Title: **Fort James Corporation, Wauna, Oregon Mill and Paper, Allied-Industrial, Chemical & Energy Workers International Union (PACE), AFL-CIO, Local 8-1097 (2000)**

K#: **8217**

Employer Name: **Fort James Corporation, Wauna, Oregon Mill**

Location: **Westport OR**

Union: **Paper, Allied-Industrial, Chemical & Energy Workers International Union (PACE), AFL-CIO**

Local: **8-1097**

SIC: **2621**

NAICS: **322121**

Sector: **P**

Number of Workers: **1000**

Effective Date: **04/01/00**

Expiration Date: **03/31/06**

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FORT JAMES

Trusted products for everyday living

CORPORATION
WAUNA MILL

1000 workers

PAPER, ALLIED - INDUSTRIAL, CHEMICAL
AND ENERGY WORKERS
INTERNATIONAL UNION
and its affiliated Local No. 8-1097

X: 3/31/06

197 PAGES

Labor Agreement
2000 - 2006

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LABOR AGREEMENT

BY AND BETWEEN FORT JAMES CORPORATION, WAUNA, OREGON MILL, hereinafter referred to as the Company, and THE PAPER, ALLIED-INDUSTRIAL, CHEMICAL & ENERGY WORKERS INTERNATIONAL UNION, AFL-CIO ON BEHALF OF ITS WAUNA LOCAL UNION No. 8-1097, ACTING as the Sole Collective Bargaining Agent hereinafter referred to as THE SIGNATORY UNION.

SECTION 1 - RECOGNITION

The Company recognizes the Signatory Union as the sole collective bargaining agent of all employees of the Company employed in the Wauna mill covered by this Agreement, excepting those engaged in the following: administration, actual supervision, watchman duties, sales, engineering and drafting, research and technical occupations requiring professional training, accounting, office clerical, stenographic and other office work.

SECTION 2 - OPERATING CONTROL

A. Except as expressly set forth in this Agreement, the right of the Company to manage its business, operations and affairs and to prescribe terms and conditions of employment shall be unimpaired.

B. The failure of the Company to exercise rights hereby reserved to it or its exercising them in a particular way shall not be deemed a waiver of said rights or a waiver of its right to exercise them in some other way not in conflict with the terms of this Agreement.

C. All matters which are within the scope of collective bargaining are closed for the duration of this Agreement, except as provided in Section 36, Paragraph D.

SECTION 3 - DEFINITIONS

Whenever used in this Agreement, including Exhibits; the male noun or pronoun is used to include the female noun or pronoun where applicable, and:

A. The word EMPLOYEES means all the employees of the Company employed in the mill covered by this Agreement, excepting those engaged in the following: administration, actual supervision, watchman duties, sales, engineering and drafting, research and technical occupations requiring professional training, accounting, office clerical, stenographic and other office work.

B. The words REGULAR EMPLOYEE means an employee filling a permanent position in the organization, or an employee regularly employed in a utility capacity, unless each employee has been personally notified in writing that his employment is temporary or probationary.

C. The words TOUR WORKERS mean employees engaged in operations, scheduled in advance, for at least twenty-four (24) hours continuous running and utilizing four (4) crews. All other workers are day workers. Refer to Section 21 for further clarification.

D. The word DAY means a period of twenty-four hours beginning at 7 A.M. or at the regular hour of changing shifts nearest to 7:00 A.M., it being understood that the hour for the beginning of a day need not be the same for every department or every section of a department in the mill.

E. The word WEEK means a period of seven (7) consecutive days beginning on Monday at the hour established by "D" above.

F. The word MILL or PLANT means the entire manufacturing facility at Wauna in which the employees are covered by this Agreement.

G. The words LOCAL UNION mean the local of the Signatory Union in which employees of the Company are members and which shall act as the representative of the Union in the performance of those provisions of this agreement which provide for action by the Local Union.

H. The words UNION STANDING COMMITTEE mean a committee selected by the Local Union which shall represent the Local Union in the performance of those provisions of this Agreement which provide for action by the Union Standing Committee.

SECTION 4 - UNION MEMBERSHIP

A. Any Employee who is a Member of the Union at the time this Agreement becomes effective shall, as a condition of employment, continue membership in good standing for the duration of this Agreement.

B. Any Employee who is not a Member of the Union at the time this Agreement becomes effective shall become a Member thereof in good standing on the thirtieth (30) day following the effective date of this Agreement, or on the thirtieth (30) day following employment, whichever is later, and shall as a condition of employment remain a Member in good standing for the duration of this Agreement.

SECTION 5 - PAYROLL DEDUCTION OF UNION DUES

A. During the life of this Agreement or any renewal or exten-

sion thereof upon the filing with the Company by the Financial Secretary of the Local Union of a valid official written authorization signed by any individual employee who is a member of said Local Union, and for as long as said authorization remains in effect, the Company will deduct from the wages due such employees in accordance with the terms of said authorizations, Union dues and initiation fees.

B. The Company shall pay over to the Financial Secretary of the Local Union the amount of deductions made in accordance with authorization filed and shall receive therefor the written receipt of the said Financial Secretary in the name of the Local Union. The details as to making of deductions and payments of same to the Local Union shall be arranged by the said Financial Secretary and the Company in such manner as most conveniently fits into the established payroll procedures of the Company and results in payments to the Local Union once a month.

C. The amount of dues to be deducted may be revised only by written notice from the Financial Secretary given in advance to the Company.

D. Any deductions made by the Company under the provisions of this Section shall be deemed trust funds until remitted to the Local Union, but such funds need not be kept separate from the Company's general funds. The Signatory Union agrees that the Company shall be saved harmless with respect to all deductions made and paid to the Local in accordance with the provisions of this Section.

SECTION 6 - NO INTERRUPTION OF WORK

It is agreed that there shall be no strike, walkout, refusal to report for work, or other interruption of work by the Signatory Union nor the Local Union or any Employee during the period of this Agreement. It is agreed there shall be no lockout by the Company during the period of this Agreement.

In the event that in violation of the provisions of the preceding paragraph a strike, walkout, refusal to report for work, or other interruption of work shall occur, neither the Signatory Union nor the Local Union shall be subject to financial liability for such violation provided that the Signatory Union and the Local Union involved immediately after the beginning of such violation each shall have (1) pub-

licly declared such action a violation of this Agreement, and (2) in utmost good faith used its best efforts to terminate such violation, it being further agreed that any Employee participating in such violation shall in the discretion of the Company be subject to immediate discharge or other disciplinary action.

A refusal to report for work, as used in this section, applies only to refusals arising out of or related to a labor dispute.

SECTION 7 - WAGES

Wage rates in accordance with Exhibit A, attached hereto and made a part hereof, shall be paid. **(See Insert; Exhibit A-4 Wage Rates)**

SECTION 8 - OVERTIME

A. Subject to the conditions set forth in paragraph B of this Section, any employee paid on an hourly basis will, in addition to his straight time pay, receive overtime;

1. At one-half the straight time hourly rate of the job for:
   a. All work performed on Sunday.
   b. All work performed on any of the holidays listed in Section 14.
   c. All work performed in excess of eight (8) straight time hours in any one day.
   d. All work performed in excess of forty (40) straight time hours in any one week.
   e. All work performed in excess of eight (8) continuous hours worked when such period of work extends across the end of a work day into the succeeding day provided that such continuous periods of work begins four (4) or more hours before the start of the succeeding day.
   f. All work performed on assigned days off, as such days are defined in Section 16, provided, however, that this sub-Paragraph (f) shall not apply if the work so performed results because a regular assigned day off has been traded for another day off at the request and for the convenience of the employee, or employees, involved.
2. At the straight time hourly rate of the job for:

a. All work performed in excess of eight (8) hours on any of the following holidays as listed in Section 14; New Years, Memorial Day, July 3, Sunday before Labor Day, and Thanksgiving.
    1. All work performed in excess of twelve (12) hours while on a regular compressed schedule for these holidays.
b. All work performed in excess of eight (8) hours on Sunday.
    1. All work performed in excess of twelve (12) hours while on a regular compressed schedule on Sunday.
c. All work performed on the following holidays as listed in Section 14; Independence Day, December 24, Christmas and Labor Day.

B. In applying the provisions of paragraph A of this Section, the following conditions shall be in effect:

1. No hour worked qualifies as an overtime hour on more than one of the above nine bases, except that work on a holiday may also qualify under A-1-d. Time worked on a holiday will be credited toward the forty (40) hour qualification.
2. When an employee works at more than one job rate during the week, payment of overtime for more than 40 hours shall be computed at the rate of the job at the time such overtime occurs.

SECTION 9 - NIGHT SHIFT DIFFERENTIAL

A. In addition to the hourly job rate, the following night shift differential shall be paid:

1. A Night Shift Differential of fifty-four (54) cents per hour shall be paid for the hours worked between 3:00 P.M. and 11:00 P.M, except for day workers between 3:00 P.M. and 3:30 P.M.
2. A Night Shift Differential of eighty-four (84) cents per hour shall be paid for the hours worked between 11:00 P.M. and 7:00 A.M.

B. Effective April 1, 2001, 2002, 2003, 2004 and 2005 the NSD will be adjusted if applicable, guided by a retrospective review by the Company and the Union beginning March 1,

2000, 2001, 2002, 2003 and 2004 of a calculated straight average of the four (4) most favorable actual cents per hour NSD adjustments having been bargained to be effective in 2000 (for a 4/1/01 Wauna adjustment), 2001 for a 4/1/02 Wauna adjustment), 2002 (for a 4/1/03 Wauna adjustment), 2003 (for a 4/1/04 Wauna adjustment), and 2004 (for a 4/1/05 Wauna adjustment) from among Fort James-Camas, Fort James-Halsey, K-C Everett, GP-Bellingham, Boise Cascade-St. Helens, Weyerhaeuser-Longview and Longview Fibre.

C. Such Night Shift Differential shall not be deemed a part of the hourly job rate when applying the provisions of this Agreement except in the payment of Overtime as provided for in Section 8.

SECTION 10 - JURY DUTY ALLOWANCE

A. Any regular employee as defined in Section 3 who is required to perform jury duty will be entitled to reimbursement at the straight time hourly rate of his regular job for the hours necessarily lost as a result of serving on the jury, provided, however, that such reimbursement shall not exceed eight (8) hours per day or forty (40) hours per week, less pay received for jury duty. The employee will be required to furnish a signed statement from a responsible officer of the court as proof of jury service and jury duty pay received.

B. Hours paid for jury duty will be counted as hours worked for the purpose of computing vacation, holiday and overtime pay.

C. Similar reimbursement as specified in Paragraphs A and B will be granted to an employee who necessarily loses time from work because of his appearance in court pursuant to proper subpoena, except when he is either a plaintiff or defendant in the court proceeding.

SECTION 11 - FUNERAL LEAVE

A. When death occurs to a member of a regular employee's immediate family, the employee, at his request, will be granted reasonable necessary time off as funeral leave of absence to attend the funeral. When the employee attends a Memorial Service rather than or in the absence of a funeral, the provisions of this sections shall apply.

If the employee attends the funeral, he will be compensated at his regular straight time hourly rate for hours lost from his regular schedule on any of the days prior to the funeral, the day of the funeral, or any days after the funeral, with a maximum of three (3) days compensation.

B. Members of an employee's immediate family shall be limited to the employee's spouse, mother, step-mother, father, step-father, brothers, sisters, sons, daughters, mother-in-law, father-in-law, grandparents, spouses grandparents, son-in-law, daughter-in-law, sister-in-law, brother-in-law, legal guardian, step-children, step-sister, step-brother, grandchildren, and step-grandchildren.

C. Compensable hours, under the terms of this Section, will be counted as hours worked for the purpose of computing vacation and holiday pay and will be counted as hours worked for the purpose of computing weekly overtime.

D. An employee who is on vacation will be granted funeral leave as outlined above.

SECTION 12 - GROUP INSURANCE PLAN

The Company shall make available a group insurance plan for its employees and their eligible dependents pursuant to the terms and conditions of Exhibit B, attached hereto and made a part hereof. Effective June 1, 2000, active hourly employees will be offered the Fort James health care plans. Fort James health care plan provisions will be described in each plan's summary plan description (SPD). Employees' per pay period contributions for the balance of 2000 and 2001 will be:

Fort James Plan	Pay Period Contribution
Primary Care Network Plan (PCN)	$16.92/Pay Period
Preferred Provider Organization Plan (PPO)	$ 29.21/Pay Period

Thereafter, composite payroll contributions and plan design will be the same as other employees enrolled in the Fort James health care plans. Refer to Exhibit B for terms and conditions, attached hereto and made a part hereof.

SECTION 13 - PENSIONS

During the term of this Agreement, including any extension thereof, the benefits provided by the Fort James Retirement Plan and by Schedule 56, of such Plan, as amended, which covers employees under this Agreement at the Fort James Wauna, Oregon Mill, shall remain in effect.

However, the Company may amend the Fort James Retirement Plan and Schedule 56 thereof to the extent necessary to maintain the qualified status of the Plan under Section 401 of the *Internal Revenue Code*, as the same may be amended from time to time and any regulations or rulings issued thereunder, and to meet the requirements of the Employee Retirement Income Security Act of 1974, including all amendments thereto and rules and regulations issued thereunder.

SECTION 14 - HOLIDAYS

A. There shall be nine (9) holidays during each year, namely:

Length

Designation	(Hours)	Starting Time	Ending Time
New Year's Day	(24)	*7:00* A.M. January 1	*7:00* A.M. January 2
Memorial Day	(24)	*7:00* A.M. Federally recognized Memorial Day	*7:00* A.M. day after Memorial Day
July 3	(16)	*7:00* A.M. July 3	*11:00* P.M. July 3
Independence Day	(32)	*11:00* P.M. July 3	*7:00* A.M. July 5
Sunday before Labor Day	(16)	*7:00* A.M. Sunday	*11:00* P.M. Sunday
Labor Day	(32)	*11:00* P.M. Sunday	*7:00* A.M. Tuesday
Thanksgiving	(24)	*7:00* A.M. Thanksgiving	*7:00* A.M. day after Thanksgiving
December 24	(24)	*7:00* A.M. December 24	*7:00* A.M. December 25
Christmas	(24)	*7:00* A.M. December 25	*7:00* A.M. December 26

1. On a holiday there are no restrictions upon any work scheduled by management.

B. In each department or section of a department of the mill the time of ending of each holiday specified in paragraph A above shall be varied from the *7:00 A.M.* above prescribed whenever necessary to coincide with the time nearest to *7:00 A.M.* which is the regular starting time for the day shift in such department or section of each department; and in the cases where such variation is so made the starting time shall be correspondingly varied to comply with the prescribed length of the holiday. The time of starting and ending of each holiday, in addition to any variation which occurs pursuant to the preceding sentence, may be further varied by mutual agreement of the management and the Union Standing Committee.

C. Subject to compliance with all the conditions set forth in "D" below, an employee who is on the payroll of the Company on any of the holidays listed in Paragraph A of this Section will be granted eight (8) hours holiday pay at the straight time rate of the job plus such additional compensation to which he is entitled under other sections of this Agreement except employees working compressed work week schedule who are scheduled off on a regularly scheduled work day, will be paid 12 hours compressed rate. His rate of pay for time not worked will be computed as follows:

1. Holiday pay for time not worked will be computed at the rate of the job to which an employee is assigned on the date the holiday occurs, or at the rate of the job to which he is assigned on his last shift just preceding the holiday in those cases where he is not scheduled to work on the holiday.
2. If the employee has accepted extra work during a shutdown of his job, department or plant which does not exceed seven (7) consecutive days just prior to the holiday and which shutdown extends into the holiday, he will receive his holiday pay for time not worked at the rate of the job to which he was assigned on the last day just preceding such shutdown or at the rate of the job on which he works during the shutdown, whichever is higher.

D. The employee must have been on the payroll for not less than ninety (90) days just preceding the holiday, and must have worked at least 260 hours during such ninety days,

provided that any employee whose failure to so work 260 hours was caused by curtailment of operations shall nevertheless be deemed to be in compliance herewith if he has been on the payroll of the Company for the one hundred eighty (180) days just preceding the holiday and has worked at least 520 hours during such 180 days, and

1. The employee must have worked his scheduled work day before and his scheduled work day after such holiday, unless failure to work his scheduled work day before or after the holiday was due to any of the following events.
   a. When the employee is on his regularly authorized paid vacation;
   b. When the employee is unable to work by reason of an industrial accident as recognized by the Workmen's Compensation Board;
   c. When the operation in which the employee is engaged is curtailed or discontinued by the decision of the management and which curtailment or discontinuance changes or eliminates the employee's scheduled work day before or his scheduled work day after such holiday;
   d. When a trade in shifts agreed upon between employees and approved in advance by management results in a temporary change of the scheduled work day before or the scheduled work day after a holiday, provided the employee works the shift agreed upon;
   e. When bona fide sickness or other bona fide compelling reasons beyond the control of the employee prevents the employee from working all or part of his scheduled work day before or his scheduled work day after a holiday, provided the employee affected, or the Local Union in his behalf, brings the case to management's attention within a reasonable time and management approves such reasons as being bona fide and beyond the control of the employee;
   f. When the employee prior to a holiday has made a written request to be excused from working all or part of his scheduled work day before and/or after such holiday and has received the written approval

of management. Failure to grant approval will not be subject to the grievance procedure but the Union Standing Committee may discuss with the Company any action which appears to it to be discriminatory.

E. An Employee who cannot meet the requirements for the number of hours worked as set forth in "D" above to qualify for holiday pay may use the following credits toward meeting the required qualifying hours:
   1. Any employee whose failure to work the 260 hours was due to absence caused by industrial injury or because of a sick leave approved by Management shall be deemed to have met that requirement as to any holiday falling during the first 12 months of such absence recognized by the Workmen's Compensation Board or such sick leave approved by management.
   2. In the case of a returned serviceman who has returned to work prior to a holiday, and who otherwise qualifies for holiday pay, the Company will waive the requirement of working 260 hours in the ninety (90) days just prior to the holiday.
   3. Time spent on a paid vacation shall count as hours worked for the purpose of qualifying for holiday pay.

F. It is agreed, however, that an employee shall not receive the holiday pay provided above in paragraph C of this Section if he is directed to work on his regular job (or relief job if he is then working on a relief job) on such holiday and fails or refuses to work, except in the case where a bona fide sickness or other bona fide reason approved by management prevents his working on such holiday.

G. Special Personal Floating Holiday(s)
   1. There shall be granted annually five (5) Special Personal Floating Holidays with pay to each regular full time employee, such special holidays to be arranged at dates mutually agreeable to the employee and the Company, during the Contract Year.
   2. For each Special Personal Floating Holiday taken, an employee will be granted eight (8) hours' pay at the straight time rate of the employee's regular job subject to the following:
      (a) New employee floating holiday(s) will be prorated during the remainder of their first contract year

according to their date of employment within the contract year as follows:

Hired 4/1 - 6/30 4 days 40 hrs. pay
Hired 7/1 - 9/30 3 days 30 hrs. pay
Hired 10/1 - 12/31 2 days 20 hrs. pay
Hired 1/1 - 3/31 1 day 10 hrs. pay

(b) An employee will not qualify for a Special Personal Floating Holiday if on leave of absence of more than nine (9) months in the Contract year except in the case of sickness or injury.

(c) If an employee is required to work on a Special Personal Floating Holiday, after a definite date has been designated for such a holiday, the employee shall be paid overtime for such work at the rate of time-and-one-half. The employee will then be entitled to take the said holiday with pay at a later date to be mutually agreed upon.

(d) When the holiday is requested in writing thirteen (13) days in advance, the payment of overtime shall not be a factor in the granting of a Personal Floating Holiday. The employee shall receive a written notice of the disposition of their request a minimum of 72 hours prior to the requested Personal Floating Holiday(s).

(e) Employees who work four (4) or more consecutive hours on Independence Day (11:00 P.M. July 3 to 7:00 a.m. July 5) will be entitled to one (1) additional floating holiday. Employees who work four (4) or more consecutive hours on the Christmas holidays (7:00 a.m. December 24 to 7:00 a.m. December 26) will be entitled to one (1) additional floating holiday.

3. Special Personal Floating Holidays requested on Holidays covered in Section 14 A. will be covered on a voluntary basis. First from the job classification, then any qualified employee.

4. At the employee's request, Special Personal Floating Holiday will be paid retroactively to cover any bonafide absence, providing the employee has not exceeded an absenteeism rate of 2.5% average over a rolling 12 month period.

SECTION 15 - HOURS OF WORK

A. The parties to the Agreement are committed to maintain the principle of a basic work week of forty (40) hours; but agree that additional time may be worked when such work is paid for as provided in other Sections of this Agreement.

B. When such overtime work is required, the Company will make reasonable effort to assign it to an employee(s) from the job classification in which the need for the overtime work occurred.

C. Employees are not guaranteed any number of hours of work in any week.

D. No employee will work in excess of sixteen (16) hours in a day, or sixteen (16) consecutive hours. For the purpose of this paragraph the hour beyond which an employee shall not work shall be arrived at by including all meal periods.

E. Any employee required to work a twelve hour shift will have the lunch period counted as hours worked for pay purposes.

SECTION 16 - SCHEDULING EMPLOYEES' WORKING TIME AND DAYS OFF

In scheduling an employee's working time and days off the Company will comply with the following obligations and restrictions:

A. The Company shall assign two (2) days off each week for each employee except for employees involved in a four shift tour schedule involving a seven (7) day continuous operation in which case one (1) day off shall be assigned for the periodic week in which the projected schedule results in one day off. A tour worker who is scheduled on such periodic weeks consecutively will also be assigned a second day off on such successive consecutive weeks for the application of Call Time and Overtime only. It is agreed that the second day off will normally be the day after the regular assigned day off.

The Company shall make reasonable and diligent effort to arrange schedules so that the assigned days off of any employee shall be consecutive.

B. An employee transferred, after the start of the week, from one job or shift or schedule to another, shall, solely for the application of the Call Time and the Overtime provisions, retain his

assigned days off, but only for the remainder of that week.

C. The Company will not, solely for the purpose of avoiding the payment of overtime, change the day or days off of a regular employee in a week in which a holiday specified in Section 14 occurs.

D. An employee who has been required to work overtime, or has been required to work on his assigned day or days off, shall not be laid off on one of his scheduled work days in the same week solely for the purpose of limiting his hours of work to forty (40).

E. When an employee is temporarily off work because of a shutdown on his job, department, or plant, extending for not less than forty-eight (48) hours in excess of that normally encountered in the working schedule, the employee's regular schedule of hours per day and days per week, including his starting time, and assigned day(s) off, shall be deemed to have been voided and shall no longer be in effect.

F. If an employee is sent home during his regular scheduled shift with instructions to return later, and his return is canceled so that he works less than eight (8) hours he was scheduled to work, he will be paid as though he had worked eight (8) hours at his regular straight-time rate.

SECTION 17 - ALLOWANCE FOR FAILURE TO PROVIDE WORK

A. In case any employee reports for work having been scheduled or ordered to report for such work, unless notified not to report before leaving home for work, and then no work is provided, he shall receive an allowance of three (3) hours pay at his straight-time rate for so reporting.

B. Notwithstanding Paragraph A above, in case an employee is scheduled or ordered to report for work on his assigned day or days off and he is subsequently notified not to report less than 36 hours prior to the start of such work, he shall receive an allowance of three (3) hours pay at his straight-time rate.

C. In case any employee has commenced work on his regularly scheduled shift, he shall receive a minimum of six (6) hours pay at his straight-time rate.

D. Failure to provide notice under Paragraphs A or B of this Section or failure to provide work under Paragraph C of this

Section shall not require such payments if the failure to provide notice or work is due to a breakdown, accident or interruption of power. This exception shall not apply to employees commencing work on any shift beginning later than eight (8) hours after the discovery of the breakdown, accident or interruption of power.

SECTION 18 - CALL TIME

A. It is agreed that in the payment of Call Time on the basis provided in this Section, not more than one basis shall be used to cover the same period of work except as provided in Paragraphs B-1 and B-5 of this Section, nor will Call Time be added to or paid in lieu of allowances payable under Section 17 or Section 19.

B. Regular hourly-paid employees will be paid four (4) hours Call Time at the straight-time day rate in addition to the actual hours worked, subject to the following conditions:

1. Call time will be paid if, in accordance with instructions from management, an employee works on Independence Day, day before Christmas, Christmas, Labor Day, or Floating Holidays as defined in Section 14, Holidays. Call time is payable for each separate or distinct shift worked wherein any of the shift hours fall within the defined holiday period.
2. Call Time will be paid if, in accordance with instructions from management, an employee works on his assigned day(s) off as defined in Section 3 and Section 16 subject to the following exceptions marked "a" and "b".
   a. When an employee works beyond his shift into his assigned day off for a period not to exceed two (2) hours, no Call Time is payable.
   b. When an employee starts his following day's work, within his assigned day off, no Call Time is payable if the period of work within the day off does not exceed two (2) hours and if at least thirty-six (36) hours notice thereof, has been given prior to the start of such work.
3. Call Time will be paid if, in accordance with instructions from management, an employee punches out, either during or at the end of his regular shift and

reports for work again in the same day subject to the following exceptions marked "a", "b", and "c":

a. When the additional period of work in the same day results from a reasonable meal period, no Call Time is payable.

b. When the additional period of work in the same day results from a single recall during a shift after a suspension of work of one (1) hour or more during a shift due to a failure of equipment or interruption of power, no Call Time is payable.

c. When the additional period of work in the same day extends into the starting time of the employee's established shift on the following day, no Call Time is payable if the period of work within the same day does not exceed two (2) hours and if at least thirty-six (36) hours notice thereof, has been given prior to the start of such work.

4. Call Time will be paid if, in accordance with instructions from management, the starting time of an employee's work is changed to a new starting time either earlier or later than the previously established starting time subject to the following exceptions marked "a" and "b":

a. When notice of the change in starting time is given at least thirty-six (36) hours prior to the newly established starting time, no Call Time is payable.

b. When the change in starting time is for a temporary period only, no Call Time is payable for the second change in starting time when the employee changes back to his previously established starting time at the end of the temporary period.

5. An additional Call Time will be paid if, in accordance with instructions from Management, a mechanic who has been called to work on an emergency job(s) is assigned to work on an additional job(s) during the same emergency call-in period. In no case shall more than two (2) call payments be made for one such period of work.

A Yard Worker, Equipment Operator, or Senior Equipment Operator called to operate mobile equip-

ment will also be covered under the provisions of this Paragraph B-5.

6. An employee who volunteers to participate in the following mill activities: Orientations, Interview Boards, Tours, Health & Wellness Committees, Health Fairs, Picnic Committees, Softness Panel, Fiber Utilization Group, S.A.C. Participants (not designated by the Company or Union as network members), Job Fair Committee, County Fairs and Finding a Better Way Committee is not eligible to receive call time. All other contract provisions will apply.

   By mutual agreement the Standing Committee may add newly created activities or committees of similar nature or delete from the above list.

C. When an employee has been notified to report for work at a time other than his regular shift under circumstances which would entitle him to a call time payment, and he is subsequently notified that such work has been canceled, he shall nevertheless be paid a call time allowance if he receives notice of cancellation after leaving the mill on his last shift preceding the canceled period of work.

D. It is agreed that the starting time of an employee's work may be changed at any time by the management.

E. It is agreed that when an employee's assigned day off is traded for another day in the same week at his request and for his own convenience, with management's consent but not at management's request, no Call Time is payable, and such a change in day off, made at the employee's request, is not to be considered a transfer initiated by the Company as outlined in Paragraph B of Section 16.

F. When certain privileges, such as working on an employee's assigned day off; trading shifts; or reporting for work at an earlier or later starting time than that established, are requested by employees for their own convenience, Call Time is not payable.

G. Paragraph B-3 of this section relating to a recall to work or a separate shift in the same day in addition to an employee's regular shift, is intended to require the payment of Call Time regardless of whether the employee reports for the separate and additional period of work in the same day before he reports for his regular shift or after he punches out from

his regular shift provided it is actually a separate period of work apart from his regular shift and does not extend into or out of his regular shift.

H. It is agreed that when an employee is temporarily off work because of a shutdown of his job, department, or plant, extending for not less than forty-eight (48) hours in excess of that normally encountered in the working schedule, the employee's regular schedule of hours per day and days per week, including his starting time, and Assigned Day(s) Off, shall be deemed to have been voided and shall no longer be in effect. Call Time shall not be payable for any assignments to extra work during the shutdown period or for assignments in connection with the resumption of operation of the job.

I. Call Time will be paid to non-tour workers who make more than two (2) shift changes in a work week; the company will not pay call time for maintenance employees exercising their choice, Labor Pool employees and people in the Utility classification.

SECTION 19 - PAPER MACHINE CLOTHING TIME

A. A tour worker called to actually put clothing on a paper machine at a time other than his regular shift, who is dismissed before his shift is scheduled to begin, shall be paid for the time worked plus four (4) hours, but not less than a total of four (4) hours for any one such period of work.

B. All machine wash-up done preparatory to putting on such paper machine clothing, and the restringing of Fourdrinier forming fabrics, shall be construed as clothing time and paid for as such.

C. A tour worker called to actually put clothing on a paper machine before his shift is scheduled to begin and who works through into his regular shift shall be paid for the time worked plus four (4) hours. If a tour worker is asked to remain after his shift is scheduled to end, and actually puts clothing on a paper machine and/or loads a wire gun, he shall be paid for the time worked, plus four (4) hours.

D. The above shall also apply to a tour worker when working on machines other than his own.

E. In cases where more than one machine is involved, the above allowances shall be paid for each machine.

F. A tour worker asked to assist in putting clothing on a paper machine other than his own, during his regular shift, shall receive

four (4) hours extra time, but in no case shall more than four (4) hours extra time be allowed.

G. A tour worker assigned to put a Fourdrinier Wire on his own machine during his regular shift shall be paid for the time worked, plus two (2) hours, but in no case shall this two (2) hour premium be paid for the same wire change on which an employee qualifies for any other premium under this Section. This paragraph G shall not apply to #5 Paper Machine.

H. Where used in this Section 19, paper machine clothing means: Fourdrinier wires; and pick-up, second, third, bottom, and dryer felts.

I. In addition to the premium set forth above, such employees who are called back to the plant while off shift for the purposes set forth in this Section shall receive an additional payment of four (4) hours at their straight time rate and shall be limited to one such payment per call back.

J. Pay for the allowance time provided above shall be figured at straight time even though the actual time worked may be paid for at the overtime rate.

K. A tour worker assigned to put a pickup felt on No. 5 Paper Machine during his regular shift shall be paid for the time worked plus two (2) hours, but in no case shall this two (2) hour premium be paid for the same pickup felt change which an employee qualifies for any other premium under this section.

SECTION 20 - STARTING AND STOPPING WORK OF TOUR WORKERS

When a tour begins, each tour worker is required to be in his place. At the end of a shift no tour worker shall leave his place to wash up and dress until his mate has changed his clothes and reported to take on responsibility of the position. If a tour worker does not report for his regular shift, his mate shall notify the supervisor. He shall then remain at his post until a substitute is secured and, if necessary, he shall work an extra shift. It is the duty of a tour worker to report for his regular shift, unless he has already arranged with his supervisor for a leave of absence. If unavoidably prevented from reporting, he must give notice to his supervisor, or at the office, at least four (4) hours before his tour goes on duty.

SECTION 21 - STARTING AND STOPPING WORK OF DAY WORKERS

Day workers shall be at their respective posts ready to begin work at the time their day starts and shall not quit work in advance of the time their day stops. For example, if a mechanic's pay time is from 7:00 a.m. to 11:00 a.m., and from 11:30 a.m. to 3:30 p.m., he shall be at his post ready to work at 7:00 a.m. and 11:30 a.m., and shall not quit work until 11:00 a.m. and 3:30 p.m.

A day worker may be required at the end of his shift to not leave his place until his mate has reported and taken on his responsibility of the position.

SECTION 22 - DISCIPLINARY ACTION

A. Causes for disciplinary action, up to and including discharge:
   1. Bringing intoxicants or illegal drugs into or consuming intoxicants or illegal drugs in the mill or on mill premises.
   2. Reporting for duty under influence of alcohol or illegal drugs.
   3. Disobedience.
   4. Smoking in prohibited areas.
   5. Deliberate destruction or removal of Company's or another employee's property.
   6. Neglect of duty.
   7. Refusal to comply with Company rules; provided that such rules shall be posted in each department where they may be read by all employees and further that no changes in present rules or no additional rules shall be made that are inconsistent with this Agreement; and further provided, that any existing or new rules or changes in rules may be the subject of discussion between the Union Standing Committee and the Mill Manager, and in case of disagreement, the procedure for other grievances shall apply.
   8. Disorderly conduct.
   9. Dishonesty.
   10. Sleeping on duty.
   11. Failure to report for duty without bona fide reasons.

B. Discharge or suspension of an employee (not including a temporary lay-off) shall be based on just and sufficient cause with full explanation given the employee in writing.

The Standing Committee of the Local Union will be notified of the discharge or suspension as soon as possible following the action taken.

C. Reprimands shall be removed from an employee's record at the end of one (1) year provided no further reprimands are issued in the one year period. Records of offenses, for which an employee received a suspension, shall be removed from an employee's work record at the end of five (5) years.
   1. No employee will be requested or required to sign a written reprimand.
   2. The Company will promptly furnish to the Local Union a copy of every written reprimand and a copy of any notation on the Employee's record relating to any verbal reprimand.

SECTION 23 - BULLETIN BOARDS

The Employer shall supply adequate enclosed official bulletin boards for the use of the Union in posting of officially signed bulletins.

SECTION 24 - SAFETY

The Company, the Union, and all employees will cooperate in promoting safe working practices and conditions in the Mill.

1. Supervisors are to confine their instructions and procedures within the generally accepted standards of safe practices.
2. Employees and the Company are to comply with all safety rules as established by the Company from time to time.
3. The Company and the Union shall establish a Safety Advisory Committee composed of two members from the Union and two members from the Company which will meet at least once a month to consider all safety problems and safety rules. The duties of this committee shall include review and recommendations of:
   a. Mill-wide safety rules
   b. Mill-wide and departmental safety inspection procedures
   c. Mill-wide safety promotion programs
   d. Safety recommendation procedures
   e. Serious accident investigations

4. The Company and the Union shall establish either departmental, progression and/or crew safety committees composed of members from the Union and the Company.
   The duties of these committees shall include:
   a. Conduct periodic safety inspections
   b. Review and recommend department safety rules
   c. Review and recommend department safety promotion programs
   d. Participate in investigations of accidents
5. If requested by an employee who has been on the payroll for over six (6) months, the Company will reimburse the employee up to $85 toward the cost of safety shoes in calendar years 2000 and 2001; $100 in calendar years 2002, 2003 and 2004; and $110 in calendar year 2005. The remaining amount from one calendar year may be carried over to the next calendar year up to a maximum of doubling the single year allowance. Repairs or rebuilds are eligible for reimbursement.
6. Safety glasses, frames and lenses (prescription lenses if needed) will be paid at 100% if purchased through the Medical Department.

SECTION 25 - SENIORITY

This section shall determine the extent of application of an employee's length of service in those situations in which seniority is a factor, namely, promotions, demotions, transfers, layoffs and recalls.

A. Definitions:
   For the purpose of this section and ground rules established hereunder the following definitions shall apply:
   1. Mill means the entire manufacturing facility at Wauna in which the employees are covered by this agreement.
   2. Mill seniority means the length of continuous service of an employee from the most recent date of hire at the Wauna mill.
   3. Progression Ladder Seniority means the length of service in a progression ladder.
   4. Job Seniority means the length of service in a given job classification.
   5. Job opening means an opening which management

decides must be filled.

6. Progression ladder means a series of reasonably related jobs.
7. Promotion means the movement of an employee from any rung on a progression ladder to a higher rung on that same ladder.
8. Demotion means the movement of an employee from a higher rung on a progression ladder to any lower rung on that same ladder and also means the movement of an employee from the bottom rung of a ladder, or from any job not on a ladder, to a layoff pool.
9. Transfer means the movement of an employee from any job to a job opening which is not a promotion or a demotion, as defined in 7 and 8 above.
10. Layoff means the movement of an employee from any job to unemployed status.
11. Recall means the return to work of an employee who has been unemployed but who has not lost seniority.
12. Qualified means the ability of an employee to satisfactorily discharge the duties and responsibilities of the job involved based on his qualifications and his past performance, and as to entry on the bottom rung of a progression ladder, means in addition, his ability to progress through the ladder.
13. Seniority Ground Rules means rules and procedures established in the manner set forth in this Section 25 for the application of seniority.
14. A Layoff Pool means the labor pool or Yard base rate jobs plus any other jobs which may be designated for the purpose of permitting qualified senior employees, who would otherwise be laid off from work, to exercise their seniority. **(See the Supplemental Agreements Section).**
15. Major curtailment is 60 consecutive days.
16. For a curtailment of up to 48 hours, the senior employee on each shift will be scheduled for any available work. For curtailments over 48 hours the senior affected employees will be scheduled for any available work.

B. Progression Ladders:

1. The parties agree that management shall have the

right to establish new progression ladders or change or eliminate existing progression ladders. However, any employee adversely affected by such action by management has the right to process a grievance, but if it reaches the arbitration stage the arbitrator's decision shall not establish, change or eliminate any progression ladder.

2. Any dispute, arising out of the claim that an employee's job rights based on his seniority have been adversely affected by the Company's application of this Section or governing ground rules may be processed through the entire grievance procedure. Should the dispute reach the arbitration stage the arbitrator's decision shall be limited to (a) directing the placement of the employee on a job giving effect to his seniority and qualifications and (b) if back pay is an issue, and the arbitrator orders payment thereof, it shall not be retroactive to a date earlier than the date the grievance was first presented to management.

C. Promotion Procedure:

1. In filling job openings other than as provided in (C.2) first consideration will be given to the qualified employee with the most job seniority in the job immediately below the job opening. When job seniority is equal, then progression ladder seniority shall prevail. When job and progression ladder seniority are equal, then mill seniority shall prevail.

2. a. On shift promotions may be made for vacation and floating holidays.

   b. All other vacancies which include but are not limited to, replacements due to sickness, accident, move out of the bargaining unit, scheduled absence, special assignments, etc. will be filled according to C.1. except as follows:

      1) On shift promotion may be made for full week vacancies that become known after day shift on Friday of the preceding week and for parts of a scheduled week. Known means reasonable notice to the department scheduler. Employees on all other sched-

ules may be moved up by on-shift of the scheduled work week.

2) A department may modify C.2. above, subject to departmental approval.

3. The Company will notify the employee involved and the Local Union of each case in which it determines that an employee lacks the qualifications to be promoted as described above. Such employee will be considered frozen as described in paragraph I.1b of this Section 25 unless he becomes qualified for a future promotion to the same job.

D. Transfer Procedure:

1. a. Job openings will be posted in the clock alley for a period of fourteen (14) days prior to the filling of that job on a permanent basis. It shall not be necessary to post temporary job openings, unless such a temporary job opening has been temporarily filled for six (6) uninterrupted months. Should a regular employee desire to bid on a posted job opening, he shall make application to the Human Resources Department prior to the end of the fourteen (14) days posting period. Such bid shall remain active until the job opening is filled.

b. Job openings in (a) above for which no qualified applicant has applied will be posted but if this does not generate a qualified candidate, the job will be filled by outside hire.

2. The Company shall consider such employees for such job openings as arise in order of their mill seniority, subject to the employee being qualified. The need for the employee in his current job may delay the transfer, following selection, but in no case shall he be held on his present job for more than 7 days from the following Monday, unless extended by agreement between the Company and the Union.

3. When an employee accepts a transfer to another job he shall have his seniority protected in his old job for a

period of 60 days to be exercised only in case he fails to qualify or elects to return to his former job. However, should an employee with longer seniority protection displace such employee after the above 60 day period has expired, such employee will have his seniority protected on his old job extended for that same longer period of time. The 60 day period may be extended by agreement between the Company and the Union Standing Committees.

4. a. An employee can transfer up to twice in a 12 month period. The transfer of an employee who is later disqualified during the probationary period by the Company and returned to his former job will not be counted in applying this Paragraph 4. Moves for substantiated medical or personal reasons acceptable to the Company will not count as a transfer, and do not have to meet the limitations of job bidding described in this paragraph 4. An employee with substantiated medical reasons will be considered for suitable job openings whether they had previously signed up or not.

   b. An employee who is transferred according to this Section D will receive 90 percent of the pay rate during the 60 day probationary period. Employees who successfully complete the probationary period or are disqualified by the Company and returned to their former job, will be reimbursed retroactively to 100% of the above pay rate during the probationary period.

E. Probationary Period:

All new employees will be required to serve a probationary period of sixty (60) working days, not to exceed 120 calendar days of continuous employment, unless extended by agreement between the Company and Union Standing Committees.

F. Loss of Seniority:

Seniority shall be terminated for the following reasons:

1. If the employee voluntarily leaves the employ of the

Company;

2. If the employee is discharged;
3. During the first year of an employee's layoff the Human Resources Department will notify the employee of a permanent job opening available in the mill which the laid-off employee has the ability and experience to fill, and to which his seniority may entitle him. Notice will be made to the employee by certified mail (return receipt requested) sent to his last known address. The notified employee will be given seven (7) days, not including weekends and holidays, after mailing of such notice to notify the Human Resources Department that he desires to return to work, and fourteen (14) days after mailing of such notice to actually report to work unless this period is extended by express permission of the Company. The failure of such laid-off employee to comply with any of the above conditions within the time limits specified, or the failure of a suitable vacancy to occur within one year of his layoff, shall result in the forfeiture of all his recall rights and he shall be terminated from the payroll of the Company.

In any case where an employee is absent from work because of a physical disability the employee's rights to any benefit under the Labor Agreement will be maintained for a period of two (2) years, unless any competent medical authority advises that such employee is deemed permanently disabled to the point where employment should not be resumed. At the end of the two (2) years of disability, Management will take no action to terminate the disabled employee without prior consultation with the Union Standing Committee. In any case where employment is held open beyond two (2) years, such employee will not accumulate seniority during such extension beyond two (2) years.

During the layoff or leave of absence period provided for herein, the employee's right to his job will be maintained; he will receive Vacation pay if qualified under Section 27; will receive Holiday pay if qualified under Section 14, and will be eligible for such Health and Welfare coverages as are available to him under the

Plan in effect during his absence.

G. Supplementary Provisions:

1. The seniority rights of Mechanics, Helpers and Applicants for Helper positions in mechanical crews and the obligations of management with respect thereto are set forth as a part of this Agreement in the Mechanics' Package Exhibit A-2.
2. The seniority rights of oilers and applicants for oiler positions, and the obligations of management with respect thereto, are set forth as a part of this Agreement in the Lubrication Package Exhibit A-5.
3. The parties agree (a) that this Section does not nullify the seniority provisions of the Mechanics' Package, nor the Lubrication Package relating to the application of seniority and (b) employees subject to the Mechanics' Package or the Lubrication Package shall have all the rights specified in this section to the extent such rights are consistent with their respective Mechanics' or Lubrication Package.
4. Current progression ladders and new or changed Seniority Ground Rules will be posted on the bulletin board of the department involved.

H. Establishment of Seniority Ground Rules:

1. Written Seniority Ground Rules (which effectuate the application of seniority as provided in this Section 25) shall continue in effect during the period of this Agreement subject to change only by mutual agreement of the parties.
2. Additional Seniority Ground Rules may be established or existing Seniority Ground Rules changed by mutual agreement of the parties.

   When mutual agreement has been reached by the Union Standing Committee and the Company Standing Committee, to be effective such Seniority Ground Rules must be reduced to writing, identified as such and signed by the Mill Manager.
3. In the event mutual agreement has not been reached as to the establishment of, or a change in, any Seniority Ground Rule, the Company may neverthe-

less keep in effect or put into effect the Ground Rule which is the subject of disagreement. Any claim that an employee's seniority rights have been adversely affected by the application of this Paragraph 3 may be processed through the entire grievance procedure.

I. Seniority Ground Rules:

1. Employees are expected to accept opportunities for promotion and may not freeze or unfreeze except by written agreement between the Company and the Union Standing Committees after the employer has notified the Local # 8-1097 Executive Board and in accordance with the following principles:
   a. When an employee uses his job seniority and bypasses another employee who is frozen in a job on the progression ladder, he will acquire job seniority rights to the job to which he has moved and will be considered permanently ahead of the by-passed employee. By-pass rights are not acquired by on-shift move-ups.
   b. Not more than one-half the number of employees on any given job above the bottom job on a progression ladder will normally be allowed to freeze at any one time.
   c. Freezing will not normally be allowed on the bottom job in any progression ladder.
2. In the event there is a reduction in the working force or curtailment of production in excess of 48 hours which results in demotions or layoffs, employees shall be demoted or laid off in the reverse order of their promotions.
3. Lay-offs from among employees in the lay-off pool will be made on the basis of inverse mill seniority. Lay-off pool job classifications shall be determined by mutual agreement between the Company and the Union -- **(See Supplemental Agreements Section).**
4. In all cases of layoff extending longer than the beginning of the second week following the day his layoff starts, a qualified senior regular employee will not be continued on layoff as long as a junior employee is working on a layoff pool job. However, if a qualified

senior regular employee is scheduled, prior to 8:00 A.M. on Friday to be laid off beginning Monday of the following week, such employee will not be laid off as long as a junior employee is working on a layoff pool job.

5. Employees who have been laid off will be recalled for any work that is available, in accordance with their mill seniority in the case of lay-off pool jobs, and in accordance with their job seniority in the case of filling other jobs to which their job seniority entitles them.
6. The Company shall furnish seniority lists to the Local Union upon request, but not more frequently than each ninety (90) days.
7. Any employee covered by this Agreement, who accepts a job with the Company, which is outside the bargaining unit may return to his former job within one hundred eighty (180) days without loss of seniority. This period may be extended by an additional 180 days by mutual agreement between the Company and the Union. An employee who accepts a job outside the bargaining unit will not perform bargaining unit work later the same day unless it is done within his regular scheduled shift.

J. Permanent Progression Ladder Closure:

In cases of permanent closure of a progression ladder and/or jobs, the affected employee(s) may exercise their progression ladder and then their mill seniority in accordance with the following principles:

1. Closure
   a. If a non-progression job or an entire line of progression is permanently eliminated, then the affected employee(s) will be offered a "One time" opportunity to displace junior employees occupying the bottom rung of remaining progression ladders in the mill. This opportunity only applies to bottom rung jobs filled after ratification of this Labor Agreement.

   b. In cases where two or more lines of progression share a common relief pool, employees affected by a permanent closure must first exercise their

progression ladder seniority and thereby displace progression ladder junior employees in the common relief pool. Relief employees who are displaced will be offered the "One time" opportunity described in 1.a.

c. Displacement of junior employees occupying the bottom rung of the remaining mill progression ladders will be limited to displacement of no more than 50% of the employees occupying the bottom rung of any progression ladder. In progression ladders where more than 50% of the employees on the bottom rung are mill junior, this restriction does not apply.

2. Grandfather Rights

a. In all instances, affected employees will be granted Grandfather Rights to return to their previous progression ladder if a permanent opening in that ladder becomes available. Employees returning under this Section will retain their previous progression seniority date. If an employee refused to exercise their Grandfather Rights, they permanently forfeit those rights.

b. If they forfeit their Grandfather Rights, to their original job, they will also forfeit their retained job rate.

c. Where jobs/progression ladders are eliminated or an employee is displaced, and that employee had bid into that job/progression ladder for less than one (1) year, that employee will have the option to return to their previously held job. If the employee declines to exercise their grandfather right of return to the job they were displaced from, then the employee will be assigned to the labor pool. If an employee has become a successful bidder after being displaced, that employee will not be assigned to the labor pool, if the employee declines their grandfather rights.

3. The above paragraphs (1-2) describe the general application of the principles which will guide the par-

ties under the circumstances described in this section. The Local Union and Company Standing Committees, by mutual agreement, have the authority to modify the specific application of this paragraph 'J' in order to respond to situations as they might arise.

SECTION 26 - MEALS

A. A meal which will be hot if practical, shall be furnished at a usual meal time by, and at the expense of the Company, or, at an employee's option, a $7.75 meal ticket shall be provided by the Company to any employee who:
   1. is required to work ten consecutive hours, or
   2. is notified to report for work with less than one (1) hour prior notice and is required to work four (4) consecutive hours.

B. An additional meal shall be furnished at a usual meal time by, and at the expense of the Company, or, at an employee's option, a meal ticket shall be provided by the Company to an employee qualifying for the benefit of A1 above for each additional four (4) consecutive hours worked beyond ten (10) hours, and to an employee qualifying for the benefit of A2 above if he is required to work for eight (8) consecutive hours; provided that an employee other than a regular employee shall not be entitled to the benefit of A2 above unless he then has an established work schedule.

C. Notwithstanding the above, a notice to report for work which is given between 10:00 p.m. and 7:00 a.m. will be considered to have been given with less than one (1) hour notice when applying the provisions of this section.

D. If, in accordance with instructions from management, an employee's unpaid lunch period is shortened, or if his unpaid lunch period is rescheduled so that it begins more than one-half hour earlier or ends more than one-half hour later than his regular unpaid lunch period, the employee will be paid for such lunch period and will be allowed to "eat on the fly."

SECTION 27 - VACATIONS

A. Employees as defined in this Agreement shall be granted **one (1) week** vacation with pay, subject to the following terms and conditions:

1. To be eligible for a weeks vacation during the year subsequent to any June 1st the employee must be on the payroll of the Company on said June 1st and either
   a. have been an employee for not less than one (1) year prior to said June 1st, during which year the employee worked a minimum of 1,000 hours or
   b. have worked a minimum of 1,500 hours prior to said June 1st.

B. Employees as defined in this Agreement shall be granted **two (2) weeks** vacation with pay, subject to the following terms and conditions:
   1. To be eligible for a two (2) weeks vacation during the year subsequent to any June 1st the employee must qualify under the conditions set forth above for a one (1) weeks vacation and in addition either
      a. have been an employee for not less than two (2) years prior to said June 1st, during which the employee worked a minimum of 1,000 hours in each of the two (2) years, or
      b. have worked a minimum of 1,500 hours prior to June 1st in the first year of his employment and a minimum of 1,000 hours prior to June 1st in one (1) additional year.

C. Employees as defined in this Agreement shall be granted **three (3) weeks** vacation with pay, subject to the following terms and conditions:
   1. To be eligible for a three (3) weeks vacation during the year subsequent to any June 1st, the employee must be on the payroll of the Company on said June 1st and have worked a minimum of 1,000 hours during the year just preceding said June 1st, and in addition must
      a. have been an employee for not less than five (5) years prior to said June 1st, or
      b. have worked a minimum of 1,500 hours prior to June 1st in the first year of his employment and have been an employee for not less than four (4) additional years.

D. Employees as defined in this Agreement shall be granted **four (4) weeks** vacation with pay, subject to the following terms and conditions:
   1. To be eligible for a four (4) weeks vacation during the

year subsequent to any June 1st, the employee must be on the payroll of the Company on said June 1st and have worked a minimum of 1,000 hours during the year just preceding said June 1st, and in addition must

a. have been an employee for not less than ten (10) years prior to said June 1st, or
b. have worked a minimum of 1,500 hours prior to June 1st in the first year of his employment and have been an employee for not less than nine (9) additional years.

E. Employees as defined in this Agreement shall be granted **five (5) weeks** vacation with pay, subject to the following terms and conditions:

1. To be eligible for a five (5) weeks vacation during the year subsequent to any June 1st, the employee must be on the payroll of the Company on said June 1st and have worked a minimum of 1,000 hours during the year just preceding said June 1st, and in addition must
   a. have been an employee for not less than fifteen (15) years prior to said June 1st, or
   b. have worked a minimum of 1,500 hours prior to June 1st in the first year of his employment and have been an employee for not less than fourteen (14) additional years.

F. Employees as defined in this Agreement shall be granted **six (6) weeks** vacation with pay, subject to the following terms and conditions:

1. To be eligible for a six (6) weeks vacation during the year subsequent to any June 1st, the employee must be on the payroll of the Company on said June 1st and have worked a minimum of 1,000 hours during the year just preceding said June 1st, and in addition must
   a. have been an employee for not less than twenty (20) years prior to said June 1st, or
   b. have worked a minimum of 1,500 hours prior to June 1st in the first year of his employment and have been an employee for not less than nineteen (19) additional years.

G. Employees as defined in this Agreement shall be granted **seven (7) weeks** vacation with pay, subject to the following terms and conditions:

1. To be eligible for a seven (7) weeks vacation during the

year subsequent to any June 1st, the employee must be on the payroll of the Company on said June 1st and have worked a minimum of 1,000 hours during the year just preceding said June 1st, and in addition must

a. have been an employee for not less than twenty-five (25) years prior to said June 1st, or
b. have worked a minimum of 1,500 hours prior to June 1st in the first year of his employment and have been an employee for not less than twenty-four (24) additional years.

H. Provided that, with respect to either sub-Paragraph "a" or "b" of Paragraphs "A", "B", "C", "D", "E", "F" or "G" above, if a termination of employment occurred in the eligibility period, credit for length of employment or for hours worked prior to the termination of employment shall not be included.

I. Any employee who does not meet the qualification of hours worked set forth in Paragraphs "A", "B", "C", "D", "E", "F" or "G", above, may where applicable use the following to qualify for a vacation:

1. Time lost as a result of an accident, as recognized by the Workmen's Compensation Board, suffered during the course of employment shall be considered as time worked in applying the above provisions.
2. For the purpose of determining the qualification for vacations of an employee with five (5) or more years of continuous service, time lost by him for which non-industrial sickness or accident benefits are paid to him under the Company's Group Insurance shall be construed as time worked in applying the provisions of Paragraphs "B", "C", "D", "E", "F" and "G" of this Section. Provided, (1) that time so lost shall be computed at eight (8) hours per day and forty (40) hours per week, and (2) that if the time lost so computed exceeds 520 hours in the prior "vacation year", only 520 hours shall be considered as time worked under the provisions of this sub-paragraph. Vacation year means twelve (12) consecutive months subsequent to any June 1st.
3. For the purpose of qualifying for vacation pay, an employee shall be considered to have worked the hours he would have been scheduled to work during

his vacation period, but not to exceed 8 hours a day and 48 hours a week.

J. The vacation pay for an employee who qualifies is to be computed in accordance with the number of hours as set forth herein and shall be computed at the higher of:

1. The job rate of his regular job as such rate exists on the day his vacation starts, or
2. The weighted average straight time hourly rate paid to the employee in the prior contract year, adjusted for the change, if any, in his average rate effective on the effective date of the last general wage increase preceding the time at which his vacation is taken. Said average rate (1) for an employee who worked at the same job rate during the entire prior contract year is that job rate and (2) for an employee who worked at more than one job rate in the prior contract year shall be determined by the following procedure: Multiply the number of hours he worked in said year at each job rate by that job rate; add the amounts so computed; and divide the sum by the total number of hours he worked in said year.

   Vacation Pay Allowance of fifty-four (54) hours will be paid for each week of earned vacation subject to all other provisions of this Section 27.

K. The vacation must be taken within the vacation year, that is it may not be accumulated to be used in the following year. However, employees who are eligible for more than two weeks of vacation may bank all or part of their vacation period over two weeks. Employees may bank only full weeks of vacation and a maximum of five (5) vacation weeks may be accumulated in the bank. Banked vacation weeks may be withdrawn at retirement or for extended vacations.

   The vacation pay for banked vacation will be based on the employee's blue slip rate at the time of withdrawal from the bank at 54 hours for each week.

L. The allotment of vacation time, including banked vacation, is to be decided by management.

1. Management is permitted, but not obligated, to adjust starting days of vacation time for employees, if so requested. However, any employee's request for vaca-

tion running from day off to day off will be granted subject to the other provisions of this Paragraph L.

2. No employee is to have the privilege of drawing the vacation pay and continuing to work in lieu of taking the vacation.
3. It is agreed that management is not committed to schedule three, four, five, six or seven consecutive weeks of vacation.
4. All employees sign up prior to May 1. From May 1 to May 23, people who signed-up for vacation weeks, but were denied - will have the opportunity to reschedule, by seniority, those weeks. All vacation sign-ups will be completed by May 23rd. Management will schedule vacation time from the requests so made on the basis of mill seniority.
5. Management shall give timely notice to each employee of his scheduled vacation and shall then consider in good faith, before making final decision, any change asked for by the employee or the Union Standing Committee. Such change may be asked for and shall be considered whether it arises from a personal preference for a vacation during a particular part of the vacation year or from an announcement by management that the vacation time is to be scheduled so as to coincide with an announced shutdown.
6. a. Employees who are eligible for three (3) or more weeks of vacation will be allowed to schedule one (1) week of vacation in full day increments of less than four (4) days for shift workers and less than five (5) days for day workers. Election to exercise this option will not be revocable once an employee has been paid.
   b. Pay for day-at-a-time vacation will be administered via a lump-sum check on the next available payday.
   c. Prior to taking the one (1) week of day-at-a-time vacation, all Personal Floating Holidays (earned in the previous contract year or carried forward from the previous contract year) must be taken. Subsequently, day at-a-time vacation days will be scheduled using the same notification/approval

requirements as per Personal Floating Holidays.

d. This procedure will be utilized for a period beginning June 1, 2000 – April 30, 2001, after which, Management or the Union may elect to terminate the program or both may agree to extend it for the term of the Agreement with or without modifications.

M. It is agreed that any employee who has left the employ of the Company prior to June 1st for the purpose of serving in the armed forces, but who otherwise has fulfilled the qualifications for a vacation during the year just preceding that June 1st, will be granted vacation pay. The vacation pay will be mailed to the employee immediately following said June 1st, provided satisfactory proof has been furnished to the Company that the employee is serving in the armed forces.

N. Any returning serviceman who -

1. was on the payroll of the Company at the time of induction into the armed forces; and
2. made application to return to the employ of the Company within ninety (90) days after being relieved from duty in the armed forces; and
3. actually performed work for the Company on or before the June 1st immediately following his return from the armed forces; and
4. had qualified for one (1) weeks vacation while in the employ of the Company in the eligibility period in which he was inducted, or in the next preceding eligibility period, or whose service with the Company immediately preceding his induction, plus his service since his return from the armed forces immediately preceding June 1st, is sufficient to qualify him for a vacation under the requirements existing at the time he returns shall be granted one (1) weeks vacation with pay, whether or not he worked 1,000 hours in the eligibility period immediately prior to said June 1st.

Any returning serviceman when he has qualified for one (1) weeks vacation on any of the basis made available to him and whose total length of service with the Company including the time spent in the armed forces is sufficient to qualify him for a longer vacation, shall be granted the longer vacation without applying the requirements of hours worked to that period spent

in the armed forces. It is understood that there shall be but one vacation for each eligibility period.

O. When an employee is retiring, he is terminated from the payroll as an employee and as such he is no longer a par of the collective bargaining unit covered by this Agreement. However, management has agreed that in the case of an employee who is retiring prior to June 1st pursuant to the retirement plan in effect, or at age 65, or later, pursuant to the Social Security Act, and who has fulfilled the requirements of the Agreement as to hours worked within the vacation year, the requirement that he be on the payroll on June 1st shall be waived and upon retirement he shall be paid a sum equivalent to vacation pay based on his then current rate. Provided, however, that if said retiring employee has not fulfilled the requirement of the Agreement as to hours worked within that vacation year, it is agreed that upon retirement he shall be paid a sum which shall be computed on a prorated basis dependent on the number of hours he worked as related to 1,000 hours.

P. In the event an employee dies while on the payroll prior to June 1st but who, prior to death, fulfilled the requirements of the Agreement as to hours worked within that vacation year, his heir (or heirs) shall upon proof of entitlement satisfactory to the Company, be paid vacation pay he would have been entitled to at his current rate. If, within six months after the employee's death no application has been made to the Company by any heir (or heirs) or the Company by reasonable effort has been unable to locate heir (or heirs) the above stated obligation shall thereupon terminate.

Q. An employee who leaves the employment of the Company prior to June 1st, and who has fulfilled the requirements of the agreement as to hours worked within the vacation year, shall have the requirement that he be on the payroll on June 1st waived. This provision does not apply to employees discharged under the terms of Section 22.

R. Subject to mutual agreement between the Company and Union, an employee may elect to donate a week(s) of vacation to another employee for legitimate humanitarian needs or emergencies. The employee receiving the donated vacation will receive the time off and the wages of the donating

employees. The hours and dollars received shall not affect vacation eligibility or average rate of vacation pay for either employee. Tax liability goes with the dollars.

SECTION 28 - ADJUSTMENT OF GRIEVANCES

A. All disputes, complaints, or grievances of any employee or the Union may be presented through the grievance procedures of this Agreement, and if not thereby settled may be processed to arbitration for a determination of whether the terms of this agreement have been violated. This Section shall not be applicable to grievances arising from discharge or suspension.

B. Standing Committees shall be maintained in the following manner:

1. The Mill Manager shall appoint a Company Standing Committee of up to five (5) individuals which shall represent that Company.
2. The Local Union shall select from its membership a Union Standing Committee of up to five (5), which shall represent the Local Union for the purposes stated in this Agreement.
3. The Company Standing Committee and the Union Standing Committee have the authority to make the final decision consistent with the terms of this Agreement on matters properly before them. Either party may express reservation that it desires to refer the question under consideration to higher authority.
4. Accurate minutes of each and every Standing Committee meeting must be kept and must be signed by the chairman of the Company Standing Committee and the chairman of the Union Standing Committee. The minutes shall include statements of positions and conclusions, if any. A copy shall be supplied to the Local Union.
5. Conclusions reached in Steps 3 and 4 shall be prepared and signed by the appropriate parties. A copy shall be supplied to the Local Union.

C. Should there be any dispute, complaint, or grievance of any employee or the Union, herein collectively referred to as grievances, the employee shall work as directed by management pending final adjustment of the grievance. Any

such grievance shall be deemed to have been waived if not presented as a formal grievance by the employee to his supervisor within thirty (30) calendar days following either the occurrence out of which the grievance arose or the first date upon which the grievance could reasonably be assumed to have been known to the employee, whichever is later.

In order to facilitate the resolution of grievances at the 1st Step, the Company and Union hereby agree that any grievance settlement at the 1st Step does not establish a precedent with respect to how a similar matter should/will be resolved in the future.

STEP 1.

Such dispute, complaint or grievance shall first be taken up with his supervisory by the employee. In the event the employee desires to submit the matter as a formal grievance he shall present it in writing to the supervisor specifying the date of submission. The employee may have the Shop Steward accompany him when he discusses the matter with his supervisor. If the supervisor and the grievant are unable to arrive at a satisfactory settlement, to be timely the grievance must be referred to Step 2 within ten (10) calendar days after the date the grievance was first presented to the supervisor as a formal grievance.

STEP 2.

Any such grievance shall be submitted in writing by the Union Standing Committee to the Company Standing Committee setting forth the circumstances out of which the grievance arose, and the remedy or correction requested. Subjects which have been presented at Step 1 but not mentioned in said written submission shall nevertheless be dealt with.

1. Within ten (10) calendar days after the date of receipt of such written grievance the two committees shall meet.
2. If the two committees are unable to arrive at a satisfactory settlement within ten (10) calendar days after their initial meeting, to be timely the Union Standing Committee must

STEP 3.

refer the grievance in writing to the Mill Manager within fifteen (15) calendar days of the expiration of the ten (10) calendar-pay *period in Step 2-2.*

1. Within ten (10) calendar days after the date of such written notice the Mill Manager and/or his representative and the representative(s) of the Local Union shall meet.
2. If the Mill Manager and/or his representative and the representative(s) of the Local Union are able to arrive at a satisfactory settlement within ten (10) calendar days after their initial meeting, to be timely the Local Union must

STEP 4.

refer the grievance in writing within fifteen (15) calendar days of the expiration of the ten (10) calendar-day period in Step 3-2 to the President of the Signatory Union or his representative, and an official of Fort James Corporation. (Copy of referral shall be delivered to Mill Manager.)

1. Within thirty (30) calendar days of date of such written notice these two shall meet.
2. If these two are unable to arrive at a satisfactory settlement within fifteen (15) calendar days of their initial meeting, to be timely the Local Union may,

STEP 5.

submit a grievance based upon an alleged violation of any provision(s) of this Agreement to the arbitrator as provided in Sections 31 and 32 of this Agreement within thirty (30) calendar days after the expiration of the fifteen (15) calendar-day period in Step 4-2 for interpretation and/or application of such provision(s). It is agreed that if the P.A.C.E. Executive Board or Local Union, pursuant to the P.A.C.E. Constitution or local bylaws or constitution or any agency or court, decides that an employee's grievance was improperly withdrawn from the grievance procedure by the Union, the grievance shall be reinstated in the grievance procedure at the step from which it was withdrawn.

D. The parties in Step 2, in Step 3 and in Step 4 may, by mutual agreement in writing, extend the time limit specified in Step 2-2 and/or in Step 3-2 and/or in Step 4-2 for a period not to exceed thirty (30) calendar days.

E. However:

1. In case of a grievance which affects a group of five (5) or more employees who have the right under this Agreement to present that grievance to their supervisor(s), an official or some other representative appointed by the Local Union shall have the right to take that grievance up directly with the Mill Manager and/or his representative in accordance with Step 3.
2. In case of a grievance affecting the rights of the Union, as such, as distinguished from grievances involving an individual employee or group of employees, the Local Union shall have the right to take that grievance up directly with the Mill Manager and/or his representative in accordance with Step 3.

SECTION 29 - APPEAL FROM DISCHARGE OR SUSPENSION

A. If an employee who is not serving his probationary period claims to have been unjustly discharged or suspended during the life of this Agreement or any continuance thereof, to be timely his case must,

STEP 1.

within seven (7) days of the date of notice to the Local Union of such discharge or suspension, be referred in writing to the Mill Manager or his representative through the Union Standing Committee.

1. These two parties shall meet within seven (7) days of the date of the referral.
2. If, upon investigation, no settlement is made within ten (10) days of their initial meeting, to be timely the case must,

STEP 2.

within thirty (30) days of the expiration of the ten (10) day period in Step 1-2 be referred to the President of the Union or his repre-

sentative, and an official of Fort James Corporation neither of whom has previously judged the case in accordance with this Section; provided that written notice of such reference or appeal shall be delivered by the appealing party to the other party.

1. Within thirty (30) days of date of such written notice these two shall meet.
2. If these two are unable to arrive at a satisfactory settlement within thirty (30) days of their initial meeting, to be timely the Union must,

STEP 3.

within thirty (30) days of the expiration of the thirty (30) day period in Step 2-2, submit the case to arbitration as provided in Sections 31 and 32 of this Agreement.

B. The parties in Step 2 may, by mutual agreement in writing extend the time limit specified in Step 2-2 for a period not to exceed thirty (30) days.

SECTION 30 - MEDIATION

If the Local Union and Mill Manager are unable to arrive at a satisfactory settlement at the Third Step of the grievance procedure or Step 1 of the appeal from discharge or suspension procedure, the Local Union may elect to refer the grievance or appeal to mediation in place of Step 4 of the grievance procedure or Step 2 of the appeal from discharge or suspension procedure. The mediation will be processed in a timely manner, with the mediator rendering a bench opinion if the parties are unable to reach agreement. The mediator shall not have the authority to force either party to accept a particular opinion. Settlement discussions by the parties during mediation may not be introduced during subsequent arbitration, nor may the comments by the mediator be referenced. The mediator will be selected from a panel provided by the American Arbitration Association, according to the same procedure used for arbitration, with the cost of the mediator paid equally by the Company and Union.

SECTION 31 - GENERAL PROVISIONS REGARDING ARBITRATION

A. In the event the parties are unable to reach a settlement of a grievance or an appeal from discharge or suspension, the

dispute may be moved to arbitration in accordance with the provisions of this Section and Section 32, only if and after the timely utilization and completion of all prior Steps in Section 28 or Section 29, whichever is applicable, have failed to produce an agreement between the parties. The prior Steps and time limits for initiation and completion are set forth in Sections 28 and 29. Failure of the charging party to act within the applicable time limit specified for any Step in Section 28 or Section 29, whichever is applicable, shall constitute waiver of the charging party's right to further consideration of the case.

B. Each party to any case submitted to arbitration (1) shall bear the expenses of preparing and presenting its own case, including witnesses, and (2) shall pay one-half of the charges for hearing room expenses, fees of the arbitrator incurred in the arbitration and the arbitrator's copy of the transcript of the hearing. If either party orders a copy of the transcript for its own use that party shall pay for its copy.

C. It is agreed that each party to a case submitted to arbitration will do everything in its power to permit early selection of and decision by the arbitrator.

SECTION 32 - ARBITRATION

A. Arbitration referred to in the preceding sections of this Agreement shall be in accordance with the provisions set forth below.

B. Arbitration shall be conducted by a single arbitrator. The determination by the Arbitrator shall be final and binding upon all parties concerned provided however:

1. The Arbitrator shall not have the authority to modify, add to, alter or detract from the provisions of the Agreement, or to impose any obligation on the Union or Company not expressly agreed to by the terms of this Agreement.
2. In suspension or discharge cases submitted to arbitration and as to which the arbitrator shall find the suspension or discharge to be unjustified, the amount of payment for lost time shall be determined by the arbitrator, but shall not exceed payment for lost time at the employee's rate of pay of the job he was on at time of

suspension or discharge.

3. The OPERATING CONTROL, as provided in Section 2, is not subject to the grievance and/or arbitration procedures of this Agreement.
4. The arbitration proceedings shall be conducted in accordance with the American Arbitration Association Voluntary Labor Arbitration Rules except as modified by the provisions of this Agreement. In the event of any conflict between the said rules and this Agreement, this Agreement shall prevail.

C. The Union shall make application to the American Arbitration Association for a panel of available arbitrators in the Pacific Northwest from which an arbitrator for the case involved shall be promptly selected by the parties. The parties to any case submitted to arbitration shall cooperate in arranging with the selected arbitrator for the time and place that, subject to the arbitrator's convenience, will best serve for the quickest disposition of the matter.

SECTION 33 - PROVISIONS FOUND TO BE IN CONTRAVENTION OF LAWS

If any provision of this Agreement is in contravention of the laws or regulations of the United States or of the State of Oregon, such provision shall be superseded by the appropriate provisions of such law or regulations so long as same is in force and effect but all other provision of this Agreement shall continue in full force and effect. If the parties are unable to agree as to whether or not any provisions hereof is in contravention of any such laws or regulations, the provisions hereof involved shall remain in effect until the disputed matter is settled by the court or other authority having jurisdiction in the matter.

SECTION 34 - GENERAL POLICIES

A. **Voting Privileges** - If work schedules are such as to make it difficult or impossible to exercise the privilege of voting, management will, at the request of an employee, arrange for the modification of the employee's schedule of work to provide him adequate time to vote.

B **Smoking Privileges** - Smoking zones will be designated by management for the convenience of employees. Smoking will be restricted to such designated areas.

C. **No Conflicting Agreements** - Neither the Company nor any supervisor shall have any private understanding or agreement with any individual employee or group of employees in conflict with this Agreement.

D. **Employees Not to be Displaced** - Supervisors and other salaried employees, shall not displace the employees covered by this Agreement by doing work which would normally be done by such employees unless the performance of such work is required for:

1. Training purposes.
2. Emergencies which have or could cause harm to individuals or property or hinder operations.
3. Incidental work to help an employee or employees.
4. Instances when a qualified employee is not available but a relief is being pursued.

E. **Contract to be Explained** - The Company agrees to explain fully the terms of this Agreement to its supervisors and the Union similarly agrees to explain it to its members.

F **Leave of Absence for Union Business** - Leave of absence without pay, will be granted under the following conditions:

1. The President and Recording Secretary of the Local Union shall be granted Leave of Absence without pay up to one full shift when necessary to enable them to attend the regular, periodic meeting of the Local Union, provided notice to the employer is given by the Local Union in writing, at least two weeks prior to each such meeting.
2. Employees duly elected or appointed to attend official Union conferences or conventions shall be granted a leave of absence without pay for the time necessary to attend such functions when notice to the employer is given by the Local Union in writing at least two weeks in advance.

   Time spent on such leave of absence shall be counted as hours worked (limited to eight (8) hours per day and forty (40) hours per week) for the purpose of qualifying for vacation and holiday pay.

G. The Company will replace privately owned tools, or parts of tools, if evidence satisfactory to the Company is given that such tools were broken or made unsafe while being proper-

ly utilized in the performance of assigned work.

H. Upon written request from an employee giving at least two (2) weeks advance notice, the Company will grant an employee(s) a personal leave of absence for the purpose of his running for elective political office. Such leave of absence shall be without pay and shall not exceed six (6) months.

1. Seniority shall not be broken but shall only accumulate for a maximum of six months.
2. An employee must return to work or report his availability for work (if no work is available) at the end of his leave or within two (2) weeks following completion of the campaign for which the leave was granted, whichever is earlier, or he will be considered to have terminated.
3. When this Agreement terminates, leaves previously granted shall be continued for their originally stated period, subject to the provisions then in effect under any new agreement.
4. In the event the employee is elected, he will be granted an extension of his leave to serve one full term but not to exceed 4 years. No employee during his total career service within the Company shall be granted leaves in excess of accumulative total of 4 1/2 years under this Paragraph H.

I. The Box Facial Section of the Converting Department will be operated under the terms of the language included in the Memorandum of Agreement signed on April 4, 1980 whenever production schedules permit.

SECTION 35 - NON-DISCRIMINATION

In the administration of this Agreement both the Company and the Union agree that there shall be no illegal discrimination against any employee because of race, color, religion, age, sex, national origin or handicap.

SECTION 36 - TERM OF AGREEMENT AND CHANGES IN AGREEMENT

This Agreement shall be in effect from April 1, 2000 up to and including March 31, 2006 and shall be automatically

renewed thereafter from year to year unless notice to terminate is given by either party as hereinafter provided.

A. This Agreement may be modified as follows:
Either party desiring any modification shall mail to the other party notice in writing by Certified mail with a Return Receipt Requested sixty (60) days prior to March 31, 2006, or prior to any subsequent March 31 on which this contract is in effect, that a modification is desired; and if no such sixty (60) day notice is given prior to any March 31, the earliest time at which such notice may later be so mailed is sixty (60) days prior to March 31 of the next year.

B. If notice of desire for modification has been given, the parties shall, as soon as agreeable to the parties following such notice meet for collective bargaining. Any agreement or modification arrived at in such negotiations and approved by a majority of the membership of the Union who vote in the referendum which shall be conducted for the purpose, shall be binding upon the parties to this Agreement.

C. In case negotiations conducted in accordance with "B" break down, either party may terminate this Agreement upon the expiration of ten days written notice mailed by registered mail, to the other party, at any time after the March 31 with reference to which the notice of modification has been mailed as provided in "A".

D. The requirements of paragraphs A through C of this Section 36 notwithstanding, any provisions of this Agreement may be changed during its term subject to the approval of all parties to the Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed.

Fort James Corporation	P.A.C.E. Union
(Richard P. Wenger) V.P. Resident Manager - Wauna Mill	(Alvin L. Lippincott, Jr.) International Representative
(Keith B. Larson)	(Billy Taylor)
(Joseph G. Hertig)	(Larry Reandeau)
(Michael Woods)	(Dan Duvall)
(Douglas Campbell)	(Roland Lee)
(Geoge Gazzana)	(Stuart Potter)
	(Gene Dixon)

EXHIBIT A

The wage changes described below are effective as of the dates shown. Wage rates effective as of April 1, 2000, 2001, 2002, 2003, 2004 and 2005 are specifically enumerated in Exhibit A-4 of this Exhibit A. **(See Insert; Exhibit A-4 Wage Rates)**

EXHIBIT A-1 - WAGE RATES

A. Effective April 1, 2000

The base rate will be increased two percent (2%). **Temporary hires** will receive $12.29 per hour (or compressed rate of $10.84 per hour if working a compressed schedule) worked a period of 120 days of continuous employment. Employees remaining on temporary status after 120 days of continuous employment will receive the full rate of the job worked. A new 120 day period commences following breaks in service.

New Regular hires will receive $12.29 per hour (or compressed rate of $10.84 per hour if working a compressed schedule) worked for a period of 60 working, not to

exceed120 calendar days unless such probationary period is extended by agreement between the Company and the Union Standing Committees. Employees who satisfactorily complete the probationary period will receive the full rate of the job worked. Journeyman mechanics and employees hired at Step 15 and above are excluded from the reduced initial rate.

Effective April 1, 2001
The base rate will be increased two and one-half percent (2½%).

Effective April 1, 2002
The base rate will be increased two and one-half percent (2½%).

Effective April 1, 2003
Lump Sum payment of two and one-half percent (2½%) of the 2002 W-2 earnings with a $1500 minimum.

Effective April 1, 2004
The base rate will be increased two percent (2%)

Effective April 1, 2005
The base rate will be increased three percent (3%)

B. The rates described in "A" shall remain in force during the period of this Agreement, excepting as to any changes which may be made pursuant to the Joint Job Analysis Program described below in Exhibit A-3 - The Job Analysis Plan.

C. Rates When Moved from Regular Job.

1. Whenever an employee is moved from his regular job to a higher rate job he shall receive the higher rate. An employee shall be deemed to be moved to a higher rate job when he takes over the duties and responsibilities of that job without the guidance of the employee who is breaking him in, and he shall then receive the higher rate. While the employee is being broken in and another employee is on the job and carrying the responsibility for the job, the employee being broken in shall receive the hourly rate of his regular job.

2. Whenever, for the convenience of the Company, an employee, during his regular shift is temporarily moved from his regular job to a lower rate job and his regular job is still available, the employee shall receive his regular job rate during that period.
3. When an employee, at the request of the Company, accepts temporary work on a lower rate job either before or after his regular shift or on his "day off" in order to fill some emergency vacancy existing, he is to receive his regular rate.
4. When a physician who is treating an employee for an injury sustained in the mill advises the Company that the injured employee is temporarily unable to perform his regular job because of such injury(s), and the Company offers a suitable lower-rate job(s) to the injured employee, he shall receive his regular job rate.
5. An employee who is working following an industrial injury will be entitled to reimbursement at the straight time hourly rate of his regular job for the hours necessarily lost from his regularly scheduled shift for company-arranged doctor visits for treatment of the industrial injury.
6. When an employee is directed to work for a temporary period on any suitable job other than his regular job, whether or not his regular job is available to him he shall receive the rate of his regular job or the rate of the job to which he is moved, whichever is higher. When an employee's regular job is not available to him and he is offered work for the temporary period on any other job, he may elect to lay off instead of moving to the job offered at the rate for that job. Where used in this Paragraph 6, "regular job" means the job to which an employee's seniority may entitle him at any point in time.
7. Where used in this Agreement a suitable job means one for which the employee has necessary clothing and which he is physically able to perform without unreasonable hazard to his health or to the safety of himself, fellow workers, and equipment.
8. When an employee at his own request and for his own convenience is temporally assigned extra work before or after his regular shift, or on his assigned day off, he is to receive the job rate of the extra work assigned.

Requests from employees for extra work will be recognized only when such requests are made in writing on appropriate forms provided for that purpose, and shall be effective until canceled by the employee in writing.

9. Notification to employees of extra work which is available is not to be construed as an order or request that they accept such work.
10. In all cases the employee is to be told the rate he is to receive before going on the job.
11. Where used in this Paragraph D, a temporary period is one so designated by the Company, but after such period has extended longer than one week and the request the Union Standing Committee to discuss the matter with the Company and such period shall terminate unless the Union Standing Committee and the Company agree otherwise.

D. Job Rate Retention:

a) An employee who was permanently displaced from his job will retain his blue slip rate in effect at the time he was displaced and will have his "rate retained". The employee will retain his rate until such time as the rate of the job to which he is assigned equals or exceeds the "retained rate" at which time the "retained rate" will be discontinued.

b) An employee who is required to change jobs due to a bona fide medical reason will, on a case by case basis, be eligible for consideration under this job rate retention provision.

c) General wage increases do not apply to an individual's "retained rate".

EXHIBIT A-2 - MECHANICS

This Section sets forth the wage rates and certain special provisions applicable to Mechanics and Helpers.

A. There shall be six (6) classes of Mechanics and two (2) classes of Helpers with rates as follows:

Note 1: The J+ program will cease on April 1, 1985 and the classifications of J++ and J+ Mechanics will be eliminated. All J++ and J+ Mechanics will be grandfathered at their present J++ and

Mechanics	Effective 4/1/00	4/1/01	4/1/02	4/1/03	4/1/04	4/1/05
J+ + Mechanics (see Note 1)	25.765	26.405	27.170	27.170	27.715	28.650
J+ Mechanics (see Note 1)	25.355	25.990	26.745	26.745	27.280	28.200
Journeyman Mechanic	24.950	25.575	26.315	26.315	26.845	27.750
Intermediate Mechanic A	20.970	21.490	22.030	22.030	22.470	23.145
Intermediate Mechanic	20.565	21.075	21.605	21.605	22.035	22.695
Junior Mechanic A	20.360	20.870	21.390	21.390	21.820	22.475
Junior Mechanic	20.155	20.660	21.175	21.175	21.600	22.250
Helpers						
Senior Helper	18.940	19.415	19.900	19.900	20.295	20.905
Helper	18.535	18.995	19.470	19.470	19.860	20.455

J+ rates and will receive the full amount of any future wage increases and other additions to compensation which may be applicable to Journeyman Mechanics.

Note 2: In addition to a Mechanic's regular rate, twenty-five (25) cents per hour shall be paid to a shift mechanic for all hours worked while assigned the normal duties of maintaining plant facilities on a rotating four-shift tour schedule.

B. Any employee whose work is primarily in any one or more of the below listed trades is subject to the provisions of this Exhibit.

Machinists	Insulator
Millwrights	Pipefitters
Electricians	Instrument Mechanics
Painters	Welders
Carpenter	Auto Mechanics
	Sheet Metal Workers

If employees are hired for trades other than those listed above, *such trades will be added to the above list of trades.* Each employee subject to this Exhibit A-2 will be classified into one of the trades listed.

C. A Journeyman Mechanic is one who is a finished mechanic and has the necessary tools required by the trade, in general, who could qualify as a journeyman in any industrial or job shop. He must be able to execute the necessary work without direct supervision. For instance, a journeyman Piper must be able to take a working drawing or blueprint of a layout; go out on the job; take the necessary measurements, requisitions, cut and install the pipe without more than the

general, normal supervision.

D. The Company will select the Helpers on its mechanical crews through a procedure which may include such tests as intelligence tests, mechanical aptitude test, interest and preference tests. Each person selected for a mechanical crew shall indicate his desire to learn a specific trade, and become a Journeyman. He shall indicate his willingness in writing, on a form provided by the Company, to take through correspondence courses or other outside schooling, whatever mathematical knowledge, blueprint reading, and other related subjects he may need to pass the required examinations.

The cost of such training limited to tuition and required books shall be borne by the Company. The Company shall not be required to reimburse the employee until a course has been successfully completed. The institution offering such schooling and the courses of study must be approved by the Company before enrollment.

On an annual basis regular employees will be given the opportunity to bid on Helper Mechanic positions. The annual posting will be held during the month of January and be effective for one year beginning April 1 of that year. Employees may elect to sign up to three Helper postings.

Employees must be on the payroll for two years to be eligible to sign a helper posting.

E. An applicant selected by the Company to learn a mechanical trade will be placed, when a vacancy exists, on the Helpers job for a period of either six (6) months elapsed time or 900 worked hours, whichever is longer; and at the end of the period if he is retained, he will be automatically promoted to Senior Helper. He will spend another period of either six (6) months elapsed time or 900 worked hours, whichever is longer, on the job as Senior Helper; and at the end of the period he will be automatically promoted to Junior Mechanic.

F. During the first ninety (90) days after an applicant has been regularly assigned to a Helpers job, he will be classified as probationary on that crew and he can be removed from the crew at any time during that period. Prior to removal from the crew of any such probationary helper because of his performance, management will notify the Union Standing

Committee of the intended action and the justification thereof. If the Union Standing Committee considers the proposed removal unjustified it may take the matter up with the Mill Manager, whose decision in the matter shall not be subject to the Arbitration procedure. If such applicant is transferred to the mechanical crew from another department in the plant, he will retain his seniority in the department from which he transferred for a period of ninety (90) days, and will be returned to the job from which he transferred if removed from the crew. If he is removed from the crew after a period of ninety (90) days he will retain his plant seniority and will be given a job preferably in the department from which he transferred at the starting rate in that department, but if that plan is not available he will be given a base rate job in the plant; however such rights shall not apply if discharged for cause. During the probationary period management will determine as quickly as is practical whether or not the applicant has the aptitude and other characteristics necessary to become a Journeyman. Unless a Helper has earlier been removed from the crew, prior to the expiration of the first ninety days after he has been regularly assigned as a Helper, the Company will review with him his progress to date.

G. (1) Any employee temporarily assigned to the mechanical crew and doing unskilled work will be paid the base rate specified in Exhibit A-1.

(2) Any employee having substantially the qualifications of a Senior Helper, temporarily assigned to work done by a Helper and working under the direct supervision of a Mechanic, will be paid the rate of a Senior Helper.

(3) An applicant transferred to the job of Helper, who has temporarily worked with the mechanical crews for continuous periods of two (2) or more forty (40) hour weeks, will be credited with all such periods up to the total time requirement of promotion to Senior Helper.

H. A Helper who has been promoted as prescribed in Paragraph E. above will be placed in the Junior Mechanic's classification and will spend a period of either nine (9) months elapsed time or 1350 worked hours, whichever is longer, in that classification, following which time he will be eligible and obligated to take a test for Junior Mechanic A.

Upon satisfactorily passing that test he will immediately be advanced to Junior Mechanic A. Upon completion of either nine (9) months elapsed time or 1350 worked hours, whichever is longer, as Junior Mechanic A, he will be eligible and obligated to take a test for Intermediate Mechanic. Upon satisfactory passing of that test he will immediately be advanced to Intermediate Mechanic. Upon completion of either nine (9) months elapsed time or 1350 worked hours, whichever is longer, as Intermediate Mechanic, he will be eligible and obligated to take a test for Intermediate Mechanic A. Upon satisfactory passing of that test he will immediately be advanced to Intermediate Mechanic A. Upon completion of either nine (9) months elapsed time or 1350 worked hours, whichever is longer, as Intermediate Mechanic A, he will be eligible and obligated to take a test for Journeyman. Upon satisfactory passing of that test, which will be designed to determine if he meets the qualifications of a Journeyman set forth in paragraph C above, he will immediately be advanced to Journeyman. It is understood in addition to the final test and examination at the end of each nine (9) month period to determine fitness for promotion, interim progress tests may also be given during each nine (9) month period in those skills or parts of a trade in which the mechanic has had an opportunity to work and acquire knowledge. Results of such interim progress tests will not be used to retard or advance a mechanic's promotion from one classification to another. It is also understood and agreed that a person who fails to pass the test after the period of either nine (9) months or 1350 worked hours, whichever is longer, in either the Junior or Junior A or Intermediate or Intermediate A classification, will be given an additional period of time, not in excess of nine (9) months, during which a second test will be given, and if he fails to pass the second test he shall be removed from the crew.

I. Outside mechanics may be employed in any of the established classifications. Before an outside mechanic is hired to fill a job opening for a Journeyman Mechanic, the Company will consider all requests for transfer from employees who claim to be qualified to fill such a job opening.

J. The progress and qualifications of each mechanic below

the grade of Journeyman will be periodically reviewed at intervals of not more than six (6) months. Records of the results of these reviews will be maintained and will, at his request, be discussed with each mechanic at six (6) month intervals. Whenever such a review of such a mechanic has been completed the Company shall notify him in writing, with copy to the Local Union, calling his attention to the completion of such review and his right to request a discussion of it. If the employee so desires, he may have his Union Representative present at the time his progress report is discussed with him.

K. Management will adopt an organized plan as far as practical of rotating each mechanic below Journeyman through different departments and under different Journeymen, in order that he may gain the widest variety of experience in the work of his chosen trade. to progress as above set forth and in any such case the Mill Manager, after consultation with the Standing Committee, may deviate from the above described progression, but unless the consent of the Standing Committee has been obtained, the Manager's action shall be subject to the grievance procedure.

M. In the event there is a reduction of the maintenance workforce, Mechanics and/or Helpers will be laid off in the reverse order of their entry into the Mechanics Package, Exhibit A-2. In the event there is a reduction in the A-2 package, those affected mechanics will be placed into the Labor Pool.

N. Nothing hereinabove shall be construed so as:
   (1) to obligate the employer to hire or retain any employee unless there is work for him, or
   (2) to mean that any right or obligation of either party to the Labor Agreement, established under that Agreement and not herein specifically amended, has been modified or revoked.

O. The Local Union shall select a "Mechanic's Committee" composed of five employees. The Local Union "Mechanic's Committee" shall participate with a Company Mechanic's Committee in developing the testing procedures and tests which shall be mutually agreed to by the parties to this Agreement.

P. The Company will pay for all State License requirements

with which any Mechanic may be required to comply.

Q. The Company may engage independent contractors for new construction, warranty work, temporary overloads of routine maintenance work, or when special skilled personnel or equipment is not available. When it becomes necessary to engage an independent contractor in the mill, the Company will notify the local Union and tell them the nature of the work involved. If the local Union so requests, an opportunity will be given for a meeting in which the Union will have the right to make suggestions for consideration by the Company.

R. Shift Mechanics will cover when premium time is paid for full shift(s). A mechanic covering the last four (4) hours of a twelve (12) hour shift(s), as continuation of his shift, will not be considered as to be in the tour classification.

EXHIBIT A-3 - JOB ANALYSIS PLAN

1. The Job Analysis Plan is a semi-scientific plan developed for the purpose of uniformly evaluating and appraising jobs according to the skill, working conditions and responsibility factors required by and contained in each job, thereby resulting in the establishment of a uniform method of wage rate determination based upon conditions which will provide job rates equitable and proper in their relationship with each other and with the base rate.

2. The Scope and Limitations of the Program:
   A. The job analysis program shall not be applied to the jobs included in the mechanical trades listed in Exhibit A-2 or the lubrication Exhibit A-5 of the Labor Agreement.

   B. The job analysis program shall not be applied to the following jobs:

Log Stacker Operator	Yard Worker
Senior Equipment Operator	Equipment Operator

   C. All other jobs covered by the Labor Agreement shall be considered eligible for analysis when presented in the

manner prescribed herein to the Joint Job Analysis Board hereinafter provided for.

3. Administration and Procedure:

A. **Job Analysis Directors:**

1. The Job Analysis Directors shall be composed of two (2) representatives of P.A.C.E. and two (2) representatives of TOC Management Services.
2. It shall be the duty of the Job Analysis Directors:

a. To direct and supervise the functioning of the Job Analysis Program in accordance with the policies and procedures adopted by the parties to the Labor Agreement through negotiations.

b. To receive reports from Plant Analysis Committees and to recommend improvements where necessary in the prodedure of the Committees.

c. To review cases of analysis upon request of either union or management members of the Plant Analysis Committees.

d. To review the general operation of the Joint Job Analysis Board as to methods, factors, procedures, delays, etc.

e. To direct the Joint Job Analysis Board as to changes in the methods which do not constitute basic changes. The Directors shall not negotiate rates or exercise any of the collective bargaining functions of the Union or of the Company.

f. To recommend improvements in the job analysis program to future conferences for consideration.

B. **Joint Job Analysis Board:**

1. The Joint Job Analysis Board shall consist of one (1) representative of the Union and one (1) representative of TOC Management Services.
2. It shall be the duty of the Joint Job Analysis Board to evaluate and set the rate for any job presented for analysis in accordance with this program. It shall also be the duty of the Board to develop, revise and maintain in an up to date manner the tables and charts nec-

essary to the functioning of the job analysis plan as directed by the Directors. All decisions of the Joint Job Analysis Board must be agreed to by both members of the Board before becoming official.

C. Plant Analysis Committee:

1. The Mill Manager and the Local Union shall create a Plant Analysis Committee which shall consist of four (4) members representing the Local Union and two (2) members representing the Company. Two of the committee members representing the Local Union will meet with the two members representing the Company to act and/or vote on each question.

2. It shall be the duty of the Plant Analysis Committee:

   a. To act upon all requests for job analysis which may arise and to make application to the Joint Job Analysis Board on forms provided when and if in their opinion such analysis would result in a rate change. Any decision to submit a job to the Joint Job Analysis Board for analysis must be unanimously agreed upon by the two members representing management, and the two members representing the Union who are acting on the question.

   b. To make investigations of jobs submitted for analysis and to assist in pointing out factual and pertinent information relative to the job to the Joint Job Analysis Board at the time of analysis.

   c. To make a written monthly report to the Job Analysis Directors, which will include:

      (1) the number of jobs the Plant Analysis Committee has submitted to the Joint Job Analysis Board for analysis, and

      (2) a list of the jobs on which the union and management members of the Committee have been unable to agree as to whether an analysis should be made, with a statement of the facts on which the disagreement was based.

3. Either the union or the management members of the Plant Analysis Committee may request a review by the Job Analysis Directors of any case of analysis where,

in their opinion, proper application of the job analysis standards has not been accomplished.

4. General Policies:

A. The analyzed job rate arrived at through official analysis by the Joint Job Analysis Board will be final and binding upon both parties to the Labor Agreement, unless review has been requested as provided in 3C, Paragraph (3). In case of such review the decision of the Job Analysis Directors shall be final and binding upon both parties.

B. In cases where an official analysis indicates an upward adjustment in the rate for a job, the adjustment will be retroactive to the date agreed upon by the Plant Analysis Committee which is entered on, and a part of, the application for analysis provided for in 3C, paragraph (2)(a) setting forth the duties of the Plant Analysis Committee.

C. When an official analysis results in a downward adjustment of a rate (other than a temporary rate), the rate prior to the analysis will be paid as a red circle rate to the following employees:

1. Any employee working on said job who was regularly assigned to said job on the day of the official analysis.
2. Any employee working on a job on a higher rung of the same progression ladder on said day in which the downward adjustment took place, if he is later moved to said job because the higher job is not then available to him; provided, that if any such employee subsequently refuses any promotion his seniority rights entitle him to, for which he is qualified, his right to the red circle rate shall cease on the date of such refusal; however, if the rate of the job to which he is promoted is less than his current red circle rate he will nevertheless retain his current red circle rate while on such higher job. Red circle rates will be adjusted upward for the full amount of each future wage increase.

D. In any case where a new job has been created the Plant Analysis Committee will make application to the Joint Job Analysis Board for a temporary rate for the new job. The temporary rate assigned will remain in effect until the official analysis is made. It will be the duty of the Plant Analysis Committee to agree on a date on which the job became sufficiently stabilized to have permitted an official analysis, and any increase resulting from the analyzed rate will be paid retroactively to that date.

E. Insofar as possible the Joint Job Analysis Board will complete its analysis of all jobs at the plant. Members of the Plant Analysis Committee shall be invited to be Insofar as possible the Joint Job Analysis Board will complete its analysis of all present during the analysis of the jobs; or at the option of the Plant Analysis Committee the Joint Job Analysis Board will explain in detail the analysis computations to the Plant Analysis Committee before leaving the plant. In those cases where it is not possible to complete the analysis at the mill the Joint Job Analysis Board will return to the plant and explain the analysis computations before making the results official.

F. Upon request, the Joint Job Analysis Board shall furnish to the Plant Analysis Committee, a copy of the job description and analysis computation forms pertaining to any specific job that has been analyzed in the plant. The copies of the forms furnished are to be retained in the files at the plant office and will be open to members of the Plant Analysis Committee for study or review.

G. Members of the Plant Analysis Committee or other employees in the plant who are relieved from their jobs during working hours to assist in carrying out the functions of the Job Analysis Program will be paid by the Company at their regular job rates for the time during their regular shifts, thereby preventing any loss in regular income. Time put in on analysis work outside

the employee's regular shift will not be paid for by the Company.

H. Only those employees on the payroll of the Company on the date the analysis is officially reported to the Union and the Company will be eligible to receive retroactive pay resulting from an increase in job rate under our Job Analysis Program, excepting that persons terminating to enter the armed forces or who are retired, or the estates of persons who are deceased will also be eligible.

EXHIBIT A-5 - LUBRICATION

This Section sets forth the special provisions applicable to Oilers.

A. There shall be four (4) classes of oilers as follows:

Senior Oiler	(After 12 months as Oiler and satisfactorily pass a test)
Oiler	(After 6 months as Junior Oiler)
Junior Oiler	(After 6 months as Helper Oiler)
Helper Oiler	(Start)

B. The Company will select Oilers for its Lubrication crew through a procedure which may include tests such as: intelligence tests, mechanical aptitude tests, interest and preference tests and interviews conducted by supervision as are considered necessary to determine basic qualifications. Each person selected as an oiler shall indicate his desire to become a Senior Oiler. He shall indicate his willingness in writing, on a form provided by the Company, to take, through correspondence courses or other outside schooling, whatever subjects he may need to pass the required final test.

The cost of such training, limited to tuition and required books, shall be borne by the Company. The Company shall not be required to reimburse the employee until a course has been successfully completed. The institution offering such schooling and the courses of study must be approved by the Company before enrollment.

On an annual basis regular employees will be given the opportunity to bid on a Helper Oiler position. The annual posting will be held during the month of January and be effective for one year beginning April 1 of that year. When an employee signs an Oiler-Helper bid it is counted as one of the four bids allowed in Section 25. To be eligible for transfer an employee must have been on the payroll for fourteen months.

C. An applicant selected by the Company to learn to be an oiler will be placed, when a vacancy exists, on the Helper Oiler's job for a period of either six (6) months elapsed time or 900 worked hours, whichever is longer; and at the end of the period if he is retained, he will be automatically promoted to Junior Oiler. During this time he will learn the lubrication routes and practical skills necessary to become a Junior Oiler.

D. During the first ninety (90) days after an applicant has been regularly assigned as a Helper Oiler, he will be classified as probationary and he can be removed at any time during that period. If such applicant is transferred to the Lubrication crew from another department in the plant, he will retain his seniority in the department from which he transferred for a period of ninety (90) days, and will be returned to the job from which he transferred if removed from the crew. During the probationary period management will determine as quickly as is practical whether or not the applicant has the aptitude and other characteristics necessary to become a Senior Oiler. Unless a Helper Oiler has earlier been removed, prior to the expiration of the first ninety days after he has been regularly assigned as a Helper Oiler, the Company will review with him his progress to date.

E. A Helper Oiler, who has been promoted as prescribed in paragraph C above, will be placed in the Junior Oiler classification and will spend a period of six months or 900 worked hours, whichever is longer, in that classification, following which time he will be automatically promoted to Oiler. A Junior Oiler, who has been promoted to Oiler, will be placed in the Oiler classification and will spend a period of twelve months or 1800 worked hours, whichever is longer, in that classification, following which time he will be eligible and obligated to take a test for Senior Oiler. Upon satisfactorily

passing the test, he will immediately be advanced to Senior Oiler. It is understood that in addition to the final test at the end of the 6 month period, interim tests may also be given but will not be used to retard or advance an Oiler's promotion to Senior Oiler. It is also understood and agreed that a person who fails to pass the final test will be given an additional period of time, not in excess of six months, during which a second test will be given, and if he fails to pass the second test, he shall be removed from the Lubrication Crew. The Senior Oiler final test referred to above shall consist of one ore more tests to adequately determine an Oiler's qualifications to become a Senior Oiler. Such tests will include both practical and theoretical skills.

F. The above program is not intended to eliminate in any way the lubrication duties performed by the present oilers or other employees.

G. In the event there is a reduction of the Lubrication work force, the Oilers and/or helpers will be laid off in reverse order of their entry into the Lubrication Package and placed into the Labor Pool.

H. The local Union shall select a "Mechanic's Committee" composed of six (6) employees to include one (1) Oiler The local Union "Mechanic's Committee" shall participate with a company Mechanic's Committee in developing the testing procedures and tests which shall be mutually agreed to by the parties to this agreement.

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EXHIBIT B
GROUP INSURANCE PLANS
(See Insert; Exhibit B Health Plan and Spending Accounts)
Health Care Coverage
(Non-Occupational) For Eligible Employees and Eligible Dependents

Eligible employees may elect to cover themselves and their eligible dependents under any Plan offered by the Company. Each year at open enrollment any one of these eligible employees may transfer himself and his dependents from one plan to another from among these plans.

Note that an eligible employee enrolled in any of the medical plans may not also be enrolled as a dependent of a spouse who is also enrolled as an eligible employee. Furthermore, eligible dependent children can be covered by one eligible employee only, if both parents are eligible employees.

Effective June 1, 2000, and annually thereafter, active hourly employees will be offered the Fort James health care plans. Fort James health care plan provisions will be described in each plan's summary plan description (SPD). Employees' per pay period contributions for the balance of 2000 and 2001 will be:

Fort James Plan	Contribution
Primary Care Network Plan	$16.92
Preferred Provider Organization Plan	$29.21

Thereafter, composite payroll contributions and plan design will be the same as other employees enrolled in the Fort James health care plans.

OTHER GROUP BENEFITS OVERVIEW

This booklet provides Wauna employees with essential information about the other Fort James Group Benefits Program. These benefits are designed to provide important protection and

security for you and your family.

The booklet has three sections. The first, "Your Health Care Program," describes the medical coverage options available to you. Information on the Dental Plan which is also detailed here.

The second section is entitled "Survivor Protection." This program provides a firm and valuable foundation of protection for your family through life insurance and accidental death and dismemberment insurance.

The third section is concerned with "Disability." The disability program offers comprehensive earnings protection when non-occupational illness or injury keeps you off the job.

You should take time to read this booklet carefully. If you have questions about any of your benefits, your local Benefits Representative will help you get them answered.

YOUR HEALTH CARE PROGRAM

Introduction

Your Health Care Program offers you substantial protection against today's high costs of medical care - hospital and surgical expenses, physicians' services, nursing service, X-rays and other types of expenses for non-occupational illness or injury.

Your Health Care Program protects you and your family from the financial burden of skyrocketing medical bills. At the same time, the program is designed to help slow down runaway health care costs by encouraging you to be a better consumer of health care services. It does this in several ways:

First, you're offered a choice of coverages so you can choose a plan best suited to your individual needs and circumstances.

Second, benefits such as the Stop Smoking benefit are provided to promote preventive care and healthier living.

You can be an enlightened health care consumer and receive excellent medical services. Take time to ask your doctor questions. Find out if there are less expensive treatments that are just as effective. Although some features of your health care benefits are described here, the official Plan documents and insurance carrier contracts govern its operation and the payment of all benefits.

Choice of Coverage

You have a choice of health plans for you and your family.

- (PCN) Primary Care Network Plan
- (PPO) Preferred Provider Organization Plan

When you enroll yourself and your family in the health plan of your choice, coverage in the Dental Plan is automatic.

This section summarizes eligibility and enrollment information and details of coverage for the Dental Plan. Be sure to make your choice of health plans carefully, since the opportunity to change plans comes only once a year, during open enrollment. The annual open enrollment period is described more fully in the **Eligibility and Enrollment** section.

ELIGIBILITY AND ENROLLMENT

Who is Eligible

The following employees are eligible for the benefits described in this booklet:

Active hourly employees represented by P.A.C.E., Local 8-1097 at the Wauna Mill, Clatskanie, Oregon.

You can also enroll members of your family. Eligible dependents include:

- Your spouse.
- Your unmarried dependent children, including step, foster and legally adopted children, to the end of the month in which they reach age 19, or age 25, provided they are attending a recognized institution of higher learning on a full-time basis (12 or more credit hours).
- Physically or mentally handicapped children who are incapable of supporting themselves can be covered indefinitely, as long as the disability begins while the child is still a dependent. Proof that your child is fully handicapped must be submitted to the Claims Administrator not later than 31 days after he or she would have ceased to be covered as a dependent. Proof of incapacity may be required periodically thereafter. Coverage is not offered if you or an otherwise eligible dependent are engaged in active military service, except during U.S. Military Reserve duty when no government coverage is provided.

Your eligible dependents must be enrolled in the Plan you select for yourself. For example, you cannot elect coverage

under the (PCN) Plan and have your dependent coverage under the (PPO) Plan.

When to Enroll

You must complete and sign a Benefit Plan Enrollment Form during the annual open enrollment period or within 31 days of becoming eligible.

- Once a year you have the opportunity to change health plans without providing evidence of good health, during the open enrollment period. You can choose the (PCN) Primary Care Network Plan or (PPO) Preferred Provider Organization Plan.
- New employee - You have 31 calendar days from your date of hire to enroll yourself and your eligible dependents.
- New spouse - You have 31 calendar days from date of marriage to enroll the spouse.
- New child - You have 31 calendar days from date of birth, legal adoption or custody to enroll the child. Your newborn child is automatically covered for the first month of life only, and you must enroll the child for further coverage.
- Working spouses - If your spouses own coverage is terminated due to loss of job, you may enroll your spouse within 31 days of the last day of work. Written proof of termination of coverage due to job loss is required.

During this 31-day enrollment period, evidence of good health is not required. But if you do not enroll within the 31 days and then want to enroll later, you'll have to file for late enrollment by submitting an Evidence of Insurability Statement to the Claims Administrator, who may also require you or your dependents to have a physical examination at your expense. Please see the section "Administrative Details" to find your Claims Administrator.

After you enroll you will receive an identification card which provides necessary ID numbers and gives the address of the claims office to which you will send your claims.

(PCN) AND (PPO) PLANS

When Coverage Begins

For new employees, when you enroll promptly, coverage begins on the first day of the month following your employment

date. Coverage for your dependents will begin on the same date. Newborn children will be covered from birth provided that you enroll them within 31 days of the date of birth.

If you file for late enrollment, coverage starts on the first of the month following approval by the Claims Administrator of your application for late enrollment.

There are some exceptions to the rules above. Coverage will not be granted to a dependent, except for a newborn child, who is confined for medical treatment in any institution or at home on the day coverage would normally begin. In this case coverage begins 31 days after the dependent is given final medical release from all such confinement.

Monthly Contribution

Your monthly contribution depends on which health plan you choose. Employee contributions begin the first of the month coinciding with, or following, the effective date of coverage and continue through the end of the month in which termination of coverage occurs.

The employee's contribution is the same as payable by other Fort James employees who are enrolled in the PCN Plan. The employee's contribution for the PPO Plan is subject to change as the costs of the Fort James medical plans increase above the amount paid by the company.

All benefits are payable according to the plan's fee schedule for in-network services, or for out-of-network services, according to the **usual, customary, and reasonable (UCR)** rule. This means that benefits will be paid up to the usual charges for services and supplies in your geographical area, as determined by the Claims Administrator.

Payment of benefits is also governed by the rule of medical necessity. That is, coverage is provided only for service and supplies that are broadly accepted professionally as essential to the treatment of disease or injury.

DENTAL PLAN

The Dental Plan is separate from the medical plans. Benefits are paid according to a fee schedule when you use dental providers that are designated as participating providers by the

dental plan administrator, or when you use non-participating providers according to what is **usual, customary and reasonable (UCR). Dental benefits are payable** according to the rule of medical necessity.

To be eligible for reimbursement under the Plan, dental services must be provided by a legally qualified dentist who is practicing within the scope of his license; or by a legally qualified physician authorized by his license to perform the particular dental service he has rendered.

Eligibility and Enrollment

Eligibility requirements are the same as for the health plans. When you enroll yourself and your family in the (PCN) or (PPO) you are automatically covered by the Dental Plan. Enrollment in the Dental Plan alone is not available.

Annual Maximum

There is an annual maximum for dental benefits of $1,500 per person.

Benefits Paid at 80% UCR

The Dental Plan will pay 80% of the UCR charges (up to the annual maximum) for the following services:

- Oral examinations, including scaling and cleaning of teeth, but not more than one examination in any period of six consecutive months.
- Topical application of sodium or stannous fluoride, but only if the insured family member has not yet attained the age of 15 years.
- Dental X-rays
- Extractions
- Oral surgery, including excision of impacted teeth
- Fillings
- Anesthetics administered in connection with oral surgery or *other covered dental services.*
- Inlays, gold fillings, crowns (including precision attachments for dentures), and initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one or more natural teeth.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.

Endodontic treatment, including adjustments during the six month period following installation) of partial or full removal dentures to replace one or more natural teeth.

- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by a new bridgework, or fixed bridgework by a new denture or by a new bridgework, or the addition of teeth to an existing partial removal denture or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Insurance Company is present that:
  a. The existing denture or bridgework cannot be made serviceable; or
  b. The existing denture or bridgework was installed at least five years prior to the replacement and that the existing denture or bridgework cannot be made serviceable; or
  c. The existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within twelve months from the date of installation of the immediate temporary denture.
- Space maintainers
- Repair or re-cementing of crowns, inlays, bridgework, or dentures, or relining of dentures.

Expenses Not Covered

Covered dental expenses do not include, and no payment will be made for any of the following:

- Expenses in connection with occupational accidents or diseases.
- Services and supplies to the extent they are not reasonably necessary for treatment of an injury or disease or to the extent they exceed customary and reasonable charges.
- Charges for treatment by other than a dentist except that scaling or cleaning of teeth may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and direction of the dentist.
- Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures.
- Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the

individual was insured under the Plan but are finally installed or delivered to such individual more than thirty days after termination of insurance.

- Charges for the replacement of a lost or stolen prosthetic device.
- Expenses paid or payable under any other Group Insurance Plan.

Orthodontia Benefits

The Plan will pay 50% of the cost of orthodontia services, up to a life-time maximum benefit of $1,500 per person.

CLAIMS PROCEDURES

In-network providers on the PCN and PPO Plans and participating dental providers will file claims on your behalf. When you use an out-of-network medical provider or a non-participating dental provider you are responsible for filing claims. Your Benefits Representative has all the forms you need to file a claim for medical or dental benefits.

Inpatient Hospital Claims – Out-of-Network

Simply show your health plan ID card at the admissions desk and provide whatever other information is requested. When you review your hospital bill, please check it carefully and notify the Claims Administrator of any discrepancies.

Other Claims – Medical Out-of-Network or Dental Non-Participating

To file other claims, such as other hospital and non-hospital medical expenses, prescription drug charges or dental costs, get the appropriate claim form from your Benefits Representative.

You should submit claims for payment as soon as possible after you incur the expense. In any event, claims submitted later than the end of the calendar year following the year in which you incurred the expense will not be paid.

It's also very important to keep accurate records. You must be able to prove all claimed expenses with bills or receipts listing:

- Social Security number.
- Patient's name - you or covered dependent.
- Nature of illness or injury, type and nature of service per-

formed, amount charged and date.

- Prescription number, name of medication and quantity, date of purchase, amount paid, name of attending physician and diagnosis.

If your claim form is not complete, it will be returned and payment delayed. A questionable medical claim may result in the Claims Administrator requiring you to be examined, at the Claims Administrator's expense, at any time while the claim is pending.

Disputed or Denied Claims:

Claims Review

Claim reviews are subject to the provisions of federal ERISA rules as defined in the most current Summary Plan Description (SPD

GENERAL INFORMATION

Coordination of Benefits – Medical

Your Fort James health care plans (PCN and PPO) coordinate benefit payments with any other group health care plan under which a participant or dependent is covered. If Fort James is your primary (pays first) coverage, the Plan will pay its usual benefits. If Fort James is your secondary (pays second) coverage, the Fort James Plan will pay its usual benefits minus any payments made by the primary plan. *However, in no event will the Fort James Plan (PCN or PPO) reimburse an amount greater than it would have paid if it had been primary.* For a more detailed description of how coordination of benefits is administered see the Summary Plan Description (SPD).

Coordination of Benefits – Dental

The purpose of your Dental care program is to help meet the covered expense you and your eligible dependents actually incur. Because individuals sometimes have protection under more than one group plan, the total benefits may not exceed the actual expenses. Such duplicate coverage may tend to unnecessarily increase the cost of the Plan. Therefore, the Fort James Dental Plan, referred to below as the Fort James Plan contains a provision coordinating payments with coverage the patient has under "Other Plans".

When a claim is made, the coordination provision deter-

mines whether the Fort James Plan will pay the regular amount or whether it will be adjusted so that the benefits paid for "Eligible Expenses" available from all plans will not exceed 100 percent of the expenses. "Eligible Expenses" are any necessary, reasonable and customary expenses covered, at least in part, by one of the plans.

"Other Plans" means dental care benefits provided by group insurance or other coverage for a group of individuals, whether on an insured or uninsured basis including any prepayment coverage, group practice or individual practice.

A plan without a coordinating provision is always the primary plan. If all plans have such a provision:

1. The plan covering the patient as an employee is primary and the other is secondary.
2. If a child is covered under both parents' plans, the Federal Birthday Rule is followed. This requires that the parent whose birthday falls first during the year is primary for insurance coverage. Should the parents have the same birthday, the parent whose plan has covered the child longest is primary. Coverage for an eligible dependent child may be continued provided he meets the carrier's definition of eligibility and is not covered by Medicare. During the time that these coverages are continued for the retiree and his eligible dependents, the Company will pay the cost of coverage.

When a claim is made, the primary plan pays its benefits first without regard to any other plan. The secondary plan adjusts its benefits so that the total benefits available from both plans will not exceed the allowable expenses. No plan will pay more than it would without the coordination provisions.

Coordination of benefits for dependent children of separated or divorced parents is as follows:

1. If the parents are divorced and both are eligible for health insurance benefits, a divorce decree is required to determine responsibility for health insurance coverage for a dependent child.
2. Benefits of the plan covering the dependent child of a re-married parent with custody will be paid first by the parent's plan.

Benefits will then be paid by the plan covering the child as a dependent of a stepparent, and finally benefits will be paid by the plan covering the child as a dependent of the natural parent with-

out custody.

Subrogation Clause

In the event of third party liability, the carrier is entitled to first payment from any settlement with or judgement obtained by the employee against a third party for all amounts paid under the contract on the employee's or dependent's behalf, less reasonable collection costs incurred.

Early Retiree Medical Coverage

Early retiree's, who retire under the terms of the Fort James Retirement Plan, are eligible for the Primary Care Network (PCN) or Preferred Provider Organization (PPO) Plan (excluding dental coverage). Early retiree's, who retired prior to June 30, 1985, will be covered under the Base/Major Medical Plan in effect on June 30, 1985. Early retiree's hired after August 11, 1995 WILL NOT be eligible for health care benefits referred to herein.

Retiree's will pay the same cost as active employees pay for coverage.

Early retiree's who are not eligible for Medicare may continue their health care coverage (excluding dental coverage) for themselves and their eligible dependents (who also are not eligible for Medicare). Coverage for the retiree will be continued until he becomes eligible for Medicare, attains age 65 (or older if modified by Medicare eligibility during the term of the agreement), or until his death, whichever occurs first. Coverage for the retiree's dependent spouse may be continued until the spouse becomes eligible for Medicare, attains age 65 (or older if modified by Medicare eligibility during the term of the agreement) or remarries, whichever comes first.

Normal Retiree Medical Coverage

Employees who retire at age 65 or continue to work beyond age 65 and then retire are no longer covered for health insurance benefits as they become eligible for Medicare. Coverage (excluding dental coverage) for their spouse will continue until they reach 65 or are eligible for Medicare. Coverage for a dependent child will continue as long as they meet the dependent child requirements and that the child is not covered by Medicare.

Coverage for Disability retiree's Under Age 55

Employees who, on or after May 1, 1976, qualify for a permanent and total disability retirement benefit under the provisions of the Fort James retirement Plan and who are not yet age 55 on the effective date of retirement, will have their health coverage continued for themselves and their eligible dependents. The cost for this coverage will be paid for by the Company. The *health coverage to be continued is that which covered the* employee when actively at work and as modified by subsequent collective-bargaining negotiations. Coverage for the retiree and his eligible dependents will be continued for 30 months or until the date on which the retiree becomes eligible for Medicare or until the end of the month in which the retiree dies, whichever is earlier.

Coverage for Spouse of Deceased Employee

When an employee dies while actively employed by the Company and that employee, at the time of death, is eligible for early retirement, group Hospital-Surgical-Medical coverages will continue for the spouse and dependent children who continue to be eligible under the respective plan definitions until either the spouse remarries, is covered by another group insurance program, or is eligible for Medicare, whichever occurs first.

Coverage During Leaves of Absence

- *Occupational Disability*

If you are absent from work due to an accident or occupational disease, as recognized by the Workmen's Compensation Board, your coverage and your eligible dependents' coverage will be continued at Company expense during the period of disability up to a maximum of twenty-four months following the month in which the disability began. If you are disabled beyond 24 months and have not terminated your employment, your coverage, and your dependents' coverage, will be canceled unless you elect to continue at your expense.

- Non-Occupational Disability

If you are absent from work due to a non-occupational accident or sickness, your coverage, and your dependents' coverage, will be continued at Company expense during the period of disability up to a maximum of twelve months following the month in

which the disability began. If you are disabled beyond 12 months and have not terminated your employment, your coverage, and your dependents' coverage, will be canceled unless you elect to continue at your expense.

- Layoff or Personal Leave of Absence

If you are on layoff due to disciplinary action or lack of work or due to an approved personal leave of absence, your coverage and your dependents' coverage, will be continued at Company expense for one month following the month in which the layoff or leave began. If the layoff or leave continues beyond one month you may continue your coverages under the COBRA PROVISIONS.

Conditions For Termination of Coverage

You should be aware that Company coverage ends when . . .

- You choose to discontinue coverage.
- A covered person loses eligibility.
- You enter military service.
- You leave the Company.
- The period of the Labor contract ends.

Coverage During Deferred Retirement

If you continue to work past age 65 and are eligible for Medicare or if your spouse is over 65 and is eligible for Medicare, federal law still requires that your employer's health insurance is primary for coverage. Medicare becomes your secondary coverage.

Prior to you and your spouses 65th birthday, it is recommended that you apply for both Parts A and B of Medicare which entitles you to Medicare coverage for doctor's visits, X-ray and lab benefits, and hospitalization. Premiums for Medicare Part B are not reimbursed by the Company.

Coverage Upon Termination

Coverage upon termination of employment will be subject to the Federal regulation called The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please refer to the most recent Summary Plan Description (SPD) to determine how "COBRA" applies to your situation.

Extension of Benefits

There are certain circumstances under which health plan coverage will continue after participation in the health plan has ended.

If you or a covered family member are totally disabled when your participation in the Plan ends, coverage would continue for 12 months after the end of the month in which participation in the Plan ends, until recovery, or until covered by another group plan, whichever comes first. The extension coverage includes all health and dental plan benefits normally covered.

STOP TOBACCO USE/SMOKING BENEFIT

A Company Benefit

Smoking and the use of other tobacco products is dangerous. It can contribute to heart trouble, various cancers including lung cancer, emphysema and chronic bronchitis. One of the best things you can do for your health is to give up smoking and the use of other tobacco products . And to help you and your eligible family members, Fort James will pay 50% of the cost of a Company-approved stop smoking program or other program that enables a person to stop using other tobacco products, up to an individual lifetime maximum of $500. This benefit is not part of your group insurance coverage. It is sponsored solely by FORT JAMES and is available to you, no matter which type of health care coverage you choose. Before starting a program, however, check with your Benefits Representative to make sure the program qualifies as one of the approved programs. Benefits are paid upon completion of the program.

YOUR SURVIVOR PROTECTION PROGRAM

Introduction

Your Fort James Survivor Protection Program provides help for your family in the event of your death. The program also provides protection if you become permanently disabled or suffer accidental loss of certain body members. The program includes:

- Life Insurance
- Accidental Death & Dismemberment Insurance

Of course we can't expect that the benefits described in this section will provide every employee with all the insurance he or she may need. But we do believe that these benefits will provide a firm and valuable foundation of protection.

The following is a non-technical summary of the main features of the life and accident benefits provided by the Fort James Employee Benefits Organization, Inc. The official Plan document and insurance contracts govern the operation of the Plan and the payment of all benefits.

ELIGIBILITY AND ENROLLMENT

Who is Eligible

The following employees are eligible for the benefits described in this section:

Active hourly employees represented by P.A.C.E., Local 8-1097 at the Wauna Mill, Clatskanie, Oregon.

When to Enroll

You should enroll within 31 days of your hire date. All you need to do is fill out an enrollment form, naming your beneficiary, and return it to your Benefits Representative.

If you do not enroll within 31 days, evidence of good health approved by the insurance company is required. You may be required to have a physical examination. This examination will be at your expense, and the results of it will be used to determine whether or not you are approved for coverage.

When Coverage Begins

Plan coverage will begin the first day of the month following your date of employment.

GROUP TERM LIFE INSURANCE

Benefit Amount

The amount of your Life Insurance depends upon your job rate bracket in the table shown in this section. This amount will be paid to your beneficiary if you die from any cause while you are insured.

Each of the hourly job rates in the table is defined as the straight-time (Blue Slip) day rate of your regular job, excluding all

premiums and fringes.

Life insurance benefits will be payable as a result of death from any cause or at any time or place while you are insured. Payment will be made in a lump sum or in installments to your beneficiary.

Be sure your beneficiary designation is current. You may wish to complete a new beneficiary designation due to changes in your family situation, such as marriage, birth, divorce or death.

If you Become Disabled

If you become totally and permanently disabled while insured and before age 60, your life insurance will remain in effect as long as you remain disabled, providing you furnish proof of your continued disability as required by the insurance company. The first proof must be filed within three months after your total disability has lasted for nine months. Subsequent proofs of disability must be furnished as may be required by the insurance company.

It is important to understand what "total and permanent disability" means. You are considered to be permanently and totally disabled at any time that both of the following conditions apply:

- You are not then actually working for pay or profit; and
- You are then, and will be presumably for life, unable to work at any gainful occupation for which you are fitted by your education, training or experience, or for which you could reasonably become fitted.

If you do become disabled under the above definition, you have the right to elect to receive 70 percent of your life insurance in equal monthly installments over a period of 60 consecutive months. The first payment will be made in the first month following the time at which the Company notifies you in writing that the insurance company has determined that you are totally and permanently disabled. The payments will continue only as long as you remain disabled.

The election described above must be made in writing when you file the first proof of disability. Please note that you cannot change this election after you make it.

If you become totally and permanently disabled, make the election described and then return to active work for the company, your life insurance will be reduced. The reduction will be equal to the total amount of monthly payments you received prior to your return to work.

If you should die while you are totally and permanently disabled and receiving the monthly payments, your beneficiary will receive in a lump sum the value of the remaining installments, plus the above-mentioned 30 percent of your life insurance.

Termination
Your life insurance coverage will terminate at the end of the day on which your employment terminates. If, however, you die within 31 days after you terminate employment, the death benefit will be paid to your beneficiary.

Conversion Privilege
Upon termination, you can convert your group term life insurance coverage to an individual life insurance policy. Under individual coverage, you pay all premiums directly to the insurance company. Application for the individual policy and payment of the first premium must be made within 31 days after termination of your group term life insurance. The individual policy will be issued without medical examination at the insurance company's regular rates.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

AD&D benefits are paid if, while you are insured, you suffer a bodily injury caused by an accident and if, within 90 days after the accident you suffer one of the losses below:

The full amount (principal sum) will be payable for the accidental loss of:

Life
Both Hands
Both Feet
One Hand and One Foot
One Hand and Sight of One Eye
One Foot and Sight on One Eye
Sight of Both Eyes

One-half the full amount will be payable for the accidental loss of: One Hand, One Foot or the Sight of One Eye.

The amount of your AD&D benefits depends upon your job rate bracket in the table shown as follows:

Fulltime Employees	HOURLY RATE OF BASIC EARNINGS "BLUE SLIP RATE"			Life Ins./ AD & D	Weekly Disability
	16.57	But Less Than	16.84	$32,000	$335
	16.84	But Less Than	17.11	$32,500	$340
	17.11	But Less Than	17.38	$33,000	$345
	17.38	But Less Than	17.65	$33,500	$350
	17.65	But Less Than	17.92	$34,000	$355
	17.92	But Less Than	18.19	$34,500	$360
	18.19	But Less Than	18.46	$35,000	$365
	18.46	But Less Than	18.73	$35,500	$370
	18.73	But Less Than	19.00	$36,000	$375
	19.00	But Less Than	19.27	$36,500	$380
	19.27	But Less Than	19.54	$37,000	$385
	19.54	But Less Than	19.81	$37,500	$390
	19.81	But Less Than	20.08	$38,000	$395
	20.08	But Less Than	20.35	$38,500	$400
	20.35	But Less Than	20.62	$39,000	$405
	20.62	But Less Than	20.89	$39,500	$410
	20.89	But Less Than	21.16	$40,000	$415
	21.16	But Less Than	21.43	$40,500	$420
	21.43	But Less Than	21.70	$41,000	$425
	21.70	But Less Than	21.97	$41,500	$430
	21.97	But Less Than	22.24	$42,000	$435
	22.24	But Less Than	22.51	$42,500	$440
	22.51	But Less Than	22.78	$43,000	$445
	22.78	But Less Than	23.05	$43,500	$450
	23.05	But Less Than	23.32	$44,000	$455
	23.32	But Less Than	23.59	$44,500	$460
	23.59	But Less Than	23.86	$45,000	$465
	23.86	But Less Than	24.13	$45,500	$470
	24.13	But Less Than	24.40	$46,000	$475
	24.40	But Less Than	24.67	$46,500	$480
	24.67	But Less Than	24.94	$47,000	$485
	24.94	But Less Than	25.21	$47,500	$490
	25.21	But Less Than	25.48	$48,000	$495
	25.48	But Less Than	25.75	$48,500	$500
	25.75	But Less Than	26.02	$49,000	$505
	26.02	But Less Than	26.29	$49,500	$510
	26.29	But Less Than	26.56	$50,000	$515
	26.56	But Less Than	26.83	$50,500	$520

Fulltime Employees	HOURLY RATE OF BASIC EARNINGS "BLUE SLIP RATE"			Life Ins./ AD & D	Weekly Disability
	26.83	But Less Than	27.10	$51,000	$525
	27.10	But Less Than	27.37	$51,500	$530
	27.37	But Less Than	27.64	$52,000	$535
	27.64	But Less Than	27.91	$52,500	$540
	27.91	But Less Than	28.18	$53,000	$545
	28.18	But Less Than	28.45	$53,500	$550
	28.45	But Less Than	28.72	$54,000	$555
	28.72	But Less Than	28.99	$54,500	$560
	28.99	But Less Than	29.26	$55,000	$565
	29.26	But Less Than	29.53	$55,500	$570
	29.53	But Less Than	29.80	$56,000	$575
	29.80	But Less Than	30.07	$56,500	$580
	30.07	But Less Than	30.34	$57,000	$585
	30.34	But Less Than	30.61	$57,500	$590
	30.61	But Less Than	30.88	$58,000	$595
	30.88	But Less Than	31.15	$58,500	$600
	31.15	But Less Than	31.42	$59,000	$605
	31.42	But Less Than	31.69	$59,500	$610
	31.69	But Less Than	31.96	$60,000	$615
	31.96	But Less Than	32.23	$60,500	$620
	32.23	But Less Than	32.50	$61,000	$625
	32.50	But Less Than	32.77	$61,500	$630
	32.77	But Less Than	33.04	$62,000	$635
	33.04	But Less Than	33.31	$62,500	$640
	33.31	But Less Than	33.58	$63,000	$645
	33.58	But Less Than	33.85	$63,500	$650
	33.85	But Less Than	34.12	$64,000	$655
	34.12	But Less Than	34.39	$64,500	$660
	34.39	But Less Than	34.66	$65,000	$665
	34.66	But Less Than	34.93	$65,500	$670
	34.93	But Less Than	35.20	$66,000	$675
	35.20	But Less Than	35.47	$66,500	$680
	35.47	But Less Than	35.74	$67,000	$685
	35.74	But Less Than	36.01	$67,500	$690
	36.01	But Less Than	36.28	$68,000	$695
	36.28	But Less Than	36.55	$68,500	$700
	36.55	And Up		$69,000	$705

YOUR DISABILITY PROGRAM

Introduction

The Disability Income Program offers you comprehensive

earnings protection when non-occupational illness or injury keeps you off the job. The program will pay you a weekly benefit for up to one year for any one period of disability, provided that you meet the eligibility criteria.

The following is a non-technical summary of the disability income portion of the employee benefits provided by the Fort James Employee Benefits Organization, Inc. The official Plan document governs the operation of the Plan and the payment of all benefits.

ELIGIBILITY AND ENROLLMENT

Who is Eligible

The following employees are eligible for the sickness and accident benefits described in this section:

Active hourly employees represented by P.A.C.E., Local 8-1097 at the Wauna Mill, Clatskanie, Oregon.

When to Enroll

You should enroll within 31 days of your hire date. All you need to do is fill out an enrollment form, naming your beneficiary, and return it to your Benefits Representative.

When Coverage Begins

For new hires, Plan coverage will begin on the first day of the month following satisfactory completion of the probationary period. This is contingent upon the fact that there are no pre-existing illness or accident conditions.

When Payments Begin

You will be eligible to receive a weekly sickness and accident disability benefit when you are unable to perform your regular or customary work and are under the care of a physician.

When medically confirmed, benefit payments will start on the **first** day of your disability caused by a non-occupational **accident** and on the **fourth** day of your disability caused by a non-occupational **sickness**. The following situations, however, can allow you to receive benefits retroactive to the first day of your sickness:

- If your sickness extends to 14 or more consecutive

days, benefit payments will be retroactive to the first day, provided you were under the care of a physician during the first four days of your illness.

- If you are confined as a registered bed patient of a hospital at any time during a period of continuous disability, benefit. This benefit will be extended to include cases where surgery is performed on an out-patient basis, when the surgery is a medically recognized alternative to hospitalization as a bed patient.

Duration of Payments

Benefits will be payable for a maximum of 52 weeks during any one period of disability.

Benefits will be payable for as many separate periods of disability that occur. Successive disabilities due to the same illness or injury will be considered one period of disability unless separated by your return to full-time work for at least two weeks.

Period of disability due to different causes are considered different periods of disability if they are separated by your return to work.

It is important that you understand that no benefits are payable for any period of disability unless you are under the care of physician. Employees will be required to accept Transitional Work jobs according to the Joint Transitional Work Process.

Benefit Amount

The amount of your sickness and accident weekly benefit is determined by your job-rate bracket In the table "Group Term Life, AD&D and Weekly Disability Benefits".

Each of the hourly job rates in the table is defined as the straight-time day rate of your regular job, excluding all premiums and fringes.

Termination

Your disability insurance coverage will terminate at the end of the day on which your employment terminates.

Your Rights Under Federal Law

In 1974 the Employee Retirement Income Security Act (ERISA) was enacted to safeguard the interests of participants

and beneficiaries in employee benefit plans.

As a member of the benefit plan described in this handbook, you have certain rights and protections under ERISA, as outlined in the following statement adapted from regulations of the U.S. Department of Labor.

While we want you to know what you are now guaranteed by law, we believe that all your rights will continue to be protected as a matter of Company policy.

ERISA provides that all Plan members are entitled to:

- Examine, without charge, at the Plan Administrator's principal office, 1650 Lake Cook Road, Deerfield, IL 60015 and other specified locations, such as work sites, all Plan documents and insurance contracts; copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and plan descriptions; and a list of all affiliated companies participating in the plans.
- Obtain copies of all documents and other Plan information by writing to the appropriate Plan Administrator. There may be a reasonable charge for the copies.
- Receive summaries of the Plan's annual financial report ("Summary Annual Report"). The Plan Administrator is required by law to furnish each plan member with a copy of this summary annual report.

In addition to creating rights for Plan members, ERISA imposes obligations on the people responsible for the operation of your Plans. These people, called "fiduciaries," have a duty to operate your Plans prudently and in the interest of all Plan members and beneficiaries.

No one - your employer or any other person - may fire you or otherwise discriminate against you in any way for the purpose of preventing you from obtaining a benefit or exercising your rights under ERISA. However, this rule neither guarantees continued employment nor affects your employer's right to terminate your employment for other reasons.

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

Under ERISA, there are steps you can take to enforce the rights listed above.

For instance, if you request Plan materials and do not

receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100-per-day until you receive them, unless they were not sent because of reasons beyond the Administrator's control.

If your claim for benefits is denied, and you have been through the Plan's appeals procedures, you may sue in a state or federal court.

If you believe that Plan fiduciaries are misusing Plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you win, the court may order the person you sued to pay these legal expenses. If you lose, the court may order you to pay the court costs and legal fees (if, for example, it finds your claim is frivolous).

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest Area Office of the Labor-Management Services Administration of the U. S. Department of Labor.

PENSIONS
RETIREMENT PLAN
INTRODUCTION

The Fort James Retirement Plan (the "Plan") is a defined benefit pension plan that has been adopted to provide retirement benefits for certain employees, including those who are members of P.A.C.E. Local No. 8-1097 working at the Fort James Wauna Mill in Clatskanie, Oregon. The Plan has been adopted in recognition of these employees' loyal and faithful service. The Plan also provides certain benefits in the event of death, disability or other termination of employment.

This summary plan description is a non-technical summary of some of the Plan's important features with respect to hourly employees at the Fort James Wauna Mill who are covered by Schedule 56 of the Plan. This summary will be revised periodically, so make sure that you have the most recent summary. All of the information contained in this summary is based on the actual Plan provisions. This summary is not meant to interpret, extend or change the Plan in any way. The provisions of the Plan can only be determined accurately by consulting the Plan itself. The actual Plan document and trust document, instead of this summary, will be used in determining all claims. The full Plan document and other governing legal documents are available for your review at the local Human Resources department.

The laws relating to defined benefit pension plans change frequently. In any case in which a Plan provision is inconsistent with any new law, regulation or ruling, the Plan will be administered in accordance with the new law, regulation or ruling regardless of the terms of the Plan or this summary.

While it is expected that the Plan will remain in effect indefinitely, Fort James Corporation ("Fort James") reserves the right to modify, suspend or discontinue the Plan at any time. However, whenever eligibility provisions or benefit levels for eligible employees and Plan participants are specified in a collective bargaining agreement between Fort James and P.A.C.E. Local 8-1097, such provisions and levels will not be changed unilaterally during the term of the applicable agreement.

Neither the Plan, nor this summary, constitutes a contract for benefits or a contract of employment.

Important names, addresses and other similar information are set forth at the end of this summary in the **General Information** section.

If you have any questions about any part of the Plan or this summary, please contact your local Human Resources department for assistance.

SOME IMPORTANT DEFINITIONS.

Several important terms will be used throughout this summary, and are defined below:

- **Benefit Service.** Your period of service with the company. However, you will not receive benefit service credit for periods of severance.
- **Period of Service.** Your total service with the company, based on years and days, measured from the date you begin work to your severance date. For purposes of participation and vesting, periods of severance will be counted as periods of service, if you return to work within 12 months from your severance date.
- **Period of Severance.** A period of time beginning on your severance date and ending on the date you return to work for the company.
- **Severance Date.** The date you resign, are discharged, retire or die. For purposes of participation and vesting, the first day following a 12-month leave of absence (due to holding a union or political office) or the first day following a 12-month period of layoff.
- **Vesting Service.** Your total service with the company, including up to 12 months layoff or 12 months leave of absence to hold a union or political office. You must complete a 5-year period of service or attain age 65 in order to be 100% vested in your accrued benefit.

ADMINISTRATION

Fort James is the Plan's administration. Fort James has appointed an Employee Benefits Committee to carry out the administrative responsibilities described in the Plan. The members of the Committee are listed in the **General Information** section at the end of this summary. The Committee has the

power to make all decisions regarding eligibility for and the amount of benefits. The Committee can be contacted at the following address: Pension Plan Administrative Committee, Fort James Corporation, 1650 Lake Cook Road, Deerfield, IL 60015

WHEN CAN I PARTICIPATE IN THE PLAN?

The Plan is for active full-time hourly paid employees of Fort James Corporation who are members of P.A.C.E. Local No. 1097 and who work at the Fort James Wauna Mill.

If you are an eligible employee, you will automatically become a participant in the Plan on your date of hire. Leased employees are not eligible to participate as well as employees whose collective bargaining agreement does not provide for their participation.

Special participation rules apply if you terminate employment and are later rehired. (See **What Service Do I Get Credit For If I Terminate Employment Before My Retirement Date and Am Rehired?**)

WHAT CONTRIBUTIONS ARE MADE TO THE PLAN?

Fort James makes contributions to a trust fund for the Plan in an amount that is actuarially determined to be sufficient to provide the benefits described in the section entitled **What Are My Normal Retirement Benefits?** The benefit that you receive will be determined by the formula described in that section. You are not required or permitted to contribute to the Plan. Amounts contributed to the Plan by Fort James are held under a trust agreement with State Street Bank and Trust Co., the Plan's trustee.

HOW ARE PLAN ASSETS INVESTED?

The Plan assets are held in a trust fund. The Plan's trustee, State Street Bank and Trust Co. is responsible for maintaining the trust fund. The Fort James Employee Benefits Committee in conjunction with Frank Russell Company is responsible for selecting the investment managers who select investments of the trust fund.

WHAT ARE MY NORMAL RETIREMENT BENEFITS?

Your normal retirement date is your 65th birthday. Your monthly normal retirement benefit will begin to be paid as of the first day of the calendar month coinciding with or next following the date on which you terminate employment after attaining age 65.

Your monthly normal retirement benefit is calculated by multiplying your years of benefit service when you retire times the monthly benefit rate, which is based on your wage rate. The result is the amount you would receive, payable as a single life annuity, for your lifetime only, with no reduction for early retirement, termination of employment, or selection of an option for a continuing spouses benefit. Monthly benefit rates are determined according to the attached Schedule A.

The following conditions can affect which wage rate is applicable:

- You are hired or rehired.
- You return to active employment from a leave of absence.
- You terminate employment while on leave of absence.
- You transfer from another location or from salaried to hourly status.
- Your previous job was eliminated and your current job pays less than your previous job.
- You are a new employee in a new position.

The effect of the situations listed above is explained in Schedule 56 of the Plan document. You will also need to refer to the Plan document for the effect of transferring from Schedule 56 to another Plan Schedule.

CAN I RETIRE EARLY?

You can retire early if you meet the following age and service requirements:

Age	Years of Vesting Service
55-57	At least 15 years
58	At least 14 years
59	At least 10 years
60 and over	At least 5 years

Your benefits are calculated in the same way as benefits at normal retirement age. The result is multiplied by an early retire-

ment factor for your age when payments will begin, as follows:

Benefits Begin at Age	Factor	Benefits Begin at Age	Factor
65	100%	59	82%
64*	97%	58	79%
63*	94%	57	76%
62*	91%	56	73%
61	88%	55	70%
60	85%		

*If you retire when you are 62 (or older) and have 20 or more years of Vesting Service, you receive your normal retirement benefit starting immediately, with no reduction.

Your monthly benefit may be further reduced based on the form of benefit payment you select. (See **How Will My retirement Benefits Be Paid?**)

CAN I WORK PAST MY NORMAL RETIREMENT DATE?

You may continue to work after you reach age 65. If you work for 8 or more days or 8 or more separate work shifts per month, your pension will not begin to be paid until you actually retire. However, you will continue to accrue benefits under the Plan. When you do retire, your monthly normal retirement benefit will be based on your benefit service at your actual retirement date and the monthly benefit rate in effect at that time.

WHAT HAPPENS IF I START RECEIVING MY RETIREMENT BENEFITS AND THEN AM REEMPLOYED?

If you retire or terminate employment and return to work for Fort James or a related company after your 65th birthday, and you work for 8 or more days or 8 or more separate work shifts during a calendar month, your retirement benefits will be suspended. However, while you are employed you may continue to accrue benefits that will become payable when you again retire. When you again retire, your monthly retirement benefit will be based on your total years of benefit service and the monthly ben-

efit rate in effect when you again retire. Your retirement benefit will then be actuarially adjusted to reflect any payments you received from the Plan before returning to work.

If you return to work after your 65th birthday and you work less than 8 days or 8 work shifts during a calendar month, you will continue to receive your retirement benefits, but you will not accrue additional benefits.

If your benefits are suspended because you returned to work after your 65th birthday, you will be notified of the suspension and the reason for the suspension during the first month the *suspension is in effect. If you are not sure whether your reem*ployment will cause a suspension of your retirement benefits, you should submit a written request for a determination to Fort James's Corporate Human Resources Department in Deerfield, IL. Finally, if you are receiving retirement benefits from the Plan and you return to work for Fort James *before* your 65th birthday, payment of your pension will be suspended until you again retire or terminate employment, regardless of the number of hours you work. When you again retire or terminate employment, your pension will be recalculated to reflect any additional benefits you accrued, and will be actuarially adjusted to reflect any pension payments you received before returning to work.

WHAT IF I BECOME DISABLED?

A Participant shall be considered totally and permanently disabled (except in the case of blindness) if the Participant is unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment that can be expected to result in death or that can be expected to last for a continuous period of not less than twelve (12) months.

A Participant shall be considered totally and permanently disabled due to blindness if he or she has attained the age of 55 and is unable, by reason of blindness, to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity previously performed with some regularity over a substantial period of time.

The Plan Administrator shall make the final and binding determination whether the Participant meets the above definition of dis-

ability, including the beginning and ending date of periods of disability. In making the disability determination, the Plan Administrator may rely on an award letter from the Social Security Administration specifying that the Participant is eligible to receive disability benefits under the Social Security Act. Alternatively, the Plan Administrator may make a separate disability determination based on guidance in the law, regulations and other written material of the Internal Revenue Service, the courts, and the Social Security Administration.

The Plan Administrator may require a Participant: (1) to furnish an award letter from the Social Security Administration indicating that the Participant is eligible to receive disability benefits under the Social Security Act; (2) to furnish medical or other information it reasonably deems appropriate to establish disability under the Plan; or (3) to submit to a medical examination, at no cost to the Participant, in order to establish disability under the Plan. The above information or medical examination shall be furnished or performed in the manner reasonably prescribed by the Plan Administrator.

The Plan Administrator also retains the right to determine, from time to time, at no expense to the Participant, whether the Participant continues to be totally and permanently disabled under the Plan. The Plan Administrator may require the Participant: (1) to submit proof that the Participant remains eligible to receive disability benefits under the Social Security Act; (2) to submit to subsequent medical examinations; or (3) to furnish such information the Plan Administrator reasonably deems appropriate to establish continued disability. Failure to furnish the requested information or failure to submit to a medical examination, if reasonably requested by the Plan Administrator, shall be grounds for a determination that the Participant is no longer totally and permanently disabled.

If a Participant is denied a distribution based on the Plan Administrators disability determination he or she may request a review of such denial in accordance with the benefit claims procedures.

In order to be eligible for disability retirement benefits, you must have completed at least 10 years of service and have been totally and permanently disabled for 6 consecutive months. If you have satisfied these conditions and Fort James has determined

you are disabled, you will be entitled to begin receiving a monthly disability retirement benefit as of the first day of any calendar month after you have filled the prescribed application form. Your disability pension will be calculated in the same way as a normal retirement. However, your disability pension will be reduced if you select the qualified joint and survivor annuity form of payment.

If you cease to be disabled, your disability pension payments will cease. At that time, you may be eligible for an early retirement benefit or a vested retirement benefit. However, you will not be entitled to a subsequent disability retirement benefit unless you return to work for Fort James and later re-qualify as disabled.

WHAT ARE MY BENEFITS IF I TERMINATE EMPLOYMENT BEFORE RETIREMENT?

If you terminate your employment with Fort James other than by reason of retirement, disability or death and, you have completed 5 years of vesting service as of your severance date, you will be entitled to receive a vested pension. Your vested pension is based on your benefit service and the monthly benefit rate in effect as of your severance date.

If you terminate employment before you have completed 5 years of vesting service and before you reach age 65, you will not be entitled to a monthly retirement benefit, and your potential benefit will be forfeited. Forfeitures are used to reduce future company contribution.

If you are entitled to a vested pension, you may elect to receive reduced monthly payments beginning before age 65, but not before age 55. In this case, your benefit will be multiplied by a factor for your age at the time payments begin:

Benefits Begin at Age	Factor
65	1.0000
64	.9090
63	.8288
62	.7580
61	.6950
60	.6389
59	.5887
58	.5436
57	.5031
56	.4664
55	.4331

If your vested benefit exceeds $5,000 at the time payment begins, you and your spouse, if any, must consent before payment may begin. Otherwise, your vested benefit will not begin to be paid until you reach age 65.

If you terminate employment and are later rehired and become a participant in this Plan, your retirement benefit when you again terminate your employment will be based on both periods of employment.

WHAT SERVICE DO I GET CREDIT FOR IF I TERMINATE EMPLOYMENT BEFORE MY RETIREMENT DATE AND AM REEMPLOYED?

If you terminate employment and return to work within 12 months of your severance date, the months during which you were away will be counted as service for purposes of participation and vesting but not for purposes of benefit service.

If you terminate employment and return *after* 12 or more consecutive months following your severance date, you will receive no credit for prior service unless you work at least one year after your reemployment date.

If you were *not vested* on your severance date, your years of service before your severance from service date will not be taken into account in determining your vested interest in your accrued benefit, or in determining your service for benefit accrual purposes, if you had a series of one year periods of severance from service that equals or exceeds the greater of (a) five or (b)

the aggregate number of your years of vesting service before your severance from service date. If you *were vested* on your severance date, you will be given credit for prior service, so long as you complete at least one year of service after your most recent reemployment date.

If you separate from service on account of maternity or paternity leave, your severance date will not occur until the *second* anniversary of the first day of your absence for maternity or paternity leave. The period between the first and second anniversaries will be neither a period of service nor a period of severance. However, the time from the first day of maternity or paternity leave up until the first anniversary of that leave will be counted for benefit and vesting service. Maternity or paternity leave is the period during which you are absent because of (a) your pregnancy, (b) the birth of your child, (c) the placement of a child in your home in connection with your adoption of the child, or (d) your caring for a child immediately after his or her birth or placement in your home for adoption.

WHAT HAPPENS IF I DIE BEFORE MY PENSION STARTS TO BE PAID?

If you die after you are vested in the Plan, but before your retirement benefits have started to be paid, your surviving spouse will be entitled to receive a death benefit, if you were married for at least one year on the date of your death. Your surviving spouse will be eligible to receive a qualified pre-retirement survivor annuity (described below) unless you reject the qualified pre-retirement survivor annuity with your spouse's written consent, on a form provided by and filed with Fort James.

The qualified pre-retirement survivor annuity will be paid only if you had been married for one year and had not rejected the pre-retirement survivor annuity with your spouse's written consent. (See **How Do I Make Payment Elections?**). If you elect to be covered by the qualified pre-retirement survivor annuity, the retirement benefits you actually receive from the Plan will be reduced. This charge reflects a reasonable actuarial risk factor for the period of time during which you and your spouse chose to have the qualified pre-retirement survivor annuity in effect. However, the charge will only be made for years during or

after the year in which you attain age 35. For further information regarding the actuarial risk factor, contact your local Human Resources Department.

The qualified pre-retirement survivor annuity is based on your years of service and the monthly benefit rate in effect as of the earlier of the date on which you separated from service or died. Payments will begin to be made to your surviving spouse on the first day of the month following the date on which you would have reached age 65. However, your spouse may elect to begin receiving payments on an earlier date: the first day of the month following the later of (a) the date you would have attained age 55 or (b) your death. If payments start before the date that would have been your 65th birthday, they will be actuarially reduced in the same manner as for early retirement (See **Can I Retire Early?**) for the actuarial reduction factors.) Generally, your surviving spouse will be entitled to receive a monthly pension for his or her lifetime equal to the same amount he or she would have received if you had retired on the day before your death, with the joint and 50% survivor form of payment in effect. (See **How Will My Benefits Be Paid?**) for a description of the joint and 50% survivor annuity.

If you decide that you do not want this qualified pre-retirement survivor benefit coverage, your spouse must agree to the waiver, in writing, and in the presence of either a designated Plan representative or a notary public. (See **How Do I Make Payment Elections?**) If you and your spouse do not reject the pre-retirement survivor benefit coverage, the coverage will automatically be in effect.

ARE THERE LIMITS ON MY BENEFITS?

The Internal Revenue Code imposes limits on the amount of benefits that you may accrue under the Plan and on the amount of the annual contributions that may be allocated to your account under the Fort James Corporation 401(k) Plan. These limits may require a reduction in the amount of benefits that you may accrue under this Plan or the amount of the company's contributions allocated to your account under the 401(k) Plan.

Also, if you are entitled to receive a benefit for the same

period of service from this Plan and from other qualified defined benefit plans to which Fort James makes contributions, your pension from this Plan will be reduced by the amount of your accrued benefit under the order plan.

HOW WILL MY BENEFITS BE PAID?

A. Forms of Retirement Benefits

1. **Automatic Forms.** If you *are married* on the date your retirement benefit is to begin being paid, your benefit will automatically be paid in the form of a joint and 50% survivor annuity, unless you select another form of payment with your spouses written consent. (See **How Do I Make Payment Elections?** below for description of the election procedures.) Under a joint and 50% survivor annuity, you will receive monthly payments for your lifetime and, after your death, monthly payments equal to 50% of the monthly payments you received will be paid to your surviving spouse for his or her lifetime. If your spouse predeceases you but after you have started receiving payments, you will continue to receive your pension in the same amount as before, and the last payment will be paid on the first day of the month in which you die.

If you are *not married* on the date your retirement benefits is to begin, your benefit under the Plan automatically will be paid in the form of a single life annuity, unless you select another form of payment. (See **How Do I Make Payment Elections?**) Under the terms of a single life annuity, payments will be paid to you for your lifetime and no payments will be made after your death.

2. **Optional Forms.** Instead of one of the automatic forms of benefits shown above, you may (with your spouse's consent if you are married) choose one of the following optional payment methods:
   a. **Single Life Annuity.** You receive the full amount produced under the benefit formula for as long as you live.
   b. **Joint and 100% Survivor Annuity.** You receive reduced monthly payments and after your death, your survivor (spouse, relative or other beneficiary) receives the same amount for life.
   c. **Joint and 50% Survivor Annuity.** You receive reduced monthly payments, and after your death, your survivor (spouse, relative or other beneficia-

ry) receives 50% of that amount for life.

d. **10-Year Certain and Life Annuity.** You receive reduced monthly payments and if you die before receiving 120 monthly payments, your survivor receives continued payments in the same amount until a total of 120 payments have been made.

e. **Level-Income Annuity.** If you retire before age 62, you may elect to have your benefit increased during those years between your early retirement and age 62. When your Social Security benefit begins at age 62, your benefit under the Plan will be reduced. The Level-Income Annuity may be paid in the form of (a), (b) or (c), above.

If you are not married and are eligible for disability retirement, or qualify as a terminated vested participant, your only available form of payment is a single life annuity. If you are married and are eligible for disability retirement, or qualify as a terminated vested participant, your only available forms of payment are a qualified joint and survivor annuity or, with the consent of your spouse, a single life annuity.

Each of the optional forms of payment is reduced by certain actuarial reduction factors and interest rates. They will also be reduced should they begin to be paid before your normal retirement date.

3. **Small Benefits.** If the amount of your monthly retirement benefit is $10 or less when payments are to begin, your benefit automatically will be paid annually in advance.

B. **Required Commencement Date.** Your benefits must begin to be paid generally not any later than the April 1 following the calendar year in which you reach age 70 1/2, whether or not you have retired. Federal income tax will be withheld from benefits payable to you from the Plan unless you elect not to have tax withheld.

HOW DO I MAKE PAYMENT ELECTIONS?

If you *are married*, the automatic forms of payment will be (a) a joint and 50% survivor annuity when you retire or terminate

employment or (b) a pre-retirement survivor annuity payable to your surviving spouse if you die before your benefits under the Plan have begun to be distributed and if you were married for the one-year period before you died. If you are *not married*, the normal form of payment will be a single life annuity when you retire or terminate employment.

You may reject the normal form of payment, with the written consent of your spouse (if you are married) during the following election periods:

1. The election period for rejecting the joint and 50% survivor annuity and the single life annuity will begin 90 days before the date your benefits become payable and will end on the date your benefits become payable.
2. The election period for rejecting the pre-retirement survivor annuity will begin on the January 1 of the Plan year in which you reach age 35 and will end on the date of your death. If you terminate employment before you reach age 35, the election period will begin on the date you terminate employment. If you are re-employed you must reaffirm any election you made before you reached age 35.

Each of the elections may be made at any time during the applicable election period, with the consent of your spouse, if you are married. Your election may be revoked only during the election period. Once you begin to receive benefits, your election becomes final and cannot be changed. Forms will be provided to you for making elections or revocations of elections.

SINGLE SUM DEATH BENEFIT.

A $1,000 payment is automatically made to your beneficiary when you die if you have retired under the Plan. Terminated vested participants are not eligible for this benefit.

This benefit is in addition to any other survivor benefits that may be payable from the Plan, and will be payable from the Plan, and will be paid to your Estate if you have no beneficiary.

WHEN IS A PLAN TOP HEAVY?

A plan is "top heavy" if the sum of the accrued benefits of "key employees" exceeds 60% of the sum of the accrued benefits of all participants in the plan. Key employees generally are employees serving as officers of Fort James and other employees who are among the most highly paid of Fort James and who have the highest percentage of ownership interest in Fort James. Fort James will determine whether the Plan is top heavy. If the Plan becomes top heavy, special rules will apply that relate to minimum benefits, accelerated vesting, and the amount of compensation that may be considered in determining the benefits under the Plan. Fort James *does not* anticipate that the Plan will be top heavy.

WHAT IS A QUALIFIED DOMESTIC RELATIONS ORDER?

A qualified domestic relations order is a court order that creates or recognizes current or former family member's right to part or all of your Plan benefits. While the Employee Retirement Income Security Act ("ERISA"), a federal pension law, generally protects Plan benefits against creditors, qualified domestic relations orders are an exception. Such an order can compel payment of benefits even though the Plan prohibits distributions earlier than retirement, termination, death, or disability. The Plan Administrator will notify you if the Plan receives a domestic relations order that affects your benefits and will also determine, within a reasonable time, if the order is qualified. You and the other party to the court order will be notified of the decision.

If you are a party to a divorce proceeding and your benefits under this Plan will be subject to a marital property agreement, your attorney should send a proposed domestic relations order to the Plan Administrator for review before it is presented to the court for final entry. By doing so the Plan Administrator can inform you of deficiencies in the proposed order that would prevent it from being deemed a "qualified domestic relations order." Proposed domestic relations orders may be sent to: H.R. Connection, 6802 Paragon, Suite 400, Richmond, VA 23230.

ARE MY BENEFITS INSURED?

Benefits under the Plan are insured by the Pension Benefit Guaranty Corporation ("PBGC") if the Plan terminates. Generally, the PBGC guarantees most vested normal retirement benefits, early retirement benefits, and certain disability and survivor's pensions. However, the PBGC does not guarantee all types of benefits under covered plans, and the amount of benefit protection is subject to certain limitations.

The PBGC guarantees vested benefits at the level in effect on the date of plan termination. However, if a plan has been in effect fewer than five years before it terminates, or if benefits have been increased within five years before plan termination, the entire amount of the plan's vested benefits or the benefit increase may not be guaranteed. In addition, there is a ceiling on the amount of monthly benefits that the PBGC guarantees, which is adjusted periodically.

For more information on the PBGC insurance protection and its limitations, you should ask a member of the Committee or the PBGC. Inquiries to the PBGC should be addressed to the Office of Communications, PBGC, 202 K Street, N.W., Washington, D.C. 20006. The PBGC Office of Communications may also be reached by calling (202) 254-4817.

WHAT LEGAL RIGHTS DO I HAVE REGARDING THE PLAN?

Claims Procedure. As a participant or beneficiary in the Plan, you are entitled to certain rights and protections under the claims procedure of ERISA. If you have a claim for a benefit under the Plan, you may file the claim in writing with the Plan Administrator. If your claim is denied, you will receive, within 90 days after you file your claim, a written notice explaining the reasons for denial and pointing out the pertinent Plan provisions on which the denial is based. The denial of the claim will describe any additional material or information that may be needed to perfect your claim and will explain why such material or information is needed. You will also receive an explanation of the procedure for reviewing claims.

If your claim is denied, you may request a review. The review must be requested by written application to the Plan Administrator within 60 days after receiving the denial. You may authorize, in writing, a representative to act in your behalf. You or

your representative may review any pertinent documents and submit issues and comments to the Plan Administrator in writing. The Plan Administrator generally will issue a written decision *within 60 days after your request for review has been filed.* The written decision will explain the reasons for the denial and will refer to the Plan provisions on which the decision is based.

ERISA Rights. As a participant or beneficiary in the Plan, you are entitled to certain rights and protections under ERISA. You can examine the Plan document, trust agreement, reports, and other Plan information, without charge, at the company's office and at other locations. You can obtain copies of the Plan document, trust agreement, and other Plan information upon written request to the company. The company may make a reasonable charge for the copies. You will receive a summary of the Plan's annual financial report. Once each year you can obtain a statement of the amount of your accrued benefit and the percentage of the amount that is vested or the earliest date on which the amount becomes vested. You must make a written request for this statement, but it will be provided free of charge. You can file suit in a federal court if you do not receive any materials, to which you are entitled within 30 days of your request, unless the materials were not sent because of matters beyond the control of the company. Fines may be imposed in case of delays.

Fiduciaries. Fiduciaries (persons who are responsible for the operations of the Plan) must act solely in the interest of the participants and must exercise prudence in the performance of their Plan duties. Fiduciaries who violate the law may be removed and may be required to make good any losses that they have caused the Plan. The company may not prevent you from obtaining the vested amount of your accrued benefit or from exercising your legal rights. If you are improperly denied the vested amount of your accrued benefit, in full or in part, you have a right to file suit in a federal or state court. If fiduciaries are misusing the Plan's assets, you have a right to file suit in a federal court or to request assistance from the U. S. Department of Labor. Legal costs, including attorney's fees, may be awarded to the successful party.

If you or your beneficiary have any questions about this statement or your rights under ERISA, you or your beneficiary should contact the nearest Area Office of the U. S. Labor -

Management Service Administration, U. S. Department of Labor.

CAN THE PLAN BE AMENDED OR TERMINATED?

Fort James may amend or terminate the Plan at any time. However, whenever eligibility provisions and benefit levels are specified in a collective bargaining agreement between Fort James and a union representing employees covered by the Plan, those provisions and benefit levels may not be changed unilaterally by Fort James during the term of the collective bargaining agreement. The Plan also may be terminated by the PBGC if certain events occur such as (a) Fort James being unable to make the required contributions to the Plan or (b) the Plan being unable to pay benefits to participants when they become due.

In the event the Plan is terminated, affected participants will be fully vested in their accrued benefit regardless of their years of vesting service.

Expenses relating to Plan termination may be paid from the trust fund before any payments are made to you or your beneficiary. Benefit payments from the Plan will be made in the order as required by ERISA.

GENERAL INFORMATION

Name of Plan:
Fort James Retirement Plan
Plan Sponsor:
Fort James Operating Company
(847) 317-5000
Plan Administrator:
Fort James Corporation
1650 Lake Cook Road, Deerfield, IL 60015-0089

Employer Identification Number (EIN):54-1237819
Plan Number: 033
Plan Year: January 1 through December 31
Plan Trustee: State Street Bank and Trust Co.
Master Trust Division
P. O. Box 1992 - M.S. D5
Boston, MA 02105-1992
Employee Benefits Committee:
Clifford A. Cutchins IV Jane R. Lateer

Daniel J. Girvan Joseph W. McGarr
Ernst A. Haberli

Agent for Service of Legal Process
(Legal notices may also be served on the Plan Administrator):
Clifford A. Cutchins, IV, Esquire
Fort James Corporation
1650 Lake Cook Road
Deerfield, IL 60015-0089

SCHEDULE A

Regular Straight Time Job Rate ("Blue Slip Rate")		Corresponding Monthly Flat Benefit Per Year of Benefit Service Payable at Age 65 on a Lifetime Only Basis					
From	To	4/1/00	4/1/01	4/1/02	4/1/03	4/1/04	4/1/05
16.51	16.85	31.00	33.00	34.50	35.50	36.50	38.50
16.86	17.19	31.50	33.50	35.00	36.00	37.00	39.00
17.20	17.53	32.00	34.00	35.50	36.50	37.50	39.50
17.54	17.87	32.50	34.50	36.00	37.00	38.00	40.00
17.88	18.22	33.00	35.00	36.50	37.50	38.50	40.50
18.23	18.56	33.50	35.50	37.00	38.00	39.00	41.00
18.57	18.90	34.00	36.00	37.50	38.50	39.50	41.50
18.91	19.24	34.50	36.50	38.00	39.00	40.00	42.00
19.25	19.58	35.00	37.00	38.50	39.50	40.50	42.50
19.59	19.92	35.50	37.50	39.00	40.00	41.00	43.00
19.93	20.26	36.00	38.00	39.50	40.50	41.50	43.50
20.27	20.61	36.50	38.50	40.00	41.00	42.00	44.00
20.62	20.95	37.00	39.00	40.50	41.50	42.50	44.50
20.96	21.30	37.50	39.50	41.00	42.00	43.00	45.00
21.31	21.65	38.00	40.00	41.50	42.50	43.50	45.50
21.66	22.00	38.50	40.50	42.00	43.00	44.00	46.00
22.01	22.35	39.00	41.00	42.50	43.50	44.50	46.50
22.36	22.70	39.50	41.50	43.00	44.00	45.00	47.00
22.71	23.05	40.00	42.00	43.50	44.50	45.50	47.50
23.06	23.40	40.50	42.50	44.00	45.00	46.00	48.00
23.41	23.75	41.00	43.00	44.50	45.50	46.50	48.50
23.76	24.11	41.50	43.50	45.00	46.00	47.00	49.00
24.12	24.47	42.00	44.00	45.50	46.50	47.50	49.50
24.48	24.83	42.50	44.50	46.00	47.00	48.00	50.00
24.84	25.19	43.00	45.00	46.50	47.50	48.50	50.50
25.20	25.55	43.50	45.50	47.00	48.00	49.00	51.00
25.56	25.91	44.00	46.00	47.50	48.50	49.50	51.50
25.92	26.27	44.50	46.50	48.00	49.00	50.00	52.00
26.28	26.63	45.00	47.00	48.50	49.50	50.50	52.50
26.64	26.98	45.50	47.50	49.00	50.00	51.00	53.00
26.99	27.33	46.00	48.00	49.50	50.50	51.50	53.50
27.34	27.68	46.50	48.50	50.00	51.00	52.00	54.00
27.69	28.03	47.00	49.00	50.50	51.50	52.50	54.50
28.04	28.38	47.50	49.50	51.00	52.00	53.00	55.00
28.39	28.73	48.00	50.00	51.50	52.50	53.50	55.50
28.74	29.08	48.50	50.50	52.00	53.00	54.00	56.00
29.09	29.43	49.00	51.00	52.50	53.50	54.50	56.50
29.44	29.78	49.50	51.50	53.00	54.00	55.00	57.00
29.79	30.13	50.00	52.00	53.50	54.50	55.50	57.50
30.14	30.48	50.50	52.50	54.00	55.00	56.00	58.00
30.49	30.83	51.00	53.00	54.50	55.50	56.50	58.50
30.84	31.18	51.50	53.50	55.00	56.00	57.00	59.00
31.19	31.54	52.00	54.00	55.50	56.50	57.50	59.50

Regular Straight Time Job Rate ("Blue Slip Rate")		Corresponding Monthly Flat Benefit Per Year of Benefit Service Payable at Age 65 on a Lifetime Only Basis					
From	To	4/1/00	4/1/01	4/1/02	4/1/03	4/1/04	4/1/05
31.55	31.88	52.50	54.50	56.00	57.00	58.00	60.00
31.89	32.23	53.00	55.00	56.50	57.50	58.50	60.50
32.24	32.58	53.50	55.50	57.00	58.00	59.00	61.00
32.59	32.93	54.00	56.00	57.50	58.50	59.50	61.50
32.94	33.28	54.50	56.50	58.00	59.00	60.00	62.00
33.29	33.63	55.00	57.00	58.50	59.50	60.50	62.50
33.64	33.98	55.50	57.50	59.00	60.00	61.00	63.00
33.99	34.33	56.00	58.00	59.50	60.50	61.50	63.50
34.34	34.68	56.50	58.50	60.00	61.00	62.00	64.00
34.69	35.03	57.00	59.00	60.50	61.50	62.50	64.50
35.04	35.38	57.50	59.50	61.00	62.00	63.00	65.00
35.39	35.73	58.00	60.00	61.50	62.50	63.50	65.50
35.74	36.08	58.50	60.50	62.00	63.00	64.00	66.00
36.09	36.43	59.00	61.00	62.50	63.50	64.50	66.50
36.44	36.78	59.50	61.50	63.00	64.00	65.00	67.00
36.79	37.13	60.00	62.00	63.50	64.50	65.50	67.50
37.14	37.48	60.50	62.50	64.00	65.00	66.00	68.00
37.49	37.83	61.00	63.00	64.50	65.50	66.50	68.50
37.84	38.18	61.50	63.50	65.00	66.00	67.00	69.00
38.19	38.53	62.00	64.00	65.50	66.50	67.50	69.50
38.54	38.88	62.50	64.50	66.00	67.00	68.00	70.00
38.89	39.23	63.00	65.00	66.50	67.50	68.50	70.50
39.24	39.58	63.50	65.50	67.00	68.00	69.00	71.00
39.59	39.93	64.00	66.00	67.50	68.50	69.50	71.50
39.94	40.28	64.50	66.50	68.00	69.00	70.00	72.00
40.29	40.63	65.00	67.00	68.50	69.50	70.50	72.50

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SUPPLEMENTAL AGREEMENTS
Layoff Pool

In accordance with Section 25 paragraphs A.14. and 1.3, the following job classifications shall be included in the Layoff Pool.

Department	Job
Storeroom	*Material Handler*
Converting	*Waste Baler*
Converting	*Roll Loader Box Facial*
Converting	*Quickstock Bagging*
Yard	Yard Laborer

Temporary expansion of the layoff pool classifications, under conditions of major curtailment, will be negotiated by the Union/Company Standing Committee.

Mechanics

1. Maintenance mechanics who are scheduled in advance to work 12 hour shifts will "eat on the fly" during such 12 hours shift and no lunch period will be scheduled.
2. Maintenance mechanics not scheduled in advance to work a 12 hour shift who are assigned, prior to the noon meal period, to work with a crew which is scheduled in advance and does work a 12 hour shift, will also "eat on the fly" during such 12 hour shift and no lunch period will be scheduled.

Welding Hood Plates

The Company agrees to supply prescription welder hood plates under the following conditions:

1. The employee request such a plate.
2. The employee performs welding as part of his regular work.
3. The employee normally wears prescription ground eye glasses.

Metric Tools

The Company agrees to have required metric tools available in the tool room for use as needed during the term of this agreement.

COMPRESSED WORK WEEK

It is understood that upon implementation of a compressed work week schedule:

1. There will be no decrease in quantity and quality of production.

2. There will be no adverse effects on employee safety, morale or attendance.

3. Adequate qualified replacements will continue to be available for relief purposes when required.

4. Qualified employee will continue to be available for wire and felt changes when required.

5. Overtime, call-time and any other extra costs will not be paid if incurred upon initial implementation or discontinuance of a compressed work week schedule.

6. If employees of a department want to cancel a schedule trial, a simple majority of employees in the department must express their desire to end the trial.

7. If employees of a department want to continue a schedule following a trial, at least 66 2/3 percent of the employees in the department must express their desire to continue the schedule.

The company and the union agree to modify the provisions of the labor agreement so that utilization of a compressed work week schedule will not result in additional cost to the company.

This understanding does not alter the company's rights under Section 2 -- Operating Control to decide to begin or to cease utilization of a compressed work week schedule.

COMPRESSED WORK WEEK LANGUAGE
WAUNA MILL

January 1, 1990
Revised April 1, 2000

For the purpose of a compressed work week schedule, the parties hereby mutually agree to the following terms and conditions:

1. Twelve (12) hour shift schedule will be permitted to those departments which, by a vote of 51%, have approved a trial period and/or then voted to work the schedule on a continuous basis by 66 2/3% approval.
2. The twelve (12) hour shift times of *7:00* a.m. to *7:00* p.m., and 7:00 p.m. to 7:00 a.m. will define a day as a period of twenty-four (24) hours beginning *7:00* a.m., and a week as a period of seven (7) calendar days beginning at *7:00* a.m. Monday.
3. The twelve (12) hour work schedule may be canceled by either party at the end of any eight week schedule cycle or within seven (7) days if mutually agreed to by the Union and the Company.
4. The implementation of the compressed work week will be on the conditions that the efficiency of any department or departments will not decrease.
5. It is clearly understood by both parties that replacements must be available of relief purposes when required. Replacements will normally come from employees on their scheduled days off. This coverage may be scheduled when necessary and be distributed as evenly as possible. When such overtime work is required, the Company will make reasonable effort to assign it to an employee(s) from the job classification in which the need for the overtime work occurred.
6. It is understood by both parties that problems may arise in working the compressed schedule. Should this occur, these problems will be referred to the Joint Standing Committee.
7. Overtime will not be paid if incurred as a result of the initial implementation or the discontinuation of the twelve (12) hour shift schedule.
8. Overtime at the rate of time and one-half will be paid

for all work in excess of eight (8) hours in any one day at the compressed pay rate for hours worked on the compressed work week schedule.

9. Tour workers shall receive time and one-half pay at the compressed rate for time worked on Sunday. Hours worked on Sunday past twelve (12) hours will be paid double time at the regular rate of pay.
10. Weekly indemnity benefits will continue to be calculated on the basis of seven (7) calendar days.
11. Floating holidays will be paid at the rate of the job assigned for that week. Rate of the job referenced, is not the compressed rate.
    a. Four 10 hour floaters or three 13½ hour floaters, with a maximum of 40 hours pay.
    b. If an employee elects to take a 10 hour or 13½ hour floating holidays, he will be committed for the rest of the year.
    c. Floaters earned by working formerly restricted periods will be computed at 12 hours and paid at the rate of the job assigned for that week the floater is taken.
12. If a floater or vacation is scheduled before the schedule is posted the preceding week (by 3:00 PM Friday), *no call time will be payable for the day shift coverage.* Call time will be paid for working the night shift on your day off.
13. Jury duty allowance is provided, however, such reimbursement shall not exceed twelve (12) hours pay at the regular rate or forty (40) hours per week.
14. The job rates of the blue slipped employees working the compressed work week schedule will be adjusted to .88235 of the rate established by the job analysis plan or job rate adjustment. However, overtime pay for work outside the regular compressed work week schedule, call time, paper machine clothing time, allowance for failure to provide work, vacation pay, holiday pay, and time worked on a holiday will be paid at the established rate of pay as defined in the Labor Agreement.

15. Funeral leave will be paid at the compressed pay rate.

16. Shift differential will be paid for all time worked on the compressed work week schedule, by calculating the current average shift differential as provided for in the labor agreement adjusted to .88235.

17. Group term life insurance, AD&D, weekly sickness and accident coverages and retirement plan monthly benefit rates will be based on the established job rate.

18. Attached is the eight week cycle for the compressed work week schedule that will be worked. (Attached Exhibit A).

19. Except as outlined above, the terms and conditions of the existing collective agreement remain unchanged.

20. Employees scheduled to attend meetings or training sessions on the mill site, including the Westport area, on a day they would have worked a twelve hour compressed shift, will be allowed to return to their regular scheduled twelve hour compressed shift after the training session in order for them to complete a twelve hour shift at the compressed rate of pay. The employee may elect to go home at the end of the training, and receive pay for time spent at the training at the regular job rate. Employees electing to go home shall not be paid more than they would have received on the compressed shift. For further clarification on scheduling and paying employees, see attached Exhibit B.

The parties agree that employees who work the Compressed Schedule may be scheduled to work on one of their assigned days off during each calendar quarter, for purposes outlined below, and Call Time will not be payable for that period of work.

The purpose of this provision is to facilitate those types of interactions where work teams (such as entire shifts or

crews, groups of crews, and/or persons in the same job classification or who perform similar duties), rather than individuals, are required. Examples of these types of interactions could include:

- *Safety training.*
- Training required to comply with federal, state, or corporate requirements.
- Quality/process improvement work where group input and discussion is necessary. Examples could include Standard Operating Procedures, centerlining, project design or review.
- Update or refresher training related to a work team's or job classification's area of responsibility at Wauna.

Groundrules for this quarterly time include:

- Days may not be accumulated or carried over quarter to quarter.
- A quarter is January-March, April-June, July-September, and October-December.
- One day per quarter **may** be so used but does not have to be used.
- The day each quarter is scheduled reasonably in advance.
- The intent is that these days not be devoted to scheduling a person in on their assigned day off to perform "normal" work.

21. If necessary on shift promotions may be made for any *reason extending up to two weeks for departments* under the compressed work week schedule. Necessary as defined means those situations when a senior move is not possible due to the conflict created by working a Sunday night shift and then a senior move to a Monday day shift.

22. Employees who work on a holiday when call time is payable, will be paid 6 hrs. Call time for working their regular scheduled 12 hour compressed shift. Employees who work during the 8 hour holiday period, when call time is payable, will be paid 4 hours call time.

23. In no case shall an employee work more than 1, 4 consecutive nights in an 8 week cycle, for the regular compressed schedule. If this is violated the last two nights of the 4 day work period shall be paid as the employee's days off. This does not apply for filling Relief Supervisor Positions.

24. It is understood that the language in Section 16, Paragraph B does not apply for the regular compressed schedule since in no situation would the regular scheduled days off change.

25. One hour floating holiday pay for each hour worked within the formerly restricted time period while on the compressed schedule. In no case shall this be more than 12 hours for a restricted period. Employees may elect 12 hours off for 8 hours pay. An employee who works on July 3 of their day off during the restricted period will be granted a 12 hour floater.

26. Department Special Provisions, see attached Exhibits C and D.

EXHIBIT A

COMPRESSED WORK WEEK SCHEDULE
8 WEEKS TO COMPLETE ONE CYCLE

	WEEK 1							WEEK 2							WEEK 3							WEEK 4						
	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
DAYS	B	B	C	C	D	D	A	A	B	B	C	C	D	D	A	A	B	B	C	C	D	D	A	A	B	B	C	C
NIGHTS	A	A	B	B	C	C	D	D	A	A	B	B	C	C	D	D	A	A	B	B	C	C	D	D	A	A	B	B
OFF	C	C	A	A	A	A	C	C	C	C	A	A	A	A	C	C	C	C	A	A	A	A	C	C	C	C	A	A
OFF	D	D	D	D	B	B	B	B	D	D	D	D	B	B	B	B	D	D	D	D	B	B	B	B	D	D	D	D

	WEEK 5							WEEK 6							WEEK 7							WEEK 8						
	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
DAYS	D	D	A	A	B	B	C	C	D	D	A	A	B	B	C	C	D	D	A	A	B	B	C	C	D	D	A	A
NIGHTS	C	C	D	D	A	A	B	B	C	C	D	D	A	A	B	B	C	C	D	D	A	A	B	B	C	C	D	D
OFF	A	A	C	C	C	C	A	A	A	A	C	C	C	C	A	A	A	A	C	C	C	C	A	A	A	A	C	C
OFF	B	B	B	B	D	D	D	D	B	B	B	B	D	D	D	D	B	B	B	B	D	D	D	D	B	B	B	B

The following guidelines are intended to provide consistency in paying employees who attend meetings on the compressed schedule in a way that minimizes the cost impact and inconveniences to the employee and the company.

Where possible, it is recommended that meetings be scheduled in the a.m., 7:00 to 9:00, and not last more than two hours. This will afford employees the opportunity to stay over and avoid disruption of the schedule.

When it is unavoidable to schedule a.m. meetings or when longer duration meetings are necessary, the following guidelines should be followed:

EXAMPLE 1. Meeting on day 1 or day 2:

DAY 1	DAY 2	DAY 3	DAY 4
DAYS	DAYS	NIGHTS	NIGHTS

Employee goes to the meeting and at the end of the meeting gets paid for time at the meeting, at the non-compressed rate and goes home, or comes back to the department to complete a 12 hour day shift and receives 12 hours pay at compressed rate.

EXAMPLE 2. Meeting during day shift on day 3:

DAY 1	DAY 2	DAY 3	DAY 4
DAYS	DAYS	NIGHTS	NIGHTS

Employee goes to the meeting and at the end of the meeting gets paid for the time at the meeting, at the non-compressed rate and goes home, or comes back to the department to complete a 12 hour day shift and receives 12 hrs. Pay at compressed rate. Employee works nights of day 4.

EXAMPLE 3. Meeting on day shift of day 4:

DAY 1	DAY 2	DAY 3	DAY 4
DAYS	DAYS	NIGHTS	NIGHTS

Employee works 12 hrs. **On day shift of day 3.** On day 4, employee goes to the meeting. At the end of the meeting employee gets paid for time at the meeting, at the non-compressed rate and goes home, or comes back to the department to complete a 12 hour day shift and receives 12 hrs. Pay at the compressed rate.

EXAMPLE 4. Meeting on day shift of day 5:

DAY 2	DAY 3	DAY 4	DAY 5
DAYS	NIGHTS	NIGHTS	DAY OFF

If the meeting will last longer than 4 hours, the employee does not work on day 4 and goes to the meeting on day 5. The employee is paid 12 hrs. At compressed rate of pay.

EXAMPLE 5.

DAY 1	DAY 2	DAY 3	DAY 4
DAYS	DAYS	NIGHTS	NIGHTS

Employees who are scheduled to attend meetings which are less than 4 hours on day 3 and 4 may, with the approval of the supervisor, attend the scheduled meeting and work the shift as scheduled. Example: meeting 8-12:00 on day 3. Employee attends the meeting and is paid for the meeting time. The employee then works the scheduled shift.

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COMPRESSED WORK WEEK SCHEDULING - Special Conditions Which Apply to Process Services Department

A. TEMPORARY VACANCIES IN THE DAY JOB CLASSIFICATIONS WHICH ARE KNOWN BEFORE THE SCHEDULE IS POSTED (WEDNESDAY) WILL BE FILLED BY CWW TESTERS IN THE ORDER OF THEIR SENIORITY.

B. MANAGEMENT WILL MAKE A REASONABLE EFFORT TO ENSURE THAT CWW TESTERS PROMOTED TO FILL SCHEDULED VACANCIES IN DAY JOB CLASSIFICATIONS WILL REMAIN SCHEDULED FOR A DAY JOB FOR AT LEAST TWO CONSECUTIVE WORK WEEKS PRIOR TO REASSIGNMENT BACK TO THE COMPRESSED WORK WEEK SCHEDULE.

C. TEMPORARY VACANCIES OF A WEEK OR MORE IN DAY JOB CLASSIFICATIONS WHICH WERE NOT KNOWN BEFORE SCHEDULE WAS POSTED (WEDNESDAY) SHALL BE FILLED FROM THE CWW TESTERS AS FOLLOWS:

1. The qualified Paper Tester who would normally work days on Sunday of the prior week shall be promoted to the day work schedule for the entire week. The tester would cover either the Monday shift or the Wednesday shift.
2. If the Paper Tester in (1) is not qualified, the senior qualified Paper Tester shall be promoted to the day work schedule for the entire week. (A Paper Tester working night shift on Sunday would not be eligible to cover a day work schedule beginning Monday.)

D. FLOATING HOLIDAY COVERAGE

1. Floating holidays shall be covered by the qualified tester who is on his second or third day off. If a day worker's floating holiday can not be covered by another day worker, the vacancy may be covered by the senior qualified Paper Tester on his day off.

2. A CWW Tester who primarily works relief on day jobs may elect to take all of his floating holidays while relieving on a day job. If he elects to take his floating holidays while relieving on a day job, he must take all of his floaters while on relief and he will be paid 8 hours per floater.

SPECIAL CONDITIONS WHICH APPLY TO SHIFT MECHANICS

The Standing Committee (Company and Union) and the Compressed Work Week Committee have agreed to the following language to clarify the rate of pay for relief shift mechanics who work the Compressed Schedule.

> Relief coverage will be paid per contract agreement for vacation, holiday, and absences less than two weeks. When known in advance that relief coverage will be necessary for period longer than two weeks, excluding vacation and holiday coverage, the compressed rate will be paid.

SPECIAL CONDITIONS WHICH APPLY TO CONVERTING

On shift promotions may be made for any reason extending up to two weeks.

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P.A.C.E. Sponsored 401 (K) PLAN

The Company hereby agrees to continue to provide payroll deduction services for those hourly employees enrolled in the P.A.C.E. Sponsored 401(k) Plan, as outlined in the Standard *Form of Agreement.*

WAUNA DRUG/ALCOHOL POLICY

I. Fort James Corporation and PACE Local 8-1097 believes that a working environment unaffected by alcohol and drugs fosters safety, quality, service and productivity, and is in the best interest of all employees.

II. Every employee shares in the responsibility to support a drug and alcohol-free environment.

III. Fort James will work actively to educate employees about the implications of drug and alcohol problems by working closely with employee groups and Local 8-1097 representing our hourly employees. Fort James will strive to develop a cooperative approach with all employees in dealing with the problem of drugs and alcohol. Toward that end, the Company offers an Employee Assistance (E.A.P.) to help employees and their families with alcohol and drug-related problems, as well as other personal problems. Participation in these programs is confidential and has proven to be *effective in helping our employees and their families with* drug and/or alcohol related difficulties.

IV. An employee will be required to submit to an alcohol or drug test to determine the presence of alcohol or illegal use of a controlled substance:

a) When s/he exhibits visible signs or abnormal behavior resulting **in a reasonable suspicion** that the employee may be in violation of the drug and alcohol policy. Before a decision is made on whether to test an employee for the presence of drugs or alcohol, based upon **reasonable suspicion**, the supervisor will:
   1) involve another supervisor (if available in a timely manner) to verify the observations.
   2) involve the Human Resources department (if available in a timely manner).
   3) involve a shop steward as an observer (if available in a timely manner).

b) When s/he is involved in a job related incident resulting in medical attention beyond first aid available in the mill (the only exception to this would be for a repetitive, cumulative exposure injury/illness i.e. carpal tunnel syndrome and hearing loss), or is otherwise involved in an incident that results in such injury or near miss to another individual.

V. Testing:

a.) Any testing will be administered by a qualified company representative or a qualified laboratory.

1. Pending results of the test, the employee will not return to work.
2. If the test is negative, the employee will be made whole for any lost wages. As appropriate, the employee would still be subject to the current disciplinary process.
3. If the test is positive, the employee will not be reimbursed for any lost wages and, under normal circumstances, will be given a management referral to E.A.P.
4. Any management referral as a result of this process will follow standard E.A.P. guidelines.
5. If an employee goes through a drug or alcohol treatment program as a result of a management referral, the employee may be required, by the company, to submit to random testing for up to two years, or as may be prescribed in a "Last Chance Agreement", following the referral.

b.) Current* threshold limits

ALCOHOL/DRUG	SAMHSA/DOT
Alcohol	.04
Amphetamine	1000 ng/ml
Methamphetamine	1000 ng/ml
Cocaine	300 ng/ml
Marijuana	50 ng/ml
Opiates (Broad range)	300 ng/ml
1. Codeine	2000 ng/ml
2. Morphine	2000 ng/ml

* Subject to changes made by SAMHSA (formerly NIDA) or DOT.

VI. Refusal to submit to a drug or alcohol test or any effort to adulterate a sample or otherwise invalidate the results of any test shall be cause for discharge.

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FORT JAMES
WAUNA MILL

AND

P.A.C.E.
Local 8-1097

Revised: 4/1/2000

FORT JAMES
WAUNA MILL

AND

P.A.C.E.
Local 8-1097

EXHIBIT A-4
Wage Rates

&

EXHIBIT B
Health Plan and Spending Accounts
(Summary Plan Descriptions)

Revised: 4/1/2000

EXHIBIT A-4

Wage Rates

Schedule A-4 (Wage Tables)

	2% Effective (4/1/00 – 3/31/01)		2.5% Effective (4/1/01 – 3/31/02)		2.5% Effective (4/1/02 – 3/31/04)		2% Effective (4/1/04 – 3/31/05)		3.0% Effective (4/1/05 – 3/31/06)	
	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed
WOOD PREPARATION										
Tugboat Operator	21.970	19.385	22.545	19.870	23.080	20.365	23.540	20.770	24.250	21.395
Log Stacker Operator	20.860	18.405	21.390	18.865	21.915	19.335	22.355	19.725	23.025	20.316
Chip Technician	20.650	18.220	21.185	18.675	21.695	19.140	22.130	19.525	22.790	20.110
Crane Operator - Logs (2 Shifts)	20.550	18.130	21.060	18.585	21.590	19.050	22.020	19.430	22.680	20.010
Chip Quality Technician (1st 3 mos.)	20.140	17.770	20.645	18.215	21.160	18.670	21.585	19.045	22.235	19.615
Crane Operator - Logs (Days)	19.940	17.595	20.440	18.035	20.950	18.485	21.370	18.855	22.010	19.420
Tugboat Mate	19.535	17.235	20.020	17.665	20.520	18.110	20.935	18.470	21.560	19.025
Senior Boom Boat Operator	19.535	17.235	20.020	17.665	20.520	18.110	20.935	18.470	21.560	19.025
44" Barker-Chipper Operator	19.330	17.055	19.815	17.485	20.310	17.920	20.715	18.280	21.335	18.825
Junior Boom Boat Operator	19.130	16.875	19.605	17.300	20.095	17.730	20.500	18.085	21.115	18.630
Knife Grinder	19.130	16.875	19.605	17.300	20.095	17.730	20.500	18.085	21.115	18.630
27" Barker-Chipper Operator	18.925	16.700	19.400	17.115	19.885	17.545	20.280	17.895	20.890	18.430
Grapple Crane Operator	18.925	16.700	19.400	17.115	19.885	17.545	20.280	17.895	20.890	18.430
Deck	17.505	15.445	17.940	15.830	18.390	16.225	18.760	16.550	19.320	17.050
Hog and Conveyor - Utility	17.505	15.445	17.940	15.830	18.390	16.225	18.760	16.550	19.320	17.050
Utility	17.300	15.265	17.735	15.645	18.175	16.040	18.540	16.360	19.095	16.850
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
Chip Screens										
Chip Screen Room Operator	20.550	18.130	21.060	18.585	21.590	19.050	22.020	19.430	22.680	20.010
Crane Operator - Chips	20.245	17.860	20.750	18.310	21.270	18.765	21.695	19.140	22.345	19.715
Front End Loader Operator	19.940	17.595	20.440	18.035	20.950	18.485	21.370	18.855	22.010	19.420
Chip Screen Room Utility	18.010	15.895	18.460	16.290	18.925	16.695	19.300	17.030	19.880	17.540
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
UTILITIES										
Utilities Lead Operator	26.635	23.500	27.300	24.090	27.985	24.690	28.545	25.185	29.400	25.940
Recovery Operator	24.905	21.710	25.220	22.256	25.850	22.810	26.370	23.266	27.160	23.966
Assistant Utilities Operator	22.475	19.830	23.035	20.325	23.615	20.835	24.085	21.250	24.810	21.890
Assistant Recovery Operator	19.735	17.415	20.230	17.850	20.735	18.295	21.150	18.660	21.785	19.220

	2%		2.5%		2.5%		2%		3.0%	
	Effective (4/1/00 - 3/31/01)		Effective (4/1/01 - 3/31/02)		Effective (4/1/02 - 3/31/04)		Effective (4/1/04 - 3/31/05)		Effective (4/1/05 - 3/31/06)	
	Base Slip	Compressed	Base Slip	Compressed	Base Slip	Compressed	Base Slip	Compressed	Base Slip	Compressed
Junior Assistant	16.215	16.070	16.670	16.475	19.135	16.885	19.520	17.225	20.105	17.740
Utilities Services Operator	22.600	20.010	23.245	20.510	23.925	21.025	24.305	21.445	25.030	22.085
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
PULPING OPERATIONS										
Kraft Mill										
Pulping Operator	25.620	22.605	26.260	23.170	26.920	23.750	27.455	24.225	28.280	24.956
Bleach Operator	24.200	21.356	24.805	21.885	25.425	22.435	25.935	22.885	26.710	23.570
Caustic and Kiln Operator	22.170	19.565	22.725	20.050	23.295	20.555	23.760	20.965	24.470	21.585
Senior Pulping Assistant	21.755	19.205	22.310	19.685	22.865	20.175	23.325	20.580	24.025	21.200
Junior Pulping Assistant	21.360	18.845	21.895	19.320	22.440	19.800	22.890	20.196	23.575	20.800
Senior Bleach Assistant	21.055	18.580	21.580	19.040	22.120	19.520	22.565	19.910	23.240	20.505
Junior Bleach Assistant	16.215	16.070	16.670	16.475	19.135	16.885	19.520	17.225	20.105	17.740
Shift Utility	17.705	15.625	18.150	16.015	18.606	16.416	18.975	16.745	19.545	17.245
Day Utility	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
Pulp Dryer										
Pulp Dryer Operator	21.970	19.385	22.515	19.870	23.080	20.365	23.540	20.770	24.250	21.395
Senior Pulp Baler Operator	19.230	16.965	19.710	17.390	20.205	17.825	20.805	18.180	21.225	18.730
Junior Pulp Dryer Operator	18.115	15.980	18.565	16.380	19.000	16.760	19.410	17.125	19.995	17.640
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
STOCK PREPARATION										
Shift Lead Operator	25.720	22.695	26.365	23.265	27.025	23.845	27.565	24.320	28.390	25.050
Color Technician A	22.375	19.740	22.935	20.235	23.505	20.740	23.975	21.155	24.695	21.780
Color Tech. B (1st 3 months)	21.155	18.670	21.685	19.135	22.230	19.615	22.670	20.005	23.355	20.605
Additives Mixer	21.155	18.670	21.685	19.135	22.230	19.615	22.670	20.005	23.355	20.605
Operator - #4	20.690	18.220	21.165	18.675	21.695	19.140	22.130	19.525	22.790	20.110
Pulper Operator #1 & #2	19.735	17.415	20.230	17.850	20.735	18.295	21.150	18.660	21.785	19.220
Pulper Operator #2	18.215	16.070	18.670	16.475	19.135	16.885	19.520	17.225	20.105	17.740
Assistant Pulper Oper. #1 & #2	18.115	15.980	18.565	16.380	19.030	16.790	19.410	17.125	19.995	17.640
Utility	17.405	15.355	17.840	15.740	18.285	16.135	18.650	16.455	19.210	16.950
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280

	2% Effective (4/1/00 – 3/31/01)		2.5% Effective (4/1/01 – 3/31/02)		2.5% Effective (4/1/02 – 3/31/04)		2% Effective (4/1/04 – 3/31/05)		3.0% Effective (4/1/05 – 3/31/06)	
	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed
1 & 2 PAPER MACHINES										
Machine Tender #2	29.480	26.010	30.215	26.660	30.970	27.330	31.590	27.875	32.540	28.710
Machine Tender #1	29.375	25.830	30.010	26.475	30.760	27.140	31.375	27.680	32.315	28.510
Back Tender #2	25.825	22.785	26.470	23.356	27.130	23.940	27.675	24.420	28.505	25.150
Back Tender #1	25.720	22.695	26.365	23.265	27.025	23.845	27.585	24.320	28.390	25.050
Third Hand #2	22.575	19.920	23.140	20.420	23.720	20.930	24.195	21.350	24.920	21.990
Third Hand #1	22.475	19.830	23.035	20.325	23.615	20.835	24.065	21.250	24.810	21.890
Fourth Hand #2	20.140	17.770	20.645	18.215	21.160	18.670	21.565	19.045	22.235	19.615
Fourth Hand #1	20.040	17.685	20.540	18.125	21.055	18.580	21.475	18.950	22.120	19.520
Fifth Hand #1 & #2	18.920	16.430	19.085	16.845	19.565	17.260	19.955	17.605	20.555	18.135
Utility/Sixth Hand #1 & #2	17.910	15.805	18.360	16.200	18.815	16.605	19.195	16.935	19.770	17.445
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
4 PAPER MACHINE										
Machine Tender	30.395	26.820	31.155	27.490	31.935	28.175	32.570	28.740	33.550	29.600
Back Tender	26.735	23.590	27.405	24.180	28.090	24.785	28.650	25.280	29.510	26.040
Third Hand	22.985	20.280	23.555	20.785	24.145	21.305	24.630	21.730	25.370	22.385
Fourth Hand	20.345	17.950	20.855	18.400	21.375	18.850	21.805	19.240	22.455	19.815
Fifth Hand	18.825	16.610	19.295	17.025	19.775	17.450	20.170	17.800	20.775	18.335
Utility/Sixth Hand	18.215	16.070	18.670	16.475	19.135	16.885	19.520	17.225	20.105	17.740
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
5 PAPER MACHINE										
Machine Tender	32.955	29.080	33.780	29.806	34.625	30.550	35.315	31.160	36.375	32.095
Back Tender	28.785	25.380	29.495	26.015	30.220	26.665	30.825	27.200	31.750	28.015
Machine Assistant	22.985	20.280	23.555	20.785	24.145	21.305	24.630	21.730	25.370	22.385
Roll Handling Utility (Seasonal)	18.010	15.895	18.460	16.290	18.925	16.695	19.300	17.030	19.880	17.540
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
PAPER MACHINES - MISC.										
Machine Clothing & Supplies Coordinator	21.055	18.580	21.580	19.040	22.120	19.520	22.585	19.910	23.240	20.505
Head Roll Wrapper Operator	19.130	16.875	19.605	17.300	20.095	17.730	20.500	18.085	21.115	18.630
Machine Clothing & Supplies Mt. Handler	20.245	17.860	20.750	18.310	21.270	18.765	21.695	19.140	22.345	19.715
Rewinder Operator 72"	18.315	16.160	18.775	16.565	19.245	16.980	19.630	17.320	20.215	17.840
Roll Wrapper Operator	17.705	15.625	18.150	16.015	18.605	16.415	18.975	16.745	19.545	17.245

	2% Effective (4/1/00 – 3/31/01)		2.5% Effective (4/1/01 – 3/31/02)		2.5% Effective (4/1/02 – 3/31/04)		2% Effective (4/1/04 – 3/31/05)		3.0% Effective (4/1/05 – 3/31/06)	
	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed
Crimper and Header Operator	17.500	16.285	17.735	16.845	18.175	16.040	18.540	16.350	19.095	16.850
Utility #4 PM	17.300	15.285	17.735	15.845	18.175	16.040	18.540	16.360	19.095	16.850
Rewinder Helper	17.900	15.085	17.525	15.465	17.965	15.850	18.325	16.170	18.875	16.655
Cleanup #1 & #2 P.M.	17.100	15.085	17.525	15.465	17.965	15.850	18.325	16.170	18.875	16.655
Cleanup	17.100	15.085	17.525	15.465	17.965	15.850	18.325	16.170	18.875	16.655
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
CONVERTING OPERATIONS										
Folded Products										
Napkins										
Head Adjuster - Lead	24.200	21.355	24.805	21.885	25.425	22.435	25.935	22.885	26.710	23.570
Intermediate Adjuster	20.955	18.490	21.475	18.950	22.015	19.425	22.455	19.815	23.130	20.405
Operator Adjuster	19.635	17.325	20.125	17.760	20.630	18.200	21.040	18.565	21.675	19.125
Case Sealer Operator	18.925	16.700	19.400	17.115	19.885	17.545	20.280	17.895	20.890	18.430
Sealer Helper	18.115	15.980	18.565	16.380	19.030	16.790	19.410	17.125	19.995	17.640
Operator - Annex	18.315	16.160	18.775	16.565	19.245	16.980	19.630	17.320	20.215	17.840
Operator - Consumer	18.420	16.250	18.880	16.656	19.350	17.075	19.735	17.415	20.330	17.935
Operator - Main Floor	18.215	16.070	18.670	16.475	19.135	16.885	19.520	17.225	20.106	17.740
Helper (Napkin)	17.100	15.085	17.525	15.465	17.965	15.850	18.325	16.170	18.875	16.655
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
Box Facts!										
Head Adjuster - Lead	22.375	19.740	22.935	20.235	23.506	20.741	23.975	21.155	24.695	21.790
Unitizing Operator	19.735	17.415	20.230	17.850	20.735	18.295	21.150	18.660	21.785	19.220
Carloner Operator	19.230	16.965	19.710	17.390	20.205	17.825	20.605	18.180	21.225	18.730
Backstand Operator	18.420	16.250	18.880	16.655	19.360	17.075	19.735	17.415	20.330	17.935
Roll Loader	17.506	15.445	17.940	15.830	18.390	16.225	18.760	16.550	19.320	17.050
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280

	2% Effective (4/1/00 – 3/31/01)		2.5% Effective (4/1/01 – 3/31/02)		2.5% Effective (4/1/02 – 3/31/04)		2% Effective (4/1/04 – 3/31/05)		3.0% Effective (4/1/05 – 3/31/06)	
	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed
CONVERTING OPERATIONS										
Rolled Products										
Household Towel										
Adjuster	23.185	20.460	23.765	20.970	24.360	21.495	24.845	21.925	25.590	22.580
Operator-Adjuster	20.760	18.310	21.270	18.765	21.800	19.235	22.235	19.620	22.905	20.210
Winder Operator	19.540	17.505	20.335	17.940	20.840	18.390	21.260	18.760	21.895	19.320
Utility Operator	18.115	15.980	18.565	16.380	19.030	16.790	19.410	17.125	19.995	17.640
Palletizer Operator	17.705	15.625	18.150	16.015	18.605	16.415	18.975	16.745	19.545	17.246
Laborer	16.715	14.750	17.135	15.120	17.560	15.496	17.915	15.805	18.450	16.280
Tissue										
No. 7 & No. 8 Complex										
Adjuster	23.895	21.085	24.495	21.610	25.105	22.150	25.610	22.595	26.375	23.275
Operator-Adjuster	21.055	18.580	21.580	19.040	22.120	19.520	22.565	19.910	23.240	20.505
Utility	18.720	16.520	19.190	16.930	19.670	17.355	20.065	17.705	20.665	18.235
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
No. 3, 4 & 5 Complex										
Adjuster	21.560	19.025	22.100	19.500	22.655	19.990	23.105	20.390	23.800	21.000
Operator-Adjuster	19.940	17.595	20.440	18.035	20.950	18.485	21.370	18.855	22.010	19.420
Utility Operator	18.520	16.340	18.980	16.750	19.455	17.165	19.845	17.510	20.440	18.035
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
General Converting										
Converting Hi-Lift Coordinator	19.230	16.965	19.710	17.390	20.205	17.825	20.605	18.180	21.225	18.730
Rolled Quickstock Operator	18.525	16.610	19.295	17.025	18.775	17.460	20.170	17.800	20.775	18.335
Rolled Quickstock Utility	18.520	16.430	19.080	16.840	19.555	17.260	19.945	17.606	20.585	18.135
Trucker, Hi-Lift Driver	18.520	16.340	18.980	16.750	19.455	17.165	19.845	17.510	20.440	18.035
Cornmaker	18.520	16.340	18.980	16.750	19.455	17.165	19.845	17.510	20.440	18.035
Waste Baler	17.510	15.715	18.255	16.105	18.710	16.510	19.085	16.840	19.655	17.345
Quick Stock - Handstacker	17.100	15.085	17.525	15.455	17.965	15.850	18.325	16.170	18.875	16.655
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280

	2%		2.5%		2.5%		2%		3.0%	
	Effective (4/1/00 - 3/31/01)		Effective (4/1/01 - 3/31/02)		Effective (4/1/02 - 3/31/04)		Effective (4/1/04 - 3/31/05)		Effective (4/1/05 - 3/31/06)	
	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed
SHIPPING, UNITIZING AND WAREHOUSING										
Shipping										
Warehouse Coordinator Lead	22.880	20.190	23.455	20.695	24.040	21.210	24.520	21.635	25.255	22.285
Dpy Coordinator	21.865	19.295	22.415	19.775	22.975	20.270	23.435	20.675	24.135	21.295
Barge Loader/Coordinator	20.750	18.310	21.270	18.765	21.800	19.235	22.236	19.620	22.905	20.210
Barge Loader	19.430	17.145	19.920	17.575	20.415	18.015	20.825	18.375	21.450	18.925
Trucker H.L Coordinator	19.130	16.875	19.605	17.300	20.095	17.730	20.500	18.085	21.115	18.630
Trucker - H.L	18.925	16.700	19.400	17.115	19.885	17.545	20.280	17.895	20.890	18.430
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
Unitizing										
Unitizer Operator/Coordinator	21.480	18.935	21.995	19.410	22.545	19.895	23.000	20.295	23.690	20.900
Assistant Unitizer Operator	20.445	18.040	20.960	18.490	21.480	18.956	21.910	19.335	22.570	19.915
Warehouse Checker	20.140	17.770	20.645	18.215	21.160	18.670	21.585	19.045	22.235	19.615
Trucker Checker	19.535	17.235	20.020	17.665	20.520	18.110	20.935	18.470	21.560	19.025
Truck Door Checker	16.925	16.700	19.400	17.115	19.885	17.545	20.280	17.895	20.890	18.430
Canon Trucker	17.910	15.805	18.360	18.200	18.815	16.605	19.195	16.935	19.770	17.445
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
MAINTENANCE SUPPORT										
Mechanics										
J Mechanic (6 Months/1200 hrs. as Instr. A)	24.950	22.015	25.575	22.565	26.215	23.220	26.845	23.685	27.750	24.485
Instr. Mech. A (6 Months/1200 hrs. as Instr.)	20.970	18.500	21.490	18.965	22.030	19.440	22.470	19.825	23.145	20.420
Instr. Mech (6 Months/1200 hrs. as Jr. A)	20.565	18.145	21.075	18.595	21.605	19.060	22.035	19.445	22.695	20.025
Jr. Mech. A (6 Months/1200 hrs. as Jr. Mech.)	20.360	17.965	20.870	18.415	21.390	18.875	21.820	19.250	22.475	19.830
Jr. Mechus (6 Months/600 hrs. as Sr. Helper)	20.155	17.785	20.660	18.230	21.175	18.685	21.600	19.060	22.250	19.630
Sr. Helper (6 Months/600 hrs. as Helper)	18.945	16.715	19.415	17.130	19.900	17.555	20.295	17.910	20.905	18.445
Helper	18.535	16.355	18.995	16.780	19.470	17.190	19.860	17.525	20.455	18.050
Oilers										
Senior Oiler (after 12 Months as Oiler)	21.095	18.615	21.620	19.080	22.165	19.555	22.608	19.945	23.285	20.545
Oiler (after 6 Months as Jr. Oiler)	20.240	17.860	20.750	18.305	21.265	18.765	21.690	19.140	22.345	19.715
Junior Oiler (after 6 Months as Helper)	19.430	17.145	19.915	17.575	20.415	18.015	20.825	18.375	21.445	18.925
Helper Oiler	18.825	16.610	19.296	17.025	19.760	17.450	20.175	17.800	20.780	18.335

	2%		2.5%		2.5%		2%		3.0%	
	Effective (4/1/00 – 3/31/01)		Effective (4/1/01 – 3/31/02)		Effective (4/1/02 – 3/31/04)		Effective (4/1/04 – 3/31/05)		Effective (4/1/05 – 3/31/06)	
	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed
Manufacturing Support Group										
Senior Equipment Operator	20.045	17.690	20.550	18.130	21.060	18.585	21.485	18.955	22.130	19.525
Equipment Operator	19.435	17.145	19.920	17.575	20.415	18.015	20.825	18.375	21.450	18.925
Yard Worker	17.805	15.710	18.250	16.105	18.705	16.505	19.080	16.835	19.655	17.340
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
Maintenance Support Misc.										
Materials Controller	18.520	16.340	18.980	16.750	19.455	17.165	19.845	17.510	20.440	18.035
Truck Shop Utility	18.315	16.160	18.775	16.565	19.245	16.980	19.630	17.320	20.215	17.840
Materials Handler	18.215	16.070	18.670	16.475	19.135	16.885	19.520	17.225	20.105	17.740
Salvage	17.910	15.805	18.360	16.200	18.815	16.605	19.195	16.935	19.770	17.445
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
Stores										
Records Coordinator	19.735	17.415	20.230	17.850	20.735	18.295	21.150	18.660	21.785	19.220
Freight Processing	19.130	16.875	19.605	17.300	20.095	17.730	20.500	18.085	21.115	18.630
Dispensing (After 1 Year)	18.620	16.430	19.085	16.840	19.565	17.260	19.955	17.605	20.555	18.130
Dispensing (After 6 mos.)	17.705	15.625	18.150	16.015	18.605	16.415	18.975	16.745	19.545	17.245
Dispensing (1st 6 mos.)	17.300	15.265	17.735	15.645	18.175	16.040	18.540	16.360	19.095	16.850
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
MISCELLANEOUS SUPPORT										
Emergency Response Support										
Emerg. Response Coord. (after 6 mos.)	22.680	20.190	23.455	20.695	24.040	21.210	24.520	21.635	25.255	22.265
Emerg. Response Coord. (1st 6 mos.)	21.950	19.545	21.895	19.320	22.440	19.800	22.890	20.195	23.575	20.800
Fire System Inspector	19.940	17.595	20.440	18.035	20.950	18.485	21.370	18.856	22.010	19.420
Laborer	16.715	14.750	17.135	15.120	17.560	15.495	17.915	15.805	18.450	16.280
TECHNICAL SERVICES										
Process Testing										
Senior Technician A	22.985	20.280	23.555	20.785	24.145	21.305	24.630	21.730	25.370	22.385
Senior Quality Technician A	22.170	19.565	22.725	20.050	23.295	20.555	23.760	20.965	24.470	21.595
Senior Technician B (1st 9 mos)	21.970	19.385	22.515	19.870	23.080	20.365	23.540	20.770	24.250	21.395
Solutions Technician	21.765	19.206	22.310	19.685	22.865	20.175	23.325	20.580	24.025	21.200

	2%		2.5%		2.5%		2%		3.0%	
	Effective (4/1/00 – 3/31/01)		Effective (4/1/01 – 3/31/02)		Effective (4/1/02 – 3/31/04)		Effective (4/1/04 – 3/31/05)		Effective (4/1/05 – 3/31/06)	
	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed	Blue Slip	Compressed
Senior Quality Technician A (1st 6 mos.)	21,155	19,620	21,685	19,135	22,230	19,615	22,670	20,005	23,356	20,605
Process Technician A	21,155	18,670	21,685	19,135	22,230	19,615	22,670	20,005	23,356	20,605
Process Technician B (1st 3 mos.)	20,345	17,960	20,855	18,400	21,375	18,860	21,806	19,240	22,458	19,815
Paper Tester	19,535	17,238	20,020	17,665	20,520	18,110	20,935	18,470	21,560	19,025
Pulp Tester	18,720	18,620	19,190	18,930	19,670	17,355	20,065	17,705	20,665	18,235
Product Quality & Development										
Quality Technician A - Tissue	20,955	18,490	21,475	18,850	22,015	19,425	22,455	19,815	23,130	20,405
Quality Tech. A - Comm. Papers	20,750	18,310	21,270	18,765	21,800	19,235	22,235	19,620	22,905	20,210
Quality Technician B - Tissue (1st 6 mos.)	19,940	17,595	20,440	18,035	20,950	18,485	21,370	18,855	22,010	19,420
Quality Tech. A - Comm. Papers (1st 6 mos.)	19,735	17,415	20,230	17,850	20,735	18,295	21,150	18,660	21,785	19,220
Quality Analyst - Tissue	18,925	16,700	19,400	17,115	19,885	17,545	20,280	17,895	20,890	18,430
Miscellaneous										
Converted Products Technician	19,130	18,875	19,606	17,300	20,095	17,730	20,500	18,085	21,115	18,630
Computer Technician A	18,925	16,700	19,400	17,115	19,885	17,545	20,280	17,895	20,890	18,430
Computer Technician B (1st 3 mos.)	18,315	16,160	18,775	16,565	19,245	16,980	19,630	17,320	20,215	17,840
Converted Products Tester	18,315	16,160	18,775	16,565	19,245	16,980	19,630	17,320	20,215	17,840
Print Technician	18,115	15,980	18,565	16,380	19,030	16,790	19,410	17,125	19,995	17,640
Laborer	16,715	14,750	17,135	15,120	17,560	15,495	17,915	15,805	18,450	16,280

EXHIBIT B

Health Plans
&
Spending Accounts

FORT JAMES

THE WAUNA HOURLY HEALTH CARE PLANS

AND

SPENDING ACCOUNTS
SUMMARY
PLAN DESCRIPTIONS

FORT JAMES

Your Benefits

At-A-Glance

Administration - Regulatory Information

Vision Discount Program

Health Care Plans

FORT JAMES

Your Benefits

At-A-Glance

Fort James strives to provide an excellent benefit program as part of a total compensation package. This section briefly summarizes your benefits and includes a chart with cost and eligibility dates. A more in-depth summary of each benefit plan is included later in this section of the guidebook.

DENTAL PLAN

Dental coverage is available for you and your eligible dependents. The dental plan provides coverage for preventive, routine, major and orthodontia dental services at reasonable and customary charges.

HEALTH CARE PLANS

Fort James offers you an unrestricted choice of two health care plans. The two choices are the Primary Care Network Plan and Preferred Provider Organization Plan. You can elect to be covered by either of the two plans.

Primary Care Network Plan

This plan has preferred (or in-network) health care providers and non-preferred (or out-of-network) health care providers. The Primary Care Network (PCN) Plan offers you the flexibility to seek care from any provider you wish. If you choose an in-network provider, your out-of-pocket costs are generally lower for covered services. Your out-of-pocket costs are generally higher if an out-of-network provider is used.

With the PCN Plan, you will establish a continuous relationship with one doctor - your Primary Care Physician (PCP) - who will provide your basic health care and coordinate your treatment if you should need to see a specialist. When your PCP coordinates your care, you will receive a higher (or preferred) level of benefits for covered services.

Preferred Provider Organization Plan

Like the Primary Care Network Plan, the Preferred Provider Organization (PPO) Plan has preferred (in-network) and non-preferred (out-of-network) health care providers. When you use an in-network provider, your out-of-pocket costs are generally lower for covered services.

An important distinction of the PPO Plan is that you can seek care from a specialist without a referral from a primary care physician. As long as you receive care from an in-network provider, even without a referral, your benefits will be paid at the in-network level for covered services.

Prescription Drugs and Vision Care

Both the PCN Plan and the PPO Plan and coverage for vision exams. In addition, you can obtain eyeglasses and contact lenses at discounted prices through the Eyemed vision program.

Administration - Regulatory Information

This section provides you with information on the Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA) and Qualified Medical Child Support Orders (QMCSO).

ERISA

In 1974, Congress passed ERISA to protect the rights of benefit plan members. Your Fort James Comprehensive Welfare Plan and Trust (health care, dental, life insurance, and long-term disability plans), Continuation Plan, Retirement Plan, and 401(k) Plan are considered ERISA plans.

CLAIM DENIAL PROCEDURES

If a plan benefit for which you think you are eligible is denied in whole or in part, you will receive a written explanation of the reason for the denial. This written notice will include:

1. The reasons why all or part of your claim was denied.
2. Specific references to the Plan provisions on which the denial was based.
3. A description of any more material needed to complete your claim and why it is needed.
4. The steps you must take to ask for a review of the decision.

You or your beneficiary should receive the notice within 90 days after the claim is filed. In special cases, another 90 days is allowed to act on the claim. If this is the case, you or your beneficiary will be notified of the reasons for the delay.

If you or your beneficiary do not receive the notice within this 90-day period (or a notice of the delay in processing your claim), the claim can be considered denied. Under these circumstances, you can proceed with the review procedure for denied claims.

APPEALING A DENIED CLAIM

If your claim has been denied, you can appeal the denial and have your claim reviewed. If you or your beneficiary want the claim to be reviewed, a written request must be submitted to the Benefit Appeals Committee within 60 days after the claim is denied. You or your beneficiary can request to:

1. Review any documents that are pertinent to the claim.
2. Submit to the Committee issues and comments in writing, and include any additional documents that support your appeal.
3. Meet with a quorum of the Committee or its designated representative as a part of the review procedure.

You or your beneficiary will receive a written notice of the Committee's decision within 60 days after requesting a review (or 120 days in special cases). The Committee's decision will be final.

YOUR RIGHTS UNDER ERISA

As a member participating in the Fort James benefit plans, you have certain rights and protections under ERISA. The following sums up your rights and protections under that law:

1. As a Plan member you have received without charge this guide containing copies of summary plan descriptions for each plan in which you participate or in which you are eligible to participate.
2. Each year, you will automatically receive a summary of the retirement and stock plan annual financial reports. If there are at least 100 participants in any of the welfare plans, you will receive a summary of that plan's annual financial report as well. The Plan Administrator is required by law to furnish each member with a copy of this information.
3. You can examine without charge certain papers relative to each plan. These papers include insurance contracts, legal plan documents, and copies of all reports filed with the U.S. Department of Labor, such as annual financial reports and plan

descriptions. These papers are available for your review in either the Plan Administrator's Office or your Human Resources Department during regular business hours. You may obtain copies of all these papers, at a nominal charge, upon written request to the Plan Administrator.

4. Once a year, upon written request, you may obtain a statement of the benefits you have earned to date under the retirement plan. If you have not earned a benefit to date, the benefit statement will tell you how many more years you must work to earn a benefit. This statement may be requested without charge to you.

In addition to retaining rights for Plan members, ERISA defines the duties of people who are responsible for the operating of the employee benefit plans. These people are called "fiduciaries." Fiduciaries must perform their duties in the interest of Plan members and beneficiaries.

The law also provides that you cannot be fired or discriminated against to prevent you from obtaining a benefit or exercising your rights guaranteed under ERISA.

If all or part of your claim to a benefit is denied, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. Under ERISA, you can take certain steps to enforce the rights described above. For example, if you request Plan materials, you must receive them within 30 days. However, if you have not received the materials after about 20 days, it would be a good idea to check with the Plan Administrator to see if there are any problems in giving you the material you requested. Then, if you have not received them within 30 days of your request, you can file suit in Federal court.

The court can require the Plan Administrator to provide the materials and pay you up to $100 for each day of delay until you receive the materials, unless they were not sent because of reasons beyond the Plan Administrator's control. Or, if all or a part of your claim for benefits is denied or ignored, you can file suit in state or Federal court, or you can ask the U.S. Department of Labor for help. If you think plan fiduciaries are misusing the Plan's money or if you feel you are being discriminated against for exercising your rights, you can get assistance from the U.S. Department of Labor or file suit in Federal court. Any time you sue, the court will decide who should pay court costs and legal fees. If you win, the court may order the person you have sued to cover these costs and fees. If you lose, you may have to pay the costs and fees.

If you have any questions about any of the plans, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C., 20210.

CONTINUATION OF COVERAGE *UNDER COBRA*

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you, your spouse and dependent children may elect to temporarily continue coverage under the Health Care Plans, Dental Plan, and Health Care Spending Account in certain instances where coverage otherwise would end.

Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your spouse

and your dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary. The COBRA provisions in this section also apply to any HMO offered through the company.

Qualifying Events

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

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

Certain events may extend an 18-month COBRA continuation period:

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

Important Note: If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary (whether or not disabled) may further extend COBRA coverage for 7 more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

The law requires that continuation of coverage rights similar to those described above may apply to retirees, spouses, and dependents if the company commences a bankruptcy proceeding and these individuals lose coverage.

Giving Notice That A COBRA Event Has Occurred

To qualify for COBRA continuation upon divorce or loss of a child's dependent status

under the Plan, you are required to notify your Plan Administrator of the divorce or loss of dependent status within 60 days of the later of the event or the date the individual would lose coverage under the Plan. You will then be contacted with instructions for continuing your medical coverage.

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

You must also notify your Plan Administrator if a divorce or loss of a child's dependent status occurs that would extend your period of COBRA coverage.

Electing and Paying for COBRA Continuation Coverage

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

- The date of the qualifying event; or
- The date the company notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

If you elect continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid within 30 days of each due date. The cost of COBRA coverage is 102 percent of the full cost of Plan coverage. The cost of coverage for the 19th through 29th months of coverage under the disability extension is 150% of the full cost of coverage, except as provided below.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, the 19th through 29th month), then the 150% rate applies to the 19th through 36th months of the COBRA continuation period.

If you elect COBRA continuation but then fail to pay the premiums due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day for which timely payment was made.

Coverage During the Continuation Period

If coverage under the Plan is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods or if a change in status occurs.

When COBRA Continuation Coverage Ends

The continued medical coverage for any person will end when the first of the following occurs:

- The applicable continuation period ends.
- Any required premium for continued coverage is not paid within 30 days after it is due.
- After the date COBRA is elected, the person becomes covered under another group medical plan (as an employee or otherwise) that does not contain an exclusion or limitation affecting the person's preexisting condition, or the other plan's preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules.

- After the date COBRA is elected, the qualified beneficiary enrolls in Medicare. (This does not apply to other qualified beneficiaries who are not enrolled in Medicare.)
- In the case of the 11-month extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that you are no longer disabled.
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends.
- The company terminates medical coverage for all employees.

Contact your HR Department for further details. Also, if you or your spouse have changed your address, please notify your COBRA administrator, whose address can be found on the premium invoice.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Medical and Dental Plans are required to provide benefits to your dependents if either plan receives a "qualified medical child support order" ("QMCSO"). A medical child support order is an order issued by a court or by an administrative agency pursuant to state law directing a participant to provide health coverage for an otherwise eligible dependent child, even if the participant is the non-custodial parent. A medical child support order must satisfy certain qualification requirements to be a QMCSO. The order must identify the child who is the "alternate recipient" of health coverage and describe the type and duration of coverage. Generally, the order may not require the Plan to provide benefits or any benefit option not otherwise available under the Plan.

Any payment made by the Plan under a QMCSO to reimburse an alternate recipient's medical expenses paid by the recipient, custodial parent or guardian, must be paid to such individual, rather than to the participant-employee.

The Plan Administrator will notify you and the custodial parent or guardian of children named in an order as alternate recipients if the Plan receives a medical child support order relating to one or more of your dependent children, and will provide each party with a copy of the Plan Administrator's procedures for reviewing such orders. The Plan Administrator will determine, within a reasonable time, if the order is "qualified". You and each dependent child or representative of the child will be notified of the decision. If the Plan Administrator determines that an order is qualified, the Plan Administrator will make arrangements for enrollment in the Plan of any alternate recipient named in the order. If you are not a participant in the Plan, the order may require that you enroll in the Plan if necessary to obtain coverage for an alternate recipient.

FUNDING OF CERTAIN PLANS

Fort James self insures its non-HMO medical and dental plans. Although the plans will continue to be administered by a third party, Fort James assumes the financial responsibility for these benefits.

REASONABLE AND CUSTOMARY

Reasonable and customary means that the Plan will reimburse you or pay your doctor, hospital, or dentist on the basis of fees which are generally charged in your area for similar services, considering complications and special

circumstances with respect to the performed services or procedures.

If you are advised that the amount charged exceeds the reasonable and customary charge, you should first check with your doctor or dentist to see if any unusual circumstances warrant the additional charges. If this is the case, the Claims Administrator should be notified for further review of your claim.

The Plan will not pay costs that are determined, after review, to be over and above the *reasonable and customary charge. You will be* responsible for payment of that portion of the bill.
You may want to determine if the provider's charge is reasonable and customary by calling the Claims Administrator. To do this, have your provider identify the CPT-4 code and the zip code in which the service will be performed. The Claims Administrator will use this information to identify if the provider's charge meets the reasonable and customary guidelines.

The reasonable and customary feature of your plan ensures that you are not overcharged for any services. In the long run, this feature should save your Plan dollars, which can then be used to your advantage.

If you participate in the PCN or the PPO Plan, the Reasonable and Customary provision applies only when you seek care out-of-network. In-network providers agree to charge pre-*negotiated rates. The Dental Plan also* negotiates fees with participating dental providers. Reasonable and Customary provisions do not apply when you use participating dental providers. If you plan to use a non-participating dental provider, you may check with your Claims Administrator to learn what the reasonable and customary rates are for similar services in your area, because the Plan will only reimburse you a fixed percentage of this amount.

COORDINATION OF BENEFITS (C.O.B.)

Your health care and dental plans coordinate benefit payments with any other group health care plan under which a participant or dependent is covered. If Fort James is your primary (pays first) coverage, the Plan will pay its usual benefits. If Fort James is your secondary (pays second) coverage, our Plan will pay its usual benefits minus any payments made by *the primary plan. However, in no event will our Plan reimburse an amount greater than it would have paid if it had been primary.*

To find out whether the regular benefits under this Plan will be reduced according to the provisions of Coordination of Benefits, the order in which the various plans will pay benefits must be figured. This will be done as follows:

1. A plan with no rules for coordination with other benefits will be deemed to pay its *benefits before a plan that contains such* rules.
2. A plan, which covers a person other than as a dependent, will be deemed to pay its benefits before a plan that covers the individual as a dependent.
3. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the child as a dependent of the parent whose birthday comes first in a calendar year will be *primary to the plan which covers the child* as a dependent of the parent whose birthday comes later in the calendar year. If the other plan does not have this provision regarding birthdays, then the rule set forth in that plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:

A. If there is a court decree which established financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

B. If there is no such court decree, then the following rules apply:

i) If the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

ii) If the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent. The benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

I. If 1, 2, and 3 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first, except that:

A. The benefits of a plan which covers the person as a laid-off or retired employee or the dependent of such person, shall be determined after the benefits of any other plan which covers such person as an employee who is not laid-off or retired or a dependent of such a person.

B. If the other plan does not have a provision regarding an employee who is laid-off or retired, and as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

J. Continuation coverage: If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

A. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent).

B. Second, the benefits under the continuation coverage.

J. No-fault Automobile Insurance: No-fault automobile insurance will always be considered primary under this Plan, regardless of whether you choose your no-fault coverage to be secondary through your automobile policy.

The coordination of benefits feature aids in controlling the total cost of your Plan, which helps us save dollars.

SUBROGATION

If a covered person suffers a loss or injury and the loss or injury is caused by the act or omission of a third party, the Plan, if it so elects, has a right to recover from the third party any medical payments made to the covered person, and the covered person agrees by the acceptance of such payments that the Plan is entitled to reimbursement.

The Plan shall be subrogated to all the covered person's rights to recover and may proceed, to

the extent permitted by law, directly against the third party to recover such payments. Alternatively, the Plan shall be subrogated to the extent of such payments to the proceeds of any settlement or recovery which the covered person may have against the third party. Such an election by the Plan shall create a lien on such proceeds to the extent of the payments made, which lien shall be enforceable by the Plan to the extent permitted by law.

When necessary, the covered person shall execute and deliver any documents that are required and do whatever else is required for the Plan to secure its subrogation rights. Fort James Corporation may bring any action under this provision on behalf of the Plan.

For the purposes of the Plan's exercise of its rights of subrogation or reimbursement under this provision, "covered person" shall mean any person receiving such payments, including the parents or legal guardians in the event that the injured person is a minor, or the heirs, administrators, or executors of the estate, when applicable.

OTHER PLAN INFORMATION

Your benefit plans are administered through the Human Resources Department of the Corporation. *Final determination of all benefits will be made in accordance with the applicable plan. Fort James is empowered to exercise discretion in the interpretation of the terms of the plans and such discretionary determinations regarding plan terms and eligibility shall be binding upon all participants. Fort James reserves the right to change or terminate these plans at any time as it relates to active employees or to retirees, regardless of the date of retirement. Changes to these plans for a group of employees covered under a collective*

YOUR PLANS

The numbers for identifying your plans consist of two parts: the identification number assigned to the Company sponsor (54-0848173) and a plan number assigned by the Company. These plan numbers and other important information can be found in the following section.

Fort James Comprehensive Welfare Plan

The Fort James Comprehensive Welfare Plan funds your Dental and Health Care Plans.

Claims Administrators:

PacifiCare – PPO (Group #4656-656)
PacifiCare – PCN (Group #4657-657)
CDS (Group #3599-00)

Plan Number: 501
Plan Year: January 1 to December 31

ADMINISTRATIVE INFORMATION ABOUT YOUR PLANS

Plan Sponsor
Fort James Corporation
1650 Lake Cook Road
Deerfield, Illinois 60015
Telephone: (847) 317-5000
E.I.N. 54-0848173

Plan Administrator
Same as Plan Sponsor
Contact: Director, Employee Benefits
Fort James Corporation
1650 Lake Cook Road
Deerfield, Illinois 60015
Telephone: (847) 317-5000

Agent for Service of Legal Process
Corporate Counsel
same address as Plan Sponsor
Legal notices may also be served upon the Plan Administrator

Benefit Appeals Committee
c/o Employee Benefits Department
Fort James Corporation
P.O. Box 89
Deerfield, Illinois 60015

Vision Discount Program

EyeMed provides a vision discount program for you and your eligible dependents who are covered under a Fort James health care plan. EyeMed's network consists of LensCrafters locations. It is not necessary to obtain a claim form prior to receiving services.

To receive your discounted vision supplies visit the nearest EyeMed location and present your EyeMed ID card. To find the nearest location, call (800) 521-3606 and ask an EyeMed representative.

Eye Examination:
Eye Examinations are covered under your Fort James Health Care Plan. (See Summary of Benefits)

Included with your EyeMed ID card is a booklet explaining the EyeMed vision discount program. Please refer to this booklet for a summary of eyewear discounts.

Health Care Plans

Primary Care Network Plan, Preferred Provider Organization Plan, Prescription Drug Plan

SUMMARY

- Coverage begins on the first day of the month following your employment date.
- You must enroll for health care within 31 days of becoming a benefits-eligible employee, within 31 days of certain qualifying events or during the annual Open Enrollment period.
- You can choose between two different health care plans: the Primary Care Network Plan and the Preferred Provider Organization Plan.
- Benefits include coverage for preventive care.
- Prescription Drug Plan and vision discount programs are available.
- There is a separate deductible and Claims Administrator for prescription drug coverage.
- Co-payments do not go towards meeting the deductible or the maximum out-of-pocket.

MEDICAL PLANS HIGHLIGHTS

Fort James offers you a choice of two medical coverage options. The Primary Care Network Plan and the Preferred Provider Organization Plan are offered at all locations. Generally, the majority of your medical costs are paid by the Plan so that medical care does not become a burden for you and your family.

Primary Care Network (PCN) Plan
The PCN Plan is built on a network of doctors, hospitals, and other health care providers who agree to provide services to plan participants at negotiated rates. These rates are often below the usual rates charged for similar services by physicians in your area.

Under this plan, you are free to visit any provider you choose anytime you need care. However, your level of coverage varies depending on whether you visit providers who are part of the PCN Plan network or not. When you designate a network provider to be your Primary Care Physician (PCP) and coordinate all your care through him/her, the Plan generally

covers 80% of your eligible expenses. For some services, the Plan pays 100% of eligible expenses, after a $10 co-pay.

If you choose to visit an "out-of-network" provider, the Plan generally covers 50% of your eligible reasonable and customary expenses, after you meet a $250 annual individual deductible.

Preferred Provider Organization (PPO) Plan

Like the PCN Plan, the PPO Plan is built on a network of doctors, hospitals, and other health care providers who agree to provide services to plan participants at negotiated rates. These rates are often below the usual rates charged for similar services by physicians in your area. Under this plan, you are free to visit any provider you choose anytime you need care. However, your level of coverage varies depending on whether you visit providers who are part of the PPO Plan network or not. However, unlike the PCN Plan, you do not need to designate or see a Primary Care Physician in order to receive the higher in-network benefits. The Plan generally covers 80% of your eligible expenses. For some services, the Plan pays 100% of eligible expenses, after a $10 co-pay.

If you choose to visit an "out-of-network" provider, the Plan generally covers 60% of your eligible reasonable and customary expenses, after you meet a $250 annual individual and $750 family deductible.

ELIGIBILITY

You are eligible to enroll in any health care plan offered in your area, on the date you begin working as a benefits-eligible employee of Fort James. You must enroll in a plan within 31 days of your eligibility date.

You may also choose coverage for your eligible dependents. Eligible dependents include:

- Your spouse: Your spouse will qualify as a dependent only if he or she is not enrolled for coverage under any other Fort James-sponsored health care plan, or is not covered by a collective bargaining agreement to which Fort James is a party. Your spouse is not eligible if you are legally separated or your marriage has been annulled.
- Your child: This includes your natural unmarried child who is under 19 years of age, or a legally adopted child who is under 19 years of age (whether or not the adoption has become final), a stepchild or other child who is under 19 years of age, who depends on you for support and lives with you in a regular parent-child relationship.
- Eligible children listed on a Qualified Medical Child Support Order: They will be covered if a request for enrollment is made within 31 days of the issuance of the Qualified Medical Child Support Order. Otherwise, these children must wait for the next Open Enrollment period held in October/November with coverage effective the following January 1.
- Your dependent child (as defined above): If your child is between the ages of 19 and 25, and if the child is a full-time student and depends solely on you for support.

STEPS TO TAKE

Medical coverage is not automatic. If you want medical coverage for yourself and your family, you must enroll in a plan to be covered. You have 31 days to enroll after you become eligible or have a qualifying event. If you miss the deadline, you must wait until the next Open Enrollment period to enroll for the following calendar year.

ENROLLMENT

To enroll in one of the health care plans, you must complete the appropriate enrollment form and return it to HR Department. You will also need to complete a form to supply information about dependents that you may be enrolling.

You and your eligible dependents may also enroll during the annual Open Enrollment period held every October/November with your election going into effect the following January 1. During the Open Enrollment period, you may change to a different medical option, if one is available. If you do not make a new election during the Open Enrollment period, your status will remain unchanged.

If you are not actively at work during the Open Enrollment period, you may not change to a different medical plan option until you return to work. When you return to work full-time, you may change to a different medical option during the first 30 days following the date you return to work.

- No person may be eligible for benefits both as an employee and as a dependent, or as a dependent of more than one employee.
- A dependent cannot become covered unless you are covered.
- If you are rehired in the same year that you are terminated, you will not be allowed to re-enroll in a health care plan until the following January 1.

COVERAGE LEVELS

If you elect coverage under any of the plans, you must choose one of the following four coverage levels:

- Employee only
- Employee and spouse
- Employee and child(ren)
- Employee and family

QUALIFYING CHANGE IN FAMILY STATUS

Current tax law prevents you from changing your medical election during a calendar year, unless you have a qualifying change in family status. If your family status changes, you will be able to drop or add dependents. However, you cannot switch plans. A change in family status includes:

- Birth of a child
- Adoption of a child
- Your marriage
- Your divorce or legal separation
- Death of a dependent
- Change in your employment status
- Changes in your spouse's health care coverage due to the start or end of his or her employment.

If any of these events occur, you should notify your HR Department. The change you want to make to your medical coverage must be consistent with your family status change. *If you do not make this change within 31 days of your family status change, you must wait until the next open enrollment period and your contributions will not be refunded back to the date of the qualifying event.*

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Your selected Health Care Plan is required to *provide benefits to your dependents if it* receives a "qualified medical child support order" (QMCSO). For more information on QMCSO, see page 6.

PORTABILITY

Additionally, Fort James allows you and/or your dependents to enroll in the Plan in the following situations:

1. If you or your dependent had declined coverage in writing because of the existence of other coverage and then any of the following happens:

A. The other coverage is terminated because of a COBRA-like qualifying event.
B. The other coverage is COBRA coverage and that coverage expires.
C. The employer contribution to the other plan is terminated.

The plan allows you and/or your dependent to enroll as long as notification of the loss and enrollment is made within 31 days. Otherwise, you must wait for the next annual Open Enrollment period.

1. You are allowed to enroll a new dependent child within 31 days of the birth, adoption, or the placement for adoption of the child. Coverage will be effective on the date of birth, date of placement or date of adoption. Otherwise, you must wait for the next annual Open Enrollment period.
2. Your new spouse may be enrolled within 31 days of the marriage. Otherwise, you must wait for the next annual Open Enrollment period.
3. If you are not enrolled, you may enroll during the special enrollment period created by a loss of coverage by a family member or family status change (birth, adoption or marriage). Additionally, your spouse can enroll in the event of a birth or adoption of a child. Enrollment must take place within 31 days of the event. Otherwise, you and/or your dependents must wait for the next annual Open Enrollment period.
4. Your mentally or physically handicapped child can be covered beyond the age limits of 19 years and 25 years, if a request for such extended coverage is submitted to and approved by the Plan Administrator prior to your child reaching their 19th or 25th birthday.

CONTRIBUTIONS

Fort James pays most of the cost of your medical coverage. You share in this cost through your contributions. In order to participate in one of the health care plans, you must authorize Fort James, in writing, to withhold your contributions weekly, on a pre-tax basis, through its Pre-Tax Contribution Plan.

Any amounts that you contribute under the Plan are not currently subject to federal income tax, or, in most cases, state income tax. In addition, you do not pay Social Security taxes. This may affect your Social Security benefits. In most cases, however, your current tax savings outweigh this future reduction.

FILING A CLAIM

Shortly after you enroll in one of the above plans, you will receive an identification card, and the address of your claims office. You should present this card to the admissions clerk at your doctor's office or hospital. All bills representing covered expenses can be sent directly to the Claims Administrator. It is important that you advise the Claims Administrator of your identification number (which is your Social Security Number) since this number is used to identify you as an employee eligible for coverage.

Claim forms are available from the Claims Administrator. If you are having difficulty obtaining a claim form, contact HR Department.

Claim forms should be mailed directly to the Claims Administrator.

Fort James is charged per transaction. Therefore, it is important that duplicate claims are not filed, or that claims are not filed until you have met your deductible. This will help to reduce the cost of the Plan.

You should file your first claim with the Claims Administrator for any calendar year after you have accumulated expenses that will exceed your deductible, unless your claim is for a covered expense for which there is no deductible requirement. Be sure to include with this initial claim all expenses incurred to that date, so the Claims Administrator will have a record of expenses that you have paid as satisfaction of your deductible. Also, check before submitting your claim, to insure that you are not duplicating a claim already submitted by your physician or the hospital.

The Claims Administrator will send you an Explanation of Benefits (E.O.B.) after your claim is processed. If necessary, to ensure that your claim is processed correctly, it may request additional information from you, such as the nature of your illness, before processing your claim.

If you are enrolled in the Primary Care Network Plan or the PPO Plan and receive care within the network, it is not necessary to submit any claim forms. The physicians or hospital will do so for you.

APPEALING A DENIED CLAIM

If your claim is denied, you can appeal the denial and have your claim reviewed. See Appealing A Denied Claim in the Administration section of this guide.

REASONABLE AND CUSTOMARY

Reasonable and Customary means that the Plan will reimburse you or pay your provider on the basis of fees which are generally charged in your area for similar services. See Reasonable and Customary in the Administration section of this guide.

COORDINATION OF BENEFITS (C.O.B.)

Your health care plans also coordinate benefit payments with any other group health care plan under which a participant or dependent is covered. See Coordination of Benefits (C.O.B.) in the Administration section of this guide.

SUBROGATION

If a covered person suffers a loss or injury and the loss or injury is caused by the act or omission of a third party, the Plan, if so elects, has a right to recover from the third party. See Subrogation in the Administration section of this guide.

Overview of Primary Care Network Plan

HOW THE PLAN WORKS

The PCN Plan includes a network of providers. Participants can choose to receive service or treatment at two separate benefit levels. The benefit levels are an "in-network" or "out-of-network basis." Fort James contracts with PacificSource to administer this plan.

You have the lowest out-of-pocket expense when you designate an in-network Primary Care Physician (PCP) to manage your care. A PCP can be a Family Care Practitioner, Generalist, Internist or Pediatrician. The participating

network providers in your area are listed in the provider directory. You can get a directory from your Claims Administrator.

When you use your PCP to direct your care, you are considered "in-network" and your out-of-pocket costs are lower than if you receive care "out-of-network." You do not have to meet an annual deductible when you go in-network. Instead you pay a co-payment (a flat dollar fee) or coinsurance (a small percentage of the cost). You do not need to worry about reasonable and customary limits because network providers' rates are pre-negotiated. In addition, when you receive care "in-network", your claims will be filed for you.

An important feature of the PCN Plan is a bi-annual physical with your PCP, which is covered for a $10 co-pay. This feature is not available "out-of-network."

You choose to go "out-of-network," by either (1) bypassing your PCP or (2) bypassing the network entirely. You still have medical coverage, but your out-of-pocket costs are higher and you must meet an annual deductible before the plan begins to pay any benefits. You are responsible for filing your own claims. In addition, the plan will only reimburse a percentage of your reasonable and customary expenses and you may need to obtain precertification of some procedures from the Plan Administrator.

Deductible

If you choose to receive out-of-network care, each participant must meet the $250 individual annual deductible before the plan begins to pay its share of benefits. Each individual must meet this deductible every calendar year and you cannot carry any of your deductibles forward into the next year. Co-payments do not apply towards deductibles. Once you reach the individual deductible (the PCN Plan does not have a family deductible), you do not have to meet any further deductibles during the year.

Coinsurance

After you have met your deductible, the Plans pay a percentage of the charges for covered medical services.

Maximum Out-of-Pocket Expenses

This is the maximum amount you or your dependents have to pay in a calendar year. (See Summary of Benefits, page 18). Once your covered out-of-pocket expenses reach a certain level, the PCN Plan pays 100% of reasonable and customary eligible expenses for the remainder of the calendar year. The $10 co-payment under the Plan does not apply toward your maximum out-of-pocket expense. This is also true of mental health and substance abuse expenses unless approved by the Utilization Review Administrator. In addition, the $50 deductible per visit to the emergency room under the PCN Plan does not apply to the maximum out-of-pocket.

Precertification

When you go out-of-network, you must call the Claims Administrator to precertify for hospitalization, inpatient mental health and alcohol /substance abuse treatment, and some outpatient services. When your treatment is precertified, the Plan will cover 50% of your reasonable and customary charges. If your care is not precertified but medically necessary, the Plan will assess a penalty of 25% of the charges up to a cap of $5,000. The PCN Plan will not cover inpatient or outpatient care that is not medically necessary.

To obtain precertification, you, your doctor or a family member must call your Claims Administrator.

You may obtain from the Claims Administrator or your human resource department a PCN utilization management guide for out-of-network care.

Additional Information

If you have any questions or need to clarify what may or may not be covered by the PCN Plan, you should contact your Claims Administrator.

Overview of PPO Plan

HOW THE PLAN WORKS The PPO Plan includes a network of providers. Participants can choose to receive service or treatment at two separate benefit levels. The benefit levels are an "in-network" or "out-of-network" basis. Fort James contracts with PacificSource to administer this plan.

You have the lowest out-of-pocket expense when you use in-network providers. When you use providers designated as "in-network" your out-of-pocket costs are lower than if you receive care "out-of-network." When you use in-network providers you pay a co-payment (a flat dollar fee) or coinsurance (a small percentage of the cost). You do not need to worry about reasonable and customary limits because network providers' rates are pre-negotiated. In addition, when you receive care "in-network", your claims will be filed for you.

An important feature of the PPO Plan is a bi-annual physical, which is covered for a $10 co-pay. This feature is not available "out-of-network."

You choose to go "out-of-network," by bypassing the network entirely. You still have medical coverage, but your out-of-pocket costs are higher and you must meet an annual deductible before the plan begins to pay any benefits. You are responsible for filing your own claims. In addition, the plan will only reimburse a percentage of your reasonable and customary expenses and you may need to obtain precertification of some procedures from the Plan Administrator.

Deductible

If you choose to receive out-of-network care, each participant must meet the $250 individual/$750 family annual deductible before the plan begins to pay its share of benefits. Each individual must meet this deductible every calendar year and you cannot carry any of your deductibles forward into the next year. Co-payments do not apply towards deductibles. Once you reach the deductible, you do not have to meet any further deductibles during the year. However, when you use out-of-network providers, such providers may bill you for amounts above reasonable and customary, even if you have satisfied your deductible.

Coinsurance

After you have met your deductible, the Plan pay a percentage of the charges for covered medical services.

Maximum Out-of-Pocket Expenses

This is the maximum amount you or your dependents have to pay in a calendar year. Once your covered out-of-pocket expenses reach a certain level, the PPO Plan pays 100% of reasonable and customary eligible expenses for the remainder of the calendar year. The $10 co-payment under the *Plan does not apply toward* your maximum out-of-pocket expense. This is also true of mental health and substance abuse expenses unless approved by the Utilization Review Administrator.

Precertification

When you go out-of-network, you must call the Claims Administrator to precertify for hospitalization, inpatient mental health and alcohol/substance abuse treatment, and some outpatient services. When your treatment is precertified, the Plan will cover 60% of your reasonable and customary charges. If your care is not precertified but medically necessary, the Plan will assess a penalty of 25% of the charges up to a cap of $5,000. The PPO Plan will not cover inpatient or outpatient care that is not medically necessary.

To obtain precertification, you, your doctor or a family member must call your Claims Administrator.
You may obtain from the Claims Administrator or your human resource department a PPO utilization management guide for out-of-network care.

Additional Information
If you have any questions or need to clarify what may or may not be covered by the PPO, please contact the Plan Administrator.

PCN AND PPO REGIONAL CLAIMS ADMINISTRATION Employees are required to call for pre certification of out-of-network medical services

Location	Plan or Claims Administrator	Claims Address	Pre-Certification Phone #
Wauna	PCN and PPO Plan -- PacificSource	PacificSource	(800) 624-6052

PORT JAMES

PRIMARY CARE NETWORK (PCN) PLAN

SUMMARY OF BENEFITS

SERVICE	PCP OR REFERRED BENEFIT	OUT-OF-PANEL / NON-REFERRED BENEFIT
Annual Deductible	None *	$250/Person
Annual Out-of-Pocket Maximum	$1,500/Person $3,000/Family	$3,000/Person $6,000/Family
Preventive Care		
Well Baby Care (6 visits first year; 1 visit per year age 1-6	$10 Copay, then 100%	Not Covered
Routine Physical 1 exam every 24 months	$10 Copay, then 100%	Not Covered
Routine Gynecological Exams	$10 Copay, then 100%	Not Covered
Eye Exams 1 exam every 24 months	$10 Copay, then 100%	Not Covered
Immunizations	$10 Copay, then 100%	Not Covered
Colo-Rectal – Age 40+, Max 1 every 3 years	$10 Copay, then 100%	Not Covered
Professional Services		
Office and Home Visits	$10 Copay, then 100%	50%
Urgent Care Center Visits	$10 Copay, then 100%	50%
Chiropractic Office Visits	$10 Copay, then 100%	50%
Chiropractic Manipulations, Therapy, Diagnostic	80%	50%
Surgery	90%	50%
Hospital Services		
Inpatient Room and Board (per admit)	$150 copay, then 90%	$500 copay, then 50%
Inpatient Rehabilitative Care (per admit)	$150 copay, then 90%	$500 copay, then 50%
Skilled Nursing Facility Care (per admit)	$150 copay, then 90%	$500 copay, then 50%
Outpatient Services		
Outpatient Surgery	90%	50%
Diagnostic and Therapeutic Radiology and Lab	90%	50%
CT Scans and MRIs	90%	50%
Emergency Room Visits*	$50 copay, then 90%	50%
Mental Health/Chemical Dependency Services		
Office Visits (max 20 visits per calendar year)	$20 copay, then 100%	50%
Inpatient Care (max 30 days per calendar year)	$150 copay, then 90%	$500 copay, then 50%
Residential (max 60 day/night stays per calendar year)	$150 copay, then 90%	$500 copay, then 50%
Other Covered Services		
Physical/Occupational Therapy	80%	50%
Speech Therapy	80%	50%
Allergy Injections	80%	50%
Ambulance Services	80%	50%
Durable Medical Equipment	80%	50%
Home Health Care (max 120 visits per calendar year)	80%	50%

*In true medical emergencies, out-of-panel providers are paid at the PCP/referred provider level.

- **PCP:** All enrolled members must select a primary care practitioner (PCP) from the PacifiCare PCN provider directory to be responsible for coordinating medical care. The PCP will coordinate healthcare resources to best meet the member's healthcare needs. If you need a specialist's care, you need a referral from your PCP to receive the highest level of benefits.
- **Deductible:** The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's "out-of-panel / non-referral" benefits begin. The deductible applies to all "out-of-panel / non-referral" services and supplies.
- **Out-of-Pocket Limit: Once the PCP-referral provider out-of-pocket limit is met, the plan pays 100% of covered charges for participating providers for the rest of that calendar year. Once the out-of-panel provider out-of-pocket limit is met, the plan pays 100% of covered charges for all providers for the rest of that calendar year. Benefits paid in full and out-of-panel provider charges in excess of the fee allowance do not contribute toward the out-of-pocket limit.**

The PCN Plan uses the PRIME provider directories

www.pacificare.com

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

SUMMARY OF BENEFITS

SERVICE	PARTICIPATING PROVIDER BENEFIT	NON-PARTICIPATING PROVIDER BENEFIT
Annual Deductible	$150/Person $450/Family	$250/Person $750/Family
Annual Out-of-Pocket Maximum	$1,500/Person $3,000/Family	$3,000/Person $6,000/Family
Preventive Care		
Well Baby Care 6 visits first year, 1 visit per year age 1-6	$10 Copay, then 100%*	Not Covered
Routine Physical 1 exam every 24 months	$10 Copay, then 100%*	Not Covered
Routine Gynecological Exams	$10 Copay, then 100%*	Not Covered
Eye Exams 1 exam every 24 months	$10 Copay, then 100%*	Not Covered
Immunizations	$10 Copay, then 100%*	Not Covered
Colo-Rectal – Age 40+. Note: 1 every 3 years	$10 Copay, then 100%*	Not Covered
Professional Services		
Office and Home Visits	$10 Copay, then 100%*	60%
Urgent Care Center Visits	$10 Copay, then 100%*	60%
Chiropractic Office Visits	$10 Copay, then 100%*	60%
Chiropractic Manipulations, Therapy, Diagnostic	80%	60%
Surgery	80%	60%
Hospital Services		
Inpatient Room and Board	80%	60%
Inpatient Rehabilitative Care	80%	60%
Skilled Nursing Facility Care	80%	60%
Outpatient Services		
Outpatient Surgery	80%	60%
Diagnostic and Therapeutic Radiology and Lab	80%	60%
CT Scans and MRI	80%	60%
Emergency Room Visits*	80%	60%
Mental Health/Chemical Dependency Services		
Office Visits (max. 20 visits per calendar year)	$20 copay, then 100%*	60%

Inpatient Care (max. 30 days per calendar year)	80%	60%
Residential (max. 60 day/night sessions per calendar year)	80%	60%
Other Covered Services		
Physical/Occupational Therapy	80%	60%
Speech Therapy	80%	60%
Allergy Injections	80%	60%
Ambulance Services	80%	60%
Durable Medical Equipment	80%	60%
Home Health Care (max. 120 visit per calendar year)	80%	60%

* In true medical emergencies, nonparticipating providers are paid at the participating provider level.

- ***Participating Providers:*** To obtain the highest level of benefit, a member should seek care from a participating provider listed in the PacificSource PPO provider directory or from the Preferred provider directory located at www.pacific-source.com. This PPO plan does not require a PCP and referrals are not required to access specialist services.
- ***Deductible:*** The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's benefits begin. The deductible applies to all services and supplies except those marked with a asterisk (*).
- ***Out-of-Pocket Limit:*** Once the participating provider out-of-pocket limit is met, this plan pays 100% of covered charges for participating providers for the rest of that calendar year. Once the nonparticipating provider out-of-pocket limit is met, this plan pays 100% of covered charges for all providers for the rest of that calendar year. Benefits paid at 80% and nonparticipating provider charges in excess of the fee allowance do not accumulate toward the out-of-pocket limit.

The PPO Plan uses the PREFERRED provider directories
www.pacific-source.com

COVERED MEDICAL SERVICES UNDER THE PRIMARY CARE NETWORK AND THE PREFERRED PROVIDER ORGANIZATION PLANS

Ambulance Service

By an agency authorized to provide such service, to transport a covered member in a vehicle staffed by medically-trained personnel and equipped to handle medical emergencies:

1. From the place where he or she is injured or stricken by disease to the nearest hospital where treatment can be furnished.
2. From the hospital which is shown to be unable to treat his/her physical condition to the nearest hospital which can provide treatment.
3. From a hospital in which he or she is confined to and back from the nearest hospital for special treatment or tests that are not available at the hospital in which he or she is confined.
4. From a hospital in which he or she is confined to the nearest convalescent facility with available space to which he or she is to be moved upon discharge.
5. From a hospital or convalescent facility upon discharge to his/her home.

Not included are any charges made to transport the covered member:

1. If an ambulance service is not required by his or her physical condition
2. In any other vehicle or to any other place.

Audiology Services

Only for an evaluation that is furnished to pinpoint the location of a disease or injury to the auditory system when definite symptoms indicate that one may exist.

Compliance

Both the Primary Care Network Plan and the Preferred Provider Organization Plan are in compliance with applicable federal regulations, including the following:
The Health Insurance Portability and Accountability Act (HIPAA), The Newborns' and Mothers' Health Protection Act (NMHPA), The Women's Health and Cancer Rights Act (WHCRA), and the Mental Health Parity Act (MHPA).

Convalescent Facility Care

The Plan will pay the reasonable and customary charges (deductibles and coinsurance apply) for confinement in a Convalescent Facility. You can receive benefits for up to 120 days. The confinement must begin within 14 days following the end of a hospital confinement of at least three days. You also must be under the direct care of a doctor while in the Convalescent Facility.

Charges made by a Convalescent Facility recognized by the Plan Administrator for the following services and supplies provided to a covered member who is confined in the facility during a convalescent period are covered:

1. Room and board. If a private room is used, any part of the daily room and board charge which is more than the facility's most common semiprivate room rate is not covered.
2. Use of special treatment rooms: X-ray and lab tests; physical, occupational, and speech therapy furnished by a Covered Health Care Provider; other medical services commonly furnished by a Convalescent Facility; and drugs, solutions, dressings, and casts.

A "convalescent period" ends after a period of 90 consecutive days of which the covered member has not been confined in any hospital, Convalescent Facility, or other medical facility that provides nursing care. Not included are any charges made:

1. For any day of confinement during a "convalescent period" exceeding 120 days.

2. For physician's services or for private or special duty nursing.
3. For care of a person only because he or she is old, senile, or suffers from alcohol or drug abuse, or because he or she is mentally retarded or has a mental disorder or chronic brain syndrome.

Diagnostic X-ray, Lab, and Pathology Tests
Only when tests are medically indicated and ordered by a covered health care provider to diagnose a disease or injury for which definite symptoms are present or start, maintain, or change a plan of treatment prescribed by a covered health care provider.

Durable Medical and Surgical Equipment
Charges for the initial purchase of such equipment and accessories needed to operate it will be covered.

If the Claims Administrator is shown that:
1. Long-term use is planned.
2. The equipment cannot be rented.
3. It is likely to cost less to buy the equipment than to rent it.

Charges for more than one item of equipment for the same or similar purpose will not be covered.
Charges for repair or replacement of purchased equipment and accessories needed to operate it will be covered, only if the Plan Administrator is shown that:
1. It is required because of a change in the covered member's physical condition.
2. It is likely to cost less to buy replacement equipment than to repair the existing equipment or to rent like equipment.

Durable medical and surgical equipment is equipment that is:
1. Made to withstand prolonged use.
2. Made for and mainly used in the treatment of a disease or injury.
3. Suited for use in the home.
4. Not normally of use to persons who do not have a disease or injury.
5. Not for use in altering air quality or temperature or for exercise or training.

Eye Exam Coverage
Routine eye exams are covered. You must receive the eye exam from an in-network provider. Otherwise, the eye exam will not be covered under the PCN or PPO Plans.

Facility Charges
Charges for use of a hospital emergency room, ambulatory surgical facility, or outpatient clinic are covered.

Home Health Care
To encourage shorter hospital stays, the Plan covers the reasonable and customary cost (deductible and coinsurance apply) of up to 120 Home Health Care Visits per year subject to review and approval by the your Plan Administrator.

Charges made by a Home Health Care Agency for the following services and supplies furnished to a covered member in his or her home, for care in accordance with a Home Health Care Plan, are covered as follows:
1. Part-time or intermittent nursing care by an RN, or by an LPN if the services of an RN are not available.
2. Part-time or intermittent home health aide services which consist mainly of caring for such member.
3. Physical, occupational, and speech therapy provided by a Home Health Care Agency.
4. Medical supplies, prescription drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a Home Health Care Agency, but only to the extent they would have been covered under this Plan if such member had been confined in a hospital or convalescent facility.

The maximum number of Home Health Care Visits to a covered member's home in any one calendar year is 120. One *Home Health Care* Visit shall be:

1. Each visit by a member of a home health care team to a covered member's home to provide nursing care, physical or occupational therapy, or speech therapy.
2. Each visit up to four hours of home health aide services.

Home Health Care expenses are not covered if they are incurred in connection with any of the following:

1. Services or supplies not included in the Home Health Care Plan.
2. Transportation services.
3. Services of a social worker.
4. Services covered as part of Hospice Care.

Hospice Cares

Similar to your home health care benefits, Hospice Care helps cut down long, expensive hospital stays by paying for expenses that used to be covered only if you remained in a hospital. The Plan pays the reasonable and customary covered expenses (deductibles and coinsurance apply) for Hospice Care, up to $5,000 a year, subject to review and approval by the Utilization Review Administrator.

The following charges made to a terminally ill member (meaning a member who is given a prognosis of approximately six months or less to live) for hospice care are covered when given as part of a Hospice Care Program:

i. Facility expenses (including a hospice care facility, hospital or convalescent facility) which are for room and board and other services and supplies furnished to a covered member as a full-time inpatient for pain control and other acute and chronic symptom management. Not included are facility charges:
   A. In excess of $5,000 per year.
   B. For services and supplies furnished to a member while not confined as a full-time inpatient.
   C. If a private room is used, any part of the daily room and board charge which is more than the semi-private room limit.
ii. Charges made by a Hospice Care Agency for:
   A. Part-time or intermittent nursing care by an RN or LPN up to 8 hours in any one day.
   B. Medical social services under the direction of a physician. This includes:
      i. Assessment of the covered member's social, emotional, and medical needs, and home and family situations
      ii. Identification of the community resources available to the covered member
      iii. Assistance to the covered member in obtaining the community resources needed to meet his or her assessed needs
   A. A Home Health Care Agency for physical or occupational therapy, part-time or intermittent home health care aide services for up to eight hours in any one day, medical supplies, drugs, and medicines prescribed by a physician; and psychological and dietary counseling. Not included are charges for bereavement, funeral arrangements, pastoral counseling and financial or legal counseling. This includes, but is not limited to, estate planning or the drafting of a will.
iii. Homemaker or caretaker services. These are services not solely related to the care of the covered member, and include sitter or companion services, transportation, housecleaning, house maintenance, or respite care, which is care furnished during a period

of time when the member's family or his or her usual caretaker cannot or chooses not to attend to the covered member's needs for any reason.

Neither the Claims Administrator nor Fort James Corporation assumes any responsibility for the outcome of any covered service or supply nor do they make any express or implied warranties concerning the outcome of any covered services or supplies.

Hospital Charges

Charges made by a general hospital or medical rehabilitation hospital recognized by your Plan Administrator, for board and room in ward, semiprivate, or intensive care unit accommodations. This includes meals, special diets, nursing care, and other hospital services and supplies furnished to a covered member. Please note: If a private room is used, any part of the daily board and room charge that is more than the hospital's most common semiprivate room rate is not covered. In other words, you will be responsible for any extra cost for a private room. Contact your Plan Administrator for additional information.

Mental Health/Substance Abuse

Provisions concerning alcohol abuse or drug abuse apply only to confinements resulting from diagnosis or recommendation by a physician. Additionally, they also apply only to expenses to the extent that they are for treatment of alcohol abuse or drug abuse in accordance with broadly accepted standards of medical practice, taking into account the current condition of the covered member. Covered charges are limited to 20 office visits, 30 days of inpatient care, and 60 day/night sessions of partial hospitalization each calendar year.

Occupational/Physical Therapy

Only for medical rehabilitation in the following cases:

1. Therapy that is expected to improve or prevent further deterioration of a body function that has been lost or impaired as the result of a disease or injury.
2. Therapy that is outlined in a specific treatment program that
   A. Details the therapy to be provided, how often and how long it will be needed
   B. Provides for ongoing reviews and is renewed only if therapy is still necessary.

Office Visits

Office visits will be paid according to the Summary of Benefits. However, if an office visit is being billed with major surgical procedures, the office visit will be combined with the surgery and benefits allowed to the physician's charge, subject to the deductible and coinsurance. Ask your physician whether or not the co-pay provisions apply.

Pre-Admission Testing

Charges made by a hospital, ambulatory surgery facility, or licensed diagnostic lab facility, for pre-operative testing related to and done within the seven days prior to scheduled surgery, are covered, but only if:

1. The covered member undergoes the scheduled surgery in the hospital or ambulatory surgery facility. This does not apply if the tests show that the surgery should not be done because of his or her physical or mental condition.
2. The charge for the surgery is a covered medical expense.
3. The tests performed were covered if the covered member were confined as an inpatient in a hospital.

4. The test results appear in the covered member's medical record kept by the hospital or the facility where the surgery is done.
5. The tests are not repeated in or by the hospital or the facility where the surgery is performed.

Preventive Services

The PCN and PPO Plans covers a physical exam every 24 months. Under the PCN Plan, the exam must be given by the in-network Primary Care Physician. Under the PPO Plan, the exam must be given by an in-network provider. Both the PCN Plan and the PPO Plan cover a vision exam. Both plans cover: immunizations, well baby care, pap smears, colo-rectal exams, mammograms. (Refer to Summary of Benefits for coverage levels.)

Prosthesis

The first prosthesis furnished to replace all or part of any internal body organ or external body part that is lost or impaired as the result of disease or injury, including but not limited to:

1. An artificial arm, leg, hip, knee, or eye.
2. An external breast prosthesis (and the first bra made solely for use therewith) furnished after a mastectomy.
3. A breast implant furnished after a mastectomy.
4. Ostomy supplies, clamps, belts, bags, lock rings.
5. A cardiac pacemaker.
6. A durable brace that is specially made for and fitted to the covered participant.

Also included are the charges for the repair or replacement for such prosthesis, but only if the Plan Administrator is shown that:

1. It is required because of a change in the covered member's physical condition.
2. It is likely to cost less to buy a new prosthesis than to repair the existing prosthesis.
3. The existing prosthesis cannot be made serviceable.

Not included are charges for or related to:

1. Eyeglasses or vision aids or hearing aids.
2. Orthopedic shoes, orthotic or other supports for the feet.
3. Trusses, corsets, and other support items.

Skilled Nursing Care

Charges for skilled nursing care will be included as Covered Medical Expenses only if they are charges made by an RN or LPN or a nursing agency for skilled nursing services.

As used here, "skilled nursing services" means:

1. Visiting nursing care by an RN or LPN. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
2. Private duty nursing by an RN or LPN if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Not included as "skilled nursing services" is:

1. That part or all of any nursing care that does not require the education, training and technical skills of an RN or LPN, such as transportation, meal preparation, charting of vital signs and companionship activities.
2. Any private duty nursing care, given while the person is an inpatient in a hospital or other health care facility.
3. Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.
4. Care provided solely for skilled observation except as follows:

   For no more than one four-hour period per day for a period of no more than 10 consecutive days following the occurrence of:

   - Change in patient medication

- Need for treatment of an emergency condition by a physician, or the onset of symptoms indicating the likely need for such treatment
- Surgery
- Release from inpatient confinement.

1. Any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by an RN or LPN.

Speech Therapy
Only for medical rehabilitation that is:

1. Expected to restore speech to a covered member who has lost speech function (the ability to express thoughts, speak words, and form sentences) as the result of disease or injury
2. Outlined in a specific treatment program which:
   A. Details the therapy to be rendered, how often and how long it will be needed
   B. Provides for ongoing reviews and is renewed only if therapy is still needed.

X-ray, Radium, and Radioactive Isotope Therapy
Benefits are provided for radiotherapy rendered by a doctor for treatment of a non-occupational accident or sickness. The benefits consist of full payment of the reasonable and customary fees for a doctor's services in rendering an X-ray, radium, or radioactive isotope treatment, including the purchase or rental of radioactive substances essential to the treatment, if the charges for these substances are submitted by the doctor rendering the treatment.

If treatment is rendered by a doctor, other than a resident physician or intern, during a hospital confinement for which no room and board charges are made and if the charges for treatment are made by the hospital, the hospital charges will be considered as charges of the doctor rendering the treatment. Radiotherapy benefits do not apply to fees for services paid under other parts of the Plan.

SERVICES NOT COVERED UNDER THE PRIMARY CARE NETWORK AND PREFERRED PROVIDER ORGANIZATION PLAN

Charges for the following are not considered "covered expenses" under these Plans:

1. Charges for plastic, reconstructive or cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
   A. Improve the function of a part of the body, other than teeth or structures that support the teeth, that is malformed as a result of a severe birth defect (such as harelip or webbed fingers or toes) or as a direct result of a disease or surgery performed to treat a disease or injury. The exclusion of "other than teeth, or structures that support the teeth," does not apply to medical treatment, surgery, services, or supplies necessary to remedy a congenital condition for children eighteen and under.
   B. Repair an injury which occurs while a person is a covered member but only if the surgery is performed in the calendar year of the accident which causes the injury or in the next calendar year.
1. Charges for or related to any eye surgery mainly to correct refractive errors, including but not limited to radial keratotomy.
2. Charges for or in conjunction with marriage, family, child, career, social adjustment, pastoral, or financial counseling services.
3. Charges for acupuncture therapy. This does not include acupuncture when it is furnished

by a Covered Health Care Provider as a form of anesthesia in connection with surgery that is covered under this Plan.

4. Charges for or related to treatment of obesity or for diet or weight control.
5. Charges for or related to pregnancy of a surrogate mother.
6. Charges for or related to artificial insemination or in vitro fertilization procedures.
7. Charges for therapy, supplies, drugs or counseling services for sexual dysfunctions or inadequacies.
8. Charges for the reversal of sterilization.
9. Charges for or related to sex change surgery or any treatment related to gender identity.
10. Charges for services of a Covered Health Care Provider who is an immediate relative or a member of the household of a covered member.
11. Charges for routine physical, vision, dental, or hearing exams, or other preventive services unless specifically mentioned in the Schedule of Benefits.
12. Charges for maintenance care.
13. Charges for custodial care.
14. Charges for services or supplies that are not necessary for the diagnosis, cure, or treatment of the physical or mental condition involved, even if prescribed, recommended or approved by a Covered Health Care Provider.
15. Charges for, or in connection with, procedures, services, drugs or other supplies that are, as determined by the Claims Administrator to be experimental, or still under clinical investigation by medical professionals. A drug, a device, a procedure, or treatment will be determined to be experimental, or investigational if:
    A. There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
    B. If required by the FDA, approval has not been granted for marketing.
    C. A recognized national medical or dental society, or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes.
    D. The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to procedures, services or supplies (other than drugs) received in connection with a disease if the Claims Administrator determines that:

A. The disease can be expected to cause death within one year, in the absence of effective treatment.
B. The care or treatment is effective for that disease or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, the Claims Administrator will take into account the results of a review by a panel of independent medical professionals. They will be selected by the Claims Administrator. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

A. Have been granted treatment investigational new drug (IND) or Group treatment IND status.

B. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute.

C. If the Claims Administrator determines that available scientific evidence demonstrates that the drug is effective, or shows promise of being effective for the disease.

1. Charges for education, special education, or job training, whether or not provided in a facility that also provides medical or psychiatric treatment.
2. Charges for services or supplies which any school system is required to provide under law.
3. Charges for services of a physician, physical therapist, occupational therapist, speech therapist, or audiologist rendered to a covered dependent child who is physically or mentally impaired or learning disabled and which any school system is required to provide under any law mainly to help him or her to benefit from special education.
4. Charges for services and supplies for which benefits are furnished, paid for, or for which benefits are provided or required under any law of a government. This does not include a plan established by a government for its own employees or their dependents.
5. Charges for services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered member in the armed forces of a government, when services or supplies are rendered due to a service-related illness or injury.
6. Charges that are made only because the benefit exists, or charges that no covered member is legally obliged to pay.
7. Charges which are not reasonable and customary.
8. Charges for care, treatment, services, or supplies that are not prescribed, recommended, and approved by the covered member's attending physician or dentist.
9. Charges for services of a resident physician or intern rendered in that capacity.
10. Charges for or related to the following types of treatment of mental disorders: primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, or carbon monoxide therapy.
11. Charges for psychoanalysis of a covered member who is a covered Health Care Provider specializing in the mental health care field and who is a psychoanalytic candidate in training.
12. Charges for services and supplies for treatment of job-related injuries or sickness.
13. Charges for treatment or supplies not ordered by a Covered Health Care Provider.
14. Charges for routine physical – except as described in the PCN Plan and PPO Plan benefit summary
15. Charges for well-baby care except for those specifically mentioned in the Schedule of Benefits. (Room and board, circumcision, and pediatrician visit charges for natural-child newborns will be paid for up to 14 days following birth, assuming no complications.) Legally adopted children will be covered on the same basis as natural dependent children, whether or not the adoption has become final.
16. Charges for treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, or bunions (except open cutting operations) and corns, calluses, or toenails.
17. Charges for services or supplies not used in the treatment of an illness or injury.
18. Ostomy supplies such as tapes, brushes, dry racks, powders, creams, soaps, rubber bands, rubber gloves, surgical dressing, sponges, scissors.
19. Private duty nursing services when the skilled services are not over and above what a *hospital should normally provide.*

20. Facility charges for other than a hospital, Ambulatory Surgery Facility, or outpatient clinic.
21. Charges for any services or supplies which are for orthodontic treatment, including correction of malocclusion.
22. Charges for the extraction of wisdom teeth.
23. Charges for oral contraceptives.
24. Charges for hearing aids.

Overview of Prescription Drug Plan

The Prescription Drug Plan is a feature of both the Primary Care Network and the PPO plans. It has two features, the Retail Card benefit and the Mail Order benefit.

The Retail Card benefit covers prescriptions of 34 days or less at a participating pharmacy. The Mail Order benefit covers prescriptions of up to 90 days. The Mail Order benefit was created to help both you and the Company manage the high cost of maintenance drugs.

Prescription Drug Administrator

PCS – Where PacificSource is Claims Administrator

Plan Membership

If you are enrolled in the PCN or the PPO Plan, you and your covered dependents are automatically covered under the Prescription Drug Plan.

- If your covered dependents have primary medical coverage through another employer's plan, they are not eligible for this Plan.

PLAN PROVISIONS

Generic Versus Brand Name Drugs

Many brand name drugs have generic equivalents available for purchase. Using the generic drug saves money, and for most people, provides the same quality. This is because, by law, generic drugs must meet the same standards for safety, strength, and effectiveness as brand name drugs. However, you can pay up to four times more for a brand name drug than for its generic equivalent, since the cost of the development, packaging, and advertising are passed on to you.

The Prescription Drug Plan encourages you to use generic drugs, when available, by reducing your out-of-pocket costs for these drugs, both at the local pharmacy as well as through the Mail Service program as explained below.

Mail Service Purchases Of Maintenance Drugs

The Plan is designed to enable you to purchase maintenance drugs through the Mail Service Program. These are medications you take on a long-term basis to treat or control chronic illnesses, such as high blood pressure, ulcers, arthritis, diabetes, etc.

The Mail Service Program is provided through both PCS Pharmacy Plan. It offers you a convenient and cost-effective way to obtain up to a 90-day supply of maintenance drugs.

Drugs ordered through Mail Service usually take 14 days to fill, after PCS has received your prescription form. You should allow for mailing time. As an added convenience, you may order medication refills or check on the status of a prescription in the mail service program by calling the appropriate toll free number.

Your cost for drugs purchased through the Mail Service is as follows:

- Generic drugs: $9 per prescription (no deductible to meet).

- Brand name drugs that have no generic substitute: $20 per prescription (no deductible to meet).
- Brand name drugs when generic is available: $20 per prescription plus the difference between generic and brand name
- The above co-pay is applicable for 30, 60, or 90-day supply.

PCS will only fill the exact days supply as prescribed by your physician for each co-payment. If you are stabilized on a maintenance medication, you should ask your physician to write a 90-day supply.

If you have questions concerning how to submit your mail order prescription or what the cost will be, you may call the appropriate toll-free number.

If you are not sure whether a generic equivalent exists before sending a brand name drug prescription to the mail order pharmacy, don't hesitate to ask your doctor.
Exceptions: If you cannot take a generic drug for medical reasons, you will need to follow these procedures:

1. Obtain a short-term prescription from your doctor and have it filled at a local pharmacy.
2. Send a written request for a generic override to your HR Department. Please include documentation from your doctor which explains the medical reason why you cannot take a generic equivalent.
3. Your request will be reviewed by the Plan Administrator's pharmacy manager. If it is approved, you will receive a one-year exception. Thereafter, for authorized prescriptions filled with the brand name drug, you will be responsible for paying only the brand name co-pay and not the difference in cost between the generic and brand name drug. If you continue to need the generic override you will be required to apply for it on an annual basis.

In certain situations, if your doctor prescribes what are known as high-cost drugs, PCS will consult with your doctor before filling the order to confirm the diagnosis and explore whether alternative therapies are available.

Local Pharmacy Purchase
Prescription drugs that are needed for acute, short-term treatment, such as penicillin for treatment of strep throat, or the first prescription of a maintenance drug, can be purchased at your local pharmacy. The maximum supply covered by the Plan for drugs purchased at a local pharmacy is 34 days and there are no limits on the number of refills.

- You pay a co-payment of $14 for each brand name drug prescription and $7 for each generic drug prescription purchased at a network pharmacy.
- If you purchase your prescriptions at a Non-network pharmacy, you must first satisfy a calendar year deductible of $50 per person, or $150 per family.
- After meeting the deductible, your co-payments are $14 for brand name drugs and $7 for generic drugs, plus you are responsible for the difference between the PCS network price and the actual pharmacy charge, if any.
- If you purchase a brand name drug when a generic is available, you are responsible for the brand name co-payment, plus the difference between the cost of the brand name and generic.
- If you purchase your brand name drug at a Non-network pharmacy, you are responsible for the brand name co-payment, plus the difference between PCS's network brand name price and the actual pharmacy charge.

The generic override feature described above is not available for local pharmacy purchases.

The deductible and co-payments for prescription drugs are separate from, and do not apply to, the medical plans' deductible or maximum out-of-pocket.

Controlled Substances
Schedule II Controlled Substances, such as Dilaudid, Demerol, etc., have special dispensing rules which vary from state to state. This Plan is designed to accommodate these state policies. Please contact the carrier for further information.

FILING A CLAIM

Network Pharmacy
If a local (retail) pharmacy purchase is made through a preferred provider pharmacy which participates in PCS's point-of-service program, the pharmacist will charge the correct amount based on plan design, and no paper claim is required for reimbursement.

Non-Network Pharmacy
PCS Prescription Drug claim forms are available from PCS. If you are having difficulty obtaining claim forms, contact HR Department.

PCS will also accept the Universal Pharmaceutical Claim Form, which may be available at your pharmacy.

Your pharmacist will need to complete a part of the claim form; or you can attach an itemized receipt, as long as it contains all the information requested on the claim form. Most pharmacies today have computerized registers that automatically provide this information, check with yours.

You will need to complete the remainder of the claim form, and then mail it to the PCS address listed on the back of the claim form. Your claim will normally be processed within 10 to 14 days from the day it is received. If the claim is not complete, it may be returned by PCS, and this will cause a delay in your reimbursement.

Mail Service Pharmacy
Mail Service order forms are available from the carrier. If you are having difficulty obtaining claim forms, contact HR Department. Simply complete the form, enclose your prescription and your co-payment, and mail it to the mail order pharmacy.

TERMINATION OF COVERAGE

Your and your eligible dependents' coverage under this Prescription Drug Program will terminate effective when your associated medical plan coverage terminates, or if you enroll in an alternative medical plan.

FORT JAMES

PRESCRIPTION DRUG PLAN

SUMMARY OF BENEFITS: Retention, a part of the Primary Care Network Plan and Indemnity Plan Prescription Plan

BI-WEEKLY PAYROLL CONTRIBUTIONS included in Medical Plan Contribution

		Network
Annual Deductible – Retail	None $150/Family	$50/Individual
Annual Deductible – Mail Order	None	None
Annual Maximum Out-of-Pocket (M.O.P.) Retail and Mail Order	None	None
Retail Pharmacy Purchases (34 day supply)	Co-Pay	Co-Pay after deductible
Generic required if available	Yes	Yes
• Generic	$7	$7
• Brand Name	$14	$14 (plus price difference between Network and Non-Network price)
• Brand Name, when generic is available	$14 (plus price difference between generic and brand name price)	$14 (plus price difference between generic and brand name price)
Mail Order Pharmacy Purchases (60, 90, 90 day supply)	Co-Pay	Co-Pay after deductible
Generic required if available	Yes	Yes
• Generic	$9	Not Covered
• Brand Name	$20	Not Covered
• Brand Name, when generic is available	$20 (plus price difference between generic and brand name price)	$20

PCS will only fill the exact days' supply as prescribed by your physician for each co-pay. If you are stabilized on a maintenance medication, you can minimize your co-pay by asking your physician to write the prescription for a 90-day supply.

Other Information for Health Care Plans

AGE 65 OPTION

If, while still actively employed, you or your spouse reach age 65, you will continue to be covered under your Health Care Plans and the Prescription Drug Plan unless you request otherwise. Any Medicare coverage for which you are eligible will be secondary to this Plan.

If you do not want to continue coverage under this Plan following your 65th birthday, you must contact HR Department.

TERMINATION OF COVERAGE

Medical coverage for you and your dependents ends in the following instances.

Employees

Your Fort James provided medical coverage ends when:

- You are no longer enrolled in the Plan
- Your employment ends, unless you or your dependents qualify for continued coverage due to death, retirement or disability
- You are no longer an eligible employee
- You stop making required contributions
- The Plan is terminated or discontinued.

Dependents

Coverage for your dependents ends when:

- Your coverage ends
- They no longer meet the eligibility requirements
- They become covered as Fort James employees
- The Plan eliminates dependent coverage
- You or your dependents stop making contributions.

CONTINUATION COVERAGE (COBRA)

You and your dependents have certain *legal* rights provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See the Administration section of this guide for more information on COBRA.

OTHER PLAN INFORMATION

Your Health Care Benefits, including the Prescription Drug Plan, are provided through the Fort James Comprehensive Welfare Trusts which are funded primarily by the Company. Fort James pays third party administrators to process claims. However, since benefits are not provided through an insurance contract, these claims are paid in their entirety by the Trust. This summary describes the essential features of the Plan in which you are enrolled. The Company pays a major portion of the cost related to you and your dependent's coverage.

The Plan is administered through the Employee Benefits Department of the Corporation. Final determination of all benefits will be made in accordance with the Plan Document.

Fort James is empowered to exercise discretion in the interpretation of the terms of this plan and such discretionary determination regarding the terms and eligibility shall be binding on all participants. Fort James reserves the right to change or terminate any of the Plans at any time as they relate to active employees or retired employees regardless of the date of employment or retirement. These retained rights include both the benefits provided and the level of contributions required. Changes to these Plans for a group of employees covered under a collective bargaining agreement will be made in accordance to the terms of the collective bargaining agreement.

Plan Amendments
Resolutions for proposed amendments to the Plan will be reviewed and voted upon by the Board of Directors of Fort James Corporation, or any person or persons to whom the Board has delegated such authority.

DEFINITIONS FOR HEALTH CARE PLANS

Ambulatory Surgery Facility:
A facility that:
1. Is licensed by the jurisdiction it is in (if required by the state).
2. Is set up, equipped, and run solely as a setting for surgery.
3. Charges for the services and supplies it provides.
4. Is run under the direction of a staff of M.D.s or D.O.s (at least one such physician must be on the premises when surgery is performed and during the recovery period).
5. Has a certified anesthesiologist on the premises when surgery requiring general or spinal anesthesia is performed and during the recovery period.
6. Extends surgical staff privileges to physicians who can perform surgery in an area hospital.
7. Has at least two operating rooms and one recovery room.
8. Has diagnostic X-ray and lab equipment, or access to such.
9. Does not provide a place for patients to stay overnight.
10. Provides full-time skilled nursing services in the operating and recovery rooms.
11. Has equipment and trained staff needed to handle medical emergencies.
12. Provides an ongoing quality assurance program.
13. Keeps a medical record on each patient.

Anesthetic Charges:
The services of a doctor who is not the operating doctor or his assistant, for administering an anesthetic, other than a local infiltration anesthetic.

Custodial Care:
Care which consists of services and supplies including room and board and other institutional services, furnished primarily to assist in activities of daily living, whether or not the individual is disabled. These services and supplies are custodial care regardless of the practitioner or provider who prescribes, recommends, or performs them.

Covered Health Care Provider:
Any of the following who are practicing within the scope of their applicable license or, in the absence of licensing requirements, certification by the appropriate professional association:
1. Physician: Any legally qualified: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Doctor of Chiropody (D.P.M.-D.S.C.).
2. Dentist: A legally qualified dentist (D.D.S. or D.M.D.) or a physician.
3. Christian Science Practitioner (C.S.): Listed in the Christian Science Journal.
4. RN: A registered nurse, including nurse practitioner practicing within the scope of applicable certification and law.
5. LPN: A licensed practical or vocational nurse.
6. Midwife: A legally qualified midwife.
7. P.A.: A qualified physician's assistant who:
   A. Is certified as such by the National Commission on Certification of Physician's Assistants; or
   B. Is a certified graduate of an approved training course which is accredited by the American Medical Association's Committee on Allied Health Education.
   C. Works for a clinic or for a physician who is an M.D. or D.O. This test does not apply if applicable law does not allow it.

1. Any legally qualified Physical Therapist, Occupational Therapist, Speech Therapist, or Audiologist.
2. Any other provider whom the Plan Administrator is required to consider as a Covered Health Care Provider under any law that applies to this Plan.

Diagnostic X-ray and Lab Charges:
Exams for diagnosis only, given by a doctor, or the interpretation of the exam by a doctor who is not a resident doctor or hospital intern.

Emergency Admission:
Admission where the physician admits the person to the hospital or treatment facility right after the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which:
1. Requires confinement right away as a full-time hospital or treatment facility inpatient; and
2. If immediate inpatient care was not given could, as determined by the Claims Administrator, reasonably be expected to result in:
   A. Loss of life or limb.
   B. Significant impairment to bodily function.
   C. Permanent dysfunction of a body part.

Emergency Care:
The first treatment given in a hospital's emergency room right after the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which:
1. Requires hospital level care because:
   A. The care could not safely and adequately have been provided other than in a hospital.
   B. Adequate care was not available elsewhere in the area at the time and place it was needed.
2. If the hospital level care was not given could, as determined by the Claims Administrator, reasonably be expected to result in:
   A. Loss of life or limb.
   B. Significant impairment to bodily function.
   C. Permanent dysfunction of a body part.

Emergency Condition:
The sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which, if the procedure or treatment were not performed right away could, as determined by the Claims Administrator, reasonably be expected to result in:
1. Loss of life or limb.
2. Significant impairment to bodily function.
3. Permanent dysfunction of a body part.

A surgical procedure in connection with which a benefit is payable for a second surgical opinion or for, which there is a penalty if a second surgical opinion is not obtained, will be deemed to be:
1. Not for an emergency.
2. Non-emergency in nature if it is performed other than for an emergency condition.

Hospice Care Agency:
An agency or organization that meets all of the following tests:
1. Has hospice care available 24 hours a day.
2. Is licensed as such by the jurisdiction it is in.
3. Provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family.
4. Provides or arranges for other services which will include: services of a physician, physical or occupational therapy, part-time or home health aide services consisting of primarily caring for a terminally ill family member, or inpatient care in a facility when needed for pain control and other acute and chronic symptom management.

Hospice Care Facility:
A facility or a distinct part of one, such as a Hospital or Convalescent Facility, that meets all of the following tests:

1. Is set up, equipped and run mainly as a setting for providing Inpatient Hospice Care to terminally ill persons.
2. Charges for the services and supplies it provides.
3. Is licensed as such by the jurisdiction it is in.
4. Keeps a medical record on each patient.
5. Provides an ongoing quality assurance program with reviews by M.D.s or D.O.s other than those that own or direct the facility.
6. Is run under the direction of a staff of M.D.s or D.O.s, at least one of such physicians must be on call at all times.
7. Provides 24 hours a day skilled-nursing services under the direction of RNs.
8. Has a full-time administrator.

Medically Necessary:
A service or supply furnished by a particular provider is necessary if it is determined by the Claims Administrator that it is appropriate for the diagnosis, the care, or the treatment of the disease or injury involved.
To be appropriate, the service or supply must:

1. Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than any alternative service or supply, both as to the disease or injury involved, and the person's overall health condition.
2. Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition.
3. As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the Claims Administrator will take into consideration:

1. Information provided on the affected person's health status.
2. Reports in peer reviewed medical literature.
3. Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data.
4. Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment.
5. The opinion of health professionals in the generally recognized health specialty involved.
6. Any other relevant information brought to the Claims Administrator's attention.

In no event will the following services or supplies be considered to be necessary:

1. *Those that do not require the technical skills of a medical, a mental health or a dental professional.*
2. *Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider or health care facility.*
3. *Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined.*
4. *Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.*

Mental Disorder:
A disease commonly understood to be a mental disorder, whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist, or a psychiatric social worker. A mental disorder includes, but is not limited to:

- Alcohol abuse and drug abuse
- Schizophrenia
- Bipolar disorder
- Pervasive Mental Development Disorder (Autism)
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive-compulsive disorder

Network Provider:
A provider of medical care who is under contract with the Claims Administrator.

Non-occupational Disease:
A disease which does not arise, and which is not caused or contributed to, by, or as a consequence of, any disease which arises out of or in the course of any employment or occupation for compensation or profit.

Non-occupational Injury:
An accidental, bodily injury which does not arise, and which is not caused or contributed to, by, or as a consequence of, any injury which arises out of or in the course of any employment or occupation for compensation or profit.

Primary Care Physician (PCP):
A physician, whom you choose, to manage all aspects of your medical care. A Primary Care Physician may be a general practitioner, internist, or podiatrician. You and your dependents may choose different Primary Care Physicians. You must identify your Primary Care Physician to the Claims Administrator.

Surgical Procedure:
Includes surgical procedures in one of the following categories performed by a doctor, and the usual, necessary and related pre-operative and post-operative care and administration of an anesthetic by the operating doctor:

1. The incision, excision or electrocauterization of any organ or part of the body.
2. The manipulative reduction of a fracture or dislocation.
3. The suturing of a wound.
4. The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder or ureter.
5. The extraction of a tooth root without the extraction of the entire tooth.
6. The closed or open reduction of fractures or dislocation of the jaw.
7. Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction of teeth.

Pre-Tax Contributions for Health Plan

SUMMARY

- Covers contributions made to your Group Medical Plans.
- Contributions are made on a pre-tax basis.
- You are eligible to participate if you are a regular full-time or part-time benefit eligible employee.
- If you are rehired in the same year that you were terminated, you may not be permitted to join the Plan until the following January 1.

Any amounts that you contribute under the Plan are not currently subject to federal income tax or, in most areas, state income tax. In addition, FICA tax is not withheld. This may affect your Social Security benefits.

PLAN MEMBERSHIP
You are eligible to participate in this Plan on the day you begin working as a benefits-eligible employee. *You must submit an election form within 31 days of eligibility or within 31 days of acquiring a newly eligible dependent if you wish to enroll that dependent.* Enrollment forms are available from your HR Department.

If you are rehired in the same year that you were terminated, you will not be permitted to join the Plan until the following January 1.

Eligibility to participate and benefit provisions for the Group Medical Plans are not determined by this Plan but by the specific provisions of the Plans themselves.

CONTRIBUTIONS
Contributions you make to the Plan will be withheld from your pay on a bi-weekly basis for your Group Medical coverages.

To participate in these benefits, you must make a written election and you must agree to have *your share of the cost paid on a pre-tax basis* through this Plan.

For specific contribution levels, please refer to the individual Plan descriptions contained in this guide.

OTHER PLAN INFORMATION
Fort James Corporation has the express discretionary authority to interpret the Plan and to resolve ambiguities, inconsistencies, or omissions.

Fort James reserves the right to change or terminate the Pre-Tax Contribution Plan at any time. These retained rights include both the benefits provided and the level of contributions required. Changes to this Plan for a group of employees covered under a collective bargaining agreement will be made in accordance to the terms of the collective bargaining agreement.

Fort James is empowered to exercise discretion in interpreting the terms of the Plan and such discretionary determination regarding the Pre-Tax Contribution terms and eligibility shall be binding upon all participants.

Plan Amendments
Resolutions for proposed amendments to the Plan will be reviewed and voted upon by the Board of Directors of Fort James Corporation, or any person or persons to whom the Board has delegated such authority.

Spending Accounts

Flexible Health Care Spending Account
Dependent Day Care Spending Account

These benefits will be available as of 7-1-2000. Enrollment information will be provided during Open Enrollment.

Health Care Spending Account

SUMMARY

- You are eligible January 1 following your date of employment if you are a full-time or part-time hourly employee.
- You must enroll within 31 days of eligibility, within 31 days of a "change in family status," or during the annual Open Enrollment period.
- Contributions are made on a pre-tax basis. Therefore, you are reimbursed with dollars that have not been taxed.

- You may receive reimbursement for certain medical or dental expenses not covered by your health care or dental plans with pre-tax dollars that you have had deducted from your paycheck.
- If you are rehired in the same calendar year that you were terminated, you will not be permitted to join the Plan until the following January 1.
- Minimum bi-weekly contribution is $2.00 ($52 per year).
- Maximum bi-weekly contribution is $115.38 ($3,000 per year).
- USE IT OR LOSE IT.

INTRODUCTION

This plan helps you pay for predictable health and dental expenses not covered by your health care or dental plans in a tax-effective way for both you and your eligible dependents.

PLAN MEMBERSHIP

You are eligible to participate in the Plan if you enroll within 31 days of becoming a benefits eligible employee or within 31 days of a "change in family status" if you are a regular full-time or part-time employee. If you are rehired in the same year that you were terminated, you will not be permitted to join the Plan until the following January 1. Dependents who can be covered by this plan include:

- Your wife or husband
- Your natural unmarried children who are under 19 years of age; or a lawfully adopted child, stepchild, or other child under the age of 19, who depends on you for support and lives with you in a regular parent-child relationship
- A dependent child (as defined above), between 19 years of age, and up to 25th birthday, if such child attends school regularly and depends solely on you for support

Enrollment

To enroll, you must complete the appropriate enrollment form and return it to HR Department. At the same time, you will be asked to supply certain information about the dependents you enroll (if any). *If you don't enroll in this plan within 31 days of your eligibility, you may not enroll until the first day of a succeeding plan year unless you experience a "change in family status" which is outlined below.*

You may enroll yourself or your eligible dependents during the annual Open Enrollment period held by the Company. This Open Enrollment period is held every October/ November with your election going into effect the first of the following year. You must make an election each Open Enrollment period to continue participation in the plan. If you do not make an election during Open Enrollment, your participation in the plan will terminate the following January 1.

CHANGE IN FAMILY STATUS

You may not elect coverage under this plan after the deadline for submitting election forms for a plan year or change your level of participation during the plan year unless you experience a "change in family status" during that year. A plan year is defined as the 12 consecutive month period beginning on January 1 and ending on December 31. *If you experience a change in family status and wish to make a change in your participation level, you must notify your HR Department no later than 31 days after the status change took place.* "Change in family status", as allowed by the I.R.S., includes:

- Marriage
- Divorce
- The death of a participant's spouse or child
- Birth, adoption of, or placement for adoption of a participant's child
- Commencement or termination of employment by a participant's spouse

- A participant's termination of employment
- The changing from full-time to part-time employment, or vice versa, by the participant or spouse
- The taking of an unpaid leave of absence by the participant or spouse
- A significant change in the health coverage of a participant or spouse attributable to the spouse's employment

CONTRIBUTIONS

You may contribute a bi-weekly minimum of $2.00 up to a bi-weekly maximum of $115.38 per plan year. These contributions will be on a pre-tax basis through automatic payroll deductions.

ELIGIBLE EXPENSES

The Health Care Spending Account is designed to help you pay for certain health care or dental expenses not covered by the health care options or dental plan with pre-tax dollars for you and your dependents. Allowable expenses are the same as those that you would be allowed to claim as an itemized deduction on your income tax return and therefore must follow I.R.S. guidelines.

Some of the expenses that would qualify for reimbursement include:

- Amounts not paid by our Medical Plan or Dental Plan, such as the deductible or the coinsurance you pay. (If you or a dependent are covered under two health care plans, only the amount not paid by either plan is eligible for reimbursement.)
- Deductibles and coinsurance for other health, prescription, dental, or vision plans under which you or your dependents are covered
- Expenses not covered by our Medical Plan such as general out-of-network physical examinations (up to $400 per year) and well-baby care. Cosmetic surgery or prescription drugs that are used for cosmetic purposes are excluded.
- Virtually all vision expenses, including corrective eyeglasses, contact lenses and contact supplies/solutions as well as the cost of a guide dog for the blind and special educational devices for the blind (such as a special typewriter)
- Hearing expenses including hearing aids, special instructors or training for the deaf (such as lip reading), and the cost of acquiring and training a dog for the deaf
- Expenses incurred for smoking cessation programs and associated prescription drug expenses. (Amounts paid for non-prescription drugs, such as nicotine gum and certain nicotine patches, are not eligible for reimbursement).
- Miscellaneous expenses including birth control pills and a weight loss program prescribed by a physician for curing a specific ailment.

The maximum amount of reimbursement that may be claimed during a given Plan Year is the amount you elected to contribute for that year. That amount is available to you during the entire year, regardless of how much you have contributed, as long as you remain an active employee.

EXCLUSIONS

Expenses that do not meet I.R.S. guidelines, including most over-the-counter medications and supplies.

FILING CLAIMS

To obtain reimbursement under the Plan, you must complete a Health Care Spending Account Reimbursement Request Form and submit it to your Claims Administrator. Directions for completion are provided on the form. The form is available at your local Human Resources Department.

Reimbursements are made by your Claims Administrator. Between January 1 and October 31 of the Plan Year, you may request reimbursement for amounts of $50 or more. After October 31, you may request reimbursement for any amount. Expenses eligible for reimbursement are only those expenses incurred during the Plan Year. You may request reimbursement for current plan year expenses until March 31 of the following year.

APPEALING A DENIED CLAIM

If your claim is denied, you can appeal the denial and have your claim reviewed. See Appealing A Denied Claim in the Administration section of this guide (page 2).

FORFEITURE - USE IT OR LOSE IT

The "use it or lose it" rule is a federal regulation. Under this rule, any unused balances in your *Health Care Spending* Account must be forfeited at the end of the year. For example, if you allocated $100 to your health care account and submitted expenses of only $80, you would forfeit the remaining $20 at the end of the year. You may be able to avoid losing any unused money if you estimate your *future expenses realistically.*

TERMINATION OF COVERAGE

You will cease to be a participant as of the earlier of (a) the date on which you cease active employment or (b) the date on which the Plan terminates. However, you may elect to continue your coverage under this Plan after your employment terminates pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 until the expiration of the coverage continuation period. See the detailed description of COBRA in the Administration section of this guide.

PAYMENT OF CLAIMS FOLLOWING TERMINATION OF PARTICIPATION

If you cease to be a participant for any reason, any election to have your compensation reduced and to receive reimbursements for Medical Care Expenses shall terminate. You (or your estate) shall be entitled to reimbursement only for Medical Care Expenses incurred within the same Plan Year and before the date your participation terminated, and only if you (or your estate) apply for such reimbursement by filing a "Claim for Reimbursement" on or before the earlier of (a) the 180th day following the date your participation terminated, and (b) March 31 of the year following the Plan year in which expenses were incurred. No such reimbursement shall exceed the remaining balance, if any, in your Medical Expense Reimbursement account for the *Plan* Year in which *the expenses* were incurred.

OTHER PLAN INFORMATION

Your Spending Account benefits are provided through the Fort James Comprehensive Welfare Plan. This summary describes the essential features of your Spending *Accounts* underwritten *by* Fort James by your Plan Administrator.

The *Spending Account is* administered through the Human Resources Department of the Corporation. Final determination of all benefits will be made in accordance with *the contract* underwritten by your current Plan Administrator.

Fort James reserves the right to change or terminate the Spending Account Plan at any time. These retained rights include both the benefits provided and the level of contributions required. Fort James is empowered to exercise discretion in interpreting the terms of the Plan and such discretionary determination regarding the Plan terms and eligibility shall be binding upon all participants.

Plan Amendments
Resolutions for proposed amendments to the Plan will be reviewed and voted upon by the Board of Directors of Fort James Corporation, or any person or persons to whom the Board has delegated such authority.

Dependent Day Care Spending Account

SUMMARY

You are eligible January 1 following the date you become a benefits eligible employee if you are a full-time or part-time hourly employee. (If you are married, your spouse must also be working in order for you to participate in this plan.)

- You must enroll within 31 days of eligibility, within 31 days of the addition of an eligible dependent, or during the annual Open Enrollment period.
- Contributions are made on a pre-tax basis. Therefore, you are reimbursed with dollars that have not been taxed.
- The Plan covers expenses related to dependent day care for children under age 13 and other disabled individuals whom you claim as dependents for income tax purposes.
- If you are rehired in the same calendar year that you were terminated, you will not be permitted to join the Plan until the following January 1.
- Minimum bi-weekly contribution is $2.00 ($52 per year). Maximum bi-weekly contribution is $192.30 ($5,000 per year).
- USE IT OR LOSE IT.

INTRODUCTION

This plan allows you (or both you and your spouse) to work by helping you to pay for predictable day care expenses with pre-tax dollars.

PLAN MEMBERSHIP

You are eligible to participate in the Plan if you enroll within 31 days of becoming a benefits eligible employee, the addition of an eligible dependent, or the commencement of employment by your spouse if you are a full-time or part-time hourly employee. If you are rehired in the same year that you were terminated, you will not be permitted to join the Plan until the following January 1.

"Eligible dependents" include children under the age of 13 for whom you are entitled to an exemption on your federal income tax return and any other dependent, or spouse, who is physically or mentally incapable of caring for himself/herself and for whom you take an exemption.

Enrollment
To enroll you must complete the appropriate enrollment form and return it to HR Department. Election to participate in the Plan shall be irrevocable during the Plan year which runs from January 1 through December 31, unless you have a "change in family status," as allowed by the I.R.S., and which are outlined below.

You may enroll yourself or your eligible dependents during the annual Open Enrollment period held by the Company. This Open Enrollment period is held every October/ November with your election going into effect the first of the following year. *You must make an election each Open Enrollment period to continue participation in the plan.* If you do not make an election during Open Enrollment, your participation in the plan will terminate the following January 1.

CHANGE IN FAMILY STATUS

You may not elect coverage under this plan after the deadline for submitting election forms for a

plan year or change your level of participation *during the plan year unless you experience a* "change in family status" during that year. A plan year is defined as the twelve consecutive month period beginning on January 1 and ending on December 31. *If you experience a change in family status and wish to make a change in your participation level, you must notify HR Department no later than 31 days after the status change took place.*

A "change in family status" shall include, but not be limited to:

- Marriage
- Divorce
- The death of a participant's spouse or child
- The birth, adoption of, or placement for adoption of a participant's child
- Commencement or termination of employment by a participant's spouse
- The changing from full-time to part-time employment, or vice versa, by the participant or spouse
- The change in the daily working shift of the participant or spouse
- The taking of an unpaid leave of absence by the participant or spouse

TAX CONSIDERATIONS

Before opening your account(s), you should decide if federal income tax credits will result in more favorable tax treatment for you. While our plan has a maximum annual contribution of $5,000, your individual tax situation may determine what limit you are allowed. See Contributions section below for more information.

You may choose between opening a Dependent Day Care Spending Account or claiming the child care tax credit on your federal income tax return. You should discuss these options with your tax advisor.

Whichever method you choose, tax credit or Dependent Day Care Spending Account, the IRS will require you to identify your day care provider on your income tax return, along with a Social Security number or Tax I.D. number.

In addition, since contributions to this Plan are not subject to FICA, your Social Security benefit may be affected at retirement. In most cases, the tax savings from participation in this Plan will be more beneficial, and the Social Security benefit reductions, if any, will not be significant. If you have any questions on the above, you should consult with your tax advisor.

CONTRIBUTIONS

Your contributions to the Dependent Day Care Spending Account are made on a pre-tax basis through payroll deductions. The maximum you may elect to contribute to the Plan may not exceed the following:

- If you are not married, the lesser of your base pay or $5,000.
- If you are married, the lesser of your income or your spouse's earned income. However, your election may not exceed $5,000 for the Plan year ($2,500 in the case of married employee filing separate returns).
- In the case of a spouse who is a full-time student or is physically or mentally incapable of caring for himself/herself, such spouse will be deemed to have earned income of not less than $200 per month if you have one dependent or $400 per month if you have two or more dependents.

The minimum contribution that you can elect is $1 times the number of weeks remaining in the Plan year.

ELIGIBLE EXPENSES

"Eligible expenses" are those expenses paid for the care of a dependent as defined above. They must be incurred in order to allow you and your spouse, if married, to be gainfully employed.

Expenses are incurred at the time the service takes place, not when you are billed or pay for them.

Eligible expenses do not include expenses incurred outside your home for the care of a dependent unless the dependent regularly spends at least eight hours each day in your household.

FILING CLAIMS

To obtain reimbursement under the Plan, you must complete a Dependent Day Care Spending Account Reimbursement Request form and submit it to your Claims Administrator. Reimbursement forms, which include instructions, are available at your local Human Resources Department. In order to be reimbursed, an employee must provide a written statement from the day care provider stating the provider's tax payer identification or Social Security number, the date the service was provided, and the amount of the expense. You must also certify that the expense is not reimbursable under any other dependent day care spending account. Reimbursements are made by your Claims Administrator. Between January 1 and October 31 of the Plan Year, you may request reimbursement for amounts of $50 or more. After October 31, you may request reimbursement for any amount. Expenses eligible for reimbursement are only those expenses incurred during the Plan year. You may request reimbursement for current plan year expenses until March 31 of the following year.

Reimbursement of covered expenses will not be made under this Plan if they exceed the balance in your Dependent Day Care Account.

APPEALING A DENIED CLAIM

If your claim is denied, you can appeal the denial and have your claim reviewed. See appealing A Denied Claim in the Administration section of this guide.

FORFEITURE - USE IT OR LOSE IT

The "use it or lose it" rule is a federal regulation. Under this rule, any unused balances in your Dependent Day Care Spending Account must be forfeited at the end of the year. For example, if you allocated $2,000 to your day care account and submitted expenses of only $1,900, you would forfeit the remaining $100 at the end of the year. You may be able to avoid losing any money if you estimate your future expenses realistically.

TERMINATION OF COVERAGE

You will cease to be a participant as of the earlier of (a) the date on which you cease active employment with Fort James; (b) the date in which your spouse is no longer actively employed; or (c) the date on which the Plan terminates. As this is not a medical benefit there are no COBRA continuation provisions.

PAYMENT OF CLAIMS FOLLOWING TERMINATION OF PARTICIPATION

If you cease to be a participant for any reason, any election to have your compensation reduced and to receive reimbursements for Dependent Day Care expenses shall terminate. You (or your estate) shall be entitled to reimbursement only for expenses incurred within the same Plan year and before the date your participation terminated, and only if you (or your estate) apply for such reimbursement by filing a "dependent care reimbursement request form" on or before the earlier of (a) the 180th day following the date your participation terminated, or (b) March 31 of the year following the Plan year in which expenses were incurred. No such reimbursement shall exceed the remaining balance, if any, in the participant's account for the Plan year in which the expenses were incurred.