

Appleton Papers Inc.

Appleton Hourly Flex Plan

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Appleton Hourly Flex Plan

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Introduction

This workbook is intended to be a short summary of the benefits available to you under the Plan. Please refer to your open enrollment materials for more detailed information on the individual benefits that are a part of the Appleton Hourly Flex Plan.

Consumerism

In order to effectively meet the many needs of each of our employees, the Appleton Hourly Flex Plan provides a meaningful variety of choices. And, as your needs change, you can redesign the benefits to best suit yourself (and your family).

Consider the following scenario

Imagine you've just been seated in a nice restaurant. A waiter approaches your table, but rather than giving you a menu from which to choose, he places before you a salad with French dressing and announces that tonight he has chosen the meal for everyone in the restaurant. Great, you think, now I won't have to read through the menu and make a decision. You sit back and wait for your dinner, thinking how nice it is to have other people make all the decisions, but then he comes back with meatloaf, creamed potatoes and brussels sprouts.

While this might sound good to some people, you are a vegetarian who is not fond of brussels sprouts. This is not such a great deal after all.

The Flex Plan allows you the opportunity to design your own "menu of benefits" based on your wants - your lifestyle - your individual circumstances.

How to Buy Benefits

Although the concept of "buying" benefits can be somewhat intimidating with all the benefit areas, options and other issues to think about, the entire process can be simplified by taking THREE STEPS - one at a time.

Step #1: Become Knowledgeable

Knowledge is power. To add to your already existing knowledge base:

- REVIEW this workbook to gain a basic understanding of concepts and terms.
- TALK with fellow employees to determine not just what benefits they selected, but why they chose those particular benefits.
- REFER to the Benefits menu, Summary Plan Description section on insideAppleton to get more information on benefit coverage, eligibility and other important details.
- CALL your human resources representative if you have any questions.

Step #2: Identify Your Personal Needs

As you gain this knowledge, you should begin to identify the benefit options that best meet your individual and/or family needs.

Consider the following:

- ✓ Your benefit needs.
- ✓ Your short and long-term future needs.
- ✓ Your budget.
- ✓ Other insurance coverage that you have.
- ✓ Tax advantages available through the Appleton Hourly Flex Plan.

Through the group purchasing power of Appleton, the cost to you for your elections under the Flex Plan is typically less than if you attempted to obtain a similar benefit level on your own, outside this plan. If you are able to purchase benefits through a different plan at a lower rate, great! Buy where it is most economical for you.

Step #3: Record Your Choice

Finally, log on to Employee Services On-Line to Enroll in Benefits. (New hires will complete a paper Personal Enrollment Form.) If you fail to complete your enrollment by the posted deadline, you may not get the benefits you really want to have! (See Adding It All Up section for the default elections listed under If You Fail to Complete Your Enrollment.)

Pay Less Taxes ... Pay Less Taxes

The Flex Plan is designed to maximize your tax advantages so you take home more of your paycheck. The portion of the premiums you pay via payroll deduction for some of your chosen benefits are not taxed for federal, state, and Social Security purposes. This means that the total amount you spend on these benefits is not included on your annual W-2 Form and is therefore not subject to tax. Remember that when you choose benefits purchased with non-taxable dollars, any employee deductions are subtracted from your pay before taxes are calculated. Thus, you save tax dollars.

Benefit Summary

Before Tax

- Medical
- Dental
- Flexible Spending Accounts
- Additional Employee Life
- Supplemental AD&D

After Tax

- Spouse Life
- Child Life

Tax Savings Example

To purchase \$500 worth of benefits on an after-tax basis, you would need to earn \$714 (assuming 30% tax rate) before taxes. This equates to \$214 in tax savings.

Flex Plan Elections May Affect Social Security Benefits

Your elections to obtain non-taxable benefits under the flex plan could have a small effect on the benefits you and your family might receive from Social Security. Because your Social Security benefits are calculated based on taxable earnings, when you reduce taxable income, your Social Security benefits may be slightly reduced.

Communicating Your Elections

When you have finally decided on each of your Flex Plan choices for the coverage period and have recorded them on Employee Services On-Line, you may wish to print out a copy of the Enrollment Confirmation page for your records. Your Current Enrollments are always available for viewing on Employee Services On-Line.

Flex Plan Eligibility / Participation

Only full-time Appleton hourly employees are eligible to participate in the Appleton Hourly Flex Plan. You are a full-time employee if your customary weekly employment is at least 35 hours, excluding overtime. You must be actively at work on January 1 in order to make changes to certain benefit elections.

You will become a participant in the plan at the time you reach welfare benefits eligibility according to the Labor Agreement.

What Happens During a Leave of Absence?

If you are paid for any portion of an approved leave of absence (for example if you are eligible to receive accident and sickness benefits during the leave), the portion for the benefits which you elected will continue to be deducted from your pay each pay date.

If you have an *unpaid* approved leave of absence, it is your responsibility to continue paying your portion for the benefits which you have elected. Arrangements can be made with human resources.

If you are on an *unpaid* leave of absence, your portion for benefits will be placed in arrears for the first twelve (12) weeks of your leave. Upon your return to work, amounts in arrears will be applied one extra deduction per pay period until amounts in arrears are satisfied.

If your *unpaid* leave of absence extends beyond twelve (12) weeks, you must make benefit contributions via check to Appleton Papers attn: Corporate Payroll at least every 30 days beginning the 13th week of your unpaid leave. You will not be billed or reminded of amounts owed or dates contributions are due. If contributions are due and not paid, benefits will be terminated.

If you fail to return to work for any reason, including the termination of your employment because your leave of absence has exceeded the maximum period permitted under company policy, all amounts in arrears will become payable to Appleton in full within 30 days following termination date.

When Does My Participation Terminate?

Your participation in the Flex Plan will terminate on the earlier of: (1) the date the plan is terminated; (2) the date you separate from employment with the company; (3) the date you fail to submit the required salary reduction payments for benefits chosen; or (4) the date you otherwise cease to be an eligible employee.

Changing Choices During the Year

In accordance with federal regulations, the benefits you choose each year during open enrollment will remain in effect until the next coverage period. You will not be able to change your benefit elections during the entire coverage period unless you have a status change. Examples of status changes are limited to the following events:

- Change in legal marital status
- Change in number of dependents; e.g. birth/adoption (or placement for adoption) of child; death of spouse or dependent
- Termination/commencement of employment by you, your spouse or dependent
- Change in eligibility status for you (or your spouse or dependents); e.g. switch between full-time and part-time employment, commencement/return from unpaid leave of absence (FMLA or otherwise)
- Change in residence or work place of you, your spouse or dependent
- Dependent child ceases to satisfy dependent definition; e.g. attainment of maximum age, loss of student status, marriage of dependent
- Entitlement to Medicare (Part A or Part B) or Medicaid coverage
- Court order resulting from divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order)
- Special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA)
- Significant cost or coverage changes (does not apply to MCFSA election)
- Coverage change made under another employer plan

The Internal Revenue Service requires that the change in benefits must be consistent with the change in status. This means that the election change must be on account of and correspond with a change in status. If you have a change in status and wish to make a benefit change, you must complete a "Change in Status" form. These forms are available in the human resources department. Assistance is available should you have any questions. ***The form must be completed within 30 days of the change in status to be eligible for the change.***

Medical

Medical coverage continues to be an important option under the Flex Plan. As you evaluate the different options, consider your medical needs during the upcoming year. If you and your spouse are both carrying family coverage with different employers, would you save money by selecting only one plan and by using the Medical Care Flexible Spending Account to a greater extent?

Please refer to your open enrollment materials for an explanation of your medical options and coverages associated with those options.

Eligibility

You may choose medical coverage for you, or you and your family, each year at open enrollment. Eligible dependents are defined as your legal spouse and/or your unmarried dependent child(ren) less than age 19 (to age 25 if a full-time student). For further explanation regarding eligibility and participation in the medical benefit, please refer to the Summary Plan Description available on insideAppleton.

You and your dependents must be enrolled in a Medical Plan to receive prescription drug plan benefits.

Electing to Waive Medical Coverage

Waiving medical coverage is available if you have medical coverage from a source other than Appleton. If you waive all medical coverage through Appleton, you will receive \$700 annually in Flex Credits paid to you on a biweekly basis on your paycheck. This can be used to obtain other benefits, be deposited to a flexible spending account to save on taxes or be taken as taxable cash. Before electing to waive all medical coverage through Appleton, you should carefully review your alternate medical plan. You will be required to provide proof of coverage elsewhere.

Medical/API Spouse

This option is available if your spouse is also employed by Appleton. You may enroll as an employee in a medical option or elect to be covered as a dependent under the plan your spouse has selected. If you wish to be covered as a dependent, select Medical/API Spouse. This allows your family to take advantage of the family deductible and out-of-pocket maximums. As a reminder, both you and your spouse may enroll separately as "employees." However, you may not be covered simultaneously as both an employee and a dependent under the Appleton medical plans.

Your Benefits Can Change As Your Needs Change

Because Appleton realizes that your individual situation may change from year to year, you will be provided an opportunity to change your medical plan selection at each open enrollment period — without proof of insurability or restrictions for pre-existing conditions. Also, any medical coverage changes made during the coverage period must be consistent with a status change (see Changing Choices During the Year).

Make Your Medical Selection

Medical coverage is purchased in non-taxable dollars.

If you fail to complete your enrollment on Employee Services On-Line, you will be enrolled as follows:

- If you are enrolled in medical in 2009, you will be enrolled in the same Plan for 2010.
- If you are not enrolled in coverage in 2009, you will not be enrolled in coverage for 2010.

Dental

Eligibility

As a participant in the plan, you may choose dental coverage for you, or you and your family. Eligible dependents are defined as your legal spouse and/or your unmarried dependent child(ren) less than age 19 (to age 25 if a full-time student).

If you and your spouse are both carrying family coverage with different employers, would you save money by selecting only one plan and by using the Medical Care Flexible Spending Account to a greater extent?

Coverage

The coverage is described in detail in the Summary Plan Description available on insideAppleton. Adjustments to your dental coverage can only be made during the year when consistent with a status change.

Types of Dental Services

Preventive Dental Services

Exams, fluoride treatments, cleanings, emergency pain relief services and x-rays.

Basic Dental Services

Minor restorations (fillings), oral surgery, anesthesia, endodontics (includes root canals), periodontics (treatment of gums) and specialist diagnostic services.

Major Dental Services

Crowns, inlays, onlays, implants, dentures and bridges.

Orthodontic Dental Services

Procedures used to re-align or re-position teeth (braces).

Procedures used to re-align or re-position teeth (braces).

QUICK REFERENCE GUIDE

Type of Service	Comprehensive Plan
Deductible	\$25 calendar year deductible for Basic and Major Services
Preventive	100%
Basic	80%
Major	50%
Annual Maximum (per person)	\$1,000
Orthodontia Deductible	\$25 Lifetime Deductible
Orthodontia	Kids Only – 50%
Ortho Lifetime Maximum (person)	\$1,000

Using Your MCFSA For Dental Expenses

Your Medical Care Flexible Spending Account (MCFSA) is an important portion of your total health care program – INCLUDING DENTAL. Remember that you can set aside monies in the MCFSA to pay for your uninsured dental care expenses, such as employee co-payments, expenses for uncovered services, and the cost for orthodontic services. With your MCFSA these expenses can be paid for on a non-taxable basis. You save tax dollars on required dental expenses.

Electing to Waive Dental Coverage

Waiving dental coverage is available if you have dental coverage from a source other than Appleton. If you waive all dental coverage through Appleton, you will receive \$100 annually in Flex Credits paid to you on a biweekly basis on your paycheck. This can be used to obtain other benefits, be deposited to a flexible spending account to save on taxes or be taken as taxable cash.

Before electing to waive all dental coverage through Appleton, you should carefully review your alternate dental plan.

Dental/API Spouse

This option is available if your spouse is also employed by Appleton. You may enroll as an employee in Dental or elect to be covered as a dependent under your spouse. If you wish to be covered as a dependent, select Dental/API Spouse. As a reminder, both you and your spouse may enroll separately as "employees." However, you may not be covered simultaneously as both an employee and a dependent under the Appleton dental plan.

Make Your Dental Selection

Dental coverage is purchased in non-taxable dollars.

If you fail to complete your enrollment on Employee Services On-Line, you will be enrolled as follows:

- If you are enrolled in dental in 2009, you will be enrolled in dental for 2010.
- If you are not enrolled in coverage in 2009, you will not be enrolled in coverage for 2010.

Medical Care Flexible Spending Account

The Medical Care Flexible Spending Account (MCFSA) is an excellent tool for budgeting your health care expenses because it allows you to put aside money on a non-taxable basis each pay period. With this account, you can be reimbursed in non-taxable dollars for medical, dental, and vision care expenses incurred by you, your spouse and your dependents. This includes copays, deductibles and services not covered by insurance.

Pay Yourself, NOT Uncle Sam!

Your tax savings with the MCFSA can be significant. You do not pay federal, state (except New Jersey) or Social Security taxes on your deposits to the account or on the reimbursements paid to you. The MCFSA is a better way to pay for items such as prescription drugs, eyeglasses, contact lenses, over-the-counter medical items, copayments and deductibles.

MCFSA — A Simple Process

The MCFSA is very simple to use. It works like a bank account. You decide how much money to deposit into your account for the coverage period. This amount will be deducted from your paychecks in equal amounts over the 26 pay periods — BEFORE TAXES! Then, as you incur eligible medical, dental or vision care expenses, you submit your claims and are reimbursed from the account and STILL are not taxed on this money! The MCFSA can also cover children of divorced parents, even if the children cannot be claimed as dependents for other income tax purposes.

Eligible Expenses

Lists of MCFSA Eligible Expenses can be found by visiting www.discoverybenefits.com.

Getting Your Money Back

During the coverage period, as you incur qualified expenses, you will have several methods to submit claims against your account.

1. Debit Card

- Deducts automatically from your account. You do not need to pay for the expense up front for reimbursement later.
- You must keep eligible purchases separate from others you make at the point-of-sale.
- IRS regulations require that all *grocery stores, discount stores and pharmacies* that accept FSA debit cards must have an “Inventory Information Approval System” (IIAS).
- An IIAS reviews the purchases you are making at the point-of-sale. If the system sees that one of the items you are purchasing is not eligible for FSA reimbursement, the transaction will be rejected on the spot.
- If you attempt to use your debit card at a retailer that does not yet have IIAS in place, your card will not work.
- Even if you use your debit card at a retailer that does have IIAS in place, your transaction may still reject if you have non-eligible items included in the transaction. So pay separately for items that are not FSA eligible.
- Discovery Benefits posts a list of IIAS merchants on their website www.discoverybenefits.com. Click on “IIAS Merchants.”
- You will need to save itemized receipts to verify eligibility of your purchases and submit the documentation periodically upon request. If you do not submit receipts when requested, Discovery will put a hold on the use of your card. Also, if you do not submit receipts when requested, your reimbursement may become taxable income to you.
- You should retain all receipts for your own tax records.

2. Online Claim Filing
 - Go to www.discoverybenefits.com to file your claim online for daily processing.
 - Documentation of your expenses can then be faxed or mailed.
 - Direct deposit of your reimbursements is available for your convenience.
3. Fax or Mail Claim Filing
 - Pay for the eligible expenses up front and file a paper claim with receipts.
 - Claim forms are available at www.discoverybenefits.com or by request at 1-866-451-3399.
 - Direct deposit of your reimbursements is available for your convenience.

Eligible expenses will be paid up to your annual election amount.

Coverage Period

Expenses may be reimbursed only if incurred in the coverage period. Expenses are treated as incurred when the service is rendered and not when you are billed or pay for the service.

The coverage period for the MCFSA is the plan year (January 1 through December 31), PLUS a “grace period” to the following March 15. The grace period applies only if you are covered on December 31. If you are covered on December 31, your coverage will automatically be extended to March 15. Any eligible expenses you incur from January 1, 2010 through March 15, 2011 are eligible to be reimbursed from your 2010 deposits. Eligible expenses incurred during the grace period will be applied first to any outstanding account balance from the prior plan year.

You have until March 31 to file claims for reimbursement (incurred during the plan year and the grace period).

If you choose to participate in the MCFSA and then terminate your employment with Appleton during the coverage period, the following policies will apply:

- Upon termination of employment, MCFSA deductions stop.
- You may continue to submit receipts and be reimbursed for eligible *expenses incurred prior to* your termination date. The grace period will not apply. The deadline for submitting receipts is March 31 of the following year.
- Federal law requires that you be allowed to continue participation in this plan on an after tax basis if you have a positive account balance at termination.

Eligibility

You can use your MCFSA to pay for eligible expenses incurred by you, your spouse, and/or a dependent who is a qualifying child or relative, per IRS Code Section 152:

A Qualifying Child is a child who:

- Is your child, stepchild, foster child, brother, sister, stepbrother, stepsister, or a descendant of any of them (for example, your grandchild, niece, or nephew).
- Is under age 19, under age 24 and a full-time student, or permanently and totally disabled.
- If married, does not file a joint tax return with his/her spouse.
- Lives with you for more than half of the year.
- Does not provide over half of his or her own support.
- Satisfies all other rules of IRS Code Section 152.

A Qualifying Relative is a person:

- Who is your:
 - Son, daughter, stepchild, foster child, or a descendant of any of them (for example, your grandchild),
 - Brother, sister, or a son or daughter of either of them,
 - Father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle),
 - Stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law, or
 - Any other person (other than your spouse) who lived with you all year as a member of your household if your relationship did not violate local law,
- Who is not a qualifying child (see Qualifying Child above) of any taxpayer, and
- For whom you provide over half of the support. But see *Children of divorced or separated parents* and *Support claimed under a multiple support agreement* in IRS Publication 502.

Points To Consider

IRS rules allow you to make changes to your deposits only if you have a status change (see Changing Choices During the Year). To do so, notify your human resources representative within 30 days of the event prompting the change. *The IRS does not allow refunds of any money left in your account after March 31.* Money cannot be transferred between the MCFSA and the Dependent Care Flexible Spending Account (DCFSA).

Appleton and the plan administrator are not responsible for ensuring that the expenses submitted by you for reimbursement under the MCFSA or DCFSA program meet all of the eligibility requirements set forth under the Internal Revenue Service regulations. Deliberately providing false information could result in penalties imposed by the Internal Revenue Service.

Plan Carefully to Determine Your Deposit Amount

You may deposit up to a maximum of \$5,000 per coverage period (\$192.30 bi-weekly).

1. Note the expenses you incur regularly for medical, dental and vision care which are not covered or totally paid for by either your plan or your spouse's plan.
2. Visit www.discoverybenefits.com and click on Calculate Savings/Eligible Expenses to help determine your annual election.
3. Expenses may be reimbursed only if incurred during the coverage period, which is the plan year (January 1 through December 31), PLUS a "grace period" to the following March 15. (See Coverage Period section above).
4. If you have orthodontic expenses, you may be reimbursed either in a lump sum or according to your payment plan.

Counselors are available at Discovery Benefits to answer your questions Monday through Friday (7:30 a.m. - 7:30 p.m. Central time) at 1-866-451-3399.

Make Your MCFSA Election

Deposits to your MCFSA are deducted before taxes are calculated and subtracted from your paycheck. After you have decided the annual amount you wish to deposit into your MCFSA account divide by 26 pay periods.

YOU MUST MAKE A NEW ELECTION EACH YEAR. The election you made last year will not be continued if you fail to enroll this year.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account (DCFSA) was established to help you pay for employment related dependent care expenses on a tax-free basis. Expenses that may be reimbursed through this account are expenses incurred in the care of your child(ren), your incapacitated spouse, your dependent parent, or a mentally or physically impaired dependent. This account is not used for dependent medical expenses.

Pay Yourself, NOT Uncle Sam!

Your tax savings with DCFSA can be significant. You do not pay federal, state (except New Jersey and Pennsylvania) or Social Security taxes on your deposits to the account or on the reimbursements paid to you.

Tax Savings Example

\$3,000 worth of dependent care expenses purchased on an after-tax basis would require you to earn \$4,109 (assuming 27% tax rate) or \$5,000 (assuming 40% tax rate) before taxes. This equates to \$1,109 or \$2,000 in tax savings.

How DCFSA Works

The DCFSA is easy to use. Like the MCFSA, it also works like a bank account. You decide how much to deposit for your dependent care expenses. Your deposits will be deducted in equal installments from your paychecks over 26 pay periods.

Getting Your Money Back

During the coverage period, as you incur qualified expenses, you will have several methods to submit claims against your account.

1. Debit Card
 - Deducts automatically from your account. You do not need to pay for the expense up front for reimbursement later.
 - Use at any day care provider that accepts MasterCard.
 - You cannot use the debit card to pay in advance of the services provided.
2. Online Claim Filing
 - Go to www.discoverybenefits.com to file your claim online for daily processing.
 - Documentation of your expenses can then be faxed or mailed.
 - Direct deposit of your reimbursements is available for your convenience.
3. Fax or Mail Claim Filing
 - Pay for the eligible expenses up front and file a paper claim with receipts.
 - Claim forms are available at www.discoverybenefits.com or by request at 1-866-451-3399.
 - Direct deposit of your reimbursements is available for your convenience.
4. Automatic Reimbursement
 - Submit one request per plan year by completing the Automatic Dependent Care Request form.
 - Your reimbursement will be automatically sent to you as your payroll contributions are received.
 - Direct deposit of your reimbursements is available for your convenience.

Unlike the MCFSA, under the DCFSA you may receive reimbursement only if you have sufficient money in your account.

Coverage Period

Expenses may be reimbursed only if incurred in the coverage period. Expenses are treated as incurred when the service is rendered and not when you are billed or pay for the service. Advance reimbursement is not permitted.

The coverage period for DCFSA is the plan year (January 1 through December 31). There is not a “grace period” extending the coverage period for DCFSA.

If your employment with Appleton ceases, your DCFSA deductions stop and you are no longer eligible to contribute to the plan. However, you may submit claims for incurred expenses not to exceed your account balance through your employment termination date.

What Is Dependent Care?

Care may be as informal as your neighbor or mother caring for your child before and after school. You may also pay a relative to take care of your dependent (remember, they must report this pay as income to the IRS). You may claim expenses you incur by paying your married child (not your dependent) to baby sit a younger brother or sister (still your dependent). However, expenses you incur by paying your teenager to baby sit for your younger child (both still your dependents) are not eligible under this plan.

The dependent care services must be to enable you, and your spouse if married, to be employed, look for employment or attend school on a full-time basis. You will be required to provide the tax identification or Social Security number of your dependent care provider.

Counselors are available at Discovery Benefits to answer your questions Monday through Friday (7:30 a.m. - 7:30 p.m. Central time) at 1-866-451-3399.

Eligibility

You can use your DCFSA to pay for eligible expenses to care for a “Qualifying Individual”, per the IRS Code Section 21(b):

A “Qualifying Individual” is your spouse, or is a “qualifying child” or “qualifying relative” (see definitions under MCFSA section), and is either:

- A “qualifying child” under the age of 13; or
- Physically or mentally incapable of self care and lives with you for more than half of your tax year.

IRS Limits/Tax Issues

IRS limits allow only \$5,000 per family to be deposited to a DCFSA. If your spouse has a similar benefit, you must watch your combined limit.

Also, in deciding how much to deposit to the DCFSA for any coverage period, please be aware that the amount you can be reimbursed under the DCFSA is further limited by federal tax law, for any calendar year, to the lesser of (1) your earned income; (2) your spouse's earned income; or (3) \$5,000 (\$2,500 for certain married individuals filing separate tax returns). Thus, for example, if your spouse is not employed, you could not use the account, unless your spouse is a full-time student or is disabled, as defined by the IRS. If your spouse is a full-time student or is disabled, the IRS assumes he/she earns \$250 a month if you have one dependent, or \$500 a month if you have two or more dependents.

If you use the Dependent Care Flexible Spending Account, you may not claim the same expenses under the federal tax credit. Most people get a greater savings with the DCFSA.

If you use the DCFSA, you must complete a Form 2441 when filing your tax return.

Appleton and the plan administrator are not responsible for ensuring that the expenses submitted by you for reimbursement under the MCFSA or DCFSA program meet all of the eligibility requirements set forth under the Internal Revenue Service regulations. Deliberately providing false information could result in penalties imposed by the Internal Revenue Service.

Plan Carefully to Determine Your Deposit Amount

You may deposit up to a maximum of \$5,000 per calendar year (\$192.30 bi-weekly). As you estimate your expenses, remember to exclude time for vacation, illness, etc., when you will not be required to pay dependent care expenses. Any amount which is not reimbursed to you will be forfeited. Thus, you should estimate your anticipated expenses carefully.

Changes are Permitted

Your elected deposit to DCFSA will remain in effect for the coverage period. However, you may change your deposit during the coverage period if you experience a status change. To do so, notify your human resources representative within 30 days of the event prompting the change.

Points to Consider

You will have until March 31 each year to submit eligible expenses incurred for the coverage period ending on December 31. IRS rules require that any money left in your DCFSA account after March 31 must be forfeited. Money cannot be transferred between the DCFSA and the MCFSA.

Make Your DCFSA Election

Deposits to your DCFSA are made from your pay. Deposits are deducted before taxes are calculated and subtracted from your paycheck. After you have decided the annual amount you wish to deposit into your DCFSA account, divide by 26 pay periods.

YOU MUST MAKE A NEW ELECTION EACH YEAR. The election you made last year will not be continued if you fail to enroll this year.

Additional Employee Life and AD&D Insurance

Employee Life and Accidental Death & Dismemberment (AD&D) Insurance provides a source of income to your beneficiary in the event of your death while you are employed by Appleton. It also pays a benefit if you should suffer certain severe injuries such as the loss of a limb or vision resulting from an accident.

Basic Life Insurance and AD&D

Your Basic Life Insurance and Accidental Death and Dismemberment benefit is \$50,000 as listed in the Labor Agreement. There is no cost to you for this coverage.

Choices

The Flex Plan offers you several options to purchase Additional Employee Life and AD&D. All options are insured by UNUM.

- \$50,000
- \$100,000
- \$150,000

How Much Do You Need?

While there is no "tried and true" method for choosing the right amount of Additional Employee Life and AD&D Insurance, take a moment to determine what your beneficiary(ies) need by identifying your different obligations—your family situation—your budget. Consider asking yourself:

- ✓ Without your paycheck, would your family have to change their standard of living?
- ✓ Are there major payments to continue, such as a mortgage or car payment?
- ✓ Are you planning to pay for college for your child(ren)?
- ✓ Are your parents dependent upon you for support?
- ✓ Do you have a handicapped child who will have special financial needs?
- ✓ Would your spouse/child(ren) be eligible for any Social Security benefits?
- ✓ Do you have other life insurance benefits that you have purchased independently?

One Election Double Payment?

If you were to elect the Additional Employee Life and AD&D Insurance benefit of \$100,000 and you were to die of natural causes or illness, the insurance company would pay your designated beneficiary(ies) \$100,000 income tax free. However, if your death were the result of an accident, then the insurance company would pay your beneficiary(ies) a double benefit.

\$100,000 (for Additional Employee Life)
\$100,000 (for Additional AD&D)
\$200,000 Total Income-Tax Free Benefit

These amounts would be in addition to the Basic Life and AD&D benefits your beneficiary(ies) is eligible for under the Labor Agreement as explained above.

Why Are Everyone's Pricetags Different?

The pricetags of each option are calculated based on the age of the employee. Additional Employee Life and AD&D Insurance is purchased in non-taxable dollars.

Pricetags may change from year to year if you move into a higher age bracket or the insurance company raises premiums on the entire group.

Tax Issues

The value of employee life insurance coverage provided in a group plan over \$50,000 is taxable to you. Because you are automatically provided the Basic \$50,000 in coverage per the Labor Agreement, any Additional coverage you purchase through the Flex Plan is taxed on its value. This value is determined from IRS tables (not from actual premiums paid), and is required by federal tax law. The taxable amount is added to your income and you must pay the taxes on this additional amount. You will see this value listed on your paystubs as "W2 Grp."

Any life or accidental death benefits are not taxed when paid to your beneficiary.

Changes to Coverage/Evidence of Insurability

If you are new to the Appleton Hourly Flex Plan, you may select any Additional Employee Life and AD&D Insurance option at this time. In future years, if you elect to add or increase coverage, you must provide evidence of insurability. Coverage will not be effective until the evidence of insurability is approved by the insurance carrier. Your human resources department will instruct you how to submit for evidence of insurability.

Changes to your elected Additional Employee Life and AD&D coverage may only be made during the coverage period due to an appropriate status change.

The effective date of any initial, increased or additional insurance will be delayed if you are not in active employment because of an injury, a sickness, a temporary layoff or leave of absence on the date that coverage would otherwise be effective. The initial, increased or additional insurance will start on the date you return to active employment.

If you are absent from work due to temporary layoff or leave of absence, coverage will continue to the end of the month following the month in which your temporary layoff or leave of absence begins.

Survivor Support

Survivor Support is a no-cost, personalized financial counseling service offered to your life insurance beneficiary in the event of your death as an active employee. A representative from Ceridian will contact your survivor to provide support in decision making on various benefits and planning questions. The Ceridian representative will work with your family attorney, accountant or financial advisor. Your survivor will receive a personalized financial plan, a Survivor Support Reference Guide, and twelve months of counseling via a toll-free 800 number. Ceridian does not engage in the offering, selling or brokering of investment products.

Who Gets Paid, and When?

Life insurance benefits are payable to your beneficiary if you die. (Does your human resources department have your current beneficiary designation on file?) You will get paid any dismemberment benefits due under the policy.

Your benefit amount will increase by \$10,000 if you suffer a covered loss as a result of an accident while wearing a seat belt. You will receive an additional \$5,000 if you were protected by an air bag.

Accelerated Benefit

Should you be diagnosed with a terminal illness, you may apply to have your employee life insurance paid out early. You may also take advantage of the Ceridian Survivor Support financial counseling services.

Make Your Additional Employee Life and AD&D Election

You must select one of the options. If you fail to complete your enrollment on Employee Services On-Line, you will continue to be enrolled under your current Additional Life and AD&D option.

Spouse and Child Life Insurance

Spouse and Child Life Insurance is an easy and economical way to provide life insurance for your family. This benefit covers your legal spouse or your dependent child(ren) from 14 days to 19 years of age (25 if full-time student). All options are insured by UNUM.

Choices

Your Spouse Life Insurance options are:

- \$5,000 spouse
- \$10,000 spouse
- \$25,000 spouse

Your Child Life Insurance options are:

- \$2,500 each child
- \$5,000 each child
- \$10,000 each child

Tax Issues/Pricetags

The IRS requires that this benefit be purchased on a taxable basis. Any benefits paid by the plan are paid to you as beneficiary and are non-taxable.

The pricetags of the Spouse Life options listed for you on Employee Services On-Line are based on the insured amount and your age.

The pricetags of the Child Life options listed for you on Employee Services On-Line are based on the insured amount. The number of covered children does not influence the pricetag. You pay one pricetag regardless of how many children you have.

Changes to Coverage/Evidence of Insurability

If you are new to the Appleton Hourly Flex Plan, you may select any Spouse or Child Life Insurance option at this time. In future years, if you elect to add or increase coverage, your dependent must provide evidence of insurability. Coverage will not be effective until the evidence of insurability is approved by the insurance carrier. Your human resources department will instruct you how to submit for evidence of insurability.

Changes to your elected Spouse or Child Life coverage may only be made during the coverage period due to an appropriate status change.

The effective date of any initial, increased or additional insurance will be delayed if you are not in active employment because of an injury, a sickness, a temporary layoff or leave of absence on the date that coverage would otherwise be effective. The initial, increased or additional insurance will start on the date you return to active employment.

If you are absent from work due to temporary layoff or leave of absence, coverage will continue to the end of the month following the month in which your temporary layoff or leave of absence begins.

Eligibility

The effective date of any initial insurance will be delayed for a dependent if that dependent is totally disabled on the date that insurance would otherwise be effective. Any request for an increase in coverage is also delayed if that dependent is totally disabled. The effective date of any increased or additional insurance will be delayed for a dependent if the employee is not an active employment.

A person may not be insured as both an employee and a dependent. An eligible dependent child may not be insured as a dependent child of more than one employee.

Make Your Spouse and/or Child Life Election

You are not required to participate in this benefit. If you fail to complete your enrollment on Employee Services On-Line, you will continue to be enrolled under your current option.

Supplemental AD&D Insurance

Supplemental Accidental Death and Dismemberment (SAD&D) Insurance is a benefit option for all eligible employees. It provides additional accidental death and dismemberment coverage for you or you and your dependents.

Choices

You have five SAD&D options under the Appleton Hourly Flex Plan:

- \$50,000
- \$100,000
- \$150,000
- \$200,000
- \$250,000

The amount shown above for each option is referred to as your principal sum. If you choose to participate in family coverage for this benefit you will be covered for the principal sum elected while your dependents will be covered as illustrated below. If death is by natural causes no benefit is paid.

Family Status (At time of accident)	Full Benefit as a Percentage of Your Elected Volume of Coverage
Spouse only	Spouse - 50%
Spouse and Child(ren)	Spouse - 40% Each Child - 10%
Child(ren)	Each Child - 15%

All options are insured by UNUM.

SAD&D Works Just Like AD&D

The SAD&D benefit works in the same way as the AD&D Insurance benefit under the Additional Employee Life and AD&D Insurance benefit area.

Your beneficiary will be paid the full benefit amount should you die within 365 days of a covered accident. If you suffer severe injury, YOU receive partial payment.

Partial Payment

One-half the SAD&D amount will be paid for:

- loss of one hand or one foot
- complete loss of sight in one eye

The entire benefit amount will be paid for:

- loss of life
- loss of both hands or both feet
- complete loss of sight in both eyes
- loss of one hand and one foot

Eligibility

As long as the plan is in force, you are an eligible employee, and you pay your premium, your coverage remains in effect. Your family members will remain insured as long as they are eligible, you are covered, and their premium is paid. Eligible dependents are your legal spouse and your dependent child(ren) less than age 19 (or until age 25 if a full-time student).

A person may not be insured as both an employee and a dependent. An eligible dependent child may not be insured as a dependent child of more than one employee.

Tax Issues/Pricetags

Your SAD&D benefit is purchased on a non-taxable basis. The pricetags represent the prices assigned to each option. You may obtain your SAD&D option using part of your non-taxable Benefit Credits.

In the event of your death, benefits will be paid to your beneficiary of record and are non-taxable. Any death benefits paid under this plan for family members will be payable to you, as beneficiary and are also non-taxable. Dismemberment benefits may also be non-taxable. If this occurs, you should consult your tax advisor.

Changes to Coverage

You may select any option at this or any future enrollment. During the coverage period, you may make a change in your SAD&D coverage election so long as the adjustment is consistent with an allowable status change.

Make Your SAD&D Election

You are not required to participate in this benefit. If you fail to complete your enrollment on Employee Services On-Line, you will continue to be enrolled under your current SAD&D option.

Health Club Membership Reimbursement

You are eligible to receive a health club membership reimbursement from Appleton for a health club facility of your choice. To qualify as a health club, the facility must be recognized as focusing on aerobic workouts and/or weight training. The club must be incorporated and identified as an "Equal Opportunity Club." Specifically excluded are social or recreational clubs and participation in league/team events.

If you elect to join a health club facility, you are eligible to receive a reimbursement of 50% of the membership fee for you and your family not to exceed an annual reimbursement of \$300 (to be treated as additional taxable income). You pay the health club facility directly, then the company will reimburse 50% upon proof of payment.

The health club membership plan is a great way to maintain your good health and save money too. It provides you an affordable choice to build a healthier lifestyle for you and your family.

It is not necessary to make an election on Employee Services On-Line. Just join in!!! Health club reimbursement forms are available from your human resources department or on insideAppleton.

Adding It All Up

After you have carefully reviewed and recorded each of your options using Employee Services On-Line, take a moment to review your choices. Consider once more your personal situation and the benefit options you have chosen.

During Open Enrollment

Current employees complete their enrollment via Employee Services On-Line. After log on:

- Select 'Benefits Eligibility' from the menu bar to see the plan options for which you are eligible and the corresponding Pricetags.
- Select 'Enroll in Benefits' from the menu bar to complete your enrollment by the posted deadline.
- You may change your elections on-line at any time during the open enrollment period by selecting 'Enroll in Benefits' again.
- The elections saved at the expiration of the open enrollment period will be your final recorded choices.
- Until January 1, you may view your 'Next Year's Enrollments' from the menu bar.
- At any point during the plan year you can view your current enrollments by selecting 'Current Enrollments' from the menu bar.

Remember that your elections are irrevocable and cannot be changed during a coverage period unless you have a status change.

New Hires During the Plan Year

New hires, or newly eligible employees, during the plan year will receive a paper enrollment form to make initial elections. Your completed form must be turned in to human resources by the given deadline.

Remember that your elections are irrevocable and cannot be changed during a coverage period unless you have a status change.

Excess Benefit Credits?

If you receive Flex Credits from the company because you Waived coverage for medical and/or dental and the Flex Credits exceed the costs of the benefits you elect, you will receive a cash benefit equal to the excess amount. The cash benefit will be paid to you in equal amounts in each paycheck over the coverage period. You will be taxed on this cash benefit like ordinary income.

In The Days Ahead

You will not be able to make changes to your elections after open enrollment unless you have a status change.

Your Appleton Hourly Flex Plan elections will remain in effect until the beginning of the next coverage period. Remember, you may change your elected benefits during the coverage period only in the case of an appropriate change in status.

If You Fail to Complete Your Enrollment

If you fail to enroll on time using Employee Services On-Line, you will automatically be enrolled in the same coverage you elected for the immediately preceding coverage period with respect to the Medical, Dental, Employee Life and AD&D, Supplemental AD&D, and Spouse and Child Life Insurance plans. You will be deemed to have waived coverage with respect to the MCFSA and DCFSA.

If this is your initial eligibility to enroll in the Appleton Hourly Flex Plan and you fail to return your Personal Enrollment Form, you will automatically be enrolled as follows:

Basic Employee Life/AD&D	\$50,000
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You will be deemed to have waived all other benefits.

ERISA

The preceding pages of this booklet have presented some details regarding how each plan works, the major benefits of each plan, limitations or restrictions that apply, and so on. More information is available in the formal plan documents and the Summary Plan Description as provided for each benefit.

This section presents other information you are entitled to know regarding the plans:

- How the plans are administered
- Your “ERISA” rights

Administrative Information

The Employee Retirement Income Security Act of 1974 (ERISA) regulates the following employee benefit plans, which are detailed in this workbook. The official plan names are:

Name of Plan	Type of Plan	Plan No.
Appleton Papers Inc. Group Medical Plan	Welfare	548
Appleton Papers Inc. Dental Plan	Welfare	550
Appleton Papers Inc. Group Life Insurance Plan	Life/AD&D	501
Appleton Papers Inc. Flexible Benefits Plan for Bargaining Unit Employees	Cafeteria	702

Plan Sponsor

Appleton Papers Inc. (36-2556469), sponsors the above benefit plans for its eligible employees.

The address and phone number of the plan sponsor is:

Appleton
PO Box 359
Appleton, WI 54912-0359
(920) 734-9841

Plan Year

The Appleton Hourly Flex Plan records are maintained on a plan year basis by human resources. The plan year is the calendar year. The Appleton Hourly Flex Plan is operated on a 12-month coverage period, commencing on January 1 and ending on December 31. The benefit elections you make under the flex plan are effective for the coverage period.

Plan Administrator

The plans are fully administered by licensed third party administrators and/or insured by insurance companies. All claims are paid by the individual carrier or Plan Sponsor. The Plan Administrator who is also designated as agent for service of legal process is:

Plan Administrator
Appleton
PO Box 359
Appleton, WI 54912-0359

Your Rights As A Participant

As a participant in Appleton benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as a detailed annual report and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.

Responsibilities of 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 plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. Your employer may not terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a benefit while exercising your rights under ERISA.

Claims Process for Medical Care Flexible Spending Account and Dependent Care Flexible Spending Account

You should submit all reimbursement claims during the Plan Year. For the Medical Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The administrator will review the claim and provide, within 60 days, a written response to the appeal (This period may be extended and additional 60 days under certain circumstances). In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Medical Care Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied: 30 days
Extension due to matters beyond the control of the Plan: 15 days
Insufficient information on the claim: Notification of 15 days
Response by Participant: 45 days
Review of claim denial: 60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific Plan provisions on which the denial was based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review;
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

Claims Process – All other Benefits

If your claim for a 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 with certain time frames. Each plan described above as detailed in this workbook has procedures governing claims for benefits, applicable time limits and remedies for redress of claims that are denied, in whole or in part. Your SPD (summary plan description) or the Plan Administrator will provide you with the procedures applicable to each plan.

If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and

consider your claim. Under ERISA there are steps you can take to enforce the above rights. For instance, if your request all or part of plan documents and do not receive them within 30 days, you may file suit in a federal court. The court may require the Plan Administrator to provide the documents and pay you up to \$110 a day until you receive the documents, unless the documents were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, 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 lose, the court may order you to pay these costs and fees (for example, if it finds your claim frivolous).

Questions and Concerns

If you have any questions about the Appleton Hourly Flex Plan, you should contact your human resources representative. If you have any questions about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, US Department of Labor listed in your telephone directory, or the Division of Technical Assistance, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Appleton encourages you to discuss any problems or questions about the Appleton Hourly Flex Plan or any company provided benefit with your human resources representative.

Plan Documents

This workbook is designed to assist you in selecting benefits that best meet your individual needs. For further detail, you may wish to refer to the official plan documents that will be available in the human resources department. If any conflicts exist between this workbook or any other written and/or verbal communications and the plan documents, then the plan documents shall govern. Appleton reserves the right to amend, change, or repeal any or all parts of this plan at its sole discretion.

Amendment and Termination

The company reserves the right to amend or terminate the Appleton Hourly Flex Plan at any time in its sole discretion.