HANCOCK WHITNEY CORPORATION
EMPLOYEE WELFARE FUND
SUMMARY PLAN DESCRIPTION

Effective May 25, 2018

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PARTICIPANT RESPONSIBILITY STATEMENT

You are responsible for decisions affecting your participation in the Hancock Whitney Corporation Welfare Benefit Fund (the "Plan") summarized in this document. No one else can make those decisions for you. You can't be sure you are receiving all of the Plan benefits for which you are eligible unless you know what those benefits are and you follow the rules for obtaining benefits under each component benefit plan (referred to in this document as "Participating Plans"). This document summarizes the Plan's rules as in effect on January 1, 2016. We strongly encourage you to study this document and its exhibits, any modifications to the document, and other notices relating to the Plan that you receive, and to keep handy a copy of each of them, whether in electronic or paper form. If you fail to learn about the benefits offered under the Plan, or if you fail to follow the rules for obtaining benefits under a particular Participating Plan, you could:

- Miss out on benefits that could be of great value to you and your family
- Have substantial expenses that are not covered by a Participating Plan, and
- Make employment decisions based on an erroneous understanding about your benefit rights.

If you have any questions about the Plan or any of its Participating Plans summarized in this document, please feel free to call **HRLink at (855) 404-5465**.

If a clerical error or other mistake occurs, that error does not create a right to benefits. Such errors may include providing information on eligibility or benefit coverage or entitlements that is later modified or corrected. It is your responsibility to confirm the accuracy of information provided to you by the applicable Participating Plan's administrator or other Plan representatives in accordance with the terms of this and other Plan documents.

SECTION 1
DEFINITIONS

"AD&D" means accidental death and dismemberment insurance.

"**Associate**" means any common-law employee of the Company. The determination of whether an individual is an Associate, an independent contractor or any other classification of worker or service provider, and the determination of whether an individual is classified as a member of any particular employee classification shall be made solely in accordance with the classifications used by the Company and shall not be dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

"Benefit Appeals Committee" means the Hancock Whitney Corporation Benefits Appeals Committee.

"Benefit Committee" means the Hancock Whitney Corporation Benefits Committee.

"**Cafeteria Plan**" means the Hancock Whitney Corporation Cafeteria Plan, established by the Company under a separate document (incorporated herein by reference), through which choices of and pre-tax payment for benefits are made in accordance with Code Section 125.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code**" means the Internal Revenue code of 1986, as amended.

"**Company**" means Hancock Whitney Corporation, or any successor thereto.

"**Covered Person**" means any Eligible Associate covered under the Plan, and any individual who is eligible for and covered under the Plan due to the individual's relationship to an Eligible Associate (such as the Associate's spouse, child, or other eligible family member). If a benefit requires enrollment, only an individual who has enrolled is considered a Covered Person with respect to that benefit.

"**Dependent Care Flexible Spending Account ("Dependent Care FSA")**" has the meaning assigned to it under Section 7.2(a) of the Cafeteria Plan. The Dependent Care FSA is a Participating Plan under the Plan.

"**Effective Date**" means January 1, 2016.

"**Eligible Associate**" means an Associate who satisfies the eligibility provisions described under Section 3, including the eligibility provisions of the applicable Participating Plan. Notwithstanding the foregoing and the provisions of any applicable Participating Plan to the contrary, effective January 1, 2018, the term Eligible Associate does not include Associates classified as interns.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

"**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

"**GINA**" means the Genetic Information Nondiscrimination Act of 2008.

"**Health Care Flexible Spending Account ("Health FSA")**" has the meaning assigned to it under Section 6.2(a) of the Cafeteria Plan. The Health FSA is a Participating Plan under the Plan.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**HITECH**" means the Health Information Technology for Economic and Clinical Health Act.

"**MHPA**" means the Mental Health Parity Act of 1996.

"**MHPAEA**" means the Mental Health Parity and Addiction Equity Act of 2008.

"**Michelle's Law**" means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

"**NMHPA**" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"**Participating Plan**" means any of the benefits listed in Exhibit I of the Plan that are offered by the Company to its Associates under this Plan.

"**Plan**" means this Hancock Whitney Corporation Welfare Benefit Fund.

"**Plan Administrator**" means the Benefits Committee or its designee.

"**Plan Sponsor**" means Hancock Whitney Corporation.

"**Plan Year**" means the 12-month period beginning each January 1 and ending each December 31.

"**PPACA**" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

"**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

"**WHCRA**"means the Women's Health and Cancer Rights Act of 1998.

SECTION 2
INTRODUCTION

Introduction

The Company, as Plan Sponsor, originally adopted the Hancock Whitney Corporation Employee Welfare Fund (previously known as the Hancock Holding Company Employee Welfare Fund) (the "Plan") effective July 1, 2003 for the exclusive benefit of its Associates and their dependents. The Plan is comprised of the Participating Plans set forth in Exhibit I. The Plan and each of the Participating Plans is intended to constitute a single employee welfare benefit plan for various purposes including, but not limited to, required governmental reports and required disclosures under ERISA.

Effective May 25, 2018, the name of the Company was changed to "Hancock Whitney Corporation" and the Plan was renamed the "Hancock Whitney Corporation Welfare Fund." Accordingly, the purpose of this amended and restated SPD is to reflect the new Plan and Company names and to make other modifications consistent with these changes, effective as of May 25, 2018 ("Effective date").

This document along with its Exhibits is intended to summarize the terms of the Plan as of the Effective Date. Since it is only a summary, your rights in some circumstances may be governed by Plan provisions not mentioned below. Certain terms used in this summary plan description ("SPD") are defined and explained more fully in the Plan document.

Prior to January 1, 2016, the Company sponsored the Hancock Holding Company Employee Protection Plan (the "Protection Plan"). The Protection Plan consisted of two component benefit plans: the Employee Health Protection Plan and the Hancock Holding Company Group Term Life Insurance Plan (collectively "Component Plans"). Health benefits under the Protection Plan were funded in part through amounts contributed to the Comprehensive Medical Plan Trust for Employees of Hancock Bank, its Subsidiaries and Affiliated Employers (the "VEBA Trust").

In an effort to simplify administration of its benefit plans, the Company terminated the Protection Plan and associated VEBA Trust, effective December 31, 2015 and October 14, 2015, respectively. In accordance with the terms of the VEBA Trust, upon its termination, any remaining trust assets were used to pay health claims under the Protection Plan until its termination date on December 31, 2015. Any remaining VEBA Trust assets after December 31, 2015, were disposed of in accordance with the terms of the VEBA Trust. Effective December 31, 2015, each of the Protection Plan's Component Plans were transferred to and incorporated as new Participating Plans under the Plan, with no interruption in either benefits or coverage.

Each of the Participating Plans is summarized in a certificate of insurance booklet issued by an insurance company, SPD prepared specifically for that Participating Plan, or other written governing document prepared by the Company, (referred generally as "SPD") each of which is listed under Exhibit I and incorporated herein by reference. You can obtain a copy of each Participating Plan's SPD or other governing documents by logging on to the Company's intranet. If you are unable to access the Company's intranet, please contact **HRLink at (855) 404-5465**.

If there is any conflict between this document and an applicable Participating Plan's SPD or governing plan documents, then such other SPD or governing plan document will control unless otherwise required by law or specified in this SPD. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

This SPD, together with the Exhibits, constitute the Plan's SPD to the extent required by Section 102 of ERISA and U.S. Department of Labor ("DOL") Regulation Sections 2520.102-2 and 2520.102-3. This document is not intended to give you any substantive rights to benefits that are not already provided under the applicable Participating Plan's governing documents. You must read each Participating Plan's SPD and this SPD to understand your benefits under the Plan.

ERISA Status

The Plan provides you with some benefits that are subject to the requirements of ERISA and other benefits that are not subject to ERISA. The Cafeteria Plan and Dependent Care FSA Participating Plans are not subject to ERISA. Including Participating Plans that are not subject to ERISA as part of the Plan is not intended to subject such Participating Plans to ERISA.

SECTION 3
ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Eligibility and Participation

An Eligible Associate with respect to the Plan is any Associate who is eligible to participate in and receive benefits under one or more of the Participating Plans in accordance with the terms and conditions of the Plan (including the terms of the applicable Participating Plan) as described in the documents listed in Exhibit I, except group health plan coverage (excluding vision and dental coverage) and post-retirement health plan coverage, which shall be determined in accordance with the rules described in Exhibit II and Exhibit III, as applicable.

An Eligible Associate begins participating in the Plan upon his or her election to participate in a Participating Plan in accordance with the terms and conditions established for that Participating Plan or, if earlier, upon meeting the eligibility criteria and becoming covered under a Participating Plan that does not require enrollment or an election. For information about when coverage begins, please read the eligibility and participation information contained in the applicable Participating Plan's SPD listed in Exhibit I.

You must satisfy the eligibility requirements under a particular Participating Plan in order to receive benefits under that plan. To determine whether you or your family members are eligible to participate in a Participating Plan, please read the eligibility information described in the Participating Plan's SPD listed in Exhibit I.

Associates acquired through a corporate transaction may become eligible to participate under the Plan and applicable Participating Plans under terms and conditions that are more favorable than those set forth in this SPD. If you became an Associate in connection with a

corporate transaction and have questions regarding eligibility under the Plan or a particular Participating Plan, please contact **HRLink at (855) 404-5465**.

Enrollment

Certain Participating Plans require enrollment (either once or annually) for coverage. In general, Eligible Associates must complete and submit an application to enroll themselves and/or their eligible spouses and dependents. Eligible Associates may be required to complete an enrolment application via electronic communication or any other method prescribed by the Company. New Associates must generally enroll within certain time periods after being hired in accordance with such procedures describe under the Cafeteria Plan and the applicable Participating Plan's SPD listed in Exhibit I. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before the beginning of each Plan year unless circumstances give rise to HIPAA special enrollment rights as described below, or unless other enrollment opportunities are available as described under the Cafeteria Plan and applicable Participating Plan.

In certain circumstances and with respect to a particular Participating Plan, enrollment may occur at times outside the open enrollment period (this is referred to as "HIPAA special enrollment"). If any Participating Plan is subject to the HIPAA special enrollment rules, you will be provided with a notice containing information about your potential HIPAA special enrollment rights. You can obtain a copy of the notice by logging on to the Company's intranet or by calling **HRLink at (855) 404-5465**. Information about which Participating Plans are subject to the HIPAA special enrollment requirements can be found in the applicable Participating Plan's SPD listed in Exhibit I.

Termination of Participation

When an Eligible Associate's participation in the Plan terminates, benefits under the Plan for the Eligible Associate and Covered Persons covered through that Eligible Associate will cease. When an Eligible Associate's participation in a Participating Plan terminates, benefits under that Participating Plan for the Eligible Associate and Covered Persons covered through that Eligible Associate will cease. Note that termination of coverage under a particular Participating Plan does not necessarily mean your coverage under the Plan in general terminates. You may still have coverage under another Participating Plan.

It is your responsibility to provide accurate information and to make accurate and truthful statements regarding family status, age relationships, etc., and to update such information in a timely manner. Failure to do so may be considered an intentional misrepresentation of material fact and may result in termination of coverage; such termination may be retroactive. Disciplinary action may also result, up to an including termination of employment. Termination of participation in a Participating Plan occurs in accordance with the terms and conditions established for that plan.

Benefits under all Participating Plans (for all Covered Persons) will cease upon termination of the Plan.

Other circumstances may result in the termination of benefits. For additional information, please refer to the applicable Participating Plan's SPD listed in Exhibit I.

Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Associate's non-custodial child as required by any qualified medical child support order (QMCSO) under ERISA § 609(a), including a National Medical Support Notice. A National Medical Support Notice (NMSN) is a federal form that is used to notify employers and group health insurance plan administrators of a court order for dependents' medical support. The Plan has procedures for determining whether an order qualifies as a QMCSO. You or your beneficiaries can obtain, without charge, a copy of such procedures by logging on to the Company's intranet or by calling **HRLink at (855) 404-5465**.

Continuation Coverage Under COBRA and USERRA

If a Covered Person's coverage under a Participating Plan that is a group health plan (e.g., vision, dental or Health FSA coverage) ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death or a child's ceasing to meet the definition of dependent), then the Covered Person may have the right to purchase continuation coverage for a temporary period of time. For additional information regarding what Participating Plans are subject to COBRA and your rights under such plans, please refer to the applicable documents listed in Exhibit I. Also, if you have any questions about your COBRA rights, please refer to the initial COBRA notice, a copy of which has been previously furnished to you and your spouse (if covered). You can obtain another copy of the COBRA notice by logging on to the Company's intranet or by calling **HRLink at (855) 404-5465**.

For purposes of COBRA, the group health, vision, dental and Health FSA Participating Plans will be treated as separate plans. For example, if you had both vision and dental coverage and then elected COBRA, you must elect continuation coverage for the vision and dental Participating Plans separately.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is included in the applicable documents listed in Exhibit I. Note also that state law may provide continuation or conversion coverage rights.

SECTION 4
SUMMARY OF PLAN BENEFITS

Benefits and Contributions

The Plan makes available to Eligible Associates and their eligible family members the benefits listed in Exhibit I. Each Participating Plan's SPD is also listed in Exhibit I. You can obtain a copy of a Participating Plan's SPD by logging on to the Company's intranet or by calling **HRLink at (855) 404-5465**.

The cost of the benefits provided through the Participating Plans is funded in part by the Company and in part by Associate contributions, solely by the Company, or solely by Associate contributions (which may be pre-tax or after-tax, subject to the terms of the Cafeteria Plan and applicable Participating Plan). The Company will determine and periodically communicate your share of the cost of the benefits provided through the applicable Participating Plan, and it may change that determination at any time.

With respect to the insured Participating Plans, the Company will pay its contribution (if applicable) and your contributions to the insurer. With respect to benefits that are self-funded, the Company will use these contributions to pay benefits directly to (or on behalf of) you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

Rebates, Refunds, and Similar Payments

The Company may retain any policy refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract, or portion thereof, that it receives from any insurance company, health maintenance organization, service plan or any other entity, that exceeds the amount necessary to fund the benefits provided by a particular Participating Plan to the maximum extent permitted under applicable law. If the Company is prohibited by law from keeping all or a portion of any such payment, the Company will allocate those amounts in a manner consistent with ERISA.

No Trust

Nothing in the Plan is intended to require the establishment of a trust. The Company pays its portion of the cost of benefits under the Plan from the Company's general assets, but reserves the right to form one or more trusts to hold Plan assets.

Right to Recover Benefit Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the Company (or its designee), or the applicable insurance company may recover that incorrect payment, whether or not it resulted from the insurance company's or Plan Administrator's own error, from the person to whom it was made or from the action or inaction of any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

With respect to Participating Plans provided through insurance, the contract language may contain information regarding the Plan's right to subrogate or reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-funded Participating Plans (if any), subrogation or reimbursement rights may be set forth in the Participating Plan's SPD or other governing documents.

Covered Person's Responsibilities

You are responsible for providing the Plan Administrator (or its designee) and the Company and, if required by an insurance company with respect to a fully insured benefit, the insurance company with your current address and other necessary information and, if required, with the address and other necessary information of any Covered Person by virtue of his or her relationship to you. Any notices required or permitted to be given to you or your eligible family members shall be deemed given if directed to the address most recently provided by you and mailed by first-class United States mail. Except as otherwise provided by ERISA, the insurance companies, the Plan Administrator, and the Company shall have no obligation or duty to locate a Covered Person.

Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully insured benefit, the insurance company with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan. The Plan Administrator (and, with respect to a fully insured benefit, the insurance company) shall have the right and opportunity to have a Covered Person examined when benefits are claimed, and when and so often as it may be required during the pendency of any claim under the Plan.

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactive termination. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Covered Person related to the person submitting the falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

SECTION 5
PLAN ADMINISTRATION

Plan Administration

The Benefits Committee is the Plan Administrator. As the Plan Administrator, the Benefits Committee is responsible for satisfying certain legal requirements under ERISA with respect to the Plan. The Benefits Committee may name others to act on its behalf.

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms, and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan.

Discretionary Authority

The Plan Administrator or its designee, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (and any applicable Participating Plans), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any applicable Participating Plans), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described above.

Role of Insurance Company

Some benefits under the Plan are fully insured and provided under insurance contracts entered into between the Company and the applicable insurance companies listed in Section 10 below. The insurance companies are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective Participating Plan and (b) prescribing claims procedures to be followed and the claims forms to be used by Covered Persons pursuant to their respective Participating Plan.

The insurance companies, not the Company, are responsible for paying claims with respect to these Participating Plans. The Company generally shares responsibility with the insurance companies for administering these benefits. As the named fiduciary, the insurance companies have the discretionary authority to interpret the Plan in order to make benefit determinations. The insurance companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of their respective Participating Plan.

If you have any questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular Participating Plan offered through the Plan, or

the amount of any benefit payable under a self-funded Participating Plan), please contact **HRLink at (855) 404-5465**.

If you have any questions regarding your eligibility for, or the amount of, any benefit payable under a fully insured Participating Plan, please contact the appropriate insurance company. Contact information can be found in Section 10 below.

SECTION 6
CIRCUMSTANCES THAT MAY AFFECT BENEFITS

Denial, Loss, and Recovery of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See also Section 3 above. Various circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. Additional information about termination, reductions, denial, or loss of benefits can be found in the applicable Participating Plan's SPD listed in Exhibit I.

Plan Termination

Benefits will cease upon termination of the Plan.

SECTION 7
AMENDMENT OR TERMINATION OF THE PLAN

Amendment or Termination

The Company, as Plan Sponsor, and its designee (including the Benefits Committee for some purposes), have the right to amend the Plan (including any Participating Plans) at any time or from time-to-time without the consent of or, to the extent permitted by law, prior notice to any Associate or participant. Further, although the Company expects to continue the Plan indefinitely, it is not legally bound to do so, and it has the right to terminate the Plan or any Participating Plan at any time without liability. The Plan may be amended or terminated by a written instrument duly adopted by the Company or its designee. For this purpose, amending the Plan includes making changes to a Participating Plan. Terminating a Participating Plan (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

Any officer duly authorized by the board of directors of the Company or the Benefits Committee may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan.

SECTION 8
CLAIMS AND APPEALS PROCEDURES

In General

Procedures for the submission and review of claims relating to benefits under the Participating Plans shall be those provided under the terms of the applicable Participating Plan as described in the applicable SPD listed in Exhibit I.

Claims and Appeals Procedures for Fully Insured Plans

For purposes of determining the amount of, and entitlement to, benefits of the Participating Plan provided under insurance or contracts, the respective insurance company is the named fiduciary under that Participating Plan, with the full power to interpret and apply the terms of the Participating Plan as they relate to the benefits provided under such plan. To obtain benefits from an insured Participating Plan, you must follow that insurer's claims procedures as described in the applicable Participant Plan's SPD listed in Exhibit I.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company or, depending on the terms of the applicable Participating Plan, the Plan Administrator for a review of the denied claim. The insurance company or Plan Administrator, as applicable, will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (typically a prerequisite to bringing suit in court). Please refer to the applicable SPD listed in Exhibit I for more information on a particular fully insured Participating Plan's claims and appeals procedures.

Claims and Appeals Procedures for Self-Funded Plans

For purposes of determining the amount of, and entitlement to, benefits under self-funded Participating Plans provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

The Plan Administrator will decide your claim in accordance with the claims procedures for the applicable Participating Plan. For Participating Plans subject to ERISA, the claims procedures will be reasonable and will comply with applicable ERISA requirements. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim. If the Plan Administrator denies your claim

in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Benefits Appeals Committee for a review of the denied claim. The Benefits Appeals Committee will decide your appeal in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies). If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (typically a prerequisite to bringing a suit in court). Please refer to the applicable SPD listed in Exhibit I for more information on a particular self-funded Participating Plan's claims and appeals procedures.

Claims and Appeals Procedures for Non-ERISA Plans

Claim for benefits under a non-ERISA Participating Plan (e.g., Dependent Care FSA, Cafeteria Plan) shall be reviewed by the Plan Administrator or its designee and decided in a uniform and nondiscriminatory manner pursuant to the applicable Participating Plan's claims procedures, or if none, applicable law. Please refer to the applicable Participating Plan's SPD listed in Exhibit I for more information on the Participating Plan's ERISA status and applicable claims and appeals procedures, if any.

External Review

To the extent a Participating Plan is subject to provisions of PPACA requiring external review (that is, review outside of the Plan), procedures to that effect will be available. Please refer to the applicable Participating Plan's SPD listed in Exhibit I for more information on whether the plan is subject to external review and applicable procedures.

Claims Deadline

Unless specifically provided otherwise in a Participating Plan or pursuant to applicable law, a claim for benefits must be made within one (1) year after the date the expense or the event (as the case may be) that gives rise to the claim occurs. It is the responsibility of the Covered Person or his or her designee to make sure this requirement is met.

Limitations Period for Filing Suit

Unless otherwise provided in a Participating Plan or pursuant to applicable law, a suit for benefits under this Plan or any ERISA Participating Plan must be brought within one (1) year from the date notice of final decision on appeal was made (or from the last day (including any extension) that the written notice could have been timely made) on the claim in accordance with the applicable Participating Plan's claims and appeals procedures.

For non-ERISA Participating Plans, a suit must be brought by no later than one (1) year from the date notice of final decision on appeal was made (or from the last day (including any extension) that the written notice could have been timely made) on the claim in accordance with the applicable Participating Plan's claims and appeals procedures. If the Participating Plan does not provide for an appeals procedure, a suit must be brought by no later than one (1) year from date notice of final decision denying a claim is made.

SECTION 9
MISCELLANEOUS

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and the Company to the effect that the individual will be employed for any specific period of time.

Coordination with Insurance Contract or Governing Document

To the extent an insurance contract (including the certificate of insurance) policy, plan document, SPD or other document governing a Participating Plan contains terms or conditions that conflict or are inconsistent with this document, the terms of the insurance contract (including the certificate of insurance or policy), plan document, SPD or other governing document shall control, rather than this document, unless such terms are prohibited by or inconsistent with applicable law. For this purpose, silence in an insurance contract (including the certificate of insurance) policy, plan document, SPD or other governing document is not a conflict or inconsistency.

No Guarantee of Tax Consequences

Notwithstanding anything in this SPD to the contrary, neither the Plan nor the Company makes any commitment or guarantee that any amounts paid to or on behalf of a Covered Person under the Plan will be excludable from the Eligible Associate's gross income for federal or state income tax purposes.

SECTION 10
GENERAL INFORMATION ABOUT THE PLAN

1.	Name, address & phone number of Plan Sponsor:	Hancock Whitney Corporation P.O. Box 4019 Hancock Whitney Plaza Gulfport, MS 39502-4019 Tel. 228-868-4000
2.	Federal Tax Identification:	64-0693170
3.	Plan Name:	Hancock Whitney Corporation Employee Welfare Fund
4.	Plan Number:	501
5.	Effective Date of Plan:	January 1, 2003
6.	Type of Plan:	The Plan is a welfare plan that provides medical, dental,

		vision, short-term and long-term disability, AD&D, group life insurance, group cancer and critical illness, business travel accident, severance and legal benefits and any other welfare benefits as may be adopted by the Company from time to time. **NOTE:** The Plan also includes a cafeteria plan under Code §125 and a dependent care reimbursement plan under Code §129. The Cafeteria Plan and dependent care reimbursement plans are not subject to ERISA.
7.	Plan Funding:	Most benefits furnished under the Plan are provided through the purchase of insurance policies and contracts. The group health plan, severance plan and the Health FSA and Dependent Care FSA reimbursement account plans under the Cafeteria Plan are considered self-funded by the Company. Insurance premiums for Associates and/or their dependents may be paid solely by Associate contributions or in part by the Company out of its general assets and in part by Associate contributions. Associate contributions towards the cost of coverage under a Participating Plan are generally made on a pre-tax basis through the Cafeteria Plan. Associate contributions will be used in funding the cost of the Plan benefits as soon as practicable after they have been received from the Associate or withheld from the Associate's pay through payroll deduction. Neither the Plan nor any of the Participating Plans have a trust.
8.	Plan Year:	January 1 – December 31
9.	Plan Administrator:	Hancock Whitney Corporation P.O. Box 4019 Hancock Whitney Plaza Gulfport, MS 39502-4019 Tel. (855) 404-5465 **NOTE:** The Plan Administrator has delegated certain day-to-day administration of the Plan and claims fiduciary responsibilities for the processing and review of claims for benefits under the Plan, including COBRA administration, to the third party administrators and claims administrators listed in Exhibit V. The Plan Administrator will also answer any questions you may have about the Plan.
10.	Third Party Administrators, Claims Administrators and	Please see Exhibit V for a complete list of third party administrators, claims administrators and insurers.

Insurers:

11.	Service of Legal Process:	The name and address of the Plan's agent for service of legal process is: Hancock Whitney Corporation P.O. Box 4019 Hancock Whitney Plaza Gulfport, MS 39502-4019 Tel. (855) 404-5465 Service of legal process may also be made upon the Plan Administrator.

Statement of ERISA Rights

Your Rights

Note that the Cafeteria Plan, Dependent Care FSA and Health Savings Account Program Participating Plans listed in Exhibit I are not covered by ERISA and this Statement of ERISA Rights does not apply to those Participating Plans.

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Hancock Whitney Corporation, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Hancock Whitney Corporation, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 10), you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EXHIBIT I
PARTICIPATING PLANS

The Plan provides benefits through the following Participating Plans, which are summarized in their respective SPDs (or, if the Participating Plan's has no SPD, the policy, contract of insurance or other governing document, including any amendment or modifications thereto, which when combined with this SPD is intended to constitute such Participating Plan's SPD), each of which is identified below and incorporated herein by reference. The Plan Administrator may from time to time add or remove Participating Plans without formal amendment to this Exhibit I. To obtain a current list of Partiapting Plans, please contact **HRLink at (855) 404-5465**.

Participating Plans subject to ERISA:

- **Group Health**
  - **Self-funded plans**:
    - Employee Booklet and Summary Plan Description for the Employee Health Protection Plan for Hancock Whitney Corporation and its Subsidiaries administered by Blue Cross Blue Shield of Mississippi, Plan Type C524.
    - Employee Booklet and Summary Plan Description for the Employee Health Protection Plan for Hancock Whitney Corporation and its Subsidiaries – High Deductible administered by Blue Cross Blue Shield of Mississippi, Plan Type HD20HD21
  - **Fully-insured plan**:
    - Evidence of coverage and Summary Plan Description for the Humana Medicare PPO Plan issued by Humana Insurance Company

- **Dental Insurance**
  - Metropolitan Life Insurance Company ("MetLife"), Group Policy No. 104250-1-G.

- **Vision Insurance**
  - Vision Service Plan (VSP) Evidence of Coverage for Plan No. 1296843.

- **Health FSA (self-funded)**
  - Hancock Whitney Corporation Cafeteria Plan.

- **Life and AD&D Insurance**
  - **Basic and Supplemental Group Life Insurance –** Standard Insurance Company Certificate and Summary Plan Description Group Life Insurance, Policy No. 643851-F.
  - **Group AD&D –** Standard Insurance Company Certificate and Summary Plan Description Group Accidental Death and Dismemberment Insurance, Policy No. 643851-I.

- **Short-Term Disability Insurance**
  - Standard Insurance Company Certificate and Summary Plan Description Group Short Term Disability Insurance, Policy No. 643851-G.

- **Long-Term Disability Insurance**
  - Standard Insurance Company Certificate and Summary Plan Description Group Long Term Disability Insurance, Policy No. 643851-H.

- **Group Cancer Insurance**
  - American Heritage Life Insurance Company ("Allstate") Group Cancer and Specified Disease Insurance Policy, Policy No. V3517.

- **Group Critical Illness Insurance**
  - Allstate Group Critical Illness Insurance Policy, Policy No. V3517.

- **Group Accident Insurance**
  - Allstate Group Accident Insurance Policy, Policy No. V3517.

- **Group Universal Life insurance**
  - Allstate Flexible Premium Adjustable Group Life Insurance Policy, Policy No. V3517.

- **Term Life Insurance**
  - Hancock Whitney Corporation Term Life Insurance Plan and Summary Plan Description.

- **Legal Plan**
  - Metlaw Summary Plan Description.

- **Business Travel Insurance**
  - Federal Insurance Company Business Travel Accident Insurance Policy, Policy No. 6410-06-88.

- **Severance Plan**
  - Hancock Whitney Corporation Severance Pay Plan and Summary Plan Description.

- **Employee Assistance Program**
  - American Behavioral EAP Program Summary

Participating Plans not subject to ERISA:

- **Cafeteria Plan**
  - Hancock Whitney Corporation Cafeteria Plan.

- **Dependent Care FSA (self funded)**
  - Hancock Whitney Corporation Cafeteria Plan.

- **Health Savings Account Program**
  - Hancock Whitney Corporation Cafeteria Plan

EXHIBIT II
ELIGIBILITY FOR GROUP HEALTH COVERAGE

The PPACA provides guidelines that must be used to determine average hours for purposes of determining eligibility for group health plan coverage. Below is summary of these guidelines as they apply to current and new Associates. Please note that this is a general summary of how these rules are applied with respect to Participating Plans subject to these rules. It is not intended to address every possible scenario. Special rules may apply depending on your particular circumstances. The term "Employee" as used in this Exhibit shall have the same meaning as Associate as defined in Section 1 of the SPD.

1. **Employee Groups.**

   a. Full-Time Employee – an Employee who works 30 or more hours per week.

   b. Part-Time Employee – an Employee who works less than 30 hour per week.

   c. Ongoing Employee – current Employees and certain rehires who have been employed for at least one complete Standard Measurement Period (defined below) and who are not a Variable-Hour Employee or Seasonal Employee as described below.

   d. Seasonal Employee – an Employee who is hired into a position for a period of six months or less, which usually begins in approximately the same part of the year, such as winter or summer.

   e. Variable-Hour Employee – an Employee who, at the start of employment, the Company cannot reasonably determine whether the Employee is expected to average 30 or more hours per week during an Initial Measurement Period (defined below).

   For purposes of this Exhibit I, the term "hour" generally means each hour of service you perform for the Company or affiliated companies.

2. **Eligibility to Enroll in Coverage.**

   a. Immediately Eligible – If you are hired as a Full-Time Employee, you will be immediately eligible to enroll in coverage. If you are hired as a Variable-Hour Employee or Seasonal Employee and at any point within your Initial Measurement Period (defined in Section 3(b) below) are expected to work 30 or more hours per week due to a change in assignment or status, you will be eligible for coverage as of the date of the change in work status. If you are rehired as a Full-Time Employee after a Break in Service (defined in Section 6) greater than 13 weeks (or, if applicable, the length of your pre-break employment), you will also be immediately eligible for coverage upon rehire.

   b. Not Immediately Eligible – If upon being hired you are classified as a Part-Time Employee, Variable-Hour Employee or Seasonal Employee, you will not be immediately eligible for coverage. However, if you are non-benefit-eligible Ongoing

Employee who transfers into a position in which you are reasonably expected to work an average of 30 or more hours per week, you will be eligible to enroll in coverage. See Change in Employment Status section below for more details.

3. **Measurement Periods.**

a. Ongoing Employees – Ongoing Employees will have a 12-month "Standard Measurement Period" generally running from mid-October through mid-October of the following calendar year. Each Standard Measurement Period is immediately followed by an administrative period that runs through the end of the calendar year. If you are an Ongoing Employee and you average 30 or more hours per week over a Standard Measurement Period, you will be offered coverage for the 12-month period immediately following the administrative period (or January 1 through December 31), provided you remain employed during this period. This period is referred to as the "Standard Stability Period". If, however, you do not average 30 or more hours during the Standard Measurement Period, you will not be eligible for coverage during the applicable Standard Stability Period, unless you experience a change in employment status as described in Section 5 below.

b. Newly Hired or Rehired (after a Break in Service) Variable-Hour or Seasonal Employees – A 12-month "Initial Measurement Period" applies effective as of the first payroll period following your date of hire. The Initial Measurement Period will be followed by an administrative period that runs through the last day of the first calendar month that begins after the end of your Initial Measurement Period. If you are a new or rehired Variable-Hour Employee or Seasonal Employee and you average 30 or more hours per week over your Initial Measurement Period, you will be offered coverage for the 12-month period following the end administrative period, provided you remain employed during this period. This period is referred to as the "Initial Stability Period". If, however, you do not average 30 or more hours during your Initial Measurement Period, you will not be eligible for coverage during your Initial Stability Period, unless you experience a change in employment status as described in Section 5 below.

c. Stability Periods – If you work 30 hours or more per week during the preceding Initial Measurement Period or Standard Measurement Period, as applicable, you will be treated as a Full-Time Employee during the subsequent Initial Stability Period or Standard Stability Period, as applicable. However, if you do not average 30 hours or more per week during the preceding Initial Measurement Period or Standard Measurement Period, as applicable, you will be treated as a Part-Time Employee for the subsequent Initial Stability Period or Standard Stability Period, as applicable, unless you experience a change in employment status as explained in Section 5 below.

The Initial Measurement Period and Initial Stability Period run concurrently with the Standard Measurement Period and Standard Stability Period described in Section 3(a) above. Once you have been employed for a full Standard Measurement Period, you will be treated as an Ongoing Employee as described in Section 3(a) above.

4. **Effective Date of Coverage.**

a. Immediately Eligible Employees. If you are hired or rehired as a Full-Time Employee, coverage will be effective on the 1st of the month coincident with or following 60 days of continuous employment. This 60-day period is referred to as the "Waiting Period."

b. Not Immediately Eligible. Except as provided in Section 5 below, if you are not immediately eligible for coverage upon your date of hire or rehire, as applicable, coverage will generally be effective as of the 1st day of the of the Initial Stability Period or Standard Stability Period, as applicable, related to the Initial Measurement Period or Standard Measurement Period, as applicable, in which you averaged 30 or more hours per week.

c. Ongoing Employees. If you are an Ongoing Employee who is a Part-Time Employee and you work 30 or more hours a week during the preceding Standard Measurement Period, coverage will be effective as of the 1st of day of the applicable Standard Stability Period, or January 1st of the applicable Plan Year.

5. **Change in Employment Status.**

a. General Rule. If you work 30 or more hours per week during an Initial Measurement Period or Standard Measurement Period, as applicable, you will be treated as a Full-Time Employee during the related Initial Stability Period or Standard Stability Period, as applicable, and therefore be eligible for benefits without regard to how many hours you actually works during such stability period.

b. Ongoing Employees:

i. Change From Part-Time to Full-Time Status. If you change from part-time to full-time status, you will become eligible to enroll and coverage will be effective as of the effective date of the change in employment status, unless you have not completed the initial 60-day Waiting Period, in which case coverage will be effective on the 1st day of the month coincident with or following the date you complete the Waiting Period.

ii. Change From Full-Time to Part-Time Status. If you are Full-Time Employee and you are expected to work fewer than 30 hours per week due to a change in assignment or are transferred to a part-time position, you will continue to be treated as a Full-Time Employee and therefore eligible for coverage through the end of the applicable Standard Stability Period. You will have the option to continue coverage for the remainder of the applicable Standard Stability Period or drop coverage in accordance with the provisions under the Cafeteria Plan. You will be treated as a Part-Time Employee for any subsequent Standard Stability Period, unless you average 30 or more hours per week during the applicable Standard Measurement Period or experience a subsequent change in employment status as described subsection (b)(i) above.

c. New Full-Time Employees. If you are hired or rehired as a Full-Time Employee and are expected to work fewer than 30 hours per week due to a change in assignment or are transferred to a part-time position prior to completing your first full Standard Measurement Period, you will continue to be treated as a Full-Time Employee through the end of your first full Standard Measurement Period. You will have the option to continue coverage through the end of your first full Standard Measurement Period or drop coverage in accordance with the provisions under the Cafeteria Plan. Thereafter, you will be treated as an Ongoing Part-Time Employee for your first (and any subsequent) Standard Stability Periods, unless you averaged 30 or more hours per week during the applicable Standard Measurement Period or experience a subsequent change in employment status as described in subsection (b)(i) above.

d. Variable Hour and Seasonal Employees. If you are a Variable-Hour Employee or Seasonal Employee and you are transferred to a full-time position, you will be eligible for coverage as of the effective date of the transfer, unless you have not completed the initial 60-day Waiting Period, in which case coverage will be effective on the 1st day of the month coincident with or following the date you complete the Waiting Period.

6. **Break in Service And Leaves of Absences.**

a. Break in Service Defined. The term "Break in Service" means a period of at least 13 consecutive weeks, starting on the date you terminate employment with the Company and ending on your subsequent rehire date, during which you were not credited with any Hours.

b. Effective Date of Coverage. If you are a former Full-Time Employee who is rehired before incurring a Break in Service, coverage shall begin on the first day of the month following your rehire date. The effective date of coverage for an Employee who is rehired after incurring in a Break in Service shall be determined in accordance with subparagraphs 4(b) and 5 above.

Notwithstanding anything in this Exhibit to the contrary, a determination as to whether an Employee has incurred in a Break in Service and the number of hours to be credited during any special unpaid leave shall be made in accordance with applicable Treasury Regulations.

EXHIBIT III
POST-RETIREMENT HEALTH COVERAGE FOR HANCOCK RETIREES

The Company provides certain Associates employed by the Company or any of its affiliates, with subsidized post-retirement health coverage. In order to be eligible for subsidized post-retirement health coverage, you must satisfy all of the following requirements:

(i) were hired (or last rehired) prior to January 1, 2000;

(ii) were enrolled in the Company's group health plan as an active Associate immediately prior to the date you retired;

(iii) are age 55 and have 10 or more Years of Service; and

(iv) do not enroll in COBRA continuation coverage at any time during the COBRA election period after becoming a retiree.

For purpose of subparagraph (iii), the term "Years of Service" means each 12 consecutive month period, beginning on your date of hire (or rehire), in which you perform services for the Company and any of its Affiliates.

If you are terminated for cause, you will not be eligible for retiree coverage, even if you meet the eligibility requirements described above. You will be considered terminated for "cause" if you are involuntarily terminated because of: unacceptable performance; insubordination; violation of Company policies or procedures; violation of the Company's Code of Conduct; or other misconduct as may be determined by the Company in its sole discretion. Any determination as to whether you were terminated for cause will be made in the sole and absolute discretion of the Company.

You may elect to cover your Spouse and other eligible Dependents if they were also covered under the Company's group health plan immediately prior to the date you retired. However, if you do not enroll yourself and your eligible Dependents when first eligible, or you and/or any of your eligible Dependents subsequently discontinue coverage, you and/or your eligible Dependents will be prohibited from enrolling or reenrolling in the future.

The amount of the Company subsidy is based on a pro-rata share of the total cost of your coverage. You will be responsible for your share of future premium increases. The Company will determine and periodically communicate your share of the cost of post-retirement benefits, and it may change that determination at any time.

The Company reserves the right to modify, suspend, or terminate post-retirement health benefits at any time and for any reason. If there is any conflict between this Exhibit and an applicable Participating Plan's SPD or governing plan documents, then such other SPD or governing plan document will control.

EXHIBIT III
POST-RETIREMENT HEALTH COVERAGE FOR HANCOCK RETIREES
(subsidized premium increases)

The Company provides certain Associates employed by the Company or any of its Affiliates, with subsidized post-retirement health coverage. In order to be eligible for subsidized post-retirement health coverage, you must satisfy all of the following requirements:

(i) were hired (or last rehired) prior to January 1, 2000;

(ii) were enrolled in the Company's group health plan as an active Associate immediately prior to the date you retired;

(iii) are age 55 and have 10 or more Years of Service; and

(iv) do not enroll in COBRA continuation coverage at any time during the COBRA election period after becoming a retiree.

For purpose of subparagraph (iii), the term "Years of Service" means each 12 consecutive month period, beginning on your date of hire (or rehire), in which you perform services for the Company and any of its Affiliates.

If you are terminated for cause, you will not be eligible for retiree coverage, even if you meet the eligibility requirements described above. You will be considered terminated for "cause" if you are involuntarily terminated because of: unacceptable performance; insubordination; violation of Company policies or procedures; violation of the Company's Code of Conduct; or other misconduct as may be determined by the Company in its sole discretion. Any determination as to whether you were terminated for cause will be made in the sole and absolute discretion of the Company.

You may elect to cover your Spouse and other eligible Dependents if they were also covered under the Company's group health plan immediately prior to the date you retired. However, if you do not enroll yourself and your eligible Dependents when first eligible, or you and/or any of your eligible Dependents subsequently discontinue coverage, you and/or your eligible Dependents will be prohibited from enrolling or reenrolling in the future.

The amount of the Company subsidy is based on a pro-rata share of the total cost of your coverage. The Company currently subsidizes the cost of any future premium increases. The Company will determine and periodically communicate your share of the cost of post-retirement benefits, and it may change that determination at any time.

The Company reserves the right to modify, suspend, or terminate post-retirement health benefits and/or the Company's share of premium subsidies at any time and for any reason. If there is any conflict between this Exhibit and an applicable Participating Plan's SPD or governing plan documents, then such other SPD or governing plan document will control.

EXHIBIT III
POST-RETIREMENT HEALTH COVERAGE FOR
WHITNEY BANK RETIREES

The Company provides certain Associates employed by Whitney National Bank prior to June 4, 2011, with subsidized post-retirement health coverage. In order to be eligible for subsidized post-retirement health coverage, you must satisfy all of the following requirements:

(i) as of December 31, 2007, you were at least 55 years of age with at least 10 years of credited service under the Whitney National Bank Retirement Plan (currently known as the Hancock Whitney Corporation Pension Plan) ("Pension Plan");

(ii) bridge immediately from either active employment or disability status to receiving monthly pension benefits under the Pension Plan. If you elect a lump sum distribution from the Pension Plan, you will not eligible for retiree medical coverage;

(iii) were covered under the group health plan for Whitney National Bank Associates as an active or disabled Associate for the three (3) consecutive years immediately preceding you retirement; and

(iv) are not enrolled in Medicare Part D coverage.

If you are terminated for cause, you will not be eligible for retiree coverage, even if you meet the eligibility requirements described above. You will be considered terminated for "cause" if you are involuntarily terminated because of: unacceptable performance; insubordination; violation of Company policies or procedures; violation of the Company's Code of Conduct; or other misconduct as may be determined by the Company in its sole discretion. Any determination as to whether you were terminated for cause will be made in the sole and absolute discretion of the Company.

You may elect to cover your Spouse and other eligible Dependents if they were also covered under the group health plan covering Whitney National Bank Associates immediately prior to you actually beginning to receive monthly pension benefits under the Pension Plan. Special enrollment rights may apply if certain conditions are met as described in the terms of the applicable Participating Plan document.

The Company's premium subsidy dollar amount is frozen at the 2007 levels. You are responsible for any future premium increases after December 31, 2007. The Company will determine and periodically communicate your share of the cost of post-retirement benefits, and it may change that determination at any time.

The Company reserves the right to modify, suspend, or terminate post-retirement health benefits and/or the Company's share of premium subsidies at any time and for any reason. If there is any conflict between this Exhibit and an applicable Participating Plan's SPD or governing plan documents, then such other SPD or governing plan document will control.

EXHIBIT IV
ELIGIBILITY FOR POST-RETIREMENT HEALTH COVERAGE
UNDER THE HUMANA MEDICARE EMPLOYER PPO PLAN

Effective January 1, 2018, the Company provides certain eligible Associates with access to fully-insured post-retirement health coverage through the Humana Medicare Employer PPO Plan ("Humana Plan"). In order to be eligible for post-retirement health coverage under the Humana Plan, in addition to meeting any other eligibility requirements described under such plan, you must be enrolled in Medicare Parts A and B.

EXHIBIT V
THIRD PARTY ADMINISTRATORS,
CLAIMS ADMINISTRATORS AND INSURERS

This exhibit provides a complete list of third party administrators, claims administrators, insurers and HSA custodians/trustees, as applicable, for each Participating Plan as of this SPD's effective date. The Plan Administrator may from time to time add, remove or change third party administrators, claims administrators, HSA custodians/trustees or insurers without formal amendment to this Exhibit V. To obtain a current list of third party administrators, claims administrators, insurers and HSA custodians/trustees please contact **HRLink at (855) 404-5465**.

1. **Major Medical:**
   Blue Cross Blue Shield of Mississippi
   P. O. Box 1043
   Jackson, MS 39215-1043
   http://www.bcbsms.com
   Tel. (601) 932-3800

   Humana Insurance Company
   Humana Inc.
   500 West Main Street
   Louisville, KY 40202
   Tel. 1-800-486-2620
   https://www.humana.com

2. **Dental Plan**:
   Metropolitan Life Insurance
   200 Park Avenue,
   New York, New York 10166
   https://mybenefits.metlife.com
   Tel. 1-800-942-0854

3. **Vision Plan**:
   Vision Service Plan
   P. O. Box 997105
   Sacramento, CA 95899-7105
   https://www.vsp.com
   Tel. 1-800-877-7195

4. **Life Insurance**:
   Standard Insurance Company
   900 SW Fifth Avenue
   Portland, Oregon 97204-1282
   https://www.standard.com
   Tel. (503) 321-7000

5. **Long-Term Disability**:
Standard Insurance Company

6. **Short-Term Disability**:
Standard Insurance Company

7. **Group Cancer, Group Critical Illness, Group Accident and Group Universal Insurance**:
Allstate
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687
www.allstateatwork.com
Tel. 1-800-521-3535

8. **Term Life Insurance:**
Benefits under this Participating Plan are insured through individual policies issued by multiple insurance carriers. To obtain a current list of insurance carriers please contact **HRLink at (855) 404-5465.**

9. **Legal Benefits**:
Hyatt Legal Plans, Inc.
1111 Superior Avenue
Cleveland, OH 44114-2507
www.legalplans.com
Tel. 1-800-821-6400

10. **Business Travel Insurance**
Federal Insurance Company
P.O. Box 1615
Warren, New Jersey 07061-1615
http://www.chubb.com/
Tels. 908-903-2000 and 1-800-252-4670

11. **COBRA Administrator**
Discovery Benefits
4321 20th Avenue S
Fargo, ND 58103
https://www.discoverybenefits.com/
866-451-3399

12. **Health FSA and Dependent Care FSA Administrator**
Discovery Benefits
4321 20th Avenue S
Fargo, ND 58103
https://www.discoverybenefits.com/
866-451-3399

13. **Health Savings Account Program Custodian/Trustee**
Healthcare Bank
3100 13th Ave. SW
Fargo, ND 58103
https://www.bellbanks.com/Personal/Banking/Health-Savings
Customer Service 1-800-450-8949

14. **Employee Assistance Program**
American Behavioral
2204 Lakeshoare Drive, Suite 135
Birmingham, AL 35209
www.americanbehavioral.com