HANCOCK HOLDING COMPANY

EMPLOYEE WELFARE FUND

(Effective January 1, 2016)

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SECTION 1.

Introduction

1.1 Purpose

The Hancock Holding Company Employee Welfare Fund (the "Plan") is maintained by Hancock Holding Company (the "Company") to provide comprehensive health and welfare benefits to certain Eligible Associates (and, where applicable, their enrolled Dependents) of the Company and its Affiliates that participate in the Plan. The Plan is hereby amended and restated effective January 1, 2016, except as otherwise provided herein. The Plan consists of the following health and welfare benefit plans:

(a) health care benefits under the Participating Medical Plans, the Participating Dental Plans, and the Participating Vision Plans;

(b) Participating Life and Accidental Death and Dismemberment ("AD&D") Plans;

(c) Participating Short Term Disability Plan;

(d) Participating Long Term Disability Plan;

(e) a Cafeteria Plan (the Hancock Holding Company Cafeteria Plan), which consists of an Insurance Premium Payment Plan ("Premium Plan"), a Health Flexible Spending Account Plan and a Dependent Care Flexible Spending Account Plan;

(f) Participating Business Travel Accident ("BTA") Plan;

(g) Participating Legal Plan;

(h) Participating Severance Plan;

(i) Participating Critical Illness Plan;

(j) Participating Accident Insurance Plan;

(k) Participating Cancer Insurance Plan;

(l) Participating Universal Life Insurance Plan;

(m) Retiree health care and life insurance benefits under the Participating Retiree Plans; and

(n) Participating Term Life Insurance Plan

(o) Any other health and welfare plan as may be adopted by the Company from time to time and deemed to be part of the Plan.

The Plan Administrator reserves the right to add, delete or modify the above list of participating health and welfare plans without a formal amendment to this Section 1.1. If a new health and welfare benefits plan is added to the Plan, the terms and provisions of such plan's governing documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference as a new supplement to the Plan. Covered Persons and Eligible Associates will be notified regarding any such changes.

Effective December 31, 2015, the Company terminated 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 Subsides and Affiliated Employers (the "VEBA Trust"). The VEBA Trust was terminated effective October 14, 2015. Effective December 31, 2015, each of the Protection Plan's Component Plans was transferred to and incorporated as a new Participating Plan under the Plan, with no interruption in either benefits or coverage.

Each health and welfare benefit plan that forms a part of the Plan is referred to as a "Participating Plan" in this Plan document. Certain types of health and welfare benefits provided under the Plan are eligible for pre-tax treatment under the Cafeteria Plan. The Plan (other than the Premium Plan and the Dependent Care Flexible Spending Account Plan under the Cafeteria Plan) is intended to constitute one consolidated employee welfare benefit plan under Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

1.2 Participating Employers

Any Affiliate of the Company may adopt the Plan with the Company's consent as described in subsection 10.2.

1.3 Effective Date

The Plan, as hereby amended and restated, is effective as of January 1, 2016, except as otherwise provided herein.

1.4 Plan Administration

The Plan is administered by the Company or such other designated representative of the Company having the authority and responsibility to direct the operation and administration of the Plan (the "Plan Administrator"). The Plan Administrator as of the Effective Date is the Benefits Committee. To the extent not delegated to a Claims Administrator under the terms of a Participating Plan, the Plan Administrator has the discretionary authority to determine all questions arising under the Plan, including the power to determine the rights or eligibility of Covered Persons and their benefits under the Plan, and to remedy ambiguities, factual determinations, inconsistencies, or omissions. The Plan Administrator may from time to time adopt such rules and regulations as may be necessary or desirable for the proper and efficient

administration of the Plan provided they are consistent with the terms of the Plan. Any notice or document required to be given to or filed with the Plan or a Participating Plan will be properly given or filed if delivered or mailed by registered mail, postage prepaid, to the Plan Administrator in care of the Company at the Company's corporate headquarters; provided, however, that any notice or document required to be given to or filed with an insured Participating Plan must also be delivered or mailed by registered mail, postage prepaid, to the applicable insurance company.

1.5 Funding of Benefits

Benefits under the Plan may be provided on either an insured or self-insured basis, or combination thereof, as shall be determined by the Company in its sole discretion. To the extent that benefits are self-insured, such benefits are funded from the Employers' general assets. Insured benefits are funded through group insurance contracts or policies. Unless required by applicable law, no trust fund or other funding vehicle will be established for any Participating Plan, and no segregation of assets to provide benefits under the Plan or any Participating Plan will be made by the Company or any Employer.

The Company may change or impose contribution requirements on Covered Persons under any of the Participating Plans at any time. Eligible Associates will be notified of any changes. All premiums for insured benefits options under the Participating Plans shall be timely remitted to the insurance companies issuing the coverage.

1.6 Named Fiduciary

The named fiduciary for the Plan and any self-insured Participating Plan is the Plan Administrator or its designated representative. The named fiduciary for a fully-insured Participating Plan is the insurance company that has issued the applicable insurance policy or contract. Names and addresses for specific named fiduciaries for fully-insured Participating Plans may be found in the Plan's Summary Plan Description distributed to Eligible Associates who elect coverage under the various Participating Plans.

1.7 Plan Supplements

Supplements are attached to and form a part of the Plan for purposes of incorporating by reference the terms and provisions of the Participating Plans. From time to time, Supplements may be added or removed for purposes of modifying provisions of the Plan or for adding or terminating Participating Plans under the Plan.

Each Participating Plan, as identified in the applicable Supplement, is documented by a separate plan document, a Summary Plan Description, an insurance policy, a certificate of coverage, and/or a membership booklet. The documentation for each Participating Plan is identified and incorporated by reference in the Plan through the Plan Supplements.

SECTION 2.

Definitions

Except as otherwise noted herein, and to the extent not in conflict with the terms of any Participating Plan, the definitions in this Section 2 shall apply to all Participating Plans and Covered Persons.

2.1 Affiliate

The term "Affiliate" means any corporation or unincorporated trade or business which is, with respect to the Company: (i) a member of a controlled group of corporations (as defined in Code Section 414(b)); (ii) under common control (as defined in Code Section 414(c)); (iii) a member of an affiliated service group (as defined in Code Section 414(m)); or (iv) any other entity required to be aggregated under Code Section 414(o).

2.2 Annual Enrollment

The term "Annual Enrollment" means the period designated by the Company and occurring during the latter part of the Plan Year when Eligible Associates may make Participating Plan enrollment elections to be effective the next following Plan Year. Enrolled COBRA qualified beneficiaries may also make Health Plan coverage elections for the following Plan Year, provided they are currently enrolled in such Health Plan(s) during the Annual Enrollment period.

2.3 Associate

The term "Associate" means an individual who is reported on the Company's payroll records and is treated and/or classified by an Employer as a common law employee of the Employer for purposes of employment taxes and wage withholding for Federal income taxes, including an individual on an approved leave of absence. If an individual is not considered to be a common law employee of an Employer in accordance with the preceding sentence, a subsequent determination by the Employer, any governmental agency, or court that the individual is a common law employee of the Employer, even if such determination is applicable to prior years, will not have a retroactive effect for purposes of eligibility to participate in the Plan for such prior years. Leased employees, contract employees, independent contractors, and temporary agency employees shall not be Associates.

2.4 Benefits Appeals Committee

The term "Benefits Appeals Committee" means the Hancock Holding Company Benefits Appeals Committee or its successor.

2.5 Benefits Committee

The term "Benefits Committee" means the Hancock Holding Company Benefits Committee or its successor.

2.6 Cafeteria Plan

The term "Cafeteria Plan" means the Hancock Holding Company Cafeteria Plan.

2.7 Change in Status

The term "Change in Status" means a change in status or other event that permits a mid-year election change, as determined under the Cafeteria Plan and the applicable Participating Plan. With respect to the Participating Medical Plans only, a Change in Status shall also include the occurrence of a special enrollment event under HIPAA.

2.8 Claims Administrator

The term "Claims Administrator" means a person or persons, or entity or entities, appointed by the Plan Administrator to serve as the administrator of claims under a Participating Plan, with the responsibility for the review and payment of claims and record keeping related thereto, and to the extent delegated by the Plan Administrator, to exercise its discretionary authority in the review of claim payments (including eligibility for benefits claimed) and appeals of claim denials under the terms of a Participating Plan. The Claims Administrator for benefit claims under a fully-insured Participating Plan is the insurance company issuing the applicable insurance policy which funds the Participating Plan. The Claims Administrator for a self-insured Participating Plan is the Plan Administrator, to the extent not delegated to another committee, entity, third party administrator or other person. For any appeal responsibilities retained by the Plan Administrator with respect to a Participating Plan, the Claims Administrator shall be the Benefits Appeals Committee. The Claims Administrator shall have the authority to make claim determinations as specified under Section 7.

2.9 COBRA

The term "COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the regulations thereunder. References to COBRA include any comparable sections of any future legislation and regulations which amend, supplement, or supersede said sections of COBRA cited herein.

2.10 Code

The term "Code" means the Internal Revenue Code of 1986, as amended, and the regulations thereunder. References to the Code include any comparable sections of any future legislation which amend, supplement, or supersede said sections of the Code cited herein.

2.11 Company

The term "Company" means Hancock Holding Company.

2.12 Covered Person

The term "Covered Person" means each Participant, the Dependents of a Participant who are enrolled in a Participating Plan that provides Dependent coverage, and any qualified

beneficiary who is covered under a Health Plan pursuant to Section 6. With respect to the right to make elections under the Cafeteria Plan, the term "Covered Person" refers only to the Participant.

2.13 Dependent

The term "Dependent" means the Associate's Spouse or Child, defined as follows:

(a) Spouse: The individual to whom the Associate is legally married and from whom the Associate is not divorced. Unless otherwise provided under the applicable Participating Plan, the term Spouse does not include a common law spouse.

(b) Child: Any of the following

(i) Child — General: Any child of the Associate who is under the of age twenty-six (26) and who is the son, daughter, stepson or stepdaughter of the Associate, including a foster child who is placed with the Associate by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction, a legally adopted child of the Associate or a child that has been lawfully placed with the Associate for legal adoption, without regard to student status, marital status, financial dependency or residency status.

(ii) Child — Incapacitated: An unmarried Child of any age who is mentally or physically incapable of self-sustaining employment and who is fully dependent upon the Associate for support because of developmental disability, mental retardation, or physical disability as of the date the Child otherwise attains any applicable maximum age under the Plan. The Associate must receive approval before extended coverage can be provided for such a Child. Periodic recertification shall be required for such a Child to retain Dependent status under the Plan.

(iii) Child — Under qualified medical child support order ("QMCSO"): A child who is an alternate recipient (as defined in Section 609(a)(2)(C) of ERISA), if coverage of such child is required under a Health Plan pursuant to a QMCSO and such child otherwise meets the applicable age requirements to qualify as a Dependent under the Health Plan.

For purposes of an insured Participating Plan, a Dependent shall also include any other child or other dependent of the Associate who meets the eligibility requirements as set forth in the applicable policy, certificate of coverage or membership booklet for the insured Participating Plan. An Eligible Associate shall be required to provide proof of Dependent status as the Plan Administrator may require, including but not limited to a marriage certificate or birth certificate, or other similar documentation.

2.14 Eligible Associate

Except as specifically set forth in the Plan Supplements with respect to individual Participating Plans, the term "Eligible Associate" means an Associate who satisfies the rules for eligibility as set forth in Section 3. Notwithstanding the foregoing, for purposes of the Participating Medical Plans, an Eligible Associate means an Associate who also satisfies the eligibility requirements under Plan Supplement A2.

2.15 Employer

The term "Employer" means the Company and any Affiliates that adopt one or more of the Participating Plans and that participate in the Plan in the manner provided in subsection 10.2. The Employers under the Plan are listed in Supplement P to the Plan, which may be revised from time to time to reflect the addition or deletion of Employers listed in Supplement P, without formal amendment of the Plan.

2.16 ERISA

The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder. References to ERISA include any comparable sections of any future legislation which amend, supplement, or supersede said sections of ERISA cited herein.

2.17 Health Plan

The term "Health Plan" means each of the following Participating Plans:

(a) The Participating Medical Plans;

(b) The Participating Dental Plans;

(c) The Participating Vision Plans;

(d) The Health Flexible Spending Account Plan component of the Cafeteria Plan;

(e) Participating Critical Illness Insurance Plan;

(f) Participating Accident Insurance Plan;

(g) Participating Cancer Insurance Plan; and

(h) The retiree health care benefits under the Participating Retiree Plans.

2.18 HIPAA

The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder. References to HIPAA include any comparable sections of any future legislation which amend, supplement, or supersede said sections of HIPAA cited herein.

2.19 HITECH

The term “HITECH” means the Health Information Technology for Economic and Clinical Health Act of 2009, as amended, and the regulations thereunder. References to HITECH include any comparable sections of any future legislation which amend, supplement, or supersede said sections of HITECH cited herein.

2.20 Initial Enrollment

The term “Initial Enrollment” means enrollment in the Plan within the period specified in the applicable Participating Plan and commencing on the Associate’s date of hire or first date of eligibility.

2.21 Participant

The term “Participant” means an Eligible Associate who is enrolled in a Participating Plan.

2.22 Participating Plan

The term “Participating Plan” means any of the benefit programs specified in the Plan Supplements.

2.23 Plan

The term “Plan” means this Hancock Holding Company Employee Welfare Fund.

2.24 Plan Administrator

The term “Plan Administrator” means the Company or such other person(s) or entity designated by the Company. As of the effective date of this restatement, the Plan Administrator is the Benefits Committee. Any reference herein to Plan Administrator shall include any designee of the Plan Administrator, for any or all tasks and responsibilities reserved to the Plan Administrator.

2.25 Plan Year

The term “Plan Year” means the twelve (12) consecutive month period commencing each January 1 and ending the next following December 31.

2.26 PPACA

The term “PPACA” means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and the regulations thereunder. References to the PPACA include any comparable sections of any future legislation which amend, supplement, or supersede said sections of PPACA cited herein.

2.27 Rescind or Rescission

The term "Rescind" or "Rescission" means a cancellation or discontinuance of coverage that has retroactive effect (i.e., a cancellation that (i) treats a policy as void from the time of the individual's or group's enrollment, or (ii) voids benefits paid up to a year before the cancellation). A cancellation or discontinuance of coverage is not a Rescission if:

(a) The cancellation or discontinuance of coverage has only a prospective effect;

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage; or

(c) Under PPACA, or any other applicable guidance issued thereunder by the Department of the Treasury, the Department of Labor, or the Department of Health and Human Services, such cancellation or discontinuance of coverage is not considered to be a Rescission.

2.28 Summary Plan Description

The term "Summary Plan Description" means the summary plan description prepared and issued by the Plan Administrator for each Participating Plan under the Plan. The certificate of coverage or membership booklet for an insured benefit option, in combination with any supplement or addendum that may be prepared and issued by the Plan Administrator, may constitute the Summary Plan Description for an insured benefit option. From time to time, a Summary Plan Description may be updated with a summary of material modifications explaining any material changes to the terms of one or more of the Participating Plans governed under ERISA. Any summary of material modifications is incorporated in and forms a part of the Summary Plan Description for the Participating Plan.

2.29 USERRA

The term "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and the regulations thereunder. References to USERRA include any comparable sections of any future legislation which amend, supplement, or supersede said sections of USERRA cited herein.

2.30 Waiting Period

The term "Waiting Period" means the period that must pass before coverage for an Associate who is otherwise eligible to enroll under the terms of the applicable Participating Plan can become effective.

SECTION 3.

Eligibility, Enrollment, and Participation

3.1 Eligibility

Subject to the provisions of subsection 3.2, each Eligible Associate will be eligible to become a Participant in the Plan on the date the Eligible Associate satisfies all of the following requirements:

(a) Meets the eligibility requirements of a Participating Plan;

(b) Completes any applicable Waiting Period; and

(c) Enrolls in a Participating Plan (or is automatically enrolled) in accordance with subsection 3.2.

3.2 Enrollment

Each Eligible Associate who has satisfied the requirements of subparagraphs 3.1(a) and 3.1(b) may become a Participant for a Plan Year by enrolling in the Plan in accordance with procedures established by the Plan Administrator for that purpose. For purposes of the Plan, references to enrollment shall include telephone enrollment, electronic enrollment, or any other form of enrollment, if and to the extent permitted by the Plan Administrator. Enrollment shall be made at such time and in such manner as the Plan Administrator shall prescribe and shall remain in effect until the first day of the next following Plan Year. As part of such enrollment, the Eligible Associate shall agree to make any required contributions towards the cost of such coverage. If a new Eligible Associate fails to enroll in the Plan during Initial Enrollment, or within 31 days of the occurrence of a Change in Status or another event entitling the Eligible Associate to an election change under this Section 3, the Eligible Associate may not enroll in the Plan until the next following Annual Enrollment period. Once made, an enrollment (and the elections made therein) may be revoked or modified during a Plan Year only on account of the Eligible Associate's termination of employment or the occurrence of an event entitling the Eligible Associate to an election change in accordance with this Section 3.

3.3 Enrollment Elections

An Eligible Associate's enrollment elections shall include, if applicable:

(a) The Eligible Associate's authorization to reduce his or her compensation for the Plan Year by:

(i) the dollar amount of any pre-tax or after-tax contributions required for coverage under Participating Plans offered to the Eligible Associate through the Cafeteria Plan for that Plan Year;

(ii) the dollar amount of any elected Cafeteria Plan contributions to the Eligible Associate's Health Flexible Spending Account and Dependent Care Flexible Spending Account; and

(iii) the dollar amount of any after-tax contributions required for any other coverage elected by the Eligible Associate under a Participating Plan for that Plan Year.

(b) The Eligible Associate's waiver of coverage under one or more of the Participating Plans, in accordance with subsection 3.5.

An Eligible Associate's enrollment shall include such other elections and require such additional information and supporting documents as may be required by the Plan Administrator or under any Participating Plan.

3.4 Leaves of Absence

Except as otherwise provided under a Participating Plan, an authorized leave of absence granted by an Employer will not interrupt participation in any Participating Plan under the Plan during such leave, provided that the Associate makes any contributions required for such coverage while on authorized leave and otherwise continues to meet the eligibility requirements for coverage under the Plan. Pre-tax contributions under the Cafeteria Plan shall neither be required nor permitted during, or with respect to, any period of such leave of absence for which no compensation is received. After-tax contributions may be required in order for an Eligible Associate to continue the coverage elected under the Cafeteria Plan or other Participating Plan for any period during which no or reduced compensation is received from an Employer. Following a Participant's commencement of and subsequent return from an approved unpaid leave of absence, a Participant who terminated coverage in one or more of the Participating Plans may be allowed to make new elections under the Plan with respect to those benefits discontinued during the approved unpaid leave of absence, subject to the terms of the applicable Participating Plan. If a Participant does not return to work with his or her Employer on or before termination of an authorized leave of absence, he or she will be considered to have terminated employment on the date such leave of absence expires, unless the Participant actually terminated employment before the expiration of his or her leave of absence.

Notwithstanding the foregoing, in the event of an unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), the Company may select one of the payment options available under Treasury Regulation Section 1.125-3, or any subsequent regulation, provided the payment option is made available on a uniform and nondiscriminatory basis to all Participants taking unpaid FMLA leave. The foregoing FMLA rule shall also apply to a Participant on military leave pursuant to the benefit requirements under USERRA, unless otherwise prohibited by subsequent regulations under Code Section 125 or USERRA. Applicable regulations issued under USERRA or Code Section 125 will supersede and apply when issued.

3.5 Waiver of Coverage

An Eligible Associate may elect to waive coverage under certain Participating Plans for the Associate and his or her Dependents. A waiver of coverage will remain in effect until the

Eligible Associate elects coverage during a subsequent Annual Enrollment or as permitted under subsection 3.6.

3.6 Election Changes

An Eligible Associate may change or revoke his or her elections during a Plan Year on account of the Associate's termination of employment, upon a Change in Status to the extent permitted under the Cafeteria Plan and the applicable Participating Plan, or as required by applicable law.

3.7 Termination of Coverage

A Participant's participation in the Plan shall cease effective as of the earliest of the following dates:

(a) The date the Plan terminates;

(b) The date all of the Participating Plans terminate;

(c) The date the Participant's coverage terminates under all of the Participating Plans;

(d) The last day for which required contributions for Participating Plans coverage were made;

(e) The date the Participant is no longer eligible for coverage under any Participating Plan; or

(f) The date of the Participant's death.

Coverage under the Plan for a Participant's Dependent ends on the earliest of the following dates:

(g) The date the Participant's coverage ends, except to the extent provided in a Participating Plan;

(h) The date the Employer no longer offers coverage for Dependents under any Participating Plan;

(i) The date the Dependent's coverage terminates under all of the Participating Plans;

(j) The last day for which required contributions for Dependent coverage were made;

(k) The date the individual ceases to be eligible for coverage as a Dependent under all Participating Plans; or

(l) The date of the Dependent's death.

Coverage for Covered Persons under a Participating Plan shall terminate effective as of the earliest of (i) the date the Participating Plan terminates, (ii) the last day for which required

contributions for coverage were made by the Covered Person or on the Covered Person's behalf (except as specifically provided under the Participating Plan), or (iii) on the first to occur of the termination events specified in the applicable Participating Plan. Coverage may also terminate pursuant to subsection 10.16.

Notwithstanding the foregoing, Covered Persons who otherwise meet the requirements for continuation and/or reinstatement of coverage under the FMLA, USERRA, or COBRA (or other similar state continuation coverage law) shall be offered the right to continue coverage under the applicable Participating Plan(s) pursuant to the terms and provisions of the applicable statute, the regulations thereunder, and the administrative rules established by the Plan Administrator.

3.8 Rehired Participants

Except as otherwise provided under Plan Supplement A2, Participants who terminate employment and are later rehired will become eligible under the Plan after meeting the requirements under subsection 3.1 above.

3.9 Medical Child Support Order

Notwithstanding anything in the Plan to the contrary, the Health Plans shall cover alternate recipients, as defined in Section 609(a)(2)(C) of ERISA, to the extent required to comply with the terms of a qualified medical child support order, as defined in Section 609(a)(2)(A) of ERISA. Such coverage shall be provided pursuant to uniform guidelines established by the Plan Administrator that are in accordance with the requirements of Section 609(a) of ERISA and that are hereby incorporated by reference. Upon receipt of a medical child support order ("MCSO"), the Plan Administrator will promptly notify the Eligible Associate and each child who is the subject of the MCSO of its receipt of the MCSO and will provide (in writing) the Plan's procedures for determining if the MCSO is qualified. Within a reasonable period of time, the Plan Administrator will determine whether the MCSO is qualified under Section 609(a) of ERISA and will notify the Eligible Associate and the child(ren) of its determination. Coverage of alternate recipients pursuant to a valid qualified MCSO under one or more of the Health Plans will continue until the earlier of the following dates: (i) the date coverage is no longer required pursuant to the terms of the qualified MCSO; or (ii) the date the alternate recipient ceases to otherwise be eligible for Dependent coverage under one or more of the Health Plans subject to the qualified MCSO.

SECTION 4.

Benefits and Limitations

4.1 Participating Plan Benefits

The benefits and limitations under each of the Participating Plans are found in the plan documents specified in the applicable Supplement for the Participating Plan in which the Covered Person is enrolled. For purposes of this subsection, such plan documents may include Summary Plan Descriptions, insurance contracts, certificates of coverage, HMO and DMO membership booklets, and other documents that are incorporated into this document by reference.

4.2 Insurance Policies

Subject to subsection 4.4, the specific benefits and limitations (including exclusions of benefits) specified in an insurance contract entered into by an Employer and identified as fully insuring a Participating Plan coverage option shall control with respect to that Participating Plan and the class or classes of Covered Persons thereunder.

4.3 Contracts and Agreements

Any agreements with health care networks, insurance companies, or other entities entered into by an Employer with the sole purpose of providing for the administration and/or delivery of benefits under a Participating Plan shall be initiated, continued, or terminated in the sole discretion of the Employer. The Employer reserves the right to change insurance carriers, insurance coverage options, and health care networks at any time and for any reason. Agreements with third-party administrators for any self-insured coverage or for administrative services relating to enrollment or payment of benefit claims are separate business agreements between the Employer and the third party administrator and are not part of this Plan document or any underlying Participating Plan.

4.4 Compliance with Applicable Laws

Notwithstanding the provisions of the Plan (including any documents incorporated herein by reference) to the contrary, all Participating Plans shall, to the extent applicable, be administered in accordance with the applicable terms of ERISA, the Code, COBRA, HIPAA, FMLA, USERRA, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, the Children's Health Insurance Program Reauthorization Act of 2009, the Mental Health Parity Act of 1996 (as amended by the Mental Health Parity and Addiction Equity Act of 2008), the Genetic Information Non-Discrimination Act of 2008, HITECH, PPACA, and all other applicable state and federal laws.

4.5 Rebates, Refunds and Similar Payments

To the maximum extent permitted by applicable law, 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,

administrative services organization, health maintenance organization, service plan or any other organizations or individuals, even if such payment exceeds the amount necessary to fund the benefits provided by a particular Participating Plan. 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.

SECTION 5.

Administration of the Plan

5.1 Plan Sponsor and Named Fiduciaries

The Company shall be the Plan Sponsor and, subject to subsection 1.6, the Named Fiduciary of the Plan. The Plan Administrator and any other committee, entity, or person(s) to whom the Company has delegated responsibility for managing and administering the Plan shall also be an additional Named Fiduciary of the Plan pursuant to the provisions of ERISA. Any Named Fiduciary may delegate any of its responsibilities hereunder, subject to the approval of the Company or the Plan Administrator, by designating in writing other entities or persons to carry out its responsibilities under the Plan, and may retain other entities or persons to advise it with regard to any of such responsibilities. Any Named Fiduciary of the Plan may serve in more than one fiduciary capacity. Named Fiduciaries of the Plan may allocate fiduciary responsibilities among themselves in any reasonable and appropriate fashion, subject to the approval of the Company or the Plan Administrator.

5.2 Plan Administration

The Plan Administrator shall have the discretionary authority and responsibility to supervise the administration of the Plan. It shall be a principal duty of the Plan Administrator to see that the terms of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan. To the extent not delegated to another Named Fiduciary or Claims Administrator, the Plan Administrator shall have full discretionary authority to interpret and administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator’s powers and duties shall include, but shall not be limited to, the following authority, in addition to all other powers and duties specifically granted to the Plan Administrator elsewhere in the Plan:

(a) To appoint Claims Administrators under the Plan to be responsible for daily administration of the respective portions of the Plan and the payment of claims under the respective portions of the Plan and/or to review and decide benefit claims on appeal.

(b) To appoint a person or entity to administer the provisions of COBRA as applicable to the Plan.

(c) To appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan.

(d) To allocate and delegate any or all of its responsibilities, powers, and duties under the Plan, and to designate other persons or committees to carry out any of its responsibilities, powers, and duties under the Plan, provided that any such allocation, delegation, or designation is in writing.

(e) To construe and interpret the provisions of the Plan (including all eligibility and enrollment requirements) and to make factual determinations thereunder, and to

remedy ambiguities, inconsistencies, or omissions, with all such determinations to be binding on all parties.

(f) To establish, adopt, and enforce such rules of procedures and regulations as in its opinion may be necessary or desirable for the proper and efficient administration of the Plan.

(g) To adopt such rules and procedures as in its opinion may be necessary or appropriate for the proper and efficient administration of MCSOs, which rules are hereby incorporated by reference.

(h) To administer the Plan in accordance with the terms of the Plan and the rules and regulations adopted by the Plan Administrator as described above.

(i) To furnish the Employers with such information as may be required by them for tax or other purposes in connection with the Plan.

(j) To receive from the Employers, Covered Persons, and other persons or entities such information as shall be necessary for the proper administration of the Plan.

The Plan Administrator shall have discretionary and final authority to interpret the terms of the Plan regarding matters for which it is responsible as set forth in this Section 5, and its decisions shall be final and binding on all parties.

SECTION 6.

COBRA Continuation Coverage

6.1 Purpose

This Section 6 describes the provisions relating to the rights of certain Covered Persons to elect to continue group health coverage under the Health Plans if, but for such election, a qualifying event described in subsection 6.2 below would result in a Covered Person's loss of coverage under the Health Plan. As described below, any individual continuing coverage under this Section 6 must pay the full cost of coverage plus an applicable administrative surcharge. The provisions of this Section 6 are intended to comply with COBRA. The Health Plans shall also comply with any applicable state continuation coverage insurance requirements, as described in the applicable certificates of coverage or membership booklets for the applicable insured Participating Plans. In the event any provision of this document, including the applicable Supplements, fails to comply with requirements of applicable law or fails to determine the right or liability of any party, the provisions of COBRA shall prevail. In no event shall the rights granted by this Plan be greater than those required to be provided by COBRA.

6.2 Qualifying Event

A qualifying event is, with respect to a Covered Person, any of the events listed in this subsection 6.2 that would result in the loss of Health Plan coverage of the Covered Person:

(a) the death of the Associate;

(b) the termination (other than by reason of gross misconduct) or retirement of the Associate, or a reduction of hours of an Associate's employment, that causes the Participant to lose eligibility under the Health Plan;

(c) divorce or legal separation;

(d) as to qualified beneficiaries other than the Associate, the Associate becomes entitled to benefits under Medicare (for purposes of this Section 6, an Associate shall be considered to be entitled to benefits under Medicare if he or she has enrolled in and is covered under Medicare); or

(e) A child ceasing to be a Dependent Child of the Associate under the Health Plan.

6.3 Qualified Beneficiaries

Qualified beneficiaries are the only individuals who may make elections to continue coverage in accordance with this Section 6. The term "qualified beneficiary" means the Participant and any other Dependent who, on the date before a qualifying event, is a Covered Person under a Health Plan and who loses coverage under the Health Plan on account of such qualifying event. In addition, any child born to or placed for adoption with a covered Associate during a period of continuation coverage is automatically considered a qualified beneficiary.

6.4 Notice of Right to Elect Continuation Coverage

To the extent the Employer is not the Plan Administrator, the Employer shall notify the Plan Administrator of the Associate's death, termination, reduction in hours of employment, or Medicare entitlement within 30 days after coverage is lost. A qualified beneficiary or family member must inform the Plan Administrator of a divorce, legal separation, or cessation of Dependent status under the Health Plan in writing in accordance with the procedures established by the Plan Administrator and within 60 days following the later of (i) the date of the qualifying event, (ii) the date that the qualified beneficiary would lose coverage on account of the qualifying event, or (iii) the date written notice of the general right to continuation of coverage is provided to the qualified beneficiary. If such notice is not provided to the Plan Administrator in writing in accordance with the procedures established by the Plan Administrator and within such 60-day time period, affected qualified beneficiaries shall not be entitled to elect to continue coverage hereunder on account of such qualifying event. Within 14 days (or 44 days after coverage is lost if the Employer is also the Plan Administrator) of the date the Plan Administrator receives timely notice of a qualifying event, the Plan Administrator shall provide each qualified beneficiary with written notice of such qualified beneficiary's right to continuation of coverage pursuant to the terms of this Section 6 and of the applicable premium for such coverage. Notification made to the Associate will be deemed made with respect to the Associate and his or her covered Spouse, if the covered Spouse resides at the same location. Notification to the Associate or the Associate's Spouse or former Spouse shall be treated as notification to all other qualified beneficiaries residing with such Associate or the Associate's Spouse or former Spouse at the time notification is made.

6.5 Election of Continuation Coverage

Subject to the conditions and limitations of this Section 6, a qualified beneficiary may elect to continue coverage hereunder during the election period described below and in accordance with the procedures established by the Plan Administrator. The election period for continuation of coverage under the Health Plan shall be the sixty (60) day period that begins on the later of (i) the date coverage terminates under the Health Plan by reason of a qualifying event, or (ii) the date written notice of the right to continuation of coverage is provided to the qualified beneficiary. If the qualifying event is an Associate's termination of employment, retirement, or reduction of hours, an election of continuation coverage made by the Participant or the covered Spouse of the Participant, unless stated otherwise, shall be deemed an election made on behalf of any other qualified beneficiary who would lose coverage as a result of the Participant's termination, retirement, or reduction of hours. If the qualifying event is the death, divorce, or legal separation of the Participant, an election of coverage made by the Spouse of the Participant, unless stated otherwise, shall be deemed an election on behalf of any other qualified beneficiary who would lose coverage as a result of such death, divorce, or legal separation. Elections under this subsection 6.5 shall be limited to the coverage option(s) in effect on the date of the qualifying event. If any qualified beneficiary does not elect to continue coverage within the applicable election period and in accordance with the procedures established by the Plan Administrator, his or her coverage under the Health Plan will end as of the date of the qualifying event.

6.6 Type of Coverage

Continuation coverage consists of coverage under the applicable Health Plan which, as of the time coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated individuals with respect to whom a qualifying event has not occurred. A qualified beneficiary does not have to show that he or she is insurable to elect continuation coverage. The Plan Administrator reserves the right to terminate continuation coverage (including retroactively) in accordance with subsection 10.16.

6.7 Duration of Coverage

If continuation of coverage is elected within the period described in subsection 6.5, coverage shall be effective retroactive to the date coverage under the Health Plan would otherwise have terminated but for such election. Subject to the conditions and limitations of this subsection 6.7, the maximum period for which coverage under the Health Plan may be continued following the occurrence of a qualifying event are as follows:

(a) In the case of a qualifying event that is a termination of employment or reduction in hours of employment, coverage may be continued for up to eighteen (18) calendar months following the date coverage would otherwise terminate under the Health Plan. Notwithstanding the foregoing, if a subsequent qualifying event occurs during such eighteen (18) month period, the maximum period shall not exceed a period of thirty-six (36) calendar months measured from the date coverage terminated under the Health Plan. The initial eighteen (18) month period may be extended to twenty-nine (29) months under certain circumstances described below.

(b) In the case of all other qualifying events, coverage may be continued for up to thirty-six (36) calendar months following the date coverage would otherwise terminate under the Health Plan.

(c) Notwithstanding paragraph (a) above, if a qualified beneficiary entitled to continuation coverage on the basis of a termination or reduction in hours is determined under Title II or XVI of the Social Security Act to have been disabled within the first sixty (60) days of COBRA continuation coverage hereunder, and the qualified beneficiary provides timely notice of such determination as required by subsection 6.11, twenty-nine (29) calendar months shall be substituted for eighteen (18) calendar months for the benefit of the disabled qualified beneficiary as well as nondisabled family members of the disabled qualified beneficiary.

6.8 Events Causing Termination of Continued Coverage

Notwithstanding the provisions of subsection 6.7, continuation of coverage pursuant to the provisions of this Section 6 as to any Covered Person (whether or not a qualified beneficiary) shall terminate upon the first to occur of the following events:

(a) failure to make timely payment of the required contribution, as set forth in subsection 6.9;

(b) the date the Health Plans and all group health plans of the Employers or any Affiliate are terminated;

(c) after the qualified beneficiary makes an election for continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not exclude or limit coverage with respect to any pre-existing conditions of the qualified beneficiary. If the exclusions or limitations for pre-existing conditions in the other group health plan would not apply to the qualified beneficiary (or would be satisfied by the qualified beneficiary) due to the requirements enacted by HIPAA or PPACA, then the Health Plan may terminate continuation coverage under this provision;

(d) after the qualified beneficiary makes an election for continuation coverage under this Section 6, the qualified beneficiary becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or

(e) if coverage is extended on the basis of a disability determination under Title II or XVI of the Social Security Act in accordance with subsection 6.7(c), the earlier of (i) the first day of the month that begins more than thirty (30) days after the date of a final determination that the qualified beneficiary is no longer disabled under Title II or XVI of the Social Security Act, provided that coverage shall not terminate before the end of the 18-month period described in subsection 6.7(a), or (ii) the end of twenty-nine (29) calendar months.

6.9 Contribution Requirement

As a condition of eligibility for continuation of coverage under this Section 6, a qualified beneficiary who elects to continue coverage (or on whose behalf such election is made) is required to make contributions not less frequently than monthly in the amounts and at the times specified by the Plan Administrator. The amounts of such contributions shall be determined by the Plan Administrator from time to time in accordance with the provisions of Section 604 of ERISA and Code Section 4980B(f)(4). Unless otherwise provided in the terms of any Health Plan, the required contribution for continuation coverage shall be an amount equal to one hundred two percent (102%) of the applicable premium as defined in ERISA and the Code; provided that if an extension of the continuation period on the basis of a disability determination under Title II or XVI of the Social Security Act in accordance with subsection 6.7(c) applies, the amount of the required contribution for any month after the eighteenth (18th) month of continuation coverage shall equal one hundred fifty percent (150%) of such applicable premium. With respect to a qualified beneficiary whose election of continuation of coverage is made after the date of the qualifying event, the initial contribution amount shall take into account the period of coverage that precedes the date of election and shall be paid in full no later than forty-five (45) days following the date of election. Subsequent contributions shall be considered timely made only if received by the Plan Administrator no later than thirty (30) days following the due date otherwise established by the Plan Administrator and communicated to the qualified beneficiary; provided, however, that no such payment shall be required to be paid any earlier than the forty-fifth (45th) day following the date of the initial election for continuation coverage hereunder. An

Employer may, in its discretion, elect to pay all or any part of such required contributions for COBRA coverage on behalf of a qualified beneficiary.

6.10 Annual Enrollment Changes

Qualified beneficiaries continuing coverage pursuant to this Section 6 shall be eligible to make enrollment changes during the Annual Enrollment period on the same basis as similarly situated Participants with respect to whom a qualifying event has not occurred, to the extent required by law. All such enrollment changes shall be made in accordance with the procedures under Section 3 and such other procedures as the Plan Administrator may establish.

6.11 Notice Requirements on Disability of Qualified Beneficiary

To qualify for coverage on the basis of a disability determination under Title II or XVI of the Social Security Act in accordance with subsection 6.7(c), a qualified beneficiary who is determined to be disabled under Title II or XVI of the Social Security Act within the first sixty (60) days of continuation coverage must notify the Plan Administrator in writing in accordance with the procedures established by the Plan Administrator within sixty (60) days after the date of such determination and within the initial eighteen (18) month period. If a final determination is made that the qualified beneficiary is no longer disabled under Title II or XVI of the Social Security Act, the qualified beneficiary must notify the Plan Administrator in writing in accordance with the procedures established by the Plan Administrator and within thirty (30) days of the date of such final determination that he or she is no longer disabled.

6.12 Medicare Entitlement — Special Rule

Notwithstanding any provision of this Section 6 to the contrary, if an Associate becomes entitled to Medicare benefits under Title XVIII of the Social Security Act and experiences a qualifying event on the basis of a termination of employment or reduction in hours of employment (without regard to whether such Medicare entitlement is a qualifying event resulting in a loss of coverage) within the 18-month period after the Associate becomes entitled to Medicare benefits, the period of continuation coverage for qualified beneficiaries other than such Associate shall not terminate before the close of the thirty-six (36) month period beginning on the date the Participant became entitled to Medicare benefits, so long as all other requirements under this Section 6 are met.

SECTION 7.

Claims Procedure

7.1 Filing Claims

Claims for benefits under each of the Participating Plans shall be subject to the requirements set forth in the Participating Plan (incorporated herein by reference via the applicable Plan Supplement) and the following Plan rules. A claim submitted under a Participating Plan must include all information requested by the Plan Administrator or the designated Claims Administrator, including any information to be provided by the Covered Person's physician or dentist, as applicable. A claim will be considered filed if a properly completed claim form is submitted to the Plan Administrator or designated Claims Administrator, as applicable. All information and medical records that may be requested by the Plan Administrator or a Claims Administrator in connection with any claim shall be furnished as requested. Should the Plan Administrator or Claims Administrator contact the Covered Person for additional information, the Covered Person must respond with the required information in order for the claim to be processed by the Plan Administrator or Claims Administrator.

7.2 Claims Procedures for ERISA Participating Plans

Claims for benefits and appeals of denied claims under the Plan (except the Premium Plan and the Dependent Care Flexible Spending Account Plan under the Cafeteria Plan, which are subject to the claims procedures set forth in subsection 7.3) shall be administered in accordance with Section 503 of ERISA, and the procedures adopted by the Plan Administrator or the appropriate Claims Administrator for such purpose, which procedures are set forth in the applicable Participating Plan and are incorporated herein by reference via the applicable Plan Supplement. Each Participating Medical Plan shall, to the extent applicable, comply with the internal claims and appeals and external review requirements under PPACA and Department of Labor Regulations Section 29 C.F.R. 2590.715-2719 and related guidance.

The Plan Administrator or Claims Administrator shall provide adequate notice to any claimant whose claim for benefits under the Plan has been denied, setting forth the reasons for such denial, and afford a reasonable opportunity to such claimant for a full and fair review by the Plan Administrator or appropriate Claims Administrator of the decision denying the claim. For purposes of this subsection 7.2 of the Plan, the term "claimant" shall mean a Covered Person or the authorized representative of the Covered Person, as determined by the Plan Administrator or Claims Administrator. A Covered Person's authorized representative shall be required by the Plan Administrator or Claims Administrator to produce evidence acceptable to the Plan Administrator or Claims Administrator of his or her authority to act on behalf of the Covered Person. The Plan Administrator or Claims Administrator reserves the right to require a Covered Person to execute a form approved by the Plan Administrator or Claims Administrator appointing an individual as his or her authorized representative for purposes of filing claims and appeals under the Plan. An assignment of benefits by a Covered Person to a health care provider shall not constitute a designation of an authorized representative for purposes of the Plan unless otherwise specifically stated in the assignment form in a manner acceptable to Plan Administrator or appropriate Claims Administrator.

Benefits will be paid under the Plan only if the Plan Administrator or Claims Administrator determines in its discretion that the claimant or other applicant is entitled to them. No action at law or in equity may be brought to recover benefits or other relief under this Plan and any applicable Participating Plan, until all of the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. Decisions made by the Plan Administrator or Claims Administrator are final and binding.

Except as otherwise stated in the applicable Participating Plan, after exhaustion of the Plan's claims and appeals procedures, as described above, any further legal action pursued against the Plan, its fiduciaries, or any Employer to appeal the denial of a claim, challenge the amount of any benefit under the Plan or any applicable Participating Plan, or bring any other action under ERISA, other than a breach of fiduciary duty claim, must be filed in a court of law by the earliest of the following dates:

(a) one (1) year from the day the final decision on the claim was notified (or from the last day (including any extension) that the final decision could have been timely notified) by the Plan Administrator or designated Claims Administrator;

(b) the statutory deadline for filing a claim or lawsuit with respect to the Plan benefits at issue in the judicial proceeding as determined by applying the most analogous statute of limitations for the State of Mississippi.

Any action brought against the insurance carrier under an insured Participating Plan must be filed within the time limit set forth in the applicable insurance contract or certificate of coverage or such other time limit as may be established under applicable state insurance law; provided however, that with respect to any contractual limitations period, if there is a conflict between the insurance certificate and the Plan, the insurance certificate's contractual limitations period will control.

7.3 Claims Procedure for Non-ERISA Participating Plans

Participant claims under the Premium Plan and the Dependent Care Flexible Spending Account Plan under the Cafeteria Plan shall be reviewed by the Plan Administrator or Claims Administrator and decided in a uniform and non-discriminatory manner pursuant to the terms of the Cafeteria Plan and regulations under Code Sections 125 and 129, respectively, to the extent appropriate. Benefits will be paid under the applicable non-ERISA Participating Plan only if the Plan Administrator or Claims Administrator determines in its discretion that the claimant is entitled to them. No action at law or in equity shall be brought to recover benefits or other relief under this Plan or any applicable non-ERISA Participating Plan until all of the appeal rights, if any, provided under the applicable non-ERISA Participating Plan have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. Decisions made by the Plan Administrator or Claims Administrator are final and binding.

Except as otherwise stated in the applicable non-ERISA Participating Plan, after exhaustion of any applicable claims and appeals procedures under such Participating Plan, any further legal action pursued against the Plan, its fiduciaries, or any Employer to appeal the denial of a claim, challenge the amount of any benefit under the Plan or non-ERISA Participating Plan,

or bring any other action under applicable law must be filed in a court of law no later than one 1 year from the day the final decision on the claim was notified (or from the last day (including any extension) that the final decision could have been timely notified) by the Plan Administrator or designated Claims Administrator.

SECTION 8.

Disclosure of Protected Health Information to the Plan Sponsor

8.1 Hybrid Entity Status

The Plan is considered a “hybrid entity” as defined by 45 C.F.R. Section 164.103 of the Privacy Rule, as defined in subsection 8.9. The Participating Plans that are Health Plans shall constitute the health care component of the hybrid entity and shall be subject to the requirements of the Privacy Rule and, to the extent the Health Plan discloses Protected Health Information to the Plan Sponsor, to this Section 8. All other Participating Plans constitute the non-covered component and are not subject to the requirements of the Privacy Rule or this Section 8.

8.2 Privacy of Health Information

In accordance with the Privacy Rule standard at 45 C.F.R. Section 164.504(f), the Health Plan will Disclose, and will permit its Business Associates or a Health Insurance Issuer or Health Maintenance Organization (“HMO”) with respect to the Health Plans to Disclose, health information, including Protected Health Information (“PHI”), to the Plan Sponsor only as provided in this Section 8.

8.3 Disclosure to the Plan Sponsor with Individual Authorization

PHI may be Disclosed to the Plan Sponsor pursuant to the valid authorization of the individual who is the subject of the PHI in accordance with the Health Plans’ policy and procedures for Disclosure upon such authorization.

8.4 Disclosure to the Plan Sponsor without Individual Authorization

The following Disclosures may be made to the Plan Sponsor by the Health Plan, a HMO, or an insurance company with respect to the Health Plans, or a Business Associate of the Health Plans, without individual authorization:

(a) Summary Health Information may be Disclosed to the Plan Sponsor if the Plan Sponsor requests such information for the following purposes:

(i) Obtaining premium bids from Health Insurance Issuers or HMOs for purposes of providing health insurance coverage under the Health Plans; or

(ii) Modifying, amending, or terminating the Health Plans.

(b) Information as to whether an individual is participating in a Health Plan or is enrolled in or has disenrolled from a fully-insured or HMO option offered under a Health Plan may be Disclosed to the Plan Sponsor.

(c) PHI may be Disclosed to the Plan Sponsor if required by law.

(d) Provided the requirements of subsection 8.5 have been met, PHI may be Disclosed to the Plan Sponsor to permit the Plan Sponsor to perform Health Plan administration functions, including Payment and Health Care Operations functions, for and on behalf of the Health Plans.

When Using or Disclosing PHI, the Plan Sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purposes of the Use or Disclosure. When requesting PHI from another party, the Plan Sponsor shall make reasonable efforts to limit any request for PHI to the minimum necessary to satisfy the purposes of the request.

8.5 Certification Requirement

The Health Plans will Disclose PHI to the Plan Sponsor without individual authorization only upon receipt of the Plan Sponsor's written certification that the Health Plans have been amended to comply with the Privacy Rule and that the Plan Sponsor agrees to:

(a) Not Use or further Disclose PHI other than as permitted or required by the Health Plans or as required by law;

(b) Ensure that any agents, including Subcontractors, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(c) Not Use or Disclose PHI for employment-related actions and decisions unless authorized by the individual who is the subject of the PHI;

(d) Not Use or Disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor (other than permitted Uses and Disclosures to another group health plan, as defined at 45 C.F.R. Section 160.103 of the Privacy Rule) unless authorized by the individual who is the subject of the PHI;

(e) Report to the Health Plans any Use or Disclosure of PHI that is inconsistent with the Uses and Disclosures provided for of which it becomes aware;

(f) Make PHI available to a Covered Person in accordance with the Privacy Rule at 45 C.F.R. Section 164.524;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rule at 45 C.F.R. Section 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule at 45 C.F. R. Section 164.528, as amended by HITECH;

(i) Make internal practices, books, and records relating to the Use and Disclosure of PHI received from the Health Plans available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Health Plans' compliance with the Privacy Rule;

(j) If feasible, return or destroy all PHI received from the Health Plans (or a health insurance issuer or HMO with respect to the Health Plans) that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which Disclosure was made (or if return or destruction is not feasible, limit further Uses and Disclosures to those purposes that make the return or destruction infeasible); and

(k) Ensure that the requirements of subsection 8.6 have been met.

8.6 Adequate Separation Between the Health Plans and the Plan Sponsor Must Be Maintained

In accordance with the Privacy Rule, only the following associates or classes of associates and other persons under the control of the Plan Sponsor may be given access to PHI:

(a) Privacy Officer;

(b) Members of the Benefits Appeals Committee;

(c) Company Senior Counsel responsible for HIPAA compliance matters; and

(d) Any other Company and Employer Human Resources, Payroll, Information Technology, and Legal Department associates with Health Plan responsibilities identified in the Company's HIPAA Compliance Manual.

The persons described in this subsection 8.6 may only have access to and Use and Disclose PHI for Payment, Health Care Operations, and other plan administration functions that the Plan Sponsor performs for the Health Plans, unless individual authorization has been given in accordance with the provisions of subsection 8.3. Persons described in this subsection 8.6 who do not comply with the provisions of this Section 8 shall be subject to the Health Plans' policy on sanctions for the improper Use and Disclosure of PHI set forth in the Plan Sponsor's HIPAA privacy policies and procedures manual.

8.7 HIPAA Security Standards

The Plan Sponsor shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Health Plans;

(b) Ensure that the adequate separation required by subsection 8.6 is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a Subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect such information;

(d) Report to the Health Plans any security incident of which Plan Sponsor becomes aware;

(e) Comply with any Participant notice requirements regarding Breaches of the security of Unsecured PHI, as required under the Privacy Rule, within 60 days of the discovery of such Breach; and

(f) Not receive remuneration for the Disclosure of PHI without authorization from the affected individual, except as otherwise allowed under the Privacy Rule.

8.8 Enrollment/Disenrollment Information

Health Plan enrollment and disenrollment activities are performed by each Employer in its role as the employer and not as the Plan Sponsor or Plan Administrator. Enrollment and disenrollment information collected by an Employer in connection with such enrollment and disenrollment activities is not considered PHI and is not subject to this Section 8.

8.9 Definitions

Capitalized terms used in this Section 8 without definition shall have the respective meanings assigned to such terms under the Privacy Rule. For purposes of this Section 8, the following terms shall have the following meanings:

(a) "Business Associate" means, pursuant to 45 C.F.R. Section 160.103 of the Privacy Rule, a natural person or organization that:

(i) On behalf of a Health Plan, creates, receives, maintains, or transmits PHI for a Health Plan function or activity regulated by the Privacy Rule, including claims processing and administration; data analysis, processing, and administration; utilization review; quality assurance; billing; benefit management; repricing; and any other Health Plan function or activity regulated by 45 C.F.R. Subtitle A, Subchapter C; or

(ii) Provides, other than in the capacity of a member of the Health Plan's or Plan Sponsor's Workforce, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for a Health Plan, where the provision of the services involves the Disclosure of PHI from the Health Plan or from another Business Associate of the Health Plan.

A "Business Associate" includes a Subcontractor that creates, receives, maintains, or transmits PHI on behalf of the Business Associate.

(b) "Plan Sponsor" means, for purposes of this Section 8, the Company and any Employer that adopts the Health Plans.

(c) "Privacy Rule" means the Administrative Simplification provisions of HIPAA, the health information privacy and security provisions of HITECH, the

prohibitions on use and disclosure of genetic information for underwriting purposes under the Genetic Information Nondiscrimination Act (GINA), and the regulations and other guidance issued thereunder, including but not limited to the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 through 164.

(d) "Protected Health Information" or "PHI" means "protected health information" as defined 45 C.F.R. Section 160.103 of the Privacy Rule. PHI is subject to this Section 8 only if created or received by or on behalf of a Health Plan.

(e) "Summary Health Information" means information that may be individually identifiable health information and that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Health Plan, provided that the information described at 45 C.F.R. Section 164.514(b)(2)(i) has been deleted, except that information described in 45 C.F.R. Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

SECTION 9.

<u>Amendment and Termination</u>

9.1 Amendment

Any part or all of the Plan, and any Participating Plan, may be amended or modified by the Company at any time. The Company has delegated to the Benefits Committee, and any such other person that the Company or the Benefits Committee may designate, authority to adopt certain amendments. An Employer may amend any policy providing insured benefits with the agreement of the insurance company at any time, except that no amendment shall reduce the amount of benefits payable for claims incurred prior to the date of amendment, determined in accordance with the Participating Plan's terms as in effect prior to that date. Any amendment under this subsection 9.1 shall be adopted in accordance with the terms of subsection 10.1.

9.2 Right to Terminate

No provision in this Plan document, including any provision in the Supplements hereto or any insurance policy, certificate of coverage or membership booklet, or Summary Plan Descriptions incorporated by reference in said Supplements, is intended to commit the Company or any Employer to the provision of permanent or lifetime welfare benefits of any type to any class of Associates or Dependents, or to the Plan's continued maintenance or existence. The Company shall have the sole discretionary authority to terminate part or all of the Plan, including as to some or all classes of Covered Persons and/or any Participating Plan, at any time. An Employer may terminate participation in any Participating Plan as to its Associates at any time with the written consent of the Company, subject to the Employer satisfying any remaining funding obligations with respect to one or more of the Participating Plans. Termination of a Participating Plan (including termination of an insurance contract through which such benefits are provided) is not a termination of the Plan, but rather an amendment to the Plan. In the event of an Employer's dissolution, merger, consolidation, or reorganization, participation in all Participating Plans shall terminate as to such Employer, unless the participation in one or more of the Participating Plans is continued by a successor to such Employer with the Company's consent. Such consent will be given only if the Employer's successor is an Affiliate. Any action taken pursuant to this subsection 9.2 shall be done in accordance with the terms of subsection 10.1.

9.3 Notice of Amendment or Termination

Covered Persons will be notified of any material amendment or termination of a Participating Plan or of the Plan within a reasonable time in accordance with applicable law. Upon the termination of a Participating Plan or the Plan, any benefit rights of all Covered Persons affected thereby shall become payable as the Plan Administrator may direct.

SECTION 10.

General Provisions

10.1 Action by Company/Employer

Any action required or permitted to be taken under the Plan or any Participating Plan by the Company shall be by resolution of the Board of Directors of the Company or by a person or persons duly authorized under the Plan or by the Board of Directors to take such action. By participating as Employers, each Employer designates the Company or its designee as the entity with authority to amend the Plan on its behalf. Any action required or permitted to be taken under the Plan or any Participating Plan by an Employer (other than the Company) shall be by resolution of the Employer's Board of Directors or by a person or persons duly authorized by such Board of Directors to take such action.

10.2 Additional Employers

Any Affiliate that is not an Employer may, with the approval of the Company, adopt the Plan and one or more Participating Plans hereunder by executing and delivering such instruments and taking such other action as may be necessary or desirable to put the Plan and the applicable Participating Plans into effect with respect to such Affiliate. An Employer who adopts the Plan pursuant to this subsection 10.2 and who ceases to be an Affiliate of the Company shall cease to be an Employer under the Plan and its Participating Plans, subject to the payment by the Employer of any outstanding financial obligations to one or more Participating Plans.

10.3 Interests Not Transferable

Except as otherwise permitted (i) by the Plan Administrator or the Claims Administrator solely to assign benefits as payment to health care providers pursuant to the terms of a Participating Plan; (ii) as may be allowed under the terms of a group insurance policy; or (iii) as required by the tax withholding provisions of any applicable law, benefits payable to a Covered Person under a Participating Plan are not in any way subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void.

10.4 Facility of Payment

When a Covered Person is under legal disability or, in the opinion of the Plan Administrator, is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator or the Claims Administrator may make payments or distributions to the Covered Person's legal representative or, until a claim is made by a conservator or other person legally charged with the care of such person, to a relative or friend of such Covered Person for such person's benefit; or the Plan Administrator may direct payments or distributions for the benefit of the Covered Person in any manner which is consistent with the provisions of the Participating Plan and any underlying insurance policy. Any payments made in accordance with the foregoing provisions of this subsection 10.4 shall be a full and complete discharge of any liability for such payment under the Plan and the Participating Plan.

10.5 Employment Rights

Coverage under the Plan or a Participating Plan does not constitute a contract of employment, and participation will not give any Covered Person the right to be employed in the service of the Company, any Employer, or any other Affiliate, nor any right or claim to any benefit under a Participating Plan, unless such right or claim has specifically accrued under the terms of the applicable Participating Plan. The Company may discipline, lay-off or discharge any Associate as freely and with the same effect as if the Plan were not in existence.

10.6 Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; in no event shall a right to benefits under the Plan be or become vested.

10.7 No Guarantee of Tax Consequences

Notwithstanding anything herein to the contrary, the Employer neither insures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to the Plan or any amounts by which a Participant's wages are reduced pursuant to Section 3 will be excludable from the Participant's gross income or wages for federal, state or local tax purposes.

10.8 Litigation by Covered Persons or Other Persons

To the extent permitted by law, if any person brings unsuccessful legal action against the Company; any Employer (or any Associate, officer, or member of the Board of Directors of the Company or an Employer); the Plan Administrator (or its delegate); or the Plan (collectively, the "Plan Parties") with respect to benefits payable under a Participating Plan, or if a legal action arises because of conflicting claims to a Covered Person's benefits, then the cost to the Plan Parties of defending the action may be charged to the sums, if any, that were involved in the action or were payable to or on behalf of the Covered Persons concerned.

10.9 Captions and Headings

The caption or heading of an article, section or provision of the Plan is for convenience and reference only and shall not to be considered in interpreting the terms and conditions of the Plan.

10.10 Gender and Number

Where the context admits, words in the masculine gender shall include the feminine and neuter genders, the singular shall include the plural, and the plural shall include the singular.

10.11 Waiver of Notice

Any notice required under the Plan or a Participating Plan may be waived by the person entitled to such notice.

10.12 Severability

In case any provisions of the Plan or a Participating Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan or Participating Plan, and the Plan or Participating Plan shall be construed and enforced as if such illegal and invalid provisions had never been set forth in the Plan or Participating Plan.

10.13 Controlling Law

Except to the extent superseded by laws of the United States, the laws of the State of Mississippi shall be controlling in all matters relating to a Participating Plan and the Plan. All Actions shall be brought within the State of Mississippi. Notwithstanding the foregoing, benefits under an insured coverage option under a Participating Plan shall be governed by the laws of the state identified in the applicable insurance contract.

10.14 Recovery of Benefits

In the event a Covered Person receives a benefit payment under a Participating Plan which is in excess of the benefit payment which should have been made, the Plan Administrator shall have the right to recover the amount of such excess from such Covered Person. The Plan Administrator may, however, at its option, direct the Claims Administrator to deduct the amount of such excess from any subsequent benefits payable under the Participating Plan to or for the benefit of the Covered Person (or a covered Dependent or other family member) to the extent allowed under applicable law. Overpayments made under an insured Participating Plan shall be recoverable under the terms of the applicable insurance policy.

10.15 Clerical Error

Clerical error by the Employer or Plan Sponsor shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

10.16 Information to be Furnished by Covered Persons; Rescission

Covered Persons under a Participating Plan must furnish the Plan Administrator and the Claims Administrator, as applicable, with such evidence, data, or information as the Plan Administrator or the Claims Administrator considers necessary or desirable for administrative purposes. A fraudulent misstatement or omission of fact made by a Covered Person on an enrollment form or a claim for benefits may be used to cancel coverage and/or to deny claims for benefits under the Participating Plan. Notwithstanding the foregoing, the Plan Administrator may Rescind a Covered Person's coverage under a Participating Medical Plan only if such Covered Person (i) performs an act, practice, or omission that constitutes fraud in an enrollment form or in a claim for benefits, or (ii) makes an intentional misrepresentation of material fact to the Plan Administrator or Claims Administrator regarding any information material to the Covered Person's eligibility for benefits. The Plan Administrator will provide at least 30 days advance written notice to each Covered Person who would be affected before Participating Medical Plan coverage is Rescinded under this subsection 10.16. This provision is intended to comply with the limitations on Rescission under PPACA. Any Rescission or cancellation of coverage shall be

treated as an adverse benefit determination for purposes of applying the Plan's claims procedures under Section 7 of the Plan.

10.17 Uniform Rules

The Plan Administrator and each Claims Administrator shall administer the Plan and Participating Plans on a reasonable and nondiscriminatory basis and shall apply uniform rules to all Covered Persons similarly situated.

10.18 Coordination with Insurance Contract or Governing Document

To the extent an insurance contract (including the certificate of insurance) policy, plan document, or other document governing a Participating Plan contains terms or conditions that conflict or are inconsistent with this document, except as specifically stated herein, the terms of the insurance contract (including the certificate of insurance or policy) plan document, 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, or other governing document is not necessarily a conflict or inconsistency.

10.19 Third-Party Reimbursement and Subrogation

The Plan shall have the rights of subrogation and reimbursement if a third party is responsible for a sickness or injury causing a Covered Person to incur expenses covered under the Plan as described in the documents governing the applicable Participating Plan. Notwithstanding the foregoing, to the extent the applicable Participating Plan does not address the right to subrogation and reimbursement, the following shall apply:

(a) The Plan and the Company shall have the following rights:

  (i) To pursue a Covered Person's legal claims or rights against another party, or any insurance company, when plan benefits are paid or provided to a Covered Person and the condition, illness or injury for which the benefits were paid either were caused by the other party or are covered by other insurance.

  (ii) To pursue a Covered Person's legal rights against any other party or under any insurance coverage with respect to any injury, illness or condition for which this Plan has provided benefits.

  (iii) To be reimbursed from any damage award or insurance proceeds by the Covered Person and his legal representatives, estate and heirs for the full value of any benefits provided in relation to an injury, illness or other condition which is caused by the other party or is covered by other insurance.

(b) Subrogation applies whenever another person or insurance carrier is, or may be considered, liable for damages or pays insurance proceeds with respect to a

Covered Person's injury, illness or condition, and this Plan has provided or paid benefits (or is legally required to pay) with respect to such injury, illness or condition. By accepting coverage or benefits under the Plan, the Covered Person:

(i) Agrees that, to the extent of the full value of any such benefits paid or provided by the Plan, the Plan and the Company are subrogated to all rights of the Covered Person against any third party or insurance company.

(ii) Agrees that the Plan and the Company may assert their subrogation rights independent of the Covered Person.

(iii) Agrees and is obligated to cooperate with the Plan and its agents to pursue and protect the Plan's and the Company's subrogation rights. Among other things, the Covered Person shall provide the Plan with any relevant information requested and shall sign and deliver any documents requested by the Plan.

(iv) Agrees that the Plan's and the Company's rights of subrogation shall be considered as a first priority claim against any other person or entity, to be paid before any claims are paid, including claims by the Covered Person for general damages.

(v) Agrees that the Plan will not pay for, offset any recovery or in any way be responsible for any fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. State law doctrines and rules such as the make whole, common fund or any other state law or rule, will not prevent the Plan from full and complete recovery (including reasonable collection costs) of its benefit payments from any and all proceeds of the recovery.

(vi) Agrees that he or she will not release any party from liability without first obtaining the written consent of the Plan.

(vii) Agrees that, if a Covered Person enters into litigation or settlement negotiations regarding the obligations of or claims against other parties, the Covered Person will notify the Plan and will not prejudice in any way the Plan's and the Company's subrogation rights.

(viii) Agrees that the Plan and/or the Company or their agents may take any lawful action to pursue and protect the Plan's and the Company's subrogation rights.

(ix) Agrees that the costs of legal representation of the Plan and the Company in matters related to subrogation shall be borne solely by the Plan and the Company, and that the costs of the Covered Person's legal representation shall be borne solely by the Covered Person, unless there is a written agreement to the contrary.

(c) Reimbursement applies whenever a Covered Person recovers damages or insurance proceeds by settlement, verdict or otherwise for or in relation to an injury, illness or other condition and the Plan and/or the Company has paid or provided benefits in relation to such injury, illness or other condition. By accepting coverage or benefits under the Plan, the Covered Person:

(i) Agrees on behalf of himself and his legal representatives, estate and heirs, that the Plan and/or the Company shall be reimbursed promptly from any settlement, verdict, insurance proceeds or other recovery, the full value of the benefits paid or provided by the Plan.

(ii) Agrees that the Plan or the Company, at their option, may collect amounts from the proceeds of any settlement, verdict, judgment, insurance coverage or other recovery (regardless of whether there is an entry of judgment against and/or a finding of fault) by the Covered Person or his legal representative, regardless of whether the Covered Person has been fully compensated. Rights under this provision cannot be defeated regardless of how the claim for recovery or proceeds is classified or whether they are allocated, in whole or in part, to non-medical damages. Also, the Plan shall be relived from making benefit payments for future medical expenses to the extent the judgment or settlement provide for such damages.

(iii) Grants the Plan and the Company a first priority lien, to the extent of the Plan's and the Company's claim for reimbursement, against the proceeds of any such settlement, verdict, insurance proceeds or other recoveries or amounts received by or on behalf of the Covered Person or his legal representatives, estate or heirs.

(iv) The Plan will not pay for, offset any recovery or in any way be responsible for any fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. State law doctrines and rules such as the make whole, common fund or any other state law or rule, will not prevent the Plan from full and complete recovery (including reasonable collection costs) of its benefit payments from any and all proceeds of the recovery.

(v) Assigns to the Plan and the Company any benefits the Covered Person may have or be entitled to under any automobile policy or any other insurance coverage, to the extent of the Plan's and the Company's claim for reimbursement.

(vi) Agrees to sign and delivery, at the request of the Plan, any documents that are needed to protect such lien or effect such assignment of benefits.

(vii) Agrees to cooperate with the Plan and its agents, to provide any requested information, and to take such actions as the Plan or its agents request, all to protect the right of reimbursement of the Plan and the Company and to

assist the Plan and/or the Company in making a full recovery of the value of the benefits paid or provided.

(viii) Agrees to take no action that would prejudice the Plan's and the Company's rights of reimbursement.

(ix) Agrees that the Plan and the Company shall be responsible only for those legal fees and expenses to which they agree in writing.

(x) Agrees to hold any proceeds of any settlement, verdict, judgment, insurance coverage or other recovery in trust for the benefit of the Plan and the Company and that the Plan and the Company shall be entitled to recover from the Covered Person reasonable attorney fees incurred in collecting such proceeds from the Covered Person.

10.20 Physical Examination and Autopsy

The Plan Administrator, the Claims Administrator, or any insurance company, at its own expense, shall have the right and opportunity to have the Covered Person whose injury or sickness is the basis of claim examined by a physician designated by it, when and as often as it may reasonably require during the pendency of a claim under any Participating Plan, and to make an autopsy in case of death, provided it is not otherwise prohibited by law.

10.21 Administrator Decisions Final

The Plan Administrator or the Claims Administrator, to the extent delegated by the Plan Administrator, has the discretionary authority to determine eligibility for benefits under the Plan and each Participating Plan, subject to the terms of the Participating Plan and any underlying insurance contract. Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator, as applicable, determines in its discretion that the Covered Person (or other claimant) is entitled to them. Subject to applicable law, any interpretation of the provisions of the Plan or a Participating Plan and any decisions on any matter within the discretion of the Plan Administrator or Claims Administrator made in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known to the parties, and the Plan Administrator or appropriate Claims Administrator (as applicable) shall make such adjustment on account thereof as it, in its discretion, considers equitable and practicable. None of the Company, any Employer, the Plan Administrator, or any Claims Administrator or insurance company shall be liable in any manner for any determination of fact made in good faith.

10.22 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Claims Administrator for coverage under a self-insured Participating Plan is not cashed within 6 months, the check will be voided and the funds will be returned to the respective Participating Plan and applied to the payment of current benefits and administrative fees under that Participating Plan. In the event the Covered Person or other Participating Plan beneficiary, as defined under ERISA, subsequently requests payment with respect to the voided check within the time period established by the applicable Claims Administrator's procedures on uncashed checks, but in no event to exceed one (1) year after the

date of issue, the Plan Administrator or the Claims Administrator for the respective Participating Plan shall make such payment under the terms and provisions of the Participating Plan as in effect when the claim was originally processed, and no interest shall be payable on such amount. If a check for a benefit payable under a Participating Plan is not presented for payment within 6-month period described above, the Participating Plan will have no liability for the benefit payment, and the amount of the check will be deemed a forfeiture. Unclaimed self-insured benefit funds may be applied only to the delivery of benefits (including administrative fees) under the applicable Participating Plan pursuant to ERISA, and no funds shall escheat to any state.

10.23 Cost of Administration

The costs and expenses incurred by the Company or the Plan Administrator in administering the Plan shall be paid by the Employers to the extent not paid by the Participating Plans.

10.24 Disclaimer

None of the services available under the Plan is warranted by the Company; and participating individuals shall look solely to the service provider with respect thereto. The Company assumes no obligations other than those set forth in the Plan and shall not be liable for acts of omission or commission on the part of any Insurer, HMO, service provider, or other party.

IN WITNESS WHEREOF, Hancock Holding Company has caused this Plan to be executed this the _____ day of December, 2016, to be effective as of the Effective Date.

HANCOCK HOLDING COMPANY

By: ____________________________

Name: ____________________________
Title: ____________________________

SUPPLEMENT A1
Participating Medical Plans

A-1. Purpose. The purpose of this Supplement A1 is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the medical plans specified in paragraph A-9 (“Participating Medical Plans”) made available to Eligible Associates, effective December 31, 2015. Unless otherwise specified in this Supplement A1, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

A-2. Eligibility. For purposes of the Participating Medical Plans, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 and Supplement A2 and any eligibility requirements specified in the applicable Participating Medical Plan documents listed below in paragraph A-9. A Dependent shall mean an individual who meets the requirements of subsection 2.13 of the Plan and any eligibility requirements specified in the applicable Participating Medical Plan documents.

Notwithstanding the foregoing, the Employer may from time to time extend coverage under the Participating Medical Plans to certain former Associates and their Dependents under special circumstances. The eligibility requirements and terms and conditions of such extensions of coverage with respect to such individuals will be determined in accordance with the provisions of individual or group agreements, which terms shall be incorporated herein by reference and described on Supplement A3, without the necessity of an amendment to the Plan.

A-3. Enrollment. Newly hired or rehired Eligible Associates shall enroll themselves and their eligible Dependents in accordance with the provisions of subsection 3.2, subject to enrollment instructions specified by the Plan Administrator. Pursuant to subsection 3.2 of the Plan document, Eligible Associates who are Ongoing Employees (as defined in Supplement A2) shall enroll or reenroll during each Annual Enrollment. Participating Eligible Associates who fail to enroll during Annual Enrollment will be deemed to waive coverage pursuant to subsection 3.5 unless the Plan Administrator adopts rules for automatic enrollment in the Participating Medical Plan. An Eligible Associate may enroll his or her Dependents in a Participating Medical Plan only if the Eligible Associate also is enrolled in the same Participating Medical Plan coverage option. COBRA beneficiaries shall enroll pursuant to the administrative rules established by the Plan Administrator and shall pay the COBRA premium for continued coverage.

Except as otherwise provided in Supplement A2, coverage for a newly hired or rehired Eligible Associate shall begin on the later of the date the Associate becomes an Eligible Associate or completes any applicable Waiting Period, provided the Eligible Associate timely enrolls. For all other Associates, coverage will be effective as provided under Supplement A2.

A-4. Special Enrollment Period for Loss of Other Creditable Coverage. If an Eligible Associate originally declined coverage under a Participating Medical Plan for him- or herself or for a Dependent due to other group health plan or health insurance coverage and such other health coverage is subsequently terminated due to (i) loss of eligibility for such coverage (loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of the coverage for causes such as making a fraudulent claim or for misrepresentation), or (ii) the termination of any employer contributions for such coverage, then the Eligible Associate may

enroll him or herself and/or his or her Dependents in a Participating Medical Plan, provided that the Eligible Associate properly enrolls within 31 days of the loss of other coverage or termination of company contributions. If the Eligible Associate initially waived coverage for the Eligible Associate and/or his or her Dependent under the Participating Medical Plans during Initial Enrollment because COBRA continuation coverage was then in effect for the Eligible Associate and/or his or her Dependents, the Eligible Associate and/or his or her Dependents must exhaust such COBRA coverage before becoming eligible to elect special enrollment under a Participating Medical Plan. Coverage will be effective as of the first day of the first month beginning after the date the Plan Administrator receives the request for special enrollment or an earlier date specified in the applicable Participating Medical Plan documents under paragraph A-9, provided, however, that except as permitted by law and the terms of the Cafeteria Plan, payment for any retroactive coverage may not be made with pre-tax contributions by the Eligible Employer. If a properly completed enrollment form is not received within 31 days of the special enrollment event, then the Eligible Associate and/or his or her Dependents are considered late enrollees and must wait until the next Annual Enrollment period in order to apply for coverage. In this case, coverage will not become effective until the first day of the Plan Year following such Annual Enrollment period. Notwithstanding anything to the contrary herein, if a special enrollment opportunity applies under this paragraph A-4 and the Eligible Associate is not otherwise enrolled, no Dependents may be enrolled unless the Eligible Associate is also enrolled.

A-5. Special Enrollment Period for Newly Acquired Dependents. If an Eligible Associate acquires a new Dependent through birth, adoption, placement for adoption, or marriage and submits an enrollment form to a Participating Medical Plan for this Dependent within 31 days (or such other period as may be specified in the applicable Participating Medical Plan) of birth, adoption, placement for adoption, or marriage, the new Dependent may enroll in the Participating Medical Plan in accordance with procedures established by the Plan Administrator. For a new Dependent through birth, adoption, or placement for adoption, coverage will become effective on the date of the birth, adoption, or placement for adoption. For a new Dependent acquired through marriage, coverage will be effective no later than the first day of the first month beginning after the Plan Administrator receives the request for special enrollment or such earlier date as may be specified in the applicable Participating Medical Plan documents under paragraph A-9. Payment for retroactive coverage may not be made with pre-tax contributions by the Eligible Associate unless permitted by applicable law and the terms of the Cafeteria Plan. The Eligible Associate and his or her eligible Spouse may also enroll during this special enrollment period for newly acquired Dependents. If the Eligible Associate does not enroll during the 31-day period commencing on the date of the birth, adoption, placement for adoption, or marriage, the new Dependent (and the Eligible Associate and/or his or her eligible Spouse, if applicable) are considered late enrollees and must wait until the next Annual Enrollment period in order to apply for coverage. In this case, coverage will not become effective until the first day of the Plan Year following such Annual Enrollment period. Notwithstanding anything to the contrary herein, if a special enrollment opportunity applies under this paragraph A-5 and the Eligible Associate is not otherwise enrolled, no Dependents may be enrolled unless the Eligible Associate is also enrolled.

A-6. Special Enrollment Period Due to Change in SCHIP or Medicaid Coverage. If an Eligible Associate or Dependent loses coverage under a State Children's Health Insurance Program ("SCHIP") or Medicaid, or becomes eligible for premium assistance from a State

towards the cost of Participating Medical Plan coverage under Medicaid or SCHIP, then the Eligible Associate and his or her Dependents may enroll in the Participating Medical Plan, provided that the Plan Administrator is notified within 60 days of the loss of coverage under SCHIP or Medicaid or the eligibility for State premium assistance in accordance with procedures established by the Plan Administrator. The effective date of coverage will be the first day of the month after the Plan Administrator receives the request for special enrollment or an earlier date specified in the applicable Participating Medical Plan documents under paragraph A-9, provided that payment for such retroactive coverage may not be made with pre-tax contributions by the Eligible Associate unless permitted by applicable law and the terms of the Cafeteria Plan. If the Plan Administrator is not properly notified of the loss of other coverage within 60 days, then the Eligible Associate and/or his or her Dependents are considered late enrollees and must wait until the next Annual Enrollment period in order to enroll in coverage. In this case, coverage will not become effective until the first day of the Plan Year following such Annual Enrollment period. Notwithstanding anything to the contrary herein, if a special enrollment opportunity applies under this paragraph A-6 and the Eligible Associate is not otherwise enrolled, no Dependents may be enrolled unless the Eligible Associate is also enrolled.

A-7. Late Enrollment. Eligible Associates and their Dependents who fail to enroll in a Participating Medical Plan during Initial Enrollment, or within 31 days of the occurrence of an event entitling them to special enrollment under paragraphs A-4 or A-5, or within 60 days of the occurrence of an event entitling them to special enrollment under paragraph A-6, must wait until the next Annual Enrollment period to enroll in the Participating Medical Plan, unless the Eligible Associate experiences an event entitling the Associate to an election change under Section 3 of the Plan.

A-8. PPACA Compliance. None of the Participating Medical Plan coverage options are intended to constitute a "grandfathered health plan" under PPACA. The Participating Medical Plan coverage options shall comply with all applicable requirements of PPACA as applied to "non-grandfathered" health plans.

A-9. Participating Medical Plan Documents Incorporated By Reference. The terms and provisions of the following Participating Medical Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph A-10, constitute the controlling terms and provisions of the applicable Participating Medical Plan:

(a) The most recent coverage booklet and Summary Plan Description for the Employee Health Protection Plan for the Employees of Whitney Bank (A Subsidiary of Hancock Holding Company), Comprehensive Medical Benefit Plan administered by Blue Cross Blue Shield of Louisiana, Plan Form No. 40HR1667 R01/15, Plan No. 78B20ERC; and

(b) The most recent Employee Booklet and Summary Plan Description for the Employee Health Protection Plan for Hancock Holding Company and Its Subsidiaries administered by Blue Cross Blue Shield of Mississippi, Plan Type C524.

Major medical coverage under the Participating Medical Plans is self-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend and/or terminate any self-insured Participating Medical Plan in accordance with the terms of the Plan and/or to change the cost of any Participating Medical Plan coverage at any time. The Plan Administrator may add or delete Participating Medical Plans or coverage options without formal amendment of this paragraph A-9 to reflect changes in coverage options offered under the Plan. If a new major medical coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

A-10. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Medical Plan in accordance with the Participating Medical Plan documentation incorporated by reference under this Supplement A1. In the event there is a conflict in the language or interpretation of the Plan document, this Supplement A1, and the Participating Medical Plan documentation incorporated by reference under this Supplement A1, the terms of the Participating Medical Plan documents incorporated herein by reference shall control first, this Supplement A1 next, and the Plan document last. With respect to any fully-insured Participating Medical Plan (if applicable), the insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage or membership booklet. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement A1, the Summary Plan Description or other governing document for a self-insured benefit option, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the certificate of coverage, policy or membership booklet, the Summary Plan Description for an insured Participating Medical Plan option.

SUPPLEMENT A2
Eligibility Under Participating Medical Plans

1.1 Purpose. For purposes of compliance with PPACA, the Employer has chosen to determine full-time employee status under the "look-back measurement method." The purpose of this Supplement A2 is to describe how the look-back measurement method applies for purposes of determining eligibility under the Participating Medical Plans made available to Employee. Unless specified otherwise in this Supplement A2, the capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

Any determination as to whether an Employee is a Full-Time Employee (defined below) shall be made by the Plan Administrator or its designee in a manner consistent with Code Section 4980H and regulations thereunder. Notwithstanding the foregoing, the Employer may treat an Employee as a Full-Time Employee for Participating Medical Plan purposes even if not required by PPACA and the regulations thereunder.

1.2 Employee Groups.

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

(b) Part-Time Employee – means Employee who works less than 30 hours per week.

(c) Ongoing Employee – means current Employees and certain rehires who have been employed for at least one complete Standard Measurement Period (as defined in subparagraph 1.4(a)) and who are not a Variable-Hour Employee or Seasonal Employee.

(d) Seasonal Employee – means 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 – means 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 subparagraph 1.4(b)).

For purposes of this Supplement A2, the term "hour" means each hour of service performed for the Company and any Affiliate within the meaning of 26 C.F.R. Section 54.4980H-1(a)(24) and 26 C.F.R. Section 54.4980H-3(b). The term "Employee" as used in this Supplement A2 shall have the same meaning as Associate as defined in Section 2 of the Plan document.

1.3 Eligibility to Enroll In Coverage.

(a) Immediately Eligible – An Employee who is hired as a Full-Time Employee will be immediately eligible to enroll in coverage. A Variable-Hour Employee or Seasonal Employee who at any point within the Initial Measurement Period is

expected to work 30 or more hours per week due to a change in assignment or status will be eligible for coverage as of the date of the change in work status. An Employee who is rehired as a Full-Time Employee after a Break in Service (defined in paragraph 1.7) greater than 13 weeks (or, if applicable, the length of the Employee's pre-break employment) will also be immediately eligible for coverage upon rehire.

(b) Not Immediately Eligible – Employees who are classified as Part-Time Employees, Variable-Hour Employees or Seasonal Employees upon hire or rehire, as applicable, will not be immediately eligible for coverage.

1.4 Measurement and Stability 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 an Ongoing Employee averages 30 or more hours per week over a Standard Measurement Period, coverage will be offered for the 12-month period immediately following the administrative period (or January 1 through December 31), provided the Employee remains employed during such period. This period is referred to as the "Standard Stability Period". If, however, an Ongoing Employee does not average 30 or more hours during the Standard Measurement Period, coverage will not be offered during the applicable Standard Stability Period, unless the Ongoing Employee experiences a change in employment status as described in paragraph 1.6 below.

(b) Newly Hired or Rehired (after a Break in Service) Variable-Hour Employee or Seasonal Employee – A 12-month "Initial Measurement Period" applies effective as of the first payroll period following the Employee's date of hire or rehire. The Initial Measurement Period will be immediately followed by an administrative period that runs through the last day of the first calendar month that begins after the end of the Initial Measurement Period. If a new or rehired Variable-Hour Employee or Seasonal Employee averages 30 or more hours per week over their Initial Measurement Period, the Employee will be offered coverage for the 12-month period immediately following the administrative period, provided the Employee remains employed during this period. This period is referred to as the "Initial Stability Period". If, however, the new or rehired Variable-Hour Employee or Seasonal Employee does not average 30 or more hours during their Initial Measurement Period, he or she will not be eligible for coverage during their Initial Stability Period, unless they experience a change in employment status as described in paragraph 1.6 below.

(c) Stability Period. Employees who work 30 hours or more per week during the preceding Initial Measurement Period or Standard Measurement Period, as applicable, will be treated as a Full-Time Employee during the subsequent Initial Stability Period or Standard Stability Period, as applicable. However, an

Employee who does not average 30 hours or more per week during the preceding Initial Measurement Period or Standard Measurement Period, as applicable, will be treated as a Part-Time Employee for the subsequent Initial Stability Period or Standard Stability Period, as applicable, unless and until the Employee experiences a change in employment status as described in paragraph 1.6 below.

The Initial Measurement Period and Initial Stability Period run concurrently with the Standard Measurement Period and Standard Stability Period described in subsection 1.4(a) above. Once a new or rehired Variable-Hour Employee or Seasonal Employee has been employed for a full Standard Measurement Period, the Employee will be treated as an Ongoing Employee as described in subsection 1.4(a) above.

1.5 Effective Date of Coverage.

(a) Immediately Eligible Employees. For new or rehired Full-Time Employees, coverage will be effective on the 1st of the month coincident with or following the end of any applicable Waiting Period.

(b) Not Immediately Eligible. Except as provided in paragraph 1.6 below, coverage for Employees who are not immediately eligible for coverage upon date of hire or rehire, as applicable, will generally be effective as of the 1st day 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 the Employee averaged 30 or more hours per week.

(c) Ongoing Employees. Coverage for an Ongoing Employee who is a Part-Time Employee and who works 30 or more hours a week during the preceding Standard Measurement Period will be effective as of the first day of the applicable Standard Stability Period, or January 1st of the applicable Plan Year.

1.6 Change in Employment Status.

(a) General rule. An Employee who works 30 or more hours per week during an Initial Measurement Period or Standard Measurement Period, as applicable, will be treated as a Full-Time Employee in the following Initial Stability Period or Standard Stability Period, as applicable, and therefore eligible for benefits without regard to how many hours the Employee actually works during such stability period.

(b) Ongoing Employees:

(i) Change From Part-Time to Full-Time Status. Eligible Employees who are moved by the Company from part-time to full-time status will become eligible to enroll and coverage will be effective as of the effective date of the change in employment status, unless the Employee has 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 the Employee completes the Waiting Period.

(ii) Change From Full-Time to Part-Time Status. Full-Time Employees who are expected to work fewer than 30 hours per week due to a change in assignment or are transferred to a part-time position, will continue to be treated as a Full-Time Employee and therefore eligible for coverage through the end of the applicable Standard Stability Period. The Employee will be treated as a Part-Time Employee for any subsequent Standard Stability Period, unless the Employee averages 30 or more hours per week during the applicable Standard Measurement Period or experiences a subsequent change in employment status as described under subparagraph (b)(i) above.

(c) New Full-Time Employees. Newly hired or rehired Full-Time Employees who 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 their first full Standard Measurement Period will continue to be treated as Full-Time Employees through the end of their first full Standard Measurement Period. The Employee will thereafter be treated as an Ongoing Part-Time Employee for their first (and any subsequent) Standard Stability Period, unless the Employee averaged 30 or more hours per week during the applicable Standard Measurement Period or experiences a subsequent change in employment status as described in subparagraph (b)(i) above.

(d) Variable-Hour and Seasonal Employees. Variable-Hour Employee or Seasonal Employees who change to a full-time position will be eligible for coverage as of the effective date of the transfer, unless the Employee has 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 the Employee completes the Waiting Period.

1.7 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 of an Employee’s termination of employment with the Company and its Affiliates and ending on the Employee’s subsequent rehire date, during which the Employee was not credited with any Hours. Notwithstanding the foregoing, the Company may apply the “rule of parity” for purpose of determining whether a Break in Service has occurred in accordance with Treasury Regulations Section 54.4980H-3(d)(6)(iv).

(b) Effective Date of Coverage. Coverage for a former Full-Time Employee who is rehired before incurring a Break in Service shall begin on the first day of the month following the Employee’s 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 1.4(b) and 1.5 above.

Notwithstanding anything in the Plan 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 Treasury Regulations Section 54.4980H-3(d)(6).

SUPPLEMENT A3
Eligibility Pursuant to Individual or Group Arrangements or Agreements

1. Change In Control Agreements related to the acquisition of Whitney National Bank.

2. Surviving Spouses of former employees of Whitney National Bank specifically identified by the last four digits of their Social Security Number below:

    a. 2339

    b. 5950

    c. 9295

    d. 0878

    e. 3906

SUPPLEMENT B
Participating Dental Plans

B-1. Purpose. The purpose of this Supplement B is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the dental plans specified in paragraph B-4 ("Participating Dental Plans") made available to Eligible Associates. Unless otherwise specified in this Supplement B, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

B-2. Eligibility and Enrollment. For purposes of the Participating Dental Plans, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Dental Plan documents listed below in paragraph B-4. A Dependent shall mean an individual who meets the requirements of subsection 2.13 of the Plan and any eligibility requirements specified in the applicable Participating Dental Plan documents. Newly hired or rehired Eligible Associates shall enroll themselves and their eligible Dependents in accordance with the provisions of subsection 3.2, subject to enrollment instructions specified by the Plan Administrator. All other Eligible Associates shall enroll or reenroll during each Annual Enrollment pursuant to subsection 3.2 of the Plan document. Participating Eligible Associates who fail to enroll during Annual Enrollment will be deemed to waive coverage pursuant to subsection 3.5 unless the Plan Administrator adopts rules for automatic enrollment in the Participating Dental Plan. An Eligible Associate may enroll his or her Dependents in a Participating Dental Plan only if the Eligible Associate also is enrolled in the same Participating Dental Plan coverage option. COBRA beneficiaries shall enroll pursuant to the administrative rules established by the Plan Administrator and shall pay the COBRA premium for continued coverage.

B-3. Late Enrollment. Eligible Associates and their Dependents who fail to enroll in a Participating Dental Plan during Initial Enrollment must wait until the next Annual Enrollment period to enroll in a Participating Dental Plan, unless the Eligible Associate experiences an event entitling the Associate to an election change under Section 3 of the Plan.

B-4. Participating Dental Plan Documents Incorporated by Reference. The terms and provisions for the following Participating Dental Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph B-5, constitute the controlling terms and provisions of the applicable Participating Dental Plan:

(a) The most recent Certificate of Insurance and Summary Plan Description for dental coverage offered to Eligible Associates under Metropolitan Life Insurance Company, Group Policy No. 104250-1-G.

Dental coverage under the Participating Dental Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend or terminate any dental insurance contract in conjunction with the applicable insurance company for any insured dental option, to amend or terminate self-insured Participating Dental Plan coverage option, and/or to change the cost of any Participating Dental Plan coverage at any time, subject to any applicable agreement with the insurance provider. The Plan Administrator may add or delete Participating Dental Plans or coverage options without formal amendment of this paragraph B-4 to reflect changes in

coverage options offered under the Plan. If a new dental coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

B-5. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Dental Plan in accordance with the Participating Dental Plan documentation incorporated by reference under this Supplement B. In the event there is a conflict in the interpretation of the Plan document, this Supplement B, and the Participating Dental Plan documentation incorporated by reference under this Supplement B, the terms of the Participating Dental Plan documents incorporated herein by reference shall control first, this Supplement B next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage or membership booklet. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement B, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the certificate of coverage, policy or membership booklet, the Summary Plan Description for an insured Participating Dental Plan option.

SUPPLEMENT C
Participating Vision Plans

C-1. Purpose. The purpose of this Supplement C is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the vision plans specified in paragraph C-4 ("Participating Vision Plans") made available to Eligible Associates. Unless otherwise specified in this Supplement C, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

C-2. Eligibility and Enrollment. For purposes of the Participating Vision Plans, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Vision Plan documents listed below in paragraph C-4. A Dependent shall mean an individual who meets the requirements of subsection 2.13 of the Plan and any eligibility requirements specified in the applicable Participating Vision Plan documents. Newly hired or rehired Eligible Associates shall enroll themselves and their eligible Dependents in accordance with the provisions of subsection 3.2, subject to enrollment instructions specified by the Plan Administrator. All other Eligible Associates shall enroll or reenroll during each Annual Enrollment pursuant to subsection 3.2 of the Plan document. Participating Eligible Associates who fail to enroll during Annual Enrollment will be deemed to waive coverage pursuant to subsection 3.5 unless the Plan Administrator adopts rules for automatic enrollment in the Participating Vision Plan. An Eligible Associate may enroll his or her Dependents in a Participating Vision Plan only if the Eligible Associate also is enrolled in the same Participating Vision Plan coverage option. COBRA beneficiaries shall enroll pursuant to the administrative rules established by the Plan Administrator and shall pay the COBRA premium for continued coverage.

C-3. Late Enrollment. Eligible Associates and their Dependents who fail to enroll in a Participating Vision Plan during Initial Enrollment must wait until the next Annual Enrollment period to enroll in a Participating Vision Plan, unless the Eligible Associate experiences an event entitling the Associate to an election change under Section 3.

C-4. Participating Vision Plan Documents Incorporated by Reference. The terms and provisions for the following Participating Vision Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph C-5, constitute the controlling terms and provisions of the applicable Participating Vision Plan:

(a) The most recent Summary Plan Description and group insurance contract for vision coverage offered to Eligible Associates under Vision Service Plan, Policy No. 1296843.

Coverage under the Participating Vision Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend or terminate any vision insurance contract in conjunction with the applicable insurance company for any insured vision option, to amend or terminate any self-insured Participating Vision Plan coverage option, and/or to change the cost of any Participating Vision Plan coverage at any time, subject to any applicable agreement with the insurance provider. The Plan Administrator may add or delete Participating Vision Plans or coverage options without formal amendment of this paragraph C-4 to reflect

changes in coverage options offered under the Plan. If a new vision coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

C-5. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Vision Plan in accordance with the Participating Vision Plan documentation incorporated by reference under this Supplement C. In the event there is a conflict in the interpretation of the Plan document, this Supplement C, and the Participating Vision Plan documentation incorporated by reference under this Supplement C, the terms of the Participating Vision Plan documents incorporated herein by reference shall control first, this Supplement C next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage or membership booklet. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement C, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the certificate of coverage, policy or membership booklet, the Summary Plan Description for an insured Participating Vision Plan option.

SUPPLEMENT D
Participating Life and AD&D Plans

D-1. Purpose. The purpose of this Supplement D is to incorporate by reference, effective January 1, 2016, the terms and provisions of the documents governing eligibility and benefits under the life and AD&D plans specified in paragraph D-4 ("Participating Life and AD&D Plans") made available to Eligible Associates. Unless otherwise specified in this Supplement D, the capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

D-2. Eligibility and Enrollment. For purposes of the Participating Life and AD&D Plans, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Life and AD&D Plan documents listed below in paragraph D-4. Each Eligible Associate shall automatically be enrolled in basic life and AD&D coverage. Eligible Associates shall also be eligible to enroll or reenroll in supplemental life and AD&D coverage, Spouse life insurance coverage, and Dependent Child life insurance coverage, subject to enrollment instructions and conditions specified by the Plan Administrator. Newly hired or rehired Eligible Associates shall enroll themselves and their eligible Dependents in supplemental life and AD&D coverage in accordance with the provisions of subsection 3.2, subject to enrollment instructions specified by the Plan Administrator. All other Eligible Associates shall enroll or reenroll in supplemental life and AD&D coverage during each Annual Enrollment pursuant to subsection 3.2 of the Plan document. Newly hired or rehired Eligible Associates who fail to enroll in supplemental life and AD&D coverage, Spouse life insurance coverage, and/or Dependent Child life insurance coverage during the Initial or Annual Enrollment period, may be required to provide evidence of insurability prior to obtaining supplemental life and AD&D coverage, Spouse life insurance coverage, and/or Dependent Child life insurance coverage under the Participating Life and AD&D Plan in accordance with rules and procedures established by the insurance company.

D-3. Late Enrollment. Eligible Associates who fail to enroll in Associate supplemental life and AD&D coverage under the Participating Life and AD&D Plan during Initial Enrollment must wait until the next Annual Enrollment period to enroll in Associate supplemental coverage, unless the Eligible Associate experiences an event entitling the Associate to an election change under Section 3. Eligible Associates who fail to enroll their Dependents in Spouse life insurance coverage and/or Dependent Child life insurance coverage under the Participating Life and AD&D Plan during Initial Enrollment shall be permitted to enroll in Spouse or Dependent Child life insurance coverage during Annual Enrollment or during the Plan year in accordance with the terms of the applicable Participating Life and AD&D Plan documents listed below in paragraph D-4.

D-4. Participating Life and AD&D Plan Documents Incorporated by Reference. The terms and provisions of the following Participating Life and AD&D Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph D-5, constitute the controlling terms and provisions of the applicable Participating Life and AD&D Plan:

(a) The most recent Summary Plan Description and group insurance contract for the basic and supplemental life insurance coverage offered to Eligible Associates under Standard Insurance Company, Policy No. 643851-F; and

(b) The most recent Summary Plan Description and group insurance contract for AD&D insurance coverage offered to Eligible Associates under Standard Insurance Company, Policy No. 643851-I.

Coverage under the Participating Life and AD&D Plans is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend the policies in conjunction with the issuing insurance company, to amend or terminate any insurance contract and/or Participating Life and AD&D Plan coverage option, and/or to change the cost of any Participating Life and AD&D Plan coverage at any time. The Plan Administrator may add or delete Participating Life and AD&D Plans or coverage options without formal amendment of this paragraph D-4 to reflect changes in coverage options offered under the Plan. If a new life and/or AD&D coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

D-5. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Life and AD&D Plan in accordance with the Participating Life and AD&D Plan documentation incorporated by reference under this Supplement D. In the event there is a conflict in the interpretation of the Plan document, this Supplement D, and the Participating Life and AD&D Plan documentation incorporated by reference under this Supplement D, the terms of the Participating Life and AD&D Plan documents incorporated herein by reference shall control first, this Supplement D next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement D, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the policy or certificate of coverage, the Summary Plan Description for the Participating Life and AD&D Plan option.

SUPPLEMENT E
Participating Short Term Disability Plan

E-1. Purpose. The purpose of this Supplement E is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the short term disability plan specified in paragraph E-3 ("Participating Short Term Disability Plan") made available to Eligible Associates. Unless otherwise specified in this Supplement E, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

E-2. Eligibility and Enrollment. For purposes of the Participating Short Term Disability Plan, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Short Term Disability Plan documents listed below in paragraph E-3. Each Eligible Associate shall be automatically enrolled in short term disability coverage pursuant to subsection 3.2 of the Plan document and subject to enrollment instructions specified by the Plan Administrator.

E-3. Participating Short Term Disability Plan Documents Incorporated by Reference. The terms and provisions of the following Participating Long Term Disability Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph E-4, constitute the controlling terms and provisions of the applicable Participating Short Term Disability Plan.

(a) The most recent certificate and Summary Plan Description for group short term disability insurance coverage offered to Eligible Associates under Standard Insurance Company, Policy No. 643851-G.

Coverage under the Participating Short Term Disability Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend the policies in conjunction with the issuing insurance company, to amend or terminate any insurance contract and/or Participating Short Term Disability Plan coverage, and/or to change the cost of Participating Short Term Disability Plan coverage at any time. The Plan Administrator may add or delete Participating Short Term Disability Plans or coverage options under the Plan without formal amendment of this paragraph E-3 to reflect changes in coverage options offered under the Plan. If a new short term disability coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

E-4. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Short Term Disability Plan in accordance with the Participating Short Term Disability Plan documentation incorporated by reference under this Supplement E. In the event there is a conflict in the interpretation of the Plan document, this Supplement E, and the Participating Short Term Disability Plan documentation incorporated by reference under this Supplement E, the terms of the Participating Short Term Disability Plan documents incorporated herein by reference shall control first, this Supplement E next, and the Plan document last. The insurance company as the

applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement E, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the certificate of coverage, the Summary Plan Description for an insured Participating Short Term Disability Plan option.

SUPPLEMENT F
Participating Long Term Disability Plan

F-1. Purpose. The purpose of this Supplement F is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the long term disability plan specified in paragraph F-3 ("Participating Long Term Disability Plan") made available to Eligible Associates. Unless otherwise specified in this Supplement F, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

F-2. Eligibility and Enrollment. For purposes of the Participating Long Term Disability Plan, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Long Term Disability Plan documents listed below in paragraph F-3. Each Eligible Associate shall be automatically enrolled in long term disability coverage pursuant to subsection 3.2 of the Plan document and subject to enrollment instructions specified by the Plan Administrator.

F-3. Participating Long Term Disability Plan Documents Incorporated by Reference. The terms and provisions of the following Participating Long Term Disability Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph F-4, constitute the controlling terms and provisions of the applicable Participating Long Term Disability Plan.

(a) The most recent certificate and Summary Plan Description for group long term disability insurance coverage offered to Eligible Associates under Standard Insurance Company, Policy No. 643851-H.

Coverage under the Participating Long Term Disability Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend the policy in conjunction with the issuing insurance company, to amend or terminate any insurance contract and/or Participating Long Term Disability Plan coverage, and/or to change the cost of Participating Long Term Disability Plan coverage at any time. The Plan Administrator may add or delete Participating Long Term Disability Plans or coverage options under the Plan without formal amendment of this paragraph F-3 to reflect changes in coverage options offered under the Plan. If a new long term disability coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

F-4. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Long Term Disability Plan in accordance with the Participating Long Term Disability Plan documentation incorporated by reference under this Supplement F. In the event there is a conflict in the interpretation of the Plan document, this Supplement F, and the Participating Long Term Disability Plan documentation incorporated by reference under this Supplement F, the terms of the Participating Long Term Disability Plan documents incorporated herein by reference shall control first, this Supplement F next, and the Plan document last. The insurance company as the

applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement F, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the policy or certificate of coverage, the Summary Plan Description for the insured Participating Long Term Disability Plan option.

SUPPLEMENT G
Cafeteria Plan

G-1. Purpose. The purpose of this Supplement G is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the Cafeteria Plan specified in paragraph G-4 ("Cafeteria Plan") made available to Eligible Associates. Unless otherwise specified in this Supplement G, the capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

G-2. Components of Cafeteria Plan. The Cafeteria Plan consists of the following components: an Insurance Premium Payment Plan ("Premium Plan"), a Health Flexible Spending Account Plan and a Dependent Care Flexible Spending Account Plan.

G-3. Eligibility and Enrollment. For purposes of the Cafeteria Plan, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Cafeteria Plan documents listed below in paragraph G-4. Eligible Associates shall enroll in the Cafeteria Plan in accordance with the provisions of subsection 3.2, subject to enrollment instructions specified by the Plan Administrator. Newly hired or rehired Eligible Associates shall enroll themselves and their eligible Dependents in accordance with the provisions of subsection 3.2, subject to enrollment instructions specified by the Plan Administrator. All other Eligible Associates shall enroll or reenroll during each Annual Enrollment pursuant to subsection 3.2 of the Plan document. Eligible Associates already participating in the Cafeteria Plan shall be required to reenroll in the Health Flexible Spending Account Plan and Dependent Care Flexible Spending Account Plan during each Annual Enrollment.

G-4. Cafeteria Plan Document Incorporated by Reference. The terms and provisions of the current Hancock Holding Company Cafeteria Plan, including any amendments thereto, are incorporated by reference and, subject to the terms of paragraph G-5, constitute the controlling terms and provisions of the Participating Cafeteria Plan. The Company, in its sole discretion, retains the right to amend the Cafeteria Plan, to terminate the Cafeteria Plan, or to change the cost of Cafeteria Plan coverage at any time. Eligible Associates will be notified regarding any change.

G-5. Resolution of Conflicts. In the event there is a conflict between the Plan document, this Supplement G, and the Cafeteria Plan documents incorporated herein by reference, the terms of the Cafeteria Plan documents incorporated herein by reference shall control first, this Supplement G next, and the Plan document last. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement G, and the Cafeteria Plan documents incorporated herein by reference.

SUPPLEMENT H
Participating Business Travel Accident Plan

H-1. Purpose. The purpose of this Supplement H is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the business travel accident ("BTA") plan specified in paragraph H-3 ("Participating BTA Plan") made available to Eligible Associates. Unless otherwise specified in this Supplement H, capitalized terms shall have the same meaning as given them in Section 2 of the Plan document.

H-2. Eligibility and Enrollment. Notwithstanding subsection 2.14 of the Plan, for purposes of the Participating BTA Plan, an Eligible Associate shall mean an Associate who meets the eligibility requirements specified in the applicable Participating BTA Plan documents listed below in paragraph H-3. Each Eligible Associate shall be automatically enrolled in BTA coverage pursuant to subsection 3.2 of the Plan document and subject to enrollment instructions specified by the Plan Administrator.

H-3. Participating BTA Plan Documents Incorporated by Reference. The terms and provisions of the following Participating BTA Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph H-4, constitute the controlling terms and provisions of the applicable Participating BTA Plan:

(a) The most recent Policy and Summary Plan Description for BTA insurance coverage offered to Eligible Associates under Federal Insurance Company, Policy No. 6410-06-88, as applied to Associates, their Spouses, and their children.

Coverage under the Participating BTA Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend the policies in conjunction with the issuing insurance company, to amend or terminate any insurance contract and/or Participating BTA Plan coverage, and/or to change the cost of Participating BTA Plan coverage at any time. The Plan Administrator may add or delete Participating BTA Plans under the Plan without formal amendment of this paragraph H-3 to reflect changes in coverage options offered under the Plan. If a new BTA coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

H-4. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating BTA Plan in accordance with the Participating BTA Plan documentation incorporated by reference under this Supplement H. In the event there is a conflict in the interpretation of the Plan document, this Supplement H, and the Participating BTA Plan documentation incorporated by reference under this Supplement H, the terms of the Participating BTA Plan documents incorporated herein by reference shall control first, this Supplement H next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement H, and any supplement or addendum that may be prepared and issued by the Plan Administrator to

constitute, in combination with the policy or certificate of coverage, the Summary Plan Description for the insured Participating BTA Plan option.

SUPPLEMENT I
Participating Legal Plan

I-1. Purpose. The purpose of this Supplement I is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the legal plan specified in paragraph I-3 ("Participating Legal Plan") made available to Eligible Associates and eligible Dependents. Unless otherwise specified in this Supplement I, capitalized terms shall have the same meaning as given them in Section 2 of the Plan document.

I-2. Eligibility and Enrollment. Notwithstanding subsections 2.13 and 2.14 of the Plan, for purposes of the Participating Legal Plan, an Eligible Associate and Dependent shall mean an individual who meets the eligibility requirements specified in the applicable Participating Legal Plan documents listed below in paragraph I-3. Newly hired or rehired Eligible Associates shall enroll themselves and their eligible Dependents in accordance with the provisions of subsection 3.2, subject to enrollment instructions specified by the Plan Administrator. Eligible Associates who elect coverage under the Participating Legal Plan shall be deemed to automatically reenroll during each Annual Enrollment absent an election to the contrary. Eligible Associates, who waive coverage during Initial Enrollment or who affirmatively drop coverage during a subsequent Annual Enrollment, can elect to enroll during a subsequent Annual Enrollment pursuant to subsection 3.2 of the Plan document. An Eligible Associate may enroll his or her Dependents in a Participating Legal Plan only if the Eligible Associate also is enrolled in the same Participating Legal Plan coverage option. Eligible Associates and their Dependents who fail to enroll the Participating Legal Plan during Initial Enrollment must wait until the next Annual Enrollment period to enroll in a Participating Legal Plan, unless the Eligible Associate experiences an event entitling the Associate to an election change under Section 3.

I-3. Participating Legal Plan Documents Incorporated by Reference. The terms and provisions of the following Participating Legal Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph I-4, constitute the controlling terms and provisions of the applicable Participating Legal Plan:

(a) The Group Legal Service Plan Policy of Insurance for the legal insurance coverage offered to Eligible Associates under Metropolitan Property and Casualty Insurance Company, Plan ID No. 150/0811, as applied to Associates and their Dependents.

Coverage under the Participating Legal Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend the policies in conjunction with the issuing insurance company, to amend or terminate any insurance contract and/or Participating Legal Plan coverage, and/or to change the cost of Participating Legal Plan coverage at any time. The Plan Administrator may add or delete Participating Legal Plans under the Plan without formal amendment of this paragraph I-3 to reflect changes in coverage options offered under the Plan. If a new legal coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

I-4. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Legal Plan in accordance with the Participating Legal Plan documentation incorporated by reference under this Supplement I. In the event there is a conflict in the interpretation of the Plan document, this Supplement I, and the Participating Legal Plan documentation incorporated by reference under this Supplement I, the terms of the Participating Legal Plan documents incorporated herein by reference shall control first, this Supplement I next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement I, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the policy or certificate of coverage, the Summary Plan Description for the Participating Legal Plan option.

SUPPLEMENT J
Participating Severance Plan

J-1. Purpose. The purpose of this Supplement J is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the severance plan specified in paragraph J-3 ("Participating Severance Plan") made available to Eligible Associates. Unless otherwise specified in this Supplement J, capitalized terms shall have the same meaning as given them in Section 2 of the Plan document.

J-2. Eligibility. Notwithstanding subsection 2.14 of the Plan, for purposes of the Participating Severance Plan, an Eligible Associate shall mean an Associate who meets the eligibility requirements specified in the applicable Participating Severance Plan documents listed below in paragraph J-3.

J-3. Participating Severance Plan Documents Incorporated by Reference. The terms and provisions of the Hancock Holding Company Severance Pay Plan and Summary Plan Description, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph J-4, constitute the controlling terms and provisions of the applicable Participating Severance Plan.

The Participating Severance Plan is self-insured. The Company or Employer, in its sole discretion, retains the right to amend the Participating Severance Plan and/or to terminate the Participating Severance Plan at any time. The Plan Administrator or its designee may add or delete Participating Severance Plans under the Plan without formal amendment of this paragraph J-3 to reflect changes in coverage options offered under the Plan. If a new or additional severance plan is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Eligible Associates will be notified of any changes.

J-4. Resolution of Conflicts. Eligibility to participate in the Participating Severance Plan shall be determined in accordance with the Participating Severance Plan document incorporated by reference under this Supplement J by the person or persons having discretionary authority to determine such eligibility pursuant to the provisions of the Participating Severance Plan document. In the event there is a conflict in the interpretation of the Plan document, this Supplement J, and the Participating Severance Plan document incorporated by reference under this Supplement J, the terms of the Participating Severance Plan documents incorporated herein by reference shall control first, this Supplement J next, and the Plan document last. Except as otherwise provided in the Participating Severance Plan document, the Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement J, the Participating Severance Plan document and any supplement or addendum thereto that may be prepared and issued by the Plan Administrator.

SUPPLEMENT K
Participating Critical Illness Plan

K-1. Purpose. The purpose of this Supplement K is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the critical illness plans specified in paragraph K-3 (each a "Participating Critical Illness Plan") made available to Eligible Associates and Dependents. Unless otherwise specified in this Supplement K, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

K-2. Eligibility and Enrollment. For purposes of the Participating Critical Illness Plan, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Critical Illness Plan documents listed below in paragraph K-3. A Dependent shall mean an individual who meets the requirements of subsection 2.13 of the Plan and any eligibility requirements specified in the applicable Participating Critical Illness Plan documents. Notwithstanding the provisions of the Participating Critical Illness Plan documents, Eligible Associates may only enroll or reenroll themselves and their eligible Dependents during each Annual Enrollment pursuant to subsection 3.2 of the Plan document, subject to enrollment instructions specified by the Plan Administrator. Eligible Associates and their Dependents who fail to enroll in a Participating Critical Illness Plan during an Annual Enrollment period must wait until the next Annual Enrollment period to enroll in a Participating Critical Illness Plan, regardless of whether the Eligible Associate experiences an event entitling the Associate to an election change under Section 3. Participating Eligible Associates who fail to enroll during Annual Enrollment will be deemed to waive coverage pursuant to subsection 3.5 unless the Plan Administrator adopts rules for automatic enrollment in the Participating Critical Illness Plan. An Eligible Associate may enroll his or her Dependents in a Participating Critical Illness Plan only if the Eligible Associate also is enrolled in the same Participating Critical Illness Plan coverage option. To the extent applicable, COBRA beneficiaries may enroll pursuant to the administrative rules established by the Plan Administrator and shall pay the COBRA premium for continued coverage.

K-3. Participating Critical Illness Plan Documents Incorporated by Reference. The terms and provisions for the following Participating Critical Illness Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph K-4, constitute the controlling terms and provisions of the applicable Participating Critical Illness Plan:

(a) The most recent Summary Plan Description and group insurance contract for critical illness coverage offered to Eligible Associates under American Heritage Life Insurance Company, Policy No. V3517.

Coverage under the Participating Critical Illness Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend the policy in conjunction with the applicable insurance company for any insured critical illness option, to amend or terminate any critical illness insurance contract and/or Participating Critical Illness Plan coverage option, and/or to change the cost of any insured Participating Critical Illness Plan coverage at any time, subject to any applicable agreement with the insurance provider. The Plan Administrator may add or delete Participating Critical Illness Plans coverage options without

formal amendment of this paragraph K-3 to reflect changes in coverage options offered under the Plan. If a new critical illness coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

K-4. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Critical Illness Plan in accordance with the Participating Critical Illness Plan documentation incorporated by reference under this Supplement K. In the event there is a conflict in the interpretation of the Plan document, this Supplement K, and the Participating Critical Illness Plan documentation incorporated by reference under this Supplement K, except as otherwise provided in paragraph K-2, the terms of the Participating Critical Illness Plan documentation incorporated by reference shall control first, this Supplement K next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage or membership booklet. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement K, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the policy or certificate of coverage, the Summary Plan Description for the Participating Critical Illness Plan option.

SUPPLEMENT L
Participating Group Cancer Plan

L-1. Purpose. The purpose of this Supplement L is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the group cancer plans specified in paragraph L-3 ("Participating Group Cancer Plan") made available to Eligible Associates and Dependents. Unless otherwise specified in this Supplement L, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

L-2. Eligibility and Enrollment. For purposes of the Participating Group Cancer Plan, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Group Cancer Plan documents listed below in paragraph L-3. A Dependent shall mean an individual who meets the requirements of subsection 2.13 of the Plan and any eligibility requirements specified in the applicable Participating Group Cancer Plan documents. Notwithstanding the provisions of the Participating Group Cancer Plan documents, Eligible Associates may only enroll or reenroll themselves and their eligible Dependents during each Annual Enrollment pursuant to subsection 3.2 of the Plan document, subject to enrollment instructions specified by the Plan Administrator. Eligible Associates and their Dependents who fail to enroll in a Participating Group Cancer Plan during an Annual Enrollment period must wait until the next Annual Enrollment to enroll in a Participating Group Cancer Plan, regardless of whether the Eligible Associate experiences an event entitling the Associate to an election change under Section 3. Participating Eligible Associates who fail to enroll during Annual Enrollment will be deemed to waive coverage pursuant to subsection 3.5 unless the Plan Administrator adopts rules for automatic enrollment in the Participating Group Cancer Plan. An Eligible Associate may enroll his or her Dependents in a Participating Group Cancer Plan only if the Eligible Associate also is enrolled in the same Participating Group Cancer Plan coverage option. To the extent applicable, COBRA beneficiaries may enroll pursuant to the administrative rules established by the Plan Administrator and shall pay the COBRA premium for continued coverage.

L-3. Participating Group Cancer Plan Documents Incorporated by Reference. The terms and provisions for the following Participating Group Cancer Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph L-4, constitute the controlling terms and provisions of the applicable Participating Group Cancer Plan:

(a) The most recent Summary Plan Description and group insurance contract for group cancer coverage offered to Eligible Associates under American Heritage Life Insurance Company, Policy No. V3517.

Coverage under the Participating Group Cancer Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend any policy in conjunction with the applicable insurance company for any insured group cancer option, to amend or terminate any group cancer insurance contract and/or Participating Group Cancer Plan coverage option, and/or to change the cost of any insured Participating Group Cancer Plan coverage at any time, subject to any applicable agreement with the insurance provider. The Plan Administrator may add or delete Participating Group Cancer Plans coverage options without formal amendment of this

paragraph L-3 to reflect changes in coverage options offered under the Plan. If a new group cancer coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

L-4. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Group Cancer Plan in accordance with the Participating Group Cancer Plan documentation incorporated by reference under this Supplement L. In the event there is a conflict in the interpretation of the Plan document, this Supplement L, and the Participating Group Cancer Plan documentation incorporated by reference under this Supplement L, except as otherwise provided in paragraph L-2, the terms of the Participating Group Cancer Plan documentation incorporated by reference shall control first, this Supplement L next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage or membership booklet. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement L, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the policy or certificate of coverage, the Summary Plan Description for the Participating Group Cancer Plan option.

SUPPLEMENT M
Participating Accident Insurance Plan

M-1. Purpose. The purpose of this Supplement M is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the group accident plans specified in paragraph M-3 ("Participating Accident Insurance Plan") made available to Eligible Associates and Dependents. Unless otherwise specified in this Supplement M, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

M-2. Eligibility and Enrollment. For purposes of the Participating Accident Insurance Plan, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Accident Insurance Plan documents listed below in paragraph M-3. A Dependent shall mean an individual who meets the requirements of subsection 2.13 of the Plan and any eligibility requirements specified in the applicable Participating Accident Insurance Plan documents. Notwithstanding the provisions of the Participating Accident Insurance Plan documents, Eligible Associates may only enroll or reenroll themselves and eligible Dependents during each Annual Enrollment pursuant to subsection 3.2 of the Plan document, subject to enrollment instructions specified by the Plan Administrator. Eligible Associates and their Dependents who fail to enroll in a Participating Accident Insurance Plan during an Annual Enrollment period must wait until the next Annual Enrollment period to enroll in a Participating Accident Insurance Plan, regardless of whether the Eligible Associate experiences an event entitling the Associate to an election change under Section 3. Participating Eligible Associates who fail to enroll during Annual Enrollment will be deemed to waive coverage pursuant to subsection 3.5 unless the Plan Administrator adopts rules for automatic enrollment in the Participating Accident Insurance Plan. An Eligible Associate may enroll his or her Dependents in a Participating Accident Insurance Plan only if the Eligible Associate also is enrolled in the same Participating Accident Insurance Plan coverage option. To the extent applicable, COBRA beneficiaries may enroll pursuant to the administrative rules established by the Plan Administrator and shall pay the COBRA premium for continued coverage.

M-3. Participating Accident Insurance Plan Documents Incorporated by Reference. The terms and provisions of the following Participating Accident Insurance Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph M-4, constitute the controlling terms and provisions of the applicable Participating Accident Insurance Plan:

(a) The most recent Summary Plan Description and group insurance contract for group accident coverage offered to Eligible Associates under American Heritage Life Insurance Company, Policy No. V3517.

Coverage under the Participating Accident Insurance Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend any policy in conjunction with the applicable insurance company for any insured group accident option, to amend or terminate any group accident insurance contract and/or Participating Accident Insurance Plan coverage option, and/or to change the cost of any insured Participating Accident Insurance Plan coverage at any time, subject to any applicable agreement with the insurance provider. The Plan

Administrator may add or delete Participating Accident Insurance Plan coverage options without formal amendment of this paragraph M-3 to reflect changes in coverage options offered under the Plan. If a new accident insurance coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

M-4. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Accident Insurance Plan in accordance with the Participating Accident Insurance Plan documentation incorporated by reference under this Supplement M. In the event there is a conflict in the interpretation of the Plan document, this Supplement M, and the Participating Accident Insurance Plan documentation incorporated by reference under this Supplement M, except as otherwise provided in paragraph M-2, the terms of the Participating Accident Insurance Plan documentation incorporated by reference shall control first, this Supplement M next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage or membership booklet. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement M, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the policy or certificate of coverage or the Summary Plan Description for the Participating Accident Insurance Plan option.

SUPPLEMENT N
Participating Universal Life Insurance Plan

N-1. Purpose. The purpose of this Supplement N is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the universal life insurance plans specified in paragraph N-3 ("Participating Universal Life Insurance Plan") made available to Eligible Associates and Dependents. Unless otherwise specified in this Supplement N, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

N-2. Eligibility. For purposes of the Participating Universal Life Insurance Plan, an Eligible Associate shall mean an individual who meets the requirements of subsection 2.14 of the Plan and any eligibility requirements specified in the applicable Participating Universal Life Insurance Plan documents listed below in paragraph N-3. A Dependent shall mean an individual who meets the requirements of subsection 2.13 of the Plan and any eligibility requirements specified in the applicable Participating Universal Life Insurance Plan documents. Notwithstanding the provisions of the Participating Universal Life Insurance Plan documents, Eligible Associates may only enroll or reenroll themselves and their eligible Dependents during each Annual Enrollment pursuant to subsection 3.2 of the Plan, subject to enrollment instructions specified by the Plan Administrator. Eligible Associates and their Dependents who fail to enroll in a Participating Universal Life Insurance Plan during an Annual Enrollment period must wait until the next Annual Enrollment period to enroll in a Participating Universal Life Insurance Plan, regardless of whether the Eligible Associate experiences an event entitling the Associate to an election change under Section 3. Participating Eligible Associates who fail to enroll during Annual Enrollment will be deemed to waive coverage pursuant to subsection 3.5 unless the Plan Administrator adopts rules for automatic enrollment in the Participating Universal Life Insurance Plan. An Eligible Associate may enroll his or her Dependents in a Participating Universal Life Insurance Plan only if the Eligible Associate also is enrolled in the same Participating Universal Life Insurance Plan coverage option.

N-3. Participating Universal Life Insurance Plan Documents Incorporated by Reference. The terms and provisions for the following Participating Universal Life Insurance Plan, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph N-4, constitute the controlling terms and provisions of the applicable Participating Universal Life Insurance Plan:

(a) The most recent Summary Plan Description and group insurance contract for universal life insurance coverage offered to Eligible Associates under American Heritage Life Insurance Company, Policy No. V3517.

Coverage under the Participating Universal Life Insurance Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend any policy in conjunction with the applicable insurance company for any insured group universal life insurance option, to amend or terminate any group universal life insurance contract and/or Participating Universal Life Insurance Plan coverage option, and/or to change the cost of any insured Participating Universal Life Insurance Plan coverage at any time, subject to any applicable agreement with the insurance provider. The Plan Administrator may add or delete Participating Universal Life Insurance Plan coverage options without formal amendment of this

paragraph N-3 to reflect changes in coverage options offered under the Plan. If a new universal life insurance coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

N-4. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Universal Life Insurance Plan in accordance with the Participating Universal Life Insurance Plan documentation incorporated by reference under this Supplement N. In the event there is a conflict in the interpretation of the Plan document, this Supplement N, and the Participating Universal Life Insurance Plan documentation incorporated by reference under this Supplement N, except as otherwise provided in paragraph N-2, the terms of the Participating Universal Life Insurance Plan documentation incorporated by reference shall control first, this Supplement N next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage or membership booklet. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement N, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the policy or certificate of coverage, the Summary Plan Description for the Participating Universal Life Insurance Plan option.

SUPPLEMENT O1
Participating Retiree Plans

O-1. Purpose. The purpose of this Supplement O1 is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the retiree benefit plans specified in paragraph O-7 ("Participating Retiree Plans") made available to certain retired Associates. Unless specified otherwise in this Supplement O1, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

O-2. Eligibility. Notwithstanding any provision of subsection 3.7 to the contrary, an Associate who terminates employment with the Company may be eligible to continue to participate in the Plan, and elect continuing coverage for his or her eligible Dependents, if the following conditions are met:

(a) The retired Associate meets the eligibility criteria specified under the retiree medical benefit plans ("Participating Retiree Medical Plan") specified in subparagraph O-7(a) or (b), as applicable, which are incorporated herein by reference, as modified by Supplement O2.

(b) The retired Associate meets the eligibility criteria specified under the retiree life insurance benefit plan ("Participating Life Insurance Plan") specified in subparagraph O-7(c), which is incorporated herein by reference.

For purposes of this Supplement O1 and O2, the terms "Dependent" and "Spouse" shall be defined in the applicable Participating Retiree Plan providing such retiree coverage. A retired Associate eligible to continue coverage under this Supplement O1 shall be referred to as a "Retired Associate."

O-3. Election, Contribution Required. A Retired Associate who meets the eligibility requirements of paragraph O-2 must make a written election of coverage under the Plan pursuant to the terms and conditions of this Supplement O1 for the Retired Associate and his or her Dependents in accordance with the procedures established by the Plan Administrator. Further, as a condition of coverage under this Supplement O1, the Retired Associate must make required contributions, if any, in the amount, time, and manner specified by the Company. Additional information regarding contribution requirements is provided in Section 1.1 of Supplement O2. The contributions required of a Retired Associate, for himself or herself and for his or her Dependents, to continue participating in the Plan pursuant to this Supplement O1 and Supplement O2, as well as the deductibles, benefit limitations, and other coverage features, may differ from the provisions applicable to active Associates.

O-4. Benefits Payable to Retired Associates and Their Dependents. If a Retired Associate is eligible under paragraph O-2 and makes the election and contributions required under paragraph O-3, the Retired Associate (and his or her Dependents, if the Retired Associate elects coverage for such Dependents) shall continue to be covered under the Plan subject to the terms and conditions of the Plan. The benefits payable under this Supplement O1 to any Retired Associate (and the Retired Associate's Dependents, if such coverage is elected by the Retired

Associate) are set forth in the applicable Participating Retiree Plan documents listed below in paragraph O-7.

O-5. Termination of Coverage. If a Retired Associate has elected coverage under this Supplement O1, such coverage shall cease on the earliest of the following dates:

(a) the date of the Retired Associate's death;

(b) at the end of the period for which the last contribution is made;

(c) the date the Plan in its entirety or retiree benefits under this Supplement O1 are terminated by the Company;

(d) the date the Retired Associate ceases to be eligible for coverage under the terms of this Supplement O1, the applicable Participating Retiree Plan or the terms and conditions of the Plan;

(e) the date the Retired Associate elects to drop coverage under the applicable Participating Retiree Plan; or

(f) any other date as specified under the terms of the Participating Retiree Plan.

In the event coverage is terminated pursuant to subparagraph (a), subject to the terms of the Participating Retiree Plan, coverage may continue through the end of the month in which the death occurred, provided premiums have been paid through the date of the period that the death occurred.

Retired Associates who elect retiree coverage under a Participating Retiree Medical Plan and who later lose coverage shall not be eligible for COBRA continuation coverage under such plan. Notwithstanding the foregoing, Dependents of a Retired Associate who meet the requirements for continuation of retiree health coverage under COBRA shall be offered the right to continue coverage under the applicable Participating Retiree Medical Plan to the extent required under COBRA, the regulations thereunder, and the administrative rules established by the Plan Administrator.

O-6. Amendment or Termination of Retiree Coverage. As described in Section 9, any part or all of the Plan may be amended by the Company at any time or from time to time. As a result, coverage under this Supplement O1 may be amended, modified or terminated by the Company at any time.

O-7. Participating Retiree Plan Documents Incorporated By Reference. The terms and provisions of the following Participating Retiree Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph O-8, constitute the controlling terms and provisions of the applicable Participating Retiree Plan:

(a) The most recent coverage booklet and Summary Plan Description for the Employee Health Protection Plan for the Retirees of Whitney Bank (A Subsidiary of Hancock Holding Company), Comprehensive Medical Benefit Plan

administered by Blue Cross Blue Shield of Louisiana Plan Form No. 40HR1670 R01/15, Plan No. 78B20ERC;

(b) The most recent Employee Booklet and Summary Plan Description for the Employee Health Protection Plan for Hancock Holding Company and Its Subsidiaries administered by Blue Cross Blue Shield of Mississippi, Plan Type C524;

(c) The most recent Summary Plan Description and group insurance contract for the retiree life insurance coverage offered to Retired Associates under Standard Insurance Company, Policy No. 643851-F, and

(d) The most recent plan document, Summary Plan Description and group insurance contract (if applicable) or other governing plan document, as applied to Retired Associates and their Dependents, for any new Participating Retiree Plan option selected by the Company.

Coverage under Participating Retiree Plan options (a) and (b) is self-insured. Coverage under Participating Retiree Plan option (c) is fully-insured. The Company, in its sole discretion, retains the right to amend or terminate any insurance contract in conjunction with the applicable insurance company for any insured plan option, to amend or terminate any self-insured Participating Retiree Plan coverage option, and/or to change the cost of any insured or self-insured Participating Retiree Plan coverage at any time, subject to any applicable agreement with the insurance provider, as applicable. The Plan Administrator may add or delete Participating Retiree Plan coverage options without formal amendment of this paragraph O-7 to reflect changes in coverage options offered under the Plan. If a new retiree coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

O-8. Resolution of Conflicts. The Plan Administrator or its designee has the discretionary authority to determine eligibility to participate in the Participating Retiree Plan in accordance with the Participating Retiree Plan documentation incorporated by reference under this Supplement O1. Except as otherwise provided in paragraph O-2 and Supplement O2, in the event there is a conflict in the interpretation of the Plan document, this Supplement O1, and the Participating Retiree Plan documentation incorporated by reference under this Supplement O1, the terms of the Participating Retiree Plan documentation incorporated by reference shall control first, this Supplement O1 next, and the Plan document last. The insurance company as the applicable Claims Administrator has the discretionary authority to interpret the terms of the insurance policy and the certificate of coverage or membership booklet. The Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement O1, and any supplement or addendum that may be prepared and issued by the Plan Administrator to constitute, in combination with the policy or certificate of coverage or membership booklet, the Summary Plan Description for an insured Participating Retiree Plan option.

SUPPLEMENT O2
Eligibility Under Participating Retiree Medical Plans

1.1 Eligibility Requirements.

(a) Associates Employed by Whitney National Bank Prior to its Merger with and into the Company ("Whitney Retirees"). A Whitney Retiree will be eligible for Company subsidized retiree medical coverage under the Participating Retiree Plan listed in paragraph O-7(a) if the Whitney Retiree satisfies the following requirements:

(i) As of December 31, 2007, was 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 Holding Company Plan and Trust Agreement) ("Pension Plan");

(ii) Bridges immediately from either active employment or disability status to receiving monthly pension benefits under the Pension Plan. Associates who elect lump sum distributions from the Pension Plan are not eligible for retiree medical coverage;

(iii) Was covered under the applicable Participating Medical Plan for Whitney National Bank Associates as an active or disabled Associate for the three consecutive years immediately preceding his or her retirement; and

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

(b) Associates Employed by Company or any of its Affiliates prior to the Merger with Whitney National Bank ("Hancock Retiree"). A Hancock Retiree will be eligible for Company subsidized retiree medical coverage under the Participating Retiree Plan listed in paragraph O-7(b) if the Hancock Retiree satisfies the following requirements:

(i) Was last hired by the Company or one of its Affiliates prior to January 1, 2000;

(ii) Is enrolled as a Participant under the applicable Participating Medical Plan as an active Associate immediately prior to the date the Associate retires;

(iii) Is age 55 and has 10 or more Years of Service, and

(iv) Does not enroll in COBRA continuation coverage under the applicable Participating Medical Plan at any time during the COBRA election period after becoming a retiree.

For purposes of this subparagraph (b), the term "Years of Service" shall mean each 12 consecutive month period, beginning on the Associate's date of hire and

each anniversary date of the Associate's date of hire, in which the Associate performs services for the Company and any of its Affiliates.

An Associate who is terminated for cause will not be eligible for coverage under a Participating Retiree Medical Plan, even if the terminated Associate otherwise meets the eligibility requirements described under (a) or (b) above, as applicable. For purposes of this Section 1.1, an Associate shall be deemed to have been terminated for "cause" if his or her employment is involuntarily terminated because of: unacceptable performance; insubordination; violation of the Employer's policies or procedures; violation of the Employer's Code of Conduct; or other misconduct as may be determined by the Employer in its sole discretion. Any determination of whether an Associate was terminated for cause will be made in the sole and absolute discretion of the Employer.

The Company's premium subsidy dollar amount for Whitney Retirees is frozen at the 2007 levels. Any premium increases after December 31, 2007, are borne solely by Whitney Retirees, or their Spouses or Dependents, as applicable. For all other retirees, the Company may cover a portion of any future premium increases, except for the following Hancock Retirees identified by the last four digits of their Social Security Number, for whom future premium increases are borne solely by the Company:

1. 6958
2. 3020
3. 3680
4. 7621
5. 6569
6. 8203
7. 5310
8. 0070
9. 4138
10. 7939
11. 6076

1.2 Dependent Coverage.

(a) Whitney Retirees. Whitney Retirees may elect to cover Spouses and/or eligible Dependents if those individuals were covered under the applicable Participating Medical Plan covering Whitney National Bank Associates immediately prior to the Whitney Retiree 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 applicable Participating Retiree Medical Plan's Plan document.

(b) Hancock Retirees. Hancock Retirees may elect to cover Spouses and/or eligible Dependents if those individuals were covered under the applicable Participating Medical Plan covering Hancock Holding Company Associates immediately prior to the date the Associate retires.

1.3 Dropping Coverage/Termination of Coverage. Except as otherwise provided in the applicable Participating Retiree Medical Plan, a Retired Associate and his or her Spouse or Dependents who are not enrolled when first eligible, or who

subsequently discontinue coverage, will be prohibited from enrolling or reenrolling in the future.

SUPPLEMENT P
Participating Term Life Insurance Plan

P-1. Purpose. The purpose of this Supplement P is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the term life insurance plan specified in paragraph P-3 ("Participating Term Life Insurance Plan") made available to Eligible Associates. Unless otherwise specified in this Supplement P, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

P-2. Eligibility. Notwithstanding subsection 2.14 of the Plan, for purposes of the Participating Term Life Insurance Plan, an Eligible Associate shall mean an Associate who meets the eligibility requirements specified in the applicable Participating Term Life Insurance Plan documents listed below in paragraph P-3.

P-3. Participating Term Life Insurance Plan Documents Incorporated by Reference. The terms and provisions of the Hancock Holding Company Term Life Insurance Plan and Summary Plan Description, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph P-4, constitute the controlling terms and provisions of the applicable Participating Term Life Insurance Plan.

Coverage under the Participating Term Life Insurance Plan is fully-insured. The Company or Employer policyholder, in its sole discretion, retains the right to amend any policy in conjunction with the applicable insurance company for any insured term life insurance option, to amend or terminate any term life insurance contract and/or Participating Term Life Insurance Plan coverage option, and/or to change the cost of any insured Participating Term Life Insurance Plan coverage at any time, subject to any applicable agreement with the insurance provider. The Plan Administrator may add or delete Participating Term Life Insurance Plan coverage options without formal amendment of this paragraph P-3 to reflect changes in coverage options offered under the Plan. If a new term life insurance coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Eligible Associates will be notified of any changes.

P-4. Resolution of Conflicts. Eligibility to participate in the Participating Term Life Insurance Plan shall be determined in accordance with the Participating Term Life Insurance Plan documents incorporated by reference under this Supplement P by the person or persons having discretionary authority to determine such eligibility pursuant to the provisions of the Participating Term Life Insurance Plan documents. In the event there is a conflict in the interpretation of the Plan document, this Supplement P, and the Participating Term Life Insurance Plan documents incorporated by reference under this Supplement P, the terms of the Participating Term Life Insurance Plan documents incorporated herein by reference shall control first, this Supplement P next, and the Plan documents last. Except as otherwise provided in the Participating Term Life Insurance Plan documents, the Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement P, the Participating Term Life Insurance Plan documents and any supplement or addendum thereto that may be prepared and issued by the Plan Administrator.

SUPPLEMENT Q
Employers

Employer	Federal Tax I.D. No.
Hancock Holding Company	64-0693170
Whitney Bank	64-0169065
Hancock Investment Services	64-0867168
Hancock Insurance Agency	64-0169103
Harrison Finance Company	64-0693324
Lighthouse Service Corporation	27-1013817
Whitney Equipment Finance	47-5079398

AMENDMENT NO. 1 TO THE
HANCOCK HOLDING COMPANY
EMPLOYEE WELFARE FUND

WHEREAS, Hancock Holding Company (the "Company") sponsors the Hancock Holding Company Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and the Company has delegated authority to amend the Plan to the Benefits Committee;

WHEREAS, the Company wishes to amend the Plan to provide service credit under the Plan and applicable Participating Plans to former First NBC Bank ("FNBC") employees hired by the Company and/or a Participating Employer in connection with the acquisition of nine FNBC branches by the Company's wholly-owned subsidiary, Whitney Bank, pursuant to that certain Purchase and Assumption Agreement by and between FNBC and Whitney Bank, dated December 30, 2016;

NOW, THEREFORE, the Plan is hereby amended to add a new Supplement R, Special Provisions Related to Certain Business Transactions, to read in its entirety as follows:

SUPPLEMENT R
Special Provisions Related To Certain Business Transactions

R-1 Purpose. The purpose of this Supplement R is to describe special provisions regarding Employees acquired in connection with certain business transactions. Unless otherwise specified in this Supplement R, capitalized terms shall have the same meaning given them in Section 2 of the Plan document.

R-2 Business Transactions.

(a) First NBC Bank ("FNBC") Acquisition.

(i) Eligibility. Subject to the provisions of subparagraph (ii) below, individuals who became Employees of the Employer on March 11, 2017 (the "Transfer Date") in connection with the acquisition by Whitney Bank of nine branches of FNBC ("Transferred Employees") shall become immediately eligible to participate under the Plan and applicable Participating Plans without regard to any applicable waiting period, provided such individuals were employed by FNBC on the day immediately preceding the Transfer Date. Coverage for Transferred Employees who enroll under the Plan and applicable Participating Plans will be effective April 1, 2017, except for coverage under the Participating Short Term Disability Plan, which shall become effective on the later of the Transfer Date or the day after their return to work date provided the Transferred Employee was on an approved leave of absence.

(ii) Service Crediting and Eligibility Under the Participating Medical Plans. Hours of service with FNBC and its affiliates will be taken into account for purposes of determining eligibility under the applicable Participant Medical Plan such that Transferred Employees in a stability period with respect to FNBC's group health plan will retain such status

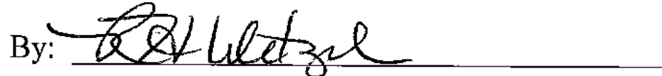
under the Participating Medical Plans through the end of such stability period. Thereafter, the measurement and stability period rules under Supplement A2 will apply and will take into account prior service with FNBC. If a Transferred Employee is not in a stability period with respect to FNBC's group health plan at the time of the transaction, then the Transferred Employee's status will be determined under the measurement and stability period rules described under Supplement A2, taking into account prior service with FNBC.

(iii) Crediting of Deductibles and Out-Of-Pocket Costs. The Employer shall recognize the dollar amount of all expenses incurred by Transferred Employees and their respective Spouses or Dependents during the calendar year that includes the Transfer Date for purposes of satisfying the deductibles and out-of-pocket limitations for such calendar year under the applicable Participating Medical Plan, to the extent taken into account for such purposes under the applicable FNBC group health plan.

R-3 Resolution of Conflicts. Unless otherwise stated in this Supplement R, the provisions of this Supplement R shall govern notwithstanding any provisions in the Plan, applicable Supplements and/or applicable Participating Plan's governing documents.

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Holding Company, as a sponsor of the Plan, adopts and executes this Amendment this 28th day of June, 2017.

HANCOCK HOLDING COMPANY

By: 

Title: EVP, CHRO

SPONSOR

AMENDMENT NO. 2 TO THE
HANCOCK HOLDING COMPANY
EMPLOYEE WELFARE FUND

WHEREAS, Hancock Holding Company (the "Company") sponsors the Hancock Holding Company Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and has delegated authority to amend the Plan to the Benefits Committee;

WHEREAS, the Company wishes to amend the Plan to provide for immediate eligibility under the Plan and applicable Participating Plans to former First NBC Bank ("FNBC") employees hired by the Company and/or a Participating Employer in connection with the acquisition of certain FNBC assets from the Federal Deposit Insurance Corporation ("FDIC") by the Company's wholly-owned subsidiary, Whitney Bank, pursuant to that certain Purchase and Assumption Agreement by and between the FDIC and Whitney Bank, dated April 28, 2017;

NOW, THEREFORE, paragraph R-2 of Supplement R of the Plan is hereby amended, effective as of May 1, 2017, by adding a new subparagraph (b), to read as follows:

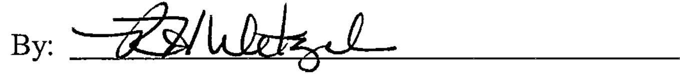
(b) FNBC Federal Deposit Insurance Corporation ("FDIC") Acquisition.

(i) Eligibility. Subject to the provisions of subparagraph (ii) below, individuals who became Employees of the Employer on April 28, 2017 (the "Hire Date") in connection with the acquisition by Whitney Bank of certain former FNBC assets from the FDIC ("Hired Employees") shall become immediately eligible to participate under the Plan and applicable Participating Plans without regard to any applicable waiting period, provided such individuals were employed by FNBC on the day immediately preceding the Hire Date and, provided further, such individuals otherwise meet the other eligibility requirements of the Plan and applicable Participating Plans. Coverage for Hired Employees who enroll under the Plan and applicable Participating Plans will be effective May 1, 2017, except for coverage under the Participating Short Term Disability Plan, Long Term Disability Plan, and company paid Life Insurance, which shall become effective on the later of May 1, 2017 or the day after their return to work date provided the Hired Employee was on an approved leave of absence.

(ii) Service Crediting and Eligibility Under the Participating Medical Plans. Hours of service with FNBC and its affiliates will not be taken into account for purposes of determining eligibility with respect to Hired Employees under the applicable Participating Medical Plan. Accordingly, except as otherwise provided in subparagraph (i) above, Hired Employees will be treated as newly-hired Employees for purposes of the measurement and stability period rules under Supplement A2.

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Holding Company, as a sponsor of the Plan, adopts and executes this Amendment this 26th day of July, 2017.

HANCOCK HOLDING COMPANY

By: 

Title: EVP, CHRO

SPONSOR

{N3423392.4}

AMENDMENT NO. 3 TO THE
HANCOCK HOLDING COMPANY
EMPLOYEE WELFARE FUND

WHEREAS, Hancock Holding Company (the "Company") sponsors the Hancock Holding Company Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and has delegated authority to amend the Plan to the Benefits Committee;

WHEREAS, the Company wishes to amend the Plan effective as of the Closing Date (as defined in the Equity Interest Purchase Agreement entered by and between Whitney Bank, a wholly owned subsidiary of the Company, and First Tower Finance Company, LLC, executed on February 22, 2018, as amended ("Agreement")) to reflect the removal of Harrison Finance Company as an Affiliate, resulting in employees of such company ceasing to be eligible for participation under the Plan in accordance with Section 5.7(h) of the Agreement;

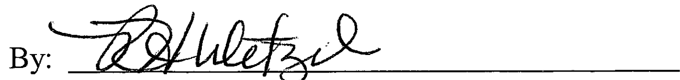
NOW, THEREFORE, Supplement Q of the Plan is hereby amended effective as of the Closing Date, to read in its entirety as follows:

SUPPLEMENT Q
Employers

Employer	Federal Tax I.D. No.
Hancock Holding Company	64-0693170
Whitney Bank	64-0169065
Hancock Investment Services	64-0867168
Hancock Insurance Agency	64-0169103
Lighthouse Service Corporation	27-1013817
Whitney Equipment Finance	47-5079398

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Holding Company, as sponsor of the Plan, adopts and executes this Amendment this 8th day of March, 2018.

HANCOCK HOLDING COMPANY

By: 

Title: EVP, Chief Human Resources Officer
SPONSOR

{N3556628.3}

**AMENDMENT NO. 4 TO THE
HANCOCK HOLDING COMPANY
EMPLOYEE WELFARE FUND**

WHEREAS, Hancock Holding Company (the "Company") sponsors the Hancock Holding Company Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and has delegated authority to amend the Plan to the Benefits Committee;

WHEREAS, effective the 25th day of May, 2018, the name of the Company will be changed to Hancock Whitney Corporation; and

WHEREAS, the Company desires to amend the Plan to change the name of the Plan and otherwise to reflect the new name of the Company.

NOW, THEREFORE, the Plan is hereby amended as follows, effective May 25, 2018:

I.

All references, in the Plan to "Hancock Holding Company," except for those under the third paragraph of Section 1.1, are hereby deleted and replaced with "Hancock Whitney Corporation."

II.

Section 2.4, **Benefits Appeals Committee**, is hereby amended and restated to read in its entirety as follows:

2.4 Benefits Appeals Committee

The term "Benefits Appeals Committee" means the Hancock Whitney Bank Benefits Appeals Committee or its successor.

III.

Section 2.5, **Benefits Committee**, is hereby amended and restated to read in its entirety as follows:

2.5 Benefits Committee

The term "Benefits Committee" means the Hancock Whitney Bank Benefits Committee or its successor.

IV.

Section 2.6, **Cafeteria Plan**, is hereby amended and restated to read in its entirety as follows and all references in the Plan to "Hancock Holding Company Cafeteria Plan" are hereby deleted and replaced with "Hancock Whitney Corporation Cafeteria Plan" accordingly:

2.6 Cafeteria Plan

The term "Cafeteria Plan" means the Hancock Whitney Corporation Cafeteria Plan.

V.

Section 2.11, **Company**, is hereby amended and restated to read in its entirety as follows:

2.11 Company

The term "Company" means Hancock Whitney Corporation.

VI.

Section 2.23, **Plan**, is hereby amended and restated to read in its entirety as follows and all references in the Plan to "Hancock Holding Company Employee Welfare Fund" are hereby deleted and replaced with "Hancock Whitney Corporation Employee Welfare Fund" accordingly:

2.23 Plan

The term "Plan" means this Hancock Whitney Corporation Employee Welfare Fund.

VII.

Section 1.1(a)(i) of Supplement O2, is hereby amended to delete all references to "Hancock Holding Company Plan and Trust Agreement" and replace them with "Hancock Whitney Corporation Pension Plan."

VIII.

Supplement R, is hereby amended and restated to read its entirety as follows:

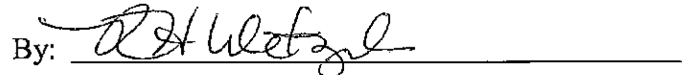
Supplement R
Employers

Employer	Federal Tax I.D. No.
Hancock Whitney Corporation	64-0693170
Hancock Whitney Bank	64-0169065

Hancock Whitney Investment Services Inc.	64-0867168
Hancock Whitney Equipment Finance, LLC	47-5079398

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Holding Company, as a sponsor of the Plan, adopts and executes this Amendment this 24th day of May 2018.

HANCOCK HOLDING COMPANY



By: ______________________

Title: EVP, CHRO

SPONSOR

AMENDMENT NO. 5 TO THE HANCOCK WHITNEY CORPORATION EMPLOYEE WELFARE FUND

WHEREAS, Hancock Whitney Corporation (previously known as Hancock Holding Company) (the "Company") sponsors the Hancock Whitney Corporation Employee Welfare Fund (previously known as the Hancock Holding Company Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and has delegated authority to amend the Plan to the Benefits Committee;

WHEREAS, the Company wishes to amend the Plan to reflect changes in the Participating Medical Plan options offered under the Plan; to clarify the eligibility requirements for coverage under the Participating Retiree Medical Plans; to clarify the date coverage ceases for Dependents covered under a Participating Retiree Plan upon a Retired Associate's death; and to add the Hancock Whitney Corporation Employee Assistance Program as a Participating Plan;

NOW, THEREFORE, the Plan is hereby amended as follows, effective January 1, 2018, unless otherwise stated:

I.

Section 2.14, **Eligible Associate**, is hereby amended and restated to read in its entirety as follows

2.14 **Eligible Associate**

Except as specifically set forth in this Section 2.14 and Plan Supplements with respect to individual Participating Plans, the term "Eligible Associate" means an Associate who satisfies the rules for eligibility as set forth in Section 3. The foregoing notwithstanding, for purposes of the Participating Medical Plans, an Eligible Associate means an Associate who also satisfies the eligibility requirements under Plan Supplement A2. Notwithstanding any provision of this Plan (including attached Supplements) or Participating Plans to the contrary, effective July 1, 2018, except for purposes of the Participating Employee Assistance Program described in Supplement Q, the term Eligible Associate shall not include Associates classified as interns.

II.

The first sentence of Section A-9, Participating Medical Plan Documents Incorporated By Reference, of Supplement A1, Participating Medical Plans, is hereby amended and restated to read in its entirety as follows:

The terms and provisions of the following Participating Medical Plan documents, including any amendments or modifications thereto, are incorporated

by reference and, subject to the terms of paragraph A-10, constitute the controlling terms and provisions of the applicable Participating Medical Plan:

(a) The most recent Employee Booklet and Summary Plan Description for the Employee Health Protection Plan for Hancock Whitney Corporation and its Subsidiaries, a Preferred Provider Organization ("PPO") plan administered by Blue Cross Blue Shield of Mississippi, Plan Type C524; and

(b) The most recent Employee Booklet and Summary Plan Description for the Employee Health Protection Plan for Hancock Whitney Corporation and its Subsidiaries – High Deductible, a High Deductible Health Plan ("HDHP") administered by Blue Cross Blue Shield of Mississippi, Plan Type HD20HD21.

III.

Section G-2, Components of Cafeteria Plan, of Supplement G, Cafeteria Plan, is hereby amended and restated in its entirety to read as follows:

G-2 Components of Cafeteria Plan. The Cafeteria Plan consists of the following components: an Insurance Premium Payment Plan ("Premium Plan"), a Health Flexible Spending Account Plan, a Dependent Care Flexible Spending Account Plan and a Health Savings Account Program.

IV.

Paragraphs (a) and (b) of Section O-2, Eligibility, of Supplement O1, Participating Retiree Plans, are hereby amended and restated in their entirety to read as follows:

(a) The retired Associate meets the eligibility criteria specified under the retiree medical benefit plans ("Participating Retiree Medical Plan") specified in subparagraph O-7(a), (b) or (c), as applicable, which are incorporated herein by reference, as modified by Supplement O2.

(b) The retired Associate meets the eligibility criteria specified under the retiree life insurance benefit plan ("Participating Life Insurance Plan") specified in subparagraph O-7(d), which is incorporated herein by reference.

V.

The second paragraph of Section O-5, Termination of Coverage, of Supplement O1, Participating Retiree Plans, is hereby amended and restated in its entirety to read as follows:

In the event coverage is terminated pursuant to subparagraph (a), subject to the terms of the Participating Retiree Plan, coverage may continue through the end of

the month in which the death occurred (or, in the case of the Participating Retiree Plan specified in subparagraph O-7(c), through the end of the month following the month in which the death occurred), provided premiums have been paid through such date.

VI.

Section O-7, Participating Retiree Plan Documents Incorporated By Reference, of Supplement O1, Participating Retiree Plans, is hereby amended and restated in its entirety to read as follows:

O-7. Participating Retiree Plan Documents Incorporated By Reference. The terms and provisions of the following Participating Retiree Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph O-8, constitute the controlling terms and provisions of the applicable Participating Retiree Plan:

(a) The most recent 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;

(b) The most recent Employee Booklet and Summary Plan Description for the Employee Health Protection Plan for Hancock Whitney Corporation and Its Subsidiaries – High Deductible, an HDHP administered by Blue Cross Blue Shield of Mississippi, Plan Type HD20HD21

(c) The most recent Evidence of Coverage and Summary Plan Description for the Humana Medicare Employer PPO issued by Humana Insurance Company;

(d) The most recent Summary Plan Description and group insurance contract for the retiree life insurance coverage offered to Retired Associates under Standard Insurance Company, Policy No. 643851-F, and

(e) The most recent plan document, Summary Plan Description and group insurance contract (if applicable) or other governing plan document, as applied to Retired Associates and their Dependents, for any new Participating Retiree Plan option selected by the Company.

Coverage under Participating Retiree Plan options (a) and (b) is self-insured. Coverage under Participating Retiree Plan options (c) and (d) is fully-insured. The Company, in its sole discretion, retains the right to amend or

terminate any insurance contract in conjunction with the applicable insurance company for any insured plan option, to amend or terminate any self-insured Participating Retiree Plan coverage option, and/or to change the cost of any insured or self-insured Participating Retiree Plan coverage at any time, subject to any applicable agreement with the insurance provider, as applicable. The Plan Administrator may add or delete Participating Retiree Plan coverage options without formal amendment of this paragraph O-7 to reflect changes in coverage options offered under the Plan. If a new retiree coverage option is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Covered Persons and Eligible Associates will be notified regarding any such changes.

VII.

Section 1.1, Eligibility Requirements, of Supplement O2, Eligibility Under Participating Retiree Medical Plans, is hereby amended to replace all references to "O-7(a)" and "O-7(b)" in subparagraphs (a) and (b), respectively, with "O-7(a), (b) or (c)" and to insert the following as a new first paragraph of the flush language at the end of such Section to read in its entirety as follows:

Notwithstanding the foregoing, a Whitney or Hancock Retiree, as applicable, will only be eligible for coverage under the Participating Retiree Plan listed in paragraph O-7(c), if the Whitney or Hancock Retiree, as applicable, is enrolled in Medicare Parts A and B.

VIII.

The Plan is hereby amended to insert a new Supplement Q, Participating Employee Assistance Program, to read in its entirety as follows and to re-designate current Supplement Q and Supplement R accordingly:

Supplement Q
Participating Employee Assistance Program

Q-1. Purpose. The purpose of this Supplement Q is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the employee assistance program specified in paragraph Q-3 ("Participating Employee Assistance Program") made available to Eligible Associates and their Dependents. Unless otherwise specified in this Supplement Q, capitalized terms shall have the same meaning as given them in Section 2 of the Plan document.

Q-2. Eligibility. Notwithstanding subsection 2.14 of the Plan, coverage under the Participating Employee Assistance Program shall be available to Eligible Associates and their Dependents who meet the eligibility requirements

specified in the Participating Employee Assistance Program plan documents listed below in paragraph Q-3.

Q-3. Participating Employee Assistance Program Plan Documents Incorporated by Reference. The terms and provisions of the Hancock Whitney Corporation Employee Assistance Program, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph Q-4, constitute the controlling terms and provisions of the applicable Participating Employee Assistance Program.

The Participating Employee Assistance Program is Company-paid, with no cost to the employee. The Company or Employer, in its sole discretion, retains the right to amend the Participating Employee Assistance Program and/or to terminate the Participating Employee Assistance Program at any time. The Plan Administrator or its designee may add or delete the Participating Employee Assistance Program under the Plan without formal amendment of this paragraph Q-3 to reflect changes in coverage options offered under the Plan. If a new or additional employee assistance program is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Eligible Associates will be notified of any changes.

Q-4. Resolution of Conflicts. Eligibility to participate in the Participating Employee Assistance Program shall be determined in accordance with the Participating Employee Assistance Program plan document incorporated by reference under this Supplement Q by the person or persons having discretionary authority to determine such eligibility pursuant to the provisions of the Participating Employee Assistance Program plan document. In the event there is a conflict in the interpretation of the Plan document, this Supplement Q, and the Participating Employee Assistance Program plan document incorporated by reference under this Supplement Q, the terms of the Participating Employee Assistance Program plan documents incorporated herein by reference shall control first, this Supplement Q next, and the Plan document last. Except as otherwise provided in the Participating Employee Assistance Program plan document, the Plan Administrator or its designee has the discretionary authority to interpret the Plan document, this Supplement Q, the Participating Employee Assistance Program plan document and any supplement or addendum thereto that may be prepared and issued by the Plan Administrator.

[signature page follows]

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Whitney Corporation, as a sponsor of the Plan, adopts and executes this Amendment this 9th day of July 2018.

HANCOCK WHITNEY CORPORATION

By: RH Wetzel

Title: EVP, CHRO

SPONSOR

AMENDMENT NO. 6 TO THE
HANCOCK WHITNEY CORPORATION
EMPLOYEE WELFARE FUND

WHEREAS, Hancock Whitney Corporation (the "Company") sponsors the Hancock Whitney Corporation Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and the Company has delegated authority to amend the Plan to the Benefits Committee;

WHEREAS, the Company desires to amend the Plan to provide credit under the Plan for Years of Service with Capital One, National Association, and certain of its affiliates ("Capital One") to employees of Capital One who became employed by the Company or an Affiliate in connection with the acquisition of certain business operations from Capital One by the Company's wholly-owned subsidiary, Hancock Whitney Bank (previously known as Whitney Bank), pursuant to that certain Transaction Agreement by and among Capital One, National Association, Interim Bank Virginia, N.A., Interim Bank Louisiana, N.A., and Hancock Whitney Bank, dated December 15, 2017;

NOW, THEREFORE, paragraph R-2 of Supplement R of the Plan is hereby amended, effective July 14, 2018, by adding a new subparagraph (c), to read as follows:

(c) Capital One, National Association ("Capital One") Acquisition.

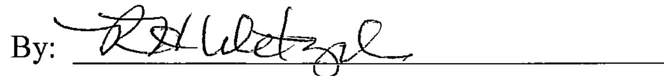
(i) Eligibility. Subject to the provisions of subparagraph (ii) below, individuals who became Employees of the Employer on July 14, 2018 (the "Transfer Date") in connection with the acquisition by Hancock Whitney Bank of certain business operations from Capital One ("Transferred Employees") shall become immediately eligible to participate under the Plan and applicable Participating Plans without regard to any applicable waiting period, provided such individuals were employed by Capital One on the day immediately preceding the Transfer Date. Coverage for Transferred Employees who enroll under the Plan and applicable Participating Plans will be effective July 14, 2018, except for coverage under the Participating Medical, Dental and Vision Plans and the Health Savings Account Program under the Cafeteria Plan, which coverage shall become effective on August 1, 2018. Notwithstanding the foregoing, coverage under the Participating Short Term Disability Plan shall become effective on the later of the Transfer Date or the day after the Transferred Employee's return to work date provided the Transferred Employee was on an approved leave of absence on July 14, 2018.

(ii) Service Crediting and Eligibility Under the Participating Medical Plans. Hours of service with Capital One and its affiliates will be taken into account for purposes of determining Transferred Employees' eligibility under the applicable Participant Medical Plan such that Transferred Employees in a stability period with respect to Capital One's group health plan will retain such status under the Participating Medical Plans through the end of such stability period. Thereafter, the measurement and

stability period rules under Supplement A2 will apply and will take into account prior service with Capital One. If a Transferred Employee is not in a stability period with respect to Capital One's group health plan at the time of the transaction, then the Transferred Employee's status will be determined under the measurement and stability period rules described under Supplement A2, taking into account prior service with Capital One.

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Whitney Corporation, as a sponsor of the Plan, adopts and executes this Amendment this 12th day of July, 2018.

HANCOCK WHITNEY CORPORATION



By: ______________________

Title: EVP, CHRO

SPONSOR

**AMENDMENT NO. 7 TO THE
HANCOCK WHITNEY CORPORATION
EMPLOYEE WELFARE FUND**

WHEREAS, Hancock Whitney Corporation (the "Company") sponsors the Hancock Whitney Corporation Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and the Company has delegated authority to amend the Plan to the Benefits Committee;

WHEREAS, MidSouth Bancorp, Inc. ("MidSouth") and its wholly-owned subsidiary, MidSouth Bank, N.A., are expected to merge with and into the Company and its wholly-owned subsidiary, Hancock Whitney Bank, pursuant to that certain Agreement and Plan of Merger by and between Hancock Whitney Bank and MidSouth Bancorp, Inc., dated April 30, 2019 (the "Mergers"); and

WHEREAS, the Company desires to amend the Plan to provide credit under the Plan for Years of Service with MidSouth and its subsidiaries to employees of MidSouth and its subsidiaries who became employed by the Company or an Affiliate in connection with the Mergers.

NOW, THEREFORE, the Plan is hereby amended as follows, effective September 21, 2019 (or, if different, the actual effective date of the Mergers), unless otherwise stated:

I.

Paragraph J-2 of Supplement J of the Plan is hereby amended and restated to read as follows:

> J-2 Eligibility. Notwithstanding Section 2.14 of the Plan, for purposes of the Participating Severance Plans listed in paragraph J-3, an Eligible Associate shall mean an Associate who meets the eligibility requirements specified in the applicable Participating Severance Plan document.

II.

Paragraph J-3 of Supplement J of the Plan is hereby amended and restated to read as follows:

> J-3 Participating Severance Plan Documents Incorporated by Reference. The terms and provisions for the following Participating Severance Plan documents, including any amendments or modifications thereto, are incorporated by reference and, subject to the terms of paragraph J-4, constitute the controlling terms and provisions of the applicable Participating Severance Plan:

(a) Hancock Whitney Corporation Severance Pay Plan and Summary Plan Description ("Hancock Severance Plan").

(b) MidSouth Bank Severance Plan and Summary Plan Description ("MidSouth Severance Plan").

The Participating Severance Plans are self-insured. The Company or Employer, in its sole discretion, retains the right to amend the Participating Severance Plans and/or to terminate the Participating Severance Plans at any time. The Plan Administrator or its designee may add or delete Participating Severance Plans under the Plan without formal amendment of this paragraph J-3 to reflect changes in coverage options offered under the Plan. If a new or additional severance plan is added to the Plan, the terms and provisions of such coverage option's documents, including any amendments or modifications thereto, shall automatically be incorporated herein by reference. Eligible Associates will be notified of any changes.

Notwithstanding any provisions in the Participating Severance Plans to the contrary: (i) only Transferred Employees (as defined in subparagraph (d) of Supplement R-2) shall be eligible for the MidSouth Severance Plan and such Transferred Employees shall be eligible as of the Transfer Date (as defined in subparagraph (d) of Supplement R-2); (ii) Transferred Employees shall first become eligible to participate in the Hancock Severance Plan on the one year anniversary of the Transfer Date (such one year anniversary is expected to occur on September 21, 2020); and (iii) the MidSouth Severance Plan will terminate and cease to be a Participating Severance Plan under the Plan effective as of the one year anniversary of the Transfer Date.

III.

Paragraph R-2 of Supplement R of the Plan is hereby amended by adding a new subparagraph (d) to read as follows:

(d) MidSouth Bancorp, Inc. ("MidSouth") Acquisition.

(i) Eligibility. Subject to the provisions of subparagraph (ii) below, individuals who become Employees of the Employer upon the mergers of MidSouth and its wholly-owned subsidiary, MidSouth Bank, N.A., with and into the Company and Hancock Whitney Bank ("Transferred Employees") (expected to occur on September 21, 2019 (the "Transfer Date")) shall be immediately eligible to participate under the Plan and applicable Participating Plans without regard to any applicable waiting period, provided such individuals were employed by MidSouth or a subsidiary thereof on the day immediately preceding the Transfer Date and provided further that, except as otherwise provided in Paragraph J-3 of Supplement J (regarding Participating Severance Plans), coverage for Transferred Employees who enroll under the Plan and applicable Participating Plans will be effective on October 1, 2019.

(ii) Service Crediting and Eligibility Under the Participating Medical Plans. Hours of service with MidSouth and its affiliates will be taken into account for purposes of determining Transferred Employees' eligibility under the applicable Participating Medical Plan such that Transferred Employees in a stability period with respect to MidSouth's group health plan will retain such status under the Participating Medical Plans through the end of such stability period. Thereafter, the measurement and stability period rules under Supplement A2 will apply and will take into account prior service with MidSouth. If a Transferred Employee is not in a stability period with respect to MidSouth's group health plan on the Transfer Date, then the Transferred Employee's status will be determined under the measurement and stability period rules described under Supplement A2, taking into account prior service with MidSouth.

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Whitney Corporation, as a sponsor of the Plan, adopts and executes this Amendment this 20th day of September, 2019.

HANCOCK WHITNEY CORPORATION

By: ____________________

Title: EVP, CHRO

SPONSOR

AMENDMENT NO. 8 TO THE
HANCOCK WHITNEY CORPORATION
EMPLOYEE WELFARE FUND

WHEREAS, Hancock Whitney Corporation (the "Company") sponsors the Hancock Whitney Corporation Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and the Company has delegated authority to amend the Plan to the Benefits Committee; and

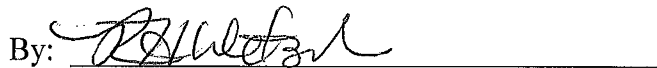
WHEREAS, the Company wishes to amend the Plan for consistency with recent changes to the Employer's disability leave policy.

NOW, THEREFORE, the first paragraph of Section 3.4 of the Plan is hereby amended, effective January 1, 2020, to add the following at the end thereof:

> Notwithstanding the foregoing and except as otherwise provided under Supplement A3 or a Participating Plan's governing documents, as applicable, coverage under the Plan and Participating Plans for an Associate who is on a leave of absence (paid or unpaid) that extends beyond 180 days shall cease, effective on the last day of the month coinciding with or following the 181st day that the Associate is on a leave of absence.

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Whitney Corporation, as a sponsor of the Plan, adopts and executes this Amendment this 5th day of February, 2020.

HANCOCK WHITNEY CORPORATION

By: 

Title: EVP, CHRO
SPONSOR

**AMENDMENT NO. 9
TO THE
HANCOCK WHITNEY CORPORATION
EMPLOYEE WELFARE FUND**

WHEREAS, Hancock Whitney Corporation (the "Company") sponsors the Hancock Whitney Corporation Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and the Company has delegated authority to amend the Plan to the Benefits Committee;

WHEREAS, the Company also sponsors the Hancock Whitney Corporation Pension Plan, which has been amended to add a new retiree medical account and applicable life insurance account feature and to allow for qualified transfers of excess pension assets to such accounts in accordance with Sections 401(h) and 420, respectively, of the Internal Revenue Code of 1986, as amended (the "Code");

WHEREAS, the Company desires to amend the Plan to require Participating Retiree Medical Plans and Participating Life Insurance Plans to satisfy the requirements under Code Section 420(c).

NOW, THEREFORE, the Plan is hereby amended, effective January 1, 2020, as follows:

I.

The second sentence of Paragraph O-8, Resolution of Conflicts, of Supplement O1, Participating Retiree Plans, is hereby amended and restated to read in its entirety as follows:

> Except as otherwise provided in paragraphs O-2 and O-9 and Supplement O2, in the event there is a conflict in the interpretation of the Plan document, this Supplement O1, and the Participating Retiree Plan documentation incorporated by reference under this Supplement O1, the terms of the Participating Retiree Plan documentation incorporated by reference shall control first, this Supplement O1 next, and the Plan document last.

II.

Supplement O1, Participating Retiree Plans, is hereby amended to add a new paragraph O-9, Minimum Cost Requirements, to read in its entirety as follows:

> O-9 Minimum Cost Requirements. To the extent benefits under a Participating Retiree Medical Plan or a Participating Life Insurance Plan are funded with assets from a Qualified Transfer made, respectively, to the Medical Benefits Account or the Applicable Life Insurance Account under Article XXV of the Pension Plan (as defined under Section 1.1 of Supplement O2), the Employer will comply with the minimum cost requirements under Code Section 420(c)(3). The minimum cost requirements are met if the Applicable Employer Cost for each taxable year during the Cost Maintenance Period is not less than the higher of the Applicable Employer Costs for each of the two (2) taxable years immediately

preceding the taxable year of the Qualified Transfer. The Employer may elect to apply the minimum cost requirements under Code Section 420(c)(3) separately as to individuals eligible for benefits under Title XVIII of the Social Security Act at any time during the year and individuals not so eligible.

For purposes of this paragraph O-9, The Applicable Employer Cost for a taxable year is determined by dividing the qualified current retiree liabilities (as defined under Code Section 420(e)(1)) of the Employer for the taxable year by the number of individuals to whom coverage for applicable health benefits or applicable life insurance benefits, as applicable, was provided during such taxable year. For this purpose, qualified current retiree liabilities are determined (a) separately with respect to applicable health benefits and applicable life insurance benefit and (b) without regard to any reduction under Code Section 420(e)(1)(B). In the case of a taxable year in which there was no Qualified Transfer, qualified current retiree liabilities shall be determined in the same manner as if there had been such a transfer at the end of the taxable year.

For the purpose of this paragraph O-9, the term "Cost Maintenance Period" shall mean the period of five (5) consecutive taxable years beginning with the taxable year in which the Qualified Transfer occurs.

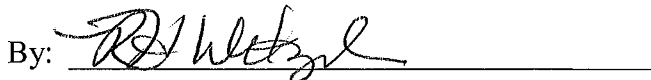
For the purpose of this paragraph O-9, the terms "applicable health benefits" and "applicable life insurance benefits" shall have such meaning as ascribed to them under Code Section 420(e)(1)(C) and (D), respectively.

If a taxable year is in two or more overlapping Cost Maintenance Periods, the requirements under this paragraph O-9 shall be applied by taking into account the highest Applicable Employer Cost required to be provided under Code Section 420(c)(3)(A) for such taxable year.

The provisions of this paragraph O-9 are hereby incorporated by this reference into, and shall be applicable with respect to, each Participating Retiree Plan notwithstanding any other provisions of such Participating Retiree Plan.

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Whitney Corporation, as a sponsor of the Plan, adopts and executes this Amendment this 6th day of February, 2020.

HANCOCK WHITNEY CORPORATION



By: ____________

Title: EVP, CHRO

SPONSOR

AMENDMENT NO. 10 TO THE
HANCOCK WHITNEY CORPORATION
EMPLOYEE WELFARE FUND

WHEREAS, Hancock Whitney Corporation (the "Company") sponsors the Hancock Whitney Corporation Employee Welfare Fund ("Plan");

WHEREAS, pursuant to Section 9.1 of the Plan, the Company has the authority to amend the Plan and has delegated such authority to the Benefits Committee; and

WHEREAS, the Company wishes to amend the Plan to provide extended group health coverage under the Participating Medical Plans for a limited period to former Associates who elect to participate in the Voluntary Early Retirement Incentive Program ("VERIP") and their eligible Dependents.

NOW, THEREFORE, the Plan is hereby amended as follows, effective January 1, 2021, unless otherwise stated:

I.

The second sentence of the second paragraph of Section A-2, Eligibility, of Supplement A1, Participating Medical Plans, is hereby deleted and replaced with the following:

> The eligibility requirements and terms and conditions of such extensions of coverage with respect to such individuals will be determined in accordance with the terms of the applicable supplement to the Plan or, if not specifically addressed in a supplement, the provisions of individual or group agreements, which terms shall be incorporated herein by reference and described on Supplement A3, without the necessity of an amendment to the Plan.

II.

The Plan is hereby amended to insert a new Supplement A4, Extension of Medical Coverage for Individuals Participating in the Voluntary Early Retirement Incentive Program, to read in its entirety as follows:

Supplement A4
Extension of Medical Coverage for Individuals Participating in the Voluntary Early Retirement Incentive Program

1.1 Eligibility Requirements Former Associates who elect to retire under the Company's Voluntary Early Retirement Incentive Program ("VERIP") ("VERIP Retiree") will be eligible for limited duration Company subsidized medical coverage under the applicable Participating Medical Plan in which the VERIP Retiree was covered on the date he or she

separates from service with the Employer on account of participation in the VERIP, if the VERIP Retiree satisfies the following requirements:

(i) as of March 31, 2021, was at least 60 years of age;

(ii) is not eligible for retiree coverage under any Participating Retiree Medical Plan pursuant to Supplements O1 and O2;

(iii) is not eligible for Medicare; and

(iv) does not enroll in COBRA continuation coverage under the applicable Participating Medical Plan at any time during the COBRA election period after the VERIP Retiree's separation from service with the Employer.

The Company's extended coverage premium subsidy shall be that amount as established by the Company and communicated to VERIP Retirees each year the VERIP Retiree remains eligible for extended coverage under this Supplement A4. The Company, in its sole discretion, retains the right to terminate or change the amount of subsidy at any time.

1.2 Dependents. VERIP Retirees may elect to continue coverage for their eligible Dependents if those individuals were covered under the applicable Participating Medical Plan covering the VERIP Retiree on the date he or she separates from service with the Employer on account of participation in the VERIP, except for those Dependents who are eligible for Medicare or who elected COBRA continuation coverage at any time during the COBRA election period after the VERIP Retiree separation from service with the Employer.

1.3 Election, Contribution Required.

(a) A VERIP Retiree who meets the eligibility requirements of Section 1.1 of this Supplement A4 must make a written election to enroll in extended coverage for the VERIP Retiree and his or her Dependents in accordance with the procedures established by the Plan Administrator. Further, as a condition of the extended coverage under this Supplement A4, the VERIP Retiree must make required contributions in the amount, time, and manner specified by the Company. The contributions required of a VERIP Retiree, for himself or herself and for his or her Dependents, to continue coverage under the applicable Participating Medical Plan pursuant to this Supplement A4, as well as the deductibles, benefit limitations, and other coverage features, may differ from those applicable to active Associates.

(b) Eligible VERIP Retirees may elect to continue medical coverage under the applicable Participating Medical Plan in which the VERIP Retiree and his or her Dependents were covered immediately prior the VERIP Retiree's retirement at the same coverage level in place on such date or a lower coverage level. For example, if the VERIP Retiree was enrolled in employee plus Spouse coverage,

he or she may instead elect to enroll in individual plus child(ren), or individual only coverage, but may not elect family coverage.

1.4 Termination of Coverage/Dropping Coverage.

(a) Extended coverage for the VERIP Retiree and covered Dependents under this Supplement A4 ends on the earlier of the following to occur:

(i) the fifth anniversary of the date on which extended coverage under this supplement A4 becomes effective, or

(ii) the date on which the VERIP Retiree or covered Dependent becomes eligible for Medicare.

(b) VERIP Retirees may cancel coverage for themselves and covered Dependents at any time. Except as otherwise provided in the applicable Participating Medical Plan, a VERIP Retiree and his or her Dependents who are not enrolled when first eligible, or who subsequently discontinue coverage, will be prohibited from enrolling or reenrolling in the future.

IN WITNESS WHEREOF, the undersigned, acting on behalf of Hancock Whitney Corporation, as a sponsor of the Plan, adopts and executes this Amendment this 31st day of December 2021.

HANCOCK WHITNEY CORPORATION

By:

Title: EVP, Chief HR Officer

SPONSOR