# Ball Benefits

# Ball Corporation Consolidated Welfare Benefit Plan for Retired Employees

# Retiree Health Reimbursement Arrangement (HRA)

# Summary Plan Description

## Effective January 1, 2021

**For the Following Medicare-Eligible Retirees:**

Eligible Salary and Plant Non-Union Retirees

# Table of Contents

# Introduction

This ***"Summary Plan Description"*** (SPD) explains how the Retiree Health Reimbursement Arrangement (HRA) component of the Ball Corporation Consolidated Welfare Benefit Plan for Retired Employees (the "Plan") works for the retired employees noted in the ***"Eligibility"*** section of this document. This summary contains the relevant HRA and Plan provisions as of the date the document was prepared, as shown on the title page, and it replaces all previous summaries. All references to the Plan refer to the HRA component.

The information included in this document describes your benefits and your obligations under the Plan. It also explains your rights and the Plan's responsibilities and includes other important information that you should know about the Plan.

As you read about your benefits, you may find words and phrases that need more explanation. In most cases, those words and phrases are explained within the text of the summary. However, if you are unsure about the meaning of a word or phrase, you may contact Via Benefits (refer to the ***"Contact Information"*** section).

# Eligibility

## Retiree

You are eligible to enroll in this Plan if you are:

- A Salary or Plant (non-union) retiree of Ball Corporation and you meet the following eligibility criteria.

If you are younger than age 65 and not eligible for Medicare, you are eligible to enroll in this Plan if you are a(n):

- Retiree enrolled in the Ball Pre-Medicare Retiree Medical Plan, remain enrolled in the Ball Pre-Medicare Retiree Medical Plan until you reach age 65, and then enroll in Medicare Eligible Medical coverage through Via Benefits when it is initially offered upon reaching age 65, or
- Active employee hired or rehired before January 1, 2016, meet the age and service requirement (at least age 55 with 10 or more years of service) by July 1, 2017, retire and enroll in the Ball Pre-Medicare Retiree Medical Plan, remain covered by the Ball Pre-Medicare Retiree Medical Plan until age 65, and then enroll in Medicare Eligible Medical coverage through Via Benefits when it is initially offered upon reaching age 65.

**Exception:** If you do not remain continuously enrolled in the Ball Pre-Medicare Retiree Medical Plan, you may still be eligible for this Plan if:

- You elected COBRA coverage at the time of retirement instead of enrolling in the Ball Pre-Medicare Retiree Medical Plan and later enroll in the Ball Pre-Medicare Retiree Medical Plan (or the Ball Post-Medicare Retiree Medical Plan, if eligible) when your COBRA coverage ended, or
- You are covered as a dependent on your spouse or domestic partner's active Ball employee medical plan.

If you are age 65 or older and eligible for Medicare, you are eligible to enroll in this Plan if you are a(n):

- Active employee hired or rehired before January 1, 2016; meet the age and service requirement (at least age 65 with 5 or more years of service) by July 1, 2017; retire and enroll in Medicare Eligible Medical coverage through Via Benefits when it is initially offered, or
- Retiree that was enrolled in the Ball Medicare Eligible Retiree Medical Plan as of July 1, 2017, and then enrolled in Medicare Eligible Medical coverage through Via Benefits when it was initially offered.

**Exception:** If you do not enroll in Medicare Eligible Medical coverage through Via Benefits when it is initially offered to you, you may still be eligible for this Plan if you are covered as a dependent on your spouse or domestic partner's active Ball employee medical plan.

## Dependent

Your spouse or domestic partner is eligible for enrollment under this Plan if he or she is your eligible dependent on the date your active employment ended and is:

- Younger than age 65, not eligible for Medicare, and:
  - You are both enrolled in the Ball Pre-Medicare Retiree Medical Plan, you both remain enrolled in the Ball Pre-Medicare Retiree Medical Plan until reaching age 65, and then enroll in Medicare Eligible Medical coverage through Via Benefits when initially offered, or
  - He or she is enrolled in the Ball Pre-Medicare Retiree Medical Plan, you are enrolled in Medicare Eligible Medical coverage through Via Benefits, provided your coverage continues and your spouse or domestic partner remains in the Ball Pre-Medicare Retiree Medical Plan until age 65, and then enrolls in Medicare Eligible Medical coverage through Via Benefits when it is initially offered upon reaching age 65, or
- Age 65 or older, eligible for Medicare, and:
  - You are both enrolled in Medicare Eligible Medical coverage through Via Benefits, or
  - He or she is enrolled in Medicare Eligible Medical coverage through Via Benefits, provided you are a pre-65 retiree enrolled in the Ball Pre-Medicare Retiree Medical Plan. When you reach age 65, your spouse or domestic partner will continue to be eligible if you enroll in Medicare Eligible Medical coverage through Via Benefits when it is initially offered upon reaching age 65.

Any individual who becomes your spouse or domestic partner after the date your active employment ended is not eligible for this Plan.

Your children are not eligible as Dependents under this Plan.

**Note:** If you enroll your eligible spouse or domestic partner, you must provide his or her name, birth date, Social Security number, and gender to the Plan. If you knowingly enroll a spouse or domestic partner who is ineligible, you will be responsible for repaying the Plan for claims paid for that spouse or domestic partner. Additionally, you may lose coverage and/or face legal action for fraud.

# Participation

Retirees and eligible dependents become participants of the Plan when they meet the eligibility and enrollment requirements of the Plan.

## When Coverage Begins

Participation can begin the first day of the month after your retirement date from the Company and after any eligibility and enrollment requirements have been met. If you retired before age 65 and you are covered in the Ball Pre-Medicare Eligible Medical Plan, participation can begin on the first day of the month after you turn age 65. If your 65th birthday is the first day of the month, participation may begin on the first day of the prior month. However:

- If you waive coverage, your dependent cannot be covered under this Plan.

- If you are Medicare-eligible but your dependent is not eligible for Medicare, you may be enrolled in this Plan.

## When Coverage Ends

Your coverage will end on the earliest of the date:

- You no longer meet the eligibility requirements
- You drop Medicare Eligible Medical coverage through Via Benefits
- You are rehired as a full-time or part-time employee with eligibility for active employee benefits
- Of your death
- The Plan is amended so that you are no longer eligible
- The Plan is terminated, or
- It is determined by the Company that you (or a person seeking coverage on your behalf) engaged in misconduct with respect to the Plan (including but not limited to intentional misrepresentations of material fact or acts of fraud regarding eligibility and claims and failure to notify the Plan of a fact or event that could affect your right to receive coverage, payment, or reimbursement under the Plan).

**Dependent No Longer Eligible**
If your covered dependent dies or is no longer eligible, you should immediately contact Via Benefits (refer to the ***"Contact Information"*** section). If applicable, allocation of the annual subsidy toward an HRA Account for your dependent will stop effective as of the date that the dependent is no longer eligible. However, you may submit claims for eligible medical expenses incurred before your dependent became ineligible up to the available balance. Claims must be submitted within 180 days of the date your dependent became ineligible.

## In the Event of Death

**Retiree**
If you die with no eligible dependent enrolled in the Plan, your HRA Account is immediately forfeited as of your date of death. However, your estate or representatives may submit claims for eligible medical expenses you incurred before your death up to the available balance. Claims must be submitted within 180 days of your death.

**Dependent**
If you die and your dependent is covered under the Plan at the time of your death, the HRA Account will continue and your dependent can continue to submit eligible medical expenses for reimbursement up to the available balance. In addition, your dependent will continue to receive the annual subsidy for the dependent's portion as long as he or she remains covered under Medicare Eligible Medical coverage through Via Benefits. This means that your dependent could continue to receive the annual subsidy until he or she is no longer eligible (e.g., until your dependent's death).

# General Plan Information

This Health Reimbursement Arrangement (HRA) component of the Plan is designed to reimburse you and your eligible dependent for eligible medical expenses that are not otherwise reimbursed by any other plan or program. Reimbursements for eligible medical expenses paid by the Plan generally are excludable from your taxable income.

The Company intends the HRA to qualify as a “health reimbursement arrangement” as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended. The Plan is also intended to be exempt from the Affordable Care Act as a separate “retiree-only” plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2). The Plan will be interpreted at all times in a manner consistent with such intent.

# How the Plan Works

- An HRA Account is established in your name.
- The Company credits your HRA Account with an annual subsidy.
- You can use your HRA Account for reimbursement of eligible medical expenses (including certain insurance premiums) for yourself and your enrolled dependent up to the available amount in your HRA at the time of reimbursement.

# Establishing an Account

To establish an HRA Account, you must follow the instructions provided in the “Enrollment Guide,” which is provided by Via Benefits.

Once you are enrolled in the Plan, an HRA Account will be established in your name. If you and your dependent are enrolled in the Plan, only one account is established, in your name. An annual subsidy for you and your dependent will be credited to this one account.

An HRA Account is merely a bookkeeping account on the Company’s records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Company’s general assets.

# Subsidy

Once you are enrolled in the Plan, the Company will credit your HRA Account with an annual subsidy. If your dependent is also enrolled, you will receive an additional annual subsidy for your dependent.

The subsidy is applied annually, as of January 1 each year. When you are initially eligible, the annual subsidy is prorated based on when your participation begins and the subsidy is applied as of the date you meet the Plan’s eligibility requirements. For example, if you become eligible and enroll as of July 1, you will receive one-half of the annual subsidy since you will only be covered under the Plan for one-half of the year.

# Eligible Medical Expenses for HRA Account Reimbursement

An eligible medical expense is an expense incurred by you or your covered dependent for medical care, as that term is defined in Internal Revenue Code Section 213(d). Generally, these are expenses related to the diagnosis, care, mitigation, treatment, or prevention of disease).

When you incur an eligible medical expense, you can use your HRA Account to reimburse yourself for eligible medical expenses incurred up to the available amount in your HRA at the time of reimbursement.

Some common examples of eligible medical expenses include:

- Medicare Part B premiums
- Individual Medicare supplemental or Medicare Advantage medical premiums
- Prescription drug plan premiums
- Vision plan premiums
- Dental plan premiums
- Long-term care premiums, and
- Other medical, dental, and vision out-of-pocket expenses.

Only eligible medical expenses incurred while you are a participant in the Plan may be reimbursed from your HRA Account. Similarly, only eligible medical expenses incurred while your dependent is a participant in the Plan may be reimbursed from your HRA Account.

Eligible medical expenses are incurred when the medical care is provided, not when you or your dependent is billed, charged, or pay for the expense. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (e.g., pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

If you need more information about whether an expense is eligible for reimbursement under the Plan, contact the Claims Administrator. The Claims Administrator (and its delegates) determines what an eligible medical expense is.

## Other Medical Plan Coverage

Only medical care expenses that have not been or will not be reimbursed by any other source may be eligible medical expenses (to the extent all other conditions for eligible medical expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement from your HRA Account.

# Expenses Not Eligible for Reimbursement

Some examples of common items that are not eligible medical expenses include:

- Prescription drug out-of-pocket expenses
- Baby-sitting and child care
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease)
- Funeral and burial expenses
- Household and domestic help
- Massage therapy
- Custodial care
- Health club or fitness program dues (unless specific requirements are satisfied), and
- Cosmetics, toiletries, toothpaste.

This is not an exhaustive list of expenses that are not eligible medical expenses. For more information about what items may or may not be eligible medical expenses, consult IRS Publication 502, “Medical and Dental Expenses,” under the headings “What Medical Expenses Are Includible” and “What Expenses Are Not Includible.” You may also contact the Claims Administrator if you have specific question about eligible expenses under this Plan.

In addition, the following expenses may not be reimbursed from an HRA Account:

- Expenses incurred for qualified long term care services
- Expenses incurred for covered Part D prescription drugs
- Expenses incurred before you became a participant in this Plan
- Expenses incurred after your participation in this Plan ends
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan, and
- Any other expenses specifically identified by the Claims Administrator as not covered by the Plan.

You may not be reimbursed for any eligible medical expenses incurred after the date your eligibility ends.

# HRA Account Balance

At any time, you may receive reimbursement for eligible medical expenses, up to the amount in your HRA Account. **Note:** The law does not allow you to make any contributions to your HRA Account.

If you do not use the entire subsidy credited to your HRA Account during the year, your credited Account balance will be carried forward to the next year. Amounts may roll over from year to year indefinitely, as long as you are eligible (or your dependent is eligible, in the event of your death) for coverage under the HRA component of the Plan. Once you are no longer eligible for the HRA component of the Plan, subsidies credited to your HRA Account will be forfeited unless otherwise provided, such as for a dependent or under COBRA (refer to the ***"Participation"*** section).

# Receiving Reimbursement

You or your dependent enrolled in the Plan may request reimbursement of eligible medical expenses.

You must complete a reimbursement form and return it to the Claims Administrator (refer to the "Contact Information" section), along with supporting documentation, which may include a copy of your insurance premium bill, an Explanation of Benefits (EOB), or, if no EOB is provided, a written statement from the service provider within any stated timeframe. Reimbursement forms and supporting documentation may be submitted online, mailed, or faxed to the Claims Administrator. The written statement from the service provider must contain:

- The name of the patient
- The date service or treatment was provided
- A description of the service or treatment
- The amount incurred, and
- Name of provider.

You can obtain a reimbursement form from the Claims Administrator.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Reimbursements paid by check, have a minimum threshold amount of $25. Approved claims under $25 will be paid once additional claims have been approved and the $25 threshold has been met. Reimbursements paid by direct deposit will be processed regardless of the amount. Claims are paid in the order in which they are received by the Claims Administrator.

The Claims Administrator determines the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

If you have any HRA Account payment that is unclaimed (e.g., uncashed benefit check or unclaimed electronic transfer) and at least six months old, you need to contact the Claims Administrator for assistance with the payment.

**Note:** The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you (note that payments related to non-spouse domestic partner coverage may be taxable to you). However, the Company cannot guarantee the tax treatment to any given participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

## Recurring Reimbursements

Via Benefits uses two methods to make premium reimbursements easier for you.

**Automatic Reimbursement**
You have the convenience of selecting automatic reimbursement of premiums you paid directly to your insurance carrier. Insurance carriers send Via Benefits a file detailing premium payments for all participants, and Via Benefits automatically reimburses you for your premiums. You only need to elect this option once (typically during your initial enrollment).

- Enrollment into the Automatic Reimbursement program most often occurs during the initial Via Benefits Medicare enrollment call with your Benefit Advisor, though you may opt into Automatic Reimbursement at any time. No paper forms need to be completed.
- Premiums will adjust automatically each year to match the premiums charged by your particular insurance carrier.
- You pay your premium directly to your insurance carrier. Your insurance carrier then sends an Automatic Reimbursement file to Via Benefits and reimbursement occurs automatically.
- Initial set-up takes up to three months, delaying initial reimbursements. If you do not want to experience the initial Automatic Reimbursement set-up delay, you have an option to submit a manual reimbursement request.
- Most, but not all insurance carriers participate.

**Recurring Reimbursement Request**
A recurring reimbursement request allows you to submit a premium reimbursement request only once annually, if the premium is a fixed monthly amount, before being reimbursed automatically for the remainder of that year. The supporting document must specify the period being requested. Reimbursements will be released at the first of the month for the requested period up to the end of the calendar year.

There are two potential recurring reimbursement request types:

- **Recurring Medicare Premium Reimbursement Request:** This request allows you to substantiate Medicare premium expenses only once each year, and then get reimbursed automatically for the remainder of the year.
  - You can use this for reimbursement of any Medicare premiums deducted from your Social Security check. Most common are Medicare Part B premiums.
  - This request type can be used by Medicare-eligible participants. You may submit your recurring reimbursement request online, or by submitting the Reimbursement Request Form by fax or mail. The form can be mailed to you or you can download it at My.ViaBenefits.com/Ball.
- **Recurring Carrier Premium Reimbursement Request:** This request allows you to substantiate premium expenses paid to insurance carriers only once each year, and then get reimbursed automatically for the remainder of the year.
  - This request type can be used by Medicare-eligible participants. You may submit your recurring reimbursement request online, or by submitting the Reimbursement Request Form by fax or mail. The form can be mailed to you or you can download it at My.ViaBenefits.com/Ball.
  - This request type cannot be used for the reimbursement of COBRA premiums.

## Overpayments and Reimbursements Made in Error

If it is determined that you or your dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your dependent will be required to refund the overpayment or erroneous reimbursement to the Company. Any overpayments or erroneous reimbursements are considered Plan assets and you are holding the assets in trust for the Plan; you cannot use overpayments for any purposes other than repaying the Plan.

If you do not refund the overpayment or erroneous payment, the Company reserves the right to offset future reimbursements equal to the overpayment or erroneous payment amount. If that is not feasible, the Company reserves the right to withhold such funds from any amounts due to you from the Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

# If a Request for Reimbursement Is Denied

If your request for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Administrator receives your request for review. If the Claims Administrator determines that an extension of this period is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that an extension of up to an additional 15 days is required. If the extension is necessary because you did not provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information.

The notice of denial will contain:

- The reason(s) for the denial
- The Plan provisions on which the denial is based
- A description of any additional information necessary for you to perfect your request for review, why the information is necessary, and the time limit for submitting the information
- A description of the Plan’s appeal procedures and the time limits applicable to these procedures, and
- A description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Administrator, you may file a written appeal. You should file your appeal with the Plan Administrator no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your request for review and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Administrator.

You cannot file suit in federal court until you have exhausted these appeals procedures. Any claim or action that is filed in a court or other tribunal against or with respect to the Plan and/or the Plan Administrator must be brought within 18 months of the date of the denied appeal for any claim or action relating to HRA Account benefits.

# Voluntary Request for Review for Adverse Determinations Regarding Eligibility and Enrollment

If you or a dependent are denied HRA benefits based on your or your dependent's eligibility for or enrollment in the HRA Account in the Plan, you may request a voluntary review by the Global Pension and Benefits Committee (GPBC). Pursuing this voluntary review will have no effect on your rights to any other benefits that might be available to you under the Plan.

You or your authorized representative must file your request for a voluntary review within 60 days after the date that you are notified of the decision. To file your request for a review, complete the *Appeal Form for Health & Group Benefits Enrollment (HRA)* which should include:

- A statement describing why you believe your claim should have been approved, and
- Any additional information and documents relevant to your request for review.

Send the request for review and any supporting documentation to the GPBC.

You will receive written notice of the decision regarding your claim within 60 days after the GPBC receives the request for review, unless special circumstances require an extension of time, in which case a decision will be rendered no later than 120 days after the request for review.

The decision by the GPBC will be based on a review of your file. The GPBC will further review all comments, documents, records, or other information relating to your request for review that you or your authorized representative submits, without regard to whether this information was previously submitted or relied upon. The GPBC will make its determination on your requested review of the benefit claim in accordance with the Plan's provisions.

The decision by the GPBC will include the specific reasons for the decision and specific references to the Plan provisions on which the decision was based.

The GPBC decision regarding a request for review of an eligibility or enrollment decision is final and there is no right to appeal further.

# Contact Information

| Via Benefits | |
|---|---|
| Contact a Benefit Advisor:<br>• With questions about your or your dependents' eligibility in the Plan<br>• To notify the Plan about the death or ineligibility of a Plan participant<br>• To submit a change in address | (855) 233-5513<br>Via Benefits Benefit Advisors are available Monday through Friday, except holidays, from 6 a.m. to 7 p.m. Mountain time. |
| Website: | My.ViaBenefits.com/Ball |
| Mailing Address: | For mailing information, contact the main number at (855) 233-5513 and obtain mailing instructions based on the material being sent. |

## Claims Administrator

Mail to:

Willis Towers Watson
PO Box 981156
El Paso, TX 79998-1156

Website: My.ViaBenefits.com/Ball
(855) 233-5513
Fax: (866) 886-0878

## COBRA Administrator

Make checks payable to National Benefit Services COBRA.

**For Payments**

National Benefit Services
COBRA Department
PO Box 670
West Jordan, UT 84084

# Administrative Rights and Obligations

The HRA Account described in this SPD represents a component to the Plan. Your specific rights to benefits under the Plan are governed solely, and in every respect, by the Plan and documents governing the benefits provided by the Plan. If there is any discrepancy between the official Plan and the descriptions of the Plan as contained in this material or documents governing the benefits provided by the Plan, the terms of the Plan or those documents will govern. The terms of the Plan are also subject to all applicable controlling statutes and regulations and the Plan will be administered by the Plan Administrator in a manner that will assure compliance with such statutes and regulations. Such management may include

modifying your elections as is permitted by the Plan or statutes and regulations or as required for compliance with such statutes and regulations.

## Agent for Service of Legal Process

Charles E. Baker
Vice President, General Counsel, and Corporate Secretary
Ball Corporation
9200 W. 108th Circle, PO Box 5000
Westminster, CO 80021-2510
Phone: (303) 469-3131

Legal process may also be served upon the Plan Administrator.

## Amendment and Termination of the Plan

The Company fully intends to continue the Plan but reserves the right to amend, change, discontinue, or terminate the Plan, or to discontinue the crediting of subsidies under the Plan at any time without notice to retirees or other participants, subject to any applicable contractual agreements. Any assets remaining when the Plan is terminated will be used to pay Plan costs or otherwise be paid or distributed in accordance with the terms of the governing Plan.

Changes to the Plan may occur in any or all parts of the Plan, subject to any applicable contractual agreements.

If the Plan is terminated or modified, your rights as a participant regarding covered charges incurred before the termination or modification are governed by and are in accordance with the terms of the Plan prior to the amendment or termination.

## Claims Administrator

Third party administrators may be engaged to process HRA claims on behalf of the Company under the Plan (refer to the ***"Contact Information"*** section). Overall, the Company is ultimately responsible for providing Plan benefits and not the third party administrators.

## Classes of Participants

The benefit described in this SPD covers the participants noted in the ***"Eligibility"*** section of the summary.

## COBRA Administrator

The appropriate COBRA Administrator is listed in the ***"Contact Information"*** section.

## Company

Ball Corporation and its participating subsidiaries, where applicable

## Discretion of the Plan Administrator

The Plan Administrator has the power and duty to do all things necessary to carry out the terms of the Plan. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan, to make findings of fact, determining the rights and status of participants and others under the Plan, and to decide disputes under the Plan including and without limitation to questions relating to eligibility for, entitlement to, and payment of benefits. See the ***"Plan Administrator/Committee"*** information below.

The Plan Administrator may delegate its duties and functions to various designees, including third party administrators who act on behalf of the Plan Administrator. In this regard, the Plan Administrator has delegated its discretionary authority to a Claims Administrator, as described below under "***Plan Type, Plan Funding, and Cost***," to interpret and apply Plan terms and to make factual determinations in connection with its review of claims under the Plan. Such discretionary authority is intended to include, but is not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the Plan, the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to the Claims Administrator the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

## Sponsor

Ball Corporation
9200 W. 108th Circle, PO Box 5000
Westminster, CO 80021-2510
Phone: (303) 469-3131

## Sponsor Identification Number

The Ball Corporation's employer identification number is 35-0160610.

## Participating Employers

Generally, Ball Corporation and its subsidiaries are Participating Employers in the Plan if the subsidiary is approved as a Participating Employer by the Company. If you have any questions about whether your employer is, or was, a Participating Employer in the plan, please contact the Plan Administrator. See the "***Plan Administrator/Committee***" information below.

## ERISA

The Company maintains the Plan in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA). As a participant in the Plan, you are entitled to certain rights and protections under ERISA (see the "***ERISA Rights***" section in this document).

## Plan Administrator/Committee

Ball Corporation
Global Pension and Benefits Committee (GPBC)
Attn: Manager, Welfare Plans Administration
9200 W. 108th Circle, PO Box 5000
Westminster, CO 80021-2510
Phone: (303) 469-3131

The Company is the administrator of the Plan; however, the Company may delegate its duties and functions to various designees, including third party administrators, who act on behalf of the Company. In this regard, the GPBC, whose members are appointed by the Company, has been delegated responsibility for the administration of the Plan. The GPBC has all of the powers and authority, described above, that are granted to the Company as the Plan Administrator.

The GPBC, or its designee, makes the decisions regarding questions, interpretation, or application of any Plan provisions. In addition, the GPBC, or its designee, is responsible for maintaining records and informing participants of their rights and answering their questions.

## Plan Name and Plan Number

The name of the Plan is Ball Corporation Consolidated Welfare Benefit Plan for Retired Employees (Plan), #515.

## Plan Type, Plan Funding, and Cost

The Plan, of which the Retiree Health Reimbursement Arrangement is a part, is a group welfare benefit plan that provides payment for health care and life benefits to certain retirees and their dependents. The HRA annual subsidy under the Plan is paid directly out of the general assets of Ball Corporation and not from a special fund, trust, or insurance policy.

Since the Plan is a self-funded plan, all costs associated with the Plan, including the HRA annual subsidy, are paid by the Company. Premiums are not currently required for HRA coverage. However, premiums are generally required for coverage under Medicare Eligible Medical coverage through Via Benefits, which is described separately. These costs may change from time to time as determined based on the Plan's experience. The amount you will need to pay may be obtained by contacting Via Benefits at (855) 233-5513 or by accessing their website at My.ViaBenefits.com/Ball.

## Self-Insured Benefits

For the Plan's self-insured benefits, the Claims Administrator is selected by the Company or its designee. Claims for benefits are sent to the Claims Administrator, which processes them and then requests and receives funds from the Company to pay the approved claims. The Claims Administrator provides the following administrative services:

- Claims payments
- Customer service, and
- Claims appeals.

## Plan Year

The Plan year is a calendar year from January 1 through December 31. All Plan records, including financial records, are kept on a calendar year basis.

## Prohibition Against Assignment of Benefits

No benefit payable at any time under the HRA Plan is subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

## Tax Advice Disclaimer

The Company does not advise you regarding tax, investment, or legal considerations relating to this Plan. If you have questions regarding benefit planning or enrollment, you should seek advice from a personal advisor (e.g., legal counsel, tax advisor, investment advisor).

# ERISA Rights

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). As a Plan participant, you are entitled to the rights described in this section.

## Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor. All documents except the Form 5500 series must be examined at the Plan Administrator's office and at other specified locations, such as worksites and union halls.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

## Continue Group Health Plan Coverage

Participants in the Plan have the right to continue health care coverage if there is a loss of coverage under the Plan, which includes the Retiree HRA Plan, because of a qualifying event. Participants that continue coverage may have to pay for such coverage. Please review the ***"Continuation of Coverage"*** section.

Because the Plans at Ball Corporation do not have any preexisting condition exclusions, you will not need to provide evidence of creditable coverage. In addition, since notices of creditable coverage are no longer required, notices will not automatically be provided. You may request a notice from the Plan Administrator.

## Prudent Actions by Plan Fiduciaries

ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may discriminate against you in any way to prevent you from obtaining a benefit to which you are entitled under the Plan for exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file an appeal. If, after you have taken all the prescribed steps for filing an appeal or if your claim or appeal is ignored, you may file a civil lawsuit to recover the amount of the benefits due under the terms of the Plan in a state or federal court. All other ERISA lawsuits, such as one involving a claim for breach of fiduciary duty, must be brought in federal court. For example, if you disagree with the Plan’s decision or lack thereof concerning a qualified medical child support order, you may file suit in federal court.

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

## Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, or the Division of Technical Assistance and Inquiries. The address for the EBSA is: Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W.,

Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

# Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides that if a qualifying event occurs *after* you retire, and you and your dependent(s) are covered by Company-provided retiree medical benefits, you and your qualified beneficiary (i.e., covered dependent enrolled in HRA on the day before qualifying event occurs) may temporarily continue that same coverage on a self-pay basis in some cases and when a qualifying event occurs. For the Retiree HRA Plan, there is no qualifying event that will occur to you after you retire that would cause you to lose coverage and trigger COBRA rights.

A qualifying event for your qualified beneficiary for the Retiree HRA Plan is if you and your qualified dependent divorce, become legally separated or end your domestic partnership if it causes your dependent to lose coverage.

You, or your qualified beneficiary (i.e., covered dependent), must notify Via Benefits within 60 days of a court entry approving or finalizing the legal separation or divorce. Failure to do so may result in the loss of the right to continue coverage under the Plan.

After being notified of a qualifying event, the COBRA Administrator will provide information about the procedures to follow to elect COBRA coverage. The information will describe the right to COBRA coverage, how to make an election, and other information you, or your qualified beneficiary, will need to understand about COBRA coverage and be able to make an informed decision about whether or not to elect COBRA coverage.

Your qualified beneficiary must elect COBRA coverage within 60 days after the date:

- Coverage would otherwise end, or
- The COBRA Administrator provides the election notice, whichever is later.

If a qualified beneficiary fails to submit the completed election form by the due date, the right to apply for COBRA coverage will be forfeited.

A qualified beneficiary may change or revoke an election to receive COBRA coverage within the 60-day election period. If a qualified beneficiary waives COBRA coverage prior to the end of the 60-day election period, the qualified beneficiary will be permitted to revoke the waiver and elect coverage at any time before the 60-day election period ends. In that case, COBRA coverage shall begin with the date the waiver is revoked, which will be considered the COBRA election date.

## COBRA Benefits

For HRA coverage, COBRA coverage means that the qualified beneficiary (i.e., covered dependent) could continue to receive the HRA subsidy that the qualified beneficiary was receiving before the qualifying event. The same rules and limits that would apply to current retirees and their dependents will apply to COBRA coverage. The rules for filing a benefit claim and appealing any claim denial also apply.

Any changes made to retiree benefits that apply to similarly situated retirees and their dependents will also apply to qualified beneficiaries during the period of COBRA coverage.

## Cost of COBRA Coverage

A monthly premium will be charged equal to 100% of the “full monthly premium” plus 2% for administrative costs.

The COBRA Administrator will notify a qualified beneficiary of the amount he or she must pay to continue participation in the Retiree HRA Plan. If the cost of coverage changes for similarly situated individuals, the cost for COBRA coverage will change for the qualified beneficiary.

## Paying for COBRA Coverage

Your qualified beneficiary has an initial 45-day grace period from the date of election to pay the first premium. The first payment will include the cost for any previous months of continued health care coverage that occurred since the date retiree medical benefits coverage would otherwise have ended. After the first payment, COBRA premiums will be due by the first of each month. There is a 31-day grace period, beginning on the first day of the month, to make each payment. Payments must be postmarked within the 31-day grace period.

It is important that payments be made on time for COBRA coverage. If your qualified beneficiary fails to make a payment as described above, coverage will end automatically on the last day of the month for which coverage was paid.

COBRA coverage that has been terminated because of late payments will not be reinstated.

## How Long COBRA Coverage Can Continue

The maximum period of COBRA coverage if the qualifying event causes a qualified beneficiary to lose coverage is for 36 months for the following qualifying event and beneficiaries:

| Qualifying Event | Qualified Beneficiaries |
|---|---|
| You divorce, become legally separated or end your domestic partnership | Covered dependent |

## When COBRA Coverage Ends

Generally, COBRA coverage for the HRA Account ends for a qualified beneficiary on the last day of the month in which any of the following events occur:

- The 36-month COBRA period expires
- The premium for COBRA coverage is not paid in a timely manner
- A qualified beneficiary ceases to be an eligible dependent as defined by the Plan, or
- The Company no longer provides HRA coverage to any of its retirees.

Once COBRA coverage ends, it cannot be reinstated.

## Questions about COBRA

If you have any questions about COBRA coverage or the application of the law, you may contact the COBRA Administrator, Plan Administrator or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the Regional and District EBSA offices are found at dol.gov/ebsa.

# HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996, as amended. (HIPAA) is a federal law that provides rights and protections to participants and their eligible dependents enrolled in group health plans. HIPAA protects participants and their eligible dependents by ensuring the privacy of such person's protected health information.

HIPAA protects the privacy and security of your health information, whether information is received by this Plan in writing, electronically, or orally. HIPAA privacy rules, however, allow the use and disclosure of your health information without your permission for certain purposes such as health care treatment, payment activities, and health care operations, provided the amount of health information used or disclosed is limited to the "minimum necessary" (as defined under HIPAA) for these purposes.

HIPAA also allows this Plan to share information without your authorization as follows:

- This Plan may disclose "summary health information" to your Plan Administrator, if requested, to obtain premium bids to provide coverage under this Plan, or for modifying, amending, or terminating this Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information has been removed.
- This Plan may disclose information to your Plan Administrator about whether you are participating in this Plan, or have enrolled or un-enrolled in an option provided by this Plan.
- This Plan may disclose health information in certain situations without your authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care, or to your legal representative.

You have the following rights, subject to the restrictions described below, with respect to your health information:

**Right to Request Restrictions on Certain Uses and Disclosures of Your Health Information**
You have the right to request that this Plan restrict the use and disclosure of your health information for treatment, payment, or health care operations (except for uses or disclosures that may be legally required). You also have the right to request that this Plan restrict the disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. If you want to exercise this right, you must make a written request to this Plan.

**Right to Receive Confidential Communications of Your Health Information**
If you believe that you could be endangered if disclosure of your health information was done by the usual means, this Plan will accommodate any reasonable request to receive health information from this Plan by an alternative means or at an alternative location. If you want to exercise this right, you must make a written request to this Plan, and your request must state that disclosure of all or part of the information could endanger you.

**Right to Inspect and Copy Your Health Information**
You have the right (with certain exceptions) to inspect or obtain a copy of certain records maintained by this Plan, which may include medical and billing records maintained by a health care provider, and enrollment, payment, claims adjudication, and case or medical management record systems maintained by this Plan. However, you do not have the right to inspect or obtain copies of confidential information regarding psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. If you want to exercise this right, you must make a written request to this Plan; however, this Plan may deny your request to inspect and copy information. In certain circumstances, you may request a review of this Plan's denial.

**Right to Amend Your Health Information that Is Inaccurate or Incomplete**
You have the right (with certain exceptions) to request that this Plan amend certain health information if this information is inaccurate or incomplete. If you want to exercise this right, you must make a written request to this Plan, and you must include supporting information regarding your request. This Plan may deny your request if it cannot substantiate the requested changes.

**Right to Receive an Accounting of Disclosures of Your Health Information**
You have the right to receive an "accounting of disclosures;" that is, a list of certain disclosures this Plan has made of your health information if the disclosure was required by law, in connection with public health activities, or in similar situations listed in the Plan's Notice of Privacy Practices. If you want to exercise this right, you must make a written request to this Plan.

**Right to Obtain a Copy of the Notice of Privacy Practices**
If you would like a copy of this Plan's Notice of Privacy Practices, please contact the Plan Administrator.