



Salaried Enrollment Workbook

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Flexible Benefits Plan Summary Plan Description

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Introduction

This enrollment workbook is intended to be a summary of the benefits available to you through the flexible benefits plan. Please refer to your open enrollment materials and Summary Plan Descriptions (SPDs) for more detailed information on the individual benefits.

Choose Benefits Right for You

Although choosing 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 your enrollment materials to get more information on benefit coverage, eligibility and other important details.
- CLICK on the many resources available online at insideAppleton.
- CONTACT your human resources representative or Employee Services 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 group purchasing power of Appleton, the cost to you for your elections 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!

Pay Less Taxes

The portion of the premiums you pay via payroll deduction for some of your chosen benefits are not taxed for federal, state (except New Jersey) 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 pre-tax dollars, any employee deductions are subtracted from your pay before taxes are calculated. Thus, you save tax dollars.

Benefit Deduction Summary

Before Tax

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

After Tax

- Spouse Life
- Child Life
- Long Term Care

- Note: Long Term Disability is company-paid, but can be selected on a before-tax or after-tax basis.

Tax Savings Example

To purchase \$500 worth of benefits on an after-tax basis, you would need to earn \$685 (assuming 27% tax rate) or \$833 (assuming 40% tax rate) before taxes. This equates to \$185 or \$333 in tax savings.

Your Elections May Affect Social Security Benefits

Your elections to obtain pre-tax benefits 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 Choices

When you have finally decided on each of your choices for the coverage period and have recorded them on Employee Services On-Line, please 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.

Eligibility / Participation

Only full-time salaried and Portage hourly non-bargaining unit employees are eligible to participate in some of the components and options available in the flex plan. See the appropriate section of this document for eligibility on each benefit. 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 July 1 in order to make changes to certain benefit elections.

You will become a participant in the plan on your date of hire, assuming you are an eligible employee on that date. Elections for Vacation purchase are not available until the July 1 following your date of hire.

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 short term disability 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 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 necessitating a change in plans
- 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

As you evaluate the different medical options, consider your medical needs during the upcoming year. Are you able to save money by selecting a plan with a lower pricetag and paying your out-of-pocket expenses through the Medical Care Flexible Spending Account (MCFSA) or Health Savings Account (HSA)? 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 coverage associated with those options. These benefit provisions are further explained in the Summary Plan Description found on insideAppleton.

Eligibility

You may choose medical coverage for you, you and one dependent, 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). Coverage is also available on a post-tax basis for same-sex domestic partners. For further explanation regarding eligibility and participation in the medical benefit, please refer to the appropriate medical Summary Plan Description available on insideAppleton.

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

What is a deductible?

A health plan deductible is the amount you pay, in full (100%), for the health care services you receive before the health plan begins to pay for your care. The deductible is only applied to health care services covered under the plan.

What is coinsurance?

Once you have satisfied your medical plan deductible, the medical plan will begin to pay a percentage of the cost of certain medical services. In the case of the Appleton health plan options, the medical plan will pay 80% of the cost of in-network services (60% of the cost of out-of-network services). You will be responsible to pay the remaining 20% of the cost for a given service (40% of the cost if out-of-network service). This 20% or 40% is referred to as coinsurance. In regard to the coinsurance provision, the out-of-pocket maximum places a limit on the amount of coinsurance that you will be required to pay during a medical plan year when added to the deductible.

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 \$1,000 annually in Opt Out 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 with pre-tax dollars. If you fail to complete your enrollment on Employee Services On-Line, you will continue to be enrolled under your current medical option. However, if you are currently enrolled in Plan 3 and do not complete the Health Risk Assessment, your election will default to Plan 2.

Dental

Nothing puts you in a good mood quite the way a smile does. To keep your smile bright and healthy, you have dental plan options.

Choices

Plan choices vary in the services covered, the plan and employee co-payments, and the costs. Covered services in each of the plans have the same limits for the employee as for each eligible family member.

Your Dental options are:

- Comprehensive Plan
- Basic Plan
- Dental/API Spouse

Your selected Dental option is a two-year election. You will not be allowed to change again until July 2012. The election you choose will be for two years.

Eligibility

As a participant in the plan, you may choose dental coverage for you, you and one dependent, 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).

Electing to Waive Dental Coverage

Waiving dental coverage is an option available to you. If you waive all dental coverage through Appleton, you will receive \$200 annually in Opt Out 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.

Comparing the Options

Each of the options is outlined below. Adjustments to your dental coverage can only be made during this two-year election period when consistent with a status change. These benefit provisions are further explained in the Summary Plan Description found on insideAppleton.

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).

QUICK REFERENCE GUIDE

Type of Service	Option/Plan	
	Comprehensive	Basic
Annual Deductible (per person)	\$25	\$25
Annual Maximum (per person)	\$1,200	\$750
Preventive Services	100%	100%
Basic Services	80%	50%
Major Services	50%	No coverage
Lifetime Orthodontic Deductible (per person)	\$25	N/A
Orthodontia	Kids Only – 50%	No coverage
Ortho Lifetime Maximum (per child)	\$1,200	N/A

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. As you review the dental plan options, 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 pre-tax basis. You save tax dollars on required dental expenses.

Case Study

John and Sue have three children. They are in good health and don't foresee braces in the next 2 years for any of the children. They decide to select the Basic Plan option. This plan will pay 100% of their Preventive services. By choosing the Basic Plan option rather than the Comprehensive Plan option, they save about \$350 in premium contributions, which can be deposited to the MCFSA to help offset the cost of any out of pocket dental expenses.

Treatment In Process

If you are currently receiving services that are covered and change to a plan for which that service is again covered, that service would be paid based on the provisions of the new plan (including higher payment levels, if applicable).

Make Your Dental Selection

Dental coverage is purchased with pre-tax dollars. If you fail to complete your enrollment, you will continue to be enrolled under your current dental option.

Remember, your selected Dental option is a two-year election. Changes can be made effective July 1 of “even” calendar years (2010, 2012, 2014, etc.).

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 pre-tax 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, 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.

Participants in Medical Plan 2 may use their Health Reimbursement Account (HRA) for reimbursement of their deductibles. Once the HRA is exhausted, any remaining deductible expense can be submitted to their MCFSA.

Participants in Medical Plan 1 may only be reimbursed for eligible dental and vision expenses through the Limited FSA.

Getting Your Money Back

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

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

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 drug 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 drug store or pharmacy that does not yet have IIAS in place, your card will not work.
 - Even if you use your debit card at a merchant 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 and 90% Rule Merchants.”
- You will need to save itemized receipts to verify eligibility of your purchases and submit the documentation 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.
- Limited FSA participants will be required to submit receipts on all transactions to verify they are for dental or vision expenses.
- 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.

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 (July 1 through June 30), PLUS a “grace period” to the following September 15. The grace period applies only if you are covered on June 30. If you are covered on June 30, your coverage will automatically be extended to September 15. Any eligible expenses you incur from July 1, 2010 through September 15, 2011 are eligible to be reimbursed from your 2010-2011 deposits. Eligible expenses incurred during the grace period will be applied first to any outstanding account balance from the prior plan year if paid by debit card. If you file claims on-line you must select the appropriate plan year for eligible expenses incurred during the grace period.

You have until September 30 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 September 30.
- 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 qualifying child or relative, per the IRS Code Section 152:

A Qualifying Child is a child who:

- Is your son, daughter, 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.
- Lives with you for more than half of the year.
- Does not provide over half of his or her own support.

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 human resources within 30 days of the event prompting the change.

The IRS does not allow refunds of any money left in your account after September 30. 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. Remember, if you are enrolled in Medical Plan 1, you may only be reimbursed for eligible dental and vision expenses through the Limited FSA.
3. Expenses may be reimbursed only if incurred during the coverage period, which is the plan year (July 1 through June 30), PLUS a "grace period" to the following September 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.

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

1. 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.

2. Automatic Reimbursement

- Requires only one claim to be filed per day care provider per year.
- Reimbursement happens automatically with every payroll deduction.

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 (July 1 through June 30). 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). Since your elections are made on a plan year basis (July – June), you will need to ensure that your total deposit into the DCFSA does not exceed \$5,000 between the months of the two plan years that make up the calendar year. 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 (see Changing Choices During the Year). To do so, notify your human resources representative within 30 days of the event prompting the change.

Points to Consider

You will have until September 30 each year to submit eligible expenses incurred for the coverage period ending on June 30. IRS rules require that any money left in your DCFSA account after September 30 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.

Employee Life and AD&D Insurance

Employee Life and Accidental Death & Dismemberment (AD&D) Insurance provides a source of income to your beneficiary(ies) in the event of your death while you are employed by Appleton. It also pays a benefit to you if you should suffer certain severe injuries such as the loss of a limb or vision resulting from an accident. Only full time salaried and Portage hourly employees are eligible for the benefits described in this section.

Appleton provides you with a Basic level of employee life and AD&D insurance, at no cost to you. You may also purchase Additional coverage via pre-tax payroll deduction. All options are insured by UNUM. You are eligible for this benefit if you are a full-time salaried or Portage hourly employee.

The total maximum employee life insurance amount is \$1,000,000, including Basic and Additional coverage.

Basic Life and AD&D

You have the choice between these Basic levels of company provided coverage:

- 2 x Annual Base Pay
- \$50,000

See the Tax Issues section below for an explanation of why you might choose the \$50,000 option in lieu of 2 x Annual Base Pay.

Additional Life and AD&D

You may make a separate election to purchase coverage in addition to the Basic coverage provided by Appleton. Your Additional Life and AD&D options are:

- 1 x Annual Base Pay
- 2 x Annual Base Pay
- 3 x Annual Base Pay
- 4 x Annual Base Pay

The pricetags to purchase Additional Life and AD&D are dependent on your annual base pay, age, and tobacco user status.

Tobacco User

Tobacco user rates apply if you used tobacco in any form (i.e. cigarettes, cigars, pipe tobacco, smokeless tobacco, chewing tobacco, etc.) during the 12 month period prior to the benefit effective date. This means July 1, 2009 - June 30, 2010 for benefits going into effect on July 1, 2010.

Falsification of any information when applying for life insurance (including "tobacco user status") could result in loss of coverage.

Tax Issues

The "value" of group life insurance over \$50,000 in total coverage is taxable to you (including Basic and Additional coverage.) This value is determined from IRS tables (not from the actual premium 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. A Life Insurance Tax Calculator is available on insideAppleton to determine the amount that will be added to your income to be taxed.

Life or accidental death benefits paid to your beneficiary upon your death are not taxed.

How Much Would Your Family Need?

While there is no "tried and true" method for choosing the right amount of life and AD&D Insurance, take a moment to determine what you and your family 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?
- ✓ Do you have other life insurance benefits that you have purchased independently?

Double Payment?

If you were to elect total coverage of \$100,000 and you were to die of natural causes or illness, the insurance company would pay your designated beneficiary \$100,000 income tax free. This is your "life insurance" benefit. However, if your death were the result of an accident, then the insurance company would also pay your beneficiary an "accidental death" benefit income tax free.

\$100,000 (for life insurance)

\$100,000 (for accidental death insurance)

\$200,000 Total Income-Tax-Free Benefit

Travel Accident Insurance

Your travel accident coverage provided by Appleton is 2 x annual base pay, (minimum \$50,000). AIG is the insurance carrier. For most salaried employees, this benefit is paid if death or dismemberment occurs due to an accident while traveling *on company business*. For frequent travelers, such as executives and field sales and tech reps, this benefit is paid if death or dismemberment occurs due to a travel accident regardless of the nature of the trip. This coverage is provided automatically by the company and is non-taxable to you.

Changes to Coverage/Evidence of Insurability

If you are newly eligible for benefits, you may select any Additional Life and AD&D Insurance option at this time without evidence of insurability.

If you do not elect Additional coverage when newly eligible, you will need to provide evidence of insurability on the entire coverage amount of your initial Additional election.

If you are currently enrolled in Additional coverage, you can elect one benefit level increase during each future enrollment period without providing evidence of insurability. (for example: moving from 2x Annual Base Pay to 3x Annual Base Pay.) If you elect to increase *more than* one level of coverage, you must provide evidence of insurability.

Evidence of insurability is also required for coverage amounts above \$500,000, regardless of when the coverage was elected.

Changes to your elected Basic or Additional Life and AD&D coverages may only be made during the coverage period in a manner consistent with a qualified 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 (unrelated to injury or sickness), coverage will continue to the end of the month following the month in which your temporary layoff or leave of absence begins.

Life Planning Services

Life Planning Services is a no-cost, personalized service offered to your life insurance beneficiary in the event of your death, or to you in the event of a terminal illness. These services include financial and legal support, and grief counseling.

Who Gets Paid, and When?

Life insurance benefits are payable to your beneficiary if you die. (Please review your current beneficiary designation on Employee Services On-Line.) You will be 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 up to half of your employee life insurance paid out early, to a maximum of \$250,000. You may also take advantage of the Life Planning Services if you are diagnosed with a terminal illness.

Make Your Employee Life and AD&D Elections

You must elect one of the Basic coverage options. Additional coverage is voluntary.

If you fail to complete your enrollment on Employee Services On-Line in 2010, you will be enrolled in the Basic and Additional options that most closely match your current election.

Spouse Life Insurance

This is an easy and economical way to provide life insurance for your legal spouse. All options are insured by UNUM. You are eligible for this benefit if you are a full-time salaried or Portage hourly employee.

Choices

Your Spouse Life Insurance options are:

- \$10,000
- \$25,000
- \$25,000 increments to a maximum of \$200,000

The amount of insurance on any one dependent may not exceed 50% of the employee's chosen total Employee Life insurance amount (Basic + Additional).

Tax Issues/Pricetags

The IRS requires that this benefit be purchased on an after-tax basis. Any benefits paid by the plan are paid to you as beneficiary and are non-taxable. The pricetags of each option are based on the insured amount and your age.

Changes to Coverage/Evidence of Insurability

If you are newly eligible for benefits, or are making an election during the coverage year within 30 days of a marriage status change with respect to a new spouse, you may elect up to \$25,000 without evidence of insurability.

If you do not elect Spouse Life upon initial eligibility, you will need to provide evidence of insurability on the entire coverage amount of your initial Spouse Life election.

If you currently participate in Spouse Life coverage and you wish to increase your benefit, you will need to provide evidence of insurability on the first opt up over the \$25,000 option. (Spousal coverage amounts in force prior to the July 1, 2010 plan year will be grandfathered for purposes of evidence of insurability.) In future enrollment periods, if you elect to increase *more than* one level of coverage, you must provide evidence of insurability.

Changes to your elected Spouse Life option may only be made during the coverage period in a manner consistent with a qualified status change.

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 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.

Make Your Spouse Life Election

You are not required to participate in this benefit. If you fail to complete your enrollment on Employee Services On-Line, your election will be defaulted to the closest available coverage option to last year's elected Dependent Life spousal coverage.

Child Life Insurance

This is an easy and economical way to provide life insurance for your dependent child(ren) from 14 days to 19 years of age (25 if full-time student). This includes your own natural offspring and lawfully adopted children. It also includes stepchildren, foster children and other children who are dependent on you for support and living with you in a regular parent-child relationship. All options are insured by UNUM. You are eligible for this benefit if you are a full-time salaried or Portage hourly employee.

Choices

Your Child Life Insurance options are:

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

Tax Issues/Pricetags

The IRS requires that this benefit be purchased on an after-tax basis. Any benefits paid by the plan are paid to you as beneficiary and are non-taxable. The pricetags of the Child Life options 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.

An eligible dependent child may not be insured as a dependent child of more than one employee.

Changes to Coverage

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 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.

Changes to your elected Child Life option may only be made during the coverage period in a manner consistent with a qualified status change.

Make Your Child Life Election

You are not required to participate in this benefit. If you fail to complete your enrollment on Employee Services On-Line, your election will be defaulted to the closest available coverage option to last year's Dependent Life child coverage.

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. You are eligible for this benefit if you are a full-time salaried or Portage hourly employee.

Choices

You have five SAD&D options:

- \$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 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 pre-tax basis. The pricetags of each option represent the prices assigned to each option.

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 qualified 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.

Disability Insurance

Short Term Disability (STD)

You are eligible for this benefit if you are a full-time salaried, Portage hourly or non-union hourly distribution center employee. Appleton provides income protection in the event that you experience a medical condition that prevents you from working for a period of less than twelve months. Your Short Term Disability coverage is 100% of base pay for the first 26 weeks of short term disability and 60% of base pay for the following 26 weeks of STD. These benefit provisions are further explained in the Summary Plan Description found on insideAppleton.

Long Term Disability Insurance (LTD)

You are eligible for this benefit if you are a full-time salaried, Portage hourly or non-union hourly distribution center employee. The Long Term Disability Insurance program provides the security of a continuing income in the event you are disabled for an extended period of time and are unable to work.

Appleton provides an LTD benefit of 60% monthly pay. There is no premium cost to you, however, salaried and Portage hourly employees may choose the taxability of the premium and benefits:

- A Pre-Tax Premium/Taxed Benefit
- An After-Tax Premium/Non-Taxed Benefit

Tax Issues

You will make the choice of having Appleton pay the premium on a pre-tax basis or a post-tax basis. If you elect that Appleton pays the premium pre-tax basis, then the amount you receive as income when disabled (“the benefit”) is taxable to you. If you elect that Appleton pays the premium on a post-tax basis, then the premium is taxable to you and the amount you receive as income when disabled (“the benefit”) is tax-free. In this case, the premium will be added to your taxable earnings each pay.

Example

Let's assume you are in a 27% tax bracket and you choose to have Appleton pay the \$250 annual premium on a pre-tax basis. There is no tax effect to you while you are employed. However, if you become disabled and collect 60% of your prior wages as disability income, you will pay income taxes on that benefit. This further reduces your benefit another 27%.

OR

You could choose to have Appleton pay the \$250 annual premium on a post-tax basis. You will have the \$250 added to your earnings as taxable income and pay taxes on that premium (\$67 in tax). However, if you become disabled, your disability benefit income is tax-free.

How Does LTD Work?

LTD Insurance benefits are payable after 360 days of disability and will continue until retirement age, the date upon which you return to work or die, or at the time you no longer meet the definition of disability in the insurance contract, whichever comes first. Applications for benefit payment must be approved by UNUM, the insurance carrier, prior to payments beginning.

Monthly pay, for LTD purposes only, is defined as base pay plus average bonus. Bonus will be defined as the average over the last thirty-six months.

Benefit payments are offset by Social Security, Workers' Compensation or other statutory benefits.

Benefits are limited to \$15,000/mo. without evidence of insurability, maximum of \$18,500/mo.

Refer to the Summary Plan Description available on insideAppleton for a detailed explanation of your LTD benefit.

Make Your LTD Election

Select an After Tax Premium/Non-Taxed Benefit if your goal is to maximize your income at the time of disability.

Vacation Purchase

After your initial year of hire, you may purchase one week of vacation during open enrollment. You are eligible for this benefit if you are a full-time salaried or Portage hourly employee.

Eligibility

Employees with a normal vacation schedule of six weeks are not eligible to purchase additional vacation.

The number of days available for purchase (4 or 5) depends on your regular weekly work schedule.

Pricetags

Your Vacation Purchase pricetag is based on your weekly rate of base pay and is purchased on a pre-tax basis.

When Do I Take Purchased Vacation Days?

Any additional days purchased must be used between July 1 and December 31 each year. No vacation carryovers into the next calendar year are permitted. Purchased vacation is scheduled in the same manner as normal vacation following departmental guidelines.

Make Your Vacation Purchase Election

You can decide each year whether or not you want to buy additional vacation days.

If you fail to complete your enrollment on Employee Services On-Line, you will be enrolled for your normal vacation.

Long Term Care Insurance

At home and in the workplace, long term care is emerging as one of the critical issues of our time. When people hear 'long term care', most think of the elderly. However, long term care needs affect people of any age and are more common than you might think. Trauma victims, patients recovering from serious illness and surgery, and people with terminal illnesses may need help with day-to-day activities. It can be unsettling to plan for a medical crisis, but it would be even more unsettling to be faced with long term care expenses that would seriously impact you and your family.

What is Long Term Care?

Long term care is the type of care received either at home or in a facility, when someone needs assistance with activities of daily living (bathing, dressing, toileting, transferring, continence and eating), or suffers severe cognitive impairment (such as Alzheimer's disease).

Won't Other Insurance or the Government Help With Long Term Care Expenses?

Medical insurance does not cover most costs associated with long term care. Most medical plans, including Appleton's, only cover expenses related to skilled nursing home care, hospice care, and home health care services for only a limited number of days. While our plans provide some coverage, you are without long term coverage after you have exhausted your limits under the medical plan.

Disability income protection insurance will replace a portion of your income should you become unable to work due to illness or injury. It is not designed to cover the added costs of care.

Medicare provides health coverage for acute care to people over age 65. Benefits received from Medicare are for a short period of time – less than four months. In most cases, assets must be depleted to welfare levels in order to qualify for benefits under Medicaid.

Eligibility

You, your spouse, parents, parents-in-law, grandparents, grandparents-in-law, siblings, and adult children are all eligible to apply for coverage through Appleton's group plan at any time by providing Unum with evidence of insurability (medical history questionnaire.)

Newly hired employees are eligible for most levels of coverage for themselves without providing evidence of insurability, as long as you apply within 30 days of hire.

How Do I Find Out More?

Detailed information about the plan options, as well as enrollment forms, are available at <http://w3.unum.com/enroll/appletonpapers/index.aspx> or by calling Unum at 1-800-227-4165. You may also contact Employee Services at 1-800-832-1718.

Health Club 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 employee must be included in the Health Club membership.

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 on insideAppleton.

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. Disability Plan for Non-Bargaining Unit Employees	LTD	540
Appleton Papers Inc. Flexible Benefits Plan for Non-Bargaining Unit Employees	Cafeteria	701

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
P.O. Box 359
Appleton, WI 54912-0359
(920) 734-9841

Plan Year

Records are maintained on a plan year basis by human resources. The plan year is the calendar year. The plan is operated on a 12-month coverage period, commencing on July 1 and ending on June 30. The benefit elections you make under the flexible benefits plan are effective for the coverage period, except Dental, which is a two-year election. Medical Care Flexible Spending Accounts have a “grace period” at the end of the coverage period of 2 ½ months.

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:

Appleton
P.O. 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.

Claim Assistance

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 you 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 flexible benefits 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 flexible benefits 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 are 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 flexible benefits plan at any time in its sole discretion.