
- The specific reason or reasons for denial, the denial code, and its corresponding meaning;
- 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 internal and external 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 level of internal appeal of the claim;
- If any internal rule, guideline, protocol, or other similar criteria were 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;
- If the denial is based on medical necessity or experimental treatment or a similar limitation or standard, a description of the standard and 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;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and appeals and external review procedures.

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.

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;
- 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); and
- Prior to issuance of a determination, provide the claimant with any new or additional evidence generated or considered by the Plan in connection with the review, as well as any new or additional rationale proposed to be used by the Plan in upholding a previous denial, and allow the claimant a reasonable opportunity to respond prior to the date on which the determination is due from the Plan.
Time for Decision on Review

1. 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.

2. 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 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 in the next section.

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:

- Information sufficient to identify the claim (including the date of service, health care provider, and claim amount, if applicable) and a statement describing the claimant’s opportunity to request applicable diagnosis and treatment codes and the corresponding meaning of those codes;
- The specific reason for the decision and reference to the provisions of the Plan on which the decision is based, as well as the denial code and its corresponding meaning;
- 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 and external review process 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 level of internal appeal of a claim;
- If any internal rule, guideline, protocol, or other similar criteria were 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;
- If the denial is based on medical necessity or experimental treatment or a similar limitation or standard, 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;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and appeals and external review procedures; and
- In the case of any denial of a claim (at the internal appeal level), a discussion of the decision.

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 30 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.
Independent External Review of Medical Judgment Determinations and Rescissions

Standard External Review

In case of claim denials attributable to medical judgment or rescissions, claimants may file a request for an external review with the Plan within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination, as described below. Whether a denial is based on a medical judgment will be determined by the independent review organization (IRO) conducting the external review but may include determinations based on medical necessity, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit, or whether a treatment or procedure was experimental or investigational.

If a claimant files a request for external review within the time allowed, then within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

- The claimant is or was covered under the Plan at the time the item or service was requested or, in the case of a retrospective review, at the time the item or service was provided;
- The prior denial relates to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- The claimant has exhausted the Plan’s internal appeal process, unless the claimant simultaneously requested and is eligible for an expedited internal appeal at the same time as the expedited external review or is not otherwise required to exhaust the internal appeals process; and
- The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing. If the claimant’s request for external review is complete but not eligible for external review, the notification will include the reasons for ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete and the claimant will be allowed to perfect the request for external review within the remainder of the four-month filing period or the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization for Standard External Review

If a claim is eligible for review and the claimant has submitted all required information, the Plan will assign the claim to an independent review organization (IRO) to conduct the external review. The Plan will take action against bias and to ensure independence, will contract with at least three (3) IROs for assignments under the Plan, and will rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection).

The IRO will provide written notice of its external review decision within 45 days after it receives the request for review. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether Plan intends to seek further judicial review of the decision.

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.

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.
Employee Assistance Program

**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 coverage for you and your covered eligible dependents and household members. The amount that the company contributes is subject to change.

**Notice on Privacy of Health Information**

Protecting the confidentiality of your personal health information has always been an important priority. We continue to maintain policies to safeguard the privacy of your medical information and comply with federal law (specifically, "HIPAA" and the privacy rules issued under HIPAA). We are required by federal law to protect the privacy of your individual health information (referred to as “Protected Health Information”). We are also required to provide you with this reminder regarding our policies and procedures on your Protected Health Information.

For more information about your privacy rights or to request a copy of the Plan's Notice of Privacy Practices please contact:

International Paper Employee Service Center
Aon Hewitt
7201 Hewitt Associates Drive
P.O. Box 563989
Charlotte, NC 28256-3989
1-888-ESC-2YOU
(1-888-372-2968)

You may also access the Notice of Privacy Practices via the My-IP Web site at www.My-IP.com under the Benefits tab.

The Notice of Privacy Practices provides detailed information on how the Plan may use your information as well as what rights you have regarding that information.