CENTURY ALUMINUM HAWESVILLE RETIREE HEALTH CARE REIMBURSEMENT PLAN AND SUMMARY PLAN DESCRIPTION

INTRODUCTION

The United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO, CLC (the "USW") and Century Aluminum of Kentucky GP (the "Company") entered into a collective bargaining agreement effective April 1, 2010 providing for certain post-retirement healthcare benefits for certain retirees at the Company's plant in Hawesville, Kentucky (the "Agreement"). The Century Aluminum Hawesville Retiree Health Care Reimbursement Trust (the "Trust") has been created to fund the post-retirement healthcare benefits for certain retired USW bargaining unit members, and for certain spouses and eligible dependents of those retirees.

This Century Aluminum Hawesville Retiree Health Care Reimbursement Plan (the "Plan") is established to enable Eligible Retirees, and Beneficiaries if applicable, to obtain reimbursement of medical, dental, prescription drug expenses, and certain other health expenses on a nontaxable basis from his or her Participant Account. The Plan is intended to constitute a medical reimbursement plan under sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the "Code") and the regulations issued thereunder, and a health reimbursement arrangement ("HRA") as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective.

The Plan is administered by a four-member committee (the "Committee"). Contact information for the Committee is listed in Section 11.02 of this booklet.

Interpretations of the terms of the Plan, including without limitation, determinations of eligibility for participation in the Plan, are made by the Committee in its sole and absolute discretion. Any inquiry relative to interpretations or other such matters regarding the Plan should be referred to the Committee. The Committee is not obligated, bound, or responsible for opinions, information, or representations coming from other sources.

The Plan, or any of the benefits described in the Plan, may be amended, modified, or terminated by the Committee in its sole and absolute discretion at any time and from time to time. The Plan is governed by the terms described in this Summary Plan Description and the Century Aluminum Hawesville Retiree Health Care Reimbursement Trust Agreement (the "Trust Agreement"). For a complete understanding of the

terms of the Plan, you may wish to review, in addition to this Summary Plan Description, the Trust Agreement.

ARTICLE 1
DEFINITIONS

When used in this booklet, unless the context otherwise requires, the following terms shall have the meanings set forth below:

1.01 "Agreement" means the collective bargaining agreement entered into effective April 1, 2010 between the USW and the Company providing for certain post-retirement healthcare benefits for certain retirees at the Company's plant in Hawesville, Kentucky.

1.02 "Beneficiary" or "Beneficiaries" means any individual who is described in Section 2.01(c).

1.03 "Benefits" means the reimbursement benefits for medical, dental, prescription drug expenses, and certain other health care expenses described under Article 4.

1.04 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

1.05 "Committee" means the USW members and Company members formed to establish and manage the Trust, to sponsor and administer the Plan, and to serve as the "named fiduciary" of the Plan within the meaning of section 402(a)(2) of ERISA.

1.06 "Company" means Century Aluminum of Kentucky GP.

1.07 "Dependent" means (a) any individual who is a Participant's child as defined by section 152(f)(1) of the Code and who has not attained age 27 and (b) any tax dependent of a Participant as defined in section 105(b) of the Code (including a domestic partner if he or she so qualifies); provided, however, that any child to whom section 152(e) of the Code applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the Participant Account will provide Benefits in accordance with the applicable requirements of any qualified medical child support order ("QMCSO") even if the child does not otherwise satisfy the definition of "Dependent."

1.08 "Eligible Employee" means any employee of the Company who is described in Section 2.01(a).

1.09 "Eligible Retiree" means any Eligible Employee who is described in Section 2.01(b).

1.10 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.11 "Participant" means the individuals who from time to time satisfy the requirements to participate in the Plan pursuant to Section 2.01.

1.12 "Participant Accounts" means the separate recordkeeping accounts established and maintained for each Participant pursuant to Section 3.02.

1.13 "Plan" means the Century Aluminum Hawesville Retiree Health Care Reimbursement Plan, as adopted and as may be amended from time to time by the Committee.

1.14 "Plan Administrator" means the Committee of the Century Aluminum Hawesville Retiree Health Care Reimbursement Plan. The Committee may delegate administrative functions to a third-party administrator from time to time.

1.15 "QMSCO" means a qualified medical child support order, as defined in section 609(a) of ERISA.

1.16 "Summary Plan Description" means this booklet describing the terms and conditions of the Plan.

1.17 "Trust Agreement" means the Century Aluminum Hawesville Retiree Health Care Reimbursement Trust Agreement effective October 23, 2012, and as amended from time to time, which is intended to constitute a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Code.

1.18 "Trust" means the property maintained in trust pursuant to the Trust Agreement.

1.19 "Trustee" means Hand Benefits & Trust Company, or any successor trustee, appointed by the Committee.

1.20 "You" means a Participant.

ARTICLE 2
ELIGIBILITY AND PARTICIPATION; PARTICIPANT CONTRIBUTIONS

2.01 Eligibility for Participation in the Plan

You are eligible to participate in the Plan if you are an Eligible Employee, an Eligible Retiree, or a Beneficiary under the term described in this Section 2.01:

(a) An *Eligible Employee* is an individual who has contributions paid to the Trust on his or her behalf pursuant to Article 17 or other provision of the Agreement;

(b) An *Eligible Retiree* is an Eligible Employee:

- for whom a Participant Account has been established;
- who has terminated employment with the Company; and
- who has attained age 65, or satisfied the requirements to commence receiving pension or disability benefits from the Steelworkers Pension Trust.

(c) A *Beneficiary* is an individual qualifies as (i) a spouse of a Eligible Employee or Eligible Retiree within the meaning of section 105 of the Code, or (ii) a dependent of a Eligible Employee or Eligible Retiree within the meaning of section 152 of the Code (as modified by the last sentence of section 105(b) of the Code), but only to the extent that such individual qualifies as a spouse or dependent pursuant to this Section 1.02 at the earlier of the time of the Eligible Employee's death or attainment of Eligible Retiree status, and only to the extent that such individual continues to qualify as a spouse or dependent of an Eligible Employee or Eligible Retiree as defined in Section 1.02 (provided that a spouse or dependent who otherwise qualifies as a Beneficiary may continue to qualify as a Beneficiary after the death of the Eligible Retiree or Participant).

An Eligible Employee or Eligible Retiree must designate his or her Beneficiaries and provide the Plan Administrator with prompt written notice of any change in his or her family status, such as marriage, divorce, or an addition or subtraction of Dependents. If a Participant has not designated a Beneficiary at the time of his or her death, the Plan may forfeit the balance credited to the Participant Account. Participants will be held responsible for any costs of the Plan attributable to a payment on behalf of an individual who is inaccurately reported to the Plan Administrator as a Beneficiary. The Plan Administrator may require proof that an individual qualifies as a Beneficiary in accordance with rules that it may establish.

2.02 When Participation Ends

Your participation in the Plan ends when no balance is credited to your Participant Account.

Upon the death of the Participant, his or her Beneficiaries will receive Benefits under the Plan until the earlier of (i) the date that the Beneficiary ceases to be a Beneficiary, or (ii) when the Participant's Participant Account does not have a remaining balance after the distribution of healthcare reimbursements and/or the allocation of investment gains and losses.

ARTICLE 3
PARTICIPANT ACCOUNTS

3.01 Contributions

The Company funds the contributions to Participant Accounts pursuant to Article 17 or other provisions of the Agreement; no Participant contributions are permitted.

3.02 Separate Accounts

The Plan Administrator shall maintain a Participant Account in the name of each Eligible Employee or Eligible Retiree. Each Participant Account will be adjusted by:

(a) any Company contributions made on behalf of the Eligible Employee;

(b) the applicable investment gains and/or losses attributable to the balance credited to the Participant Account as described in Section 3.03;

(c) forfeitures as described in Section 3.05; and

(d) debits for any reimbursement of incurred medical, dental, prescription drug expenses, and certain other health care expenses.

3.03. Investment of Participant Accounts

You are responsible for directing the investment of the contributions, and the balance credited, to your Participant Account. You will be provided with a range of investment options into which you may direct the Trustee to invest. You may change your investment directions as frequently as daily; however, certain investments might restrict the frequency of such directions. You may make separate investment directions for new contributions to your Participant Account and to the balance already credited to your Participant Account. To direct the investment of your Participant Account, you should follow the instructions in the investment information provided to you by the Plan's third-

party administrator and recordkeeper. You may request the investment information by calling 866-401-5272 or visiting, https://www.bpas.com/VEBA-115Trust/employees_veba_account_access.htm.

This Plan is intended to comply with the requirements of section 404(c) of ERISA, as if applicable to the Plan. To comply, the Plan provides you with a range of investment choices, the ability to change your investment choices, and certain required information regarding your investments and investment choices as described in the regulations promulgated under section 404(c).

You are solely responsible for the investment of contributions, and the balance credited, to your Participant Account. You may lose money and opportunities for gains with any investment strategy. No other party, including without limitation, the Plan, the Trust, the Committee, the Trustee, the third-party administrator, the recordkeeper, USW, or the Company shall be liable for such losses.

It is important that you affirmatively direct the investment of the contributions, and the balance credited, to your Participant Account. In the unforeseen event that the Plan has not received your investment direction with respect to any contribution, or balance credited, to your Participant Account, those amounts will be invested temporarily in the Plan's designated default investment fund until you make an affirmative election via https://www.bpas.com/VEBA-115Trust/employees_veba_account_access.htm for the investment of future contributions and/or transfer the existing balance credited to your Participant Account into investment funds that you select.

3.04 Valuation of Assets

The Trustee shall revalue the balances credited to each Participant Account at the close of business each day that the stock market is open. Any increase or decrease in market value shall be apportioned to such Participant Account in accordance with each Participant's investment direction.

3.05 Forfeitures

The balance credited to a Participant Account shall be fully vested during the lifetime of the Eligible Employee or Eligible Retiree for whom such Participant Account is maintained and during the lifetime of the Beneficiaries of such Eligible Employees or Eligible Retirees so long as any such Beneficiary continues to satisfy the requirements provided from time to time in Section 2.01 to be treated as a Beneficiary under the Plan. Any balance credited to a Participant Account remaining after the later of the death of the Eligible Employee or Eligible Retiree with respect to whom the Participant Account is maintained and the death or failure to satisfy the requirements of Section 2.01 by any remaining Beneficiary shall be forfeited.

As soon as administratively practicable after the close of each calendar quarter, any forfeited Participant Account balances during such calendar quarter will be allocated on a *per capita* basis to the remaining Participant Accounts maintained as of the last day of such calendar quarter.

ARTICLE 4
BENEFITS

4.01 Benefits

An Eligible Retiree, or Beneficiary if the Participant is deceased, is entitled to receive Benefits in the form of reimbursements for expenses paid as described in section 213(d) of the Code, and as described in Section 4.02. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for medical, dental, prescription drug expenses, and certain other health expenses.

4.02 Eligible Medical, Dental, Prescription Drug Expenses, and Certain Other Health Expenses

An Eligible Retiree, or Beneficiary if the Participant is deceased, may receive reimbursement for incurred medical, dental, prescription drug expenses, and certain other health expenses.

(a) A medical, dental, prescription drug expense, and certain other health expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Expenses incurred before a Participant becomes an Eligible Retiree are not eligible for reimbursement.

(b) "Medical, dental, prescription drug expenses, and certain other health expenses" means expenses incurred by an Eligible Retiree or his Beneficiaries, as defined in section 213(d) of the Code (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs.) Reimbursements due for such expenses incurred by the Eligible Retiree or his or her Beneficiaries shall be charged against the Eligible Retiree's Participant Account.

(c) Expenses may be reimbursed from the Eligible Retiree's Participant Account only to the extent that the Eligible Retiree or Beneficiary is not reimbursed for the expense (nor is the expense reimbursable) through other insurance, or any other accident or health plan. If only a portion of the expense has been reimbursed elsewhere, the Participant Account may reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article 4.

4.03 Reimbursement Procedure

(a) Timing. Within 30 days after receipt by the third-party administrator of a reimbursement claim request from an Eligible Retiree, or Beneficiary if applicable, the third-party administrator will process the request for reimbursement on behalf of the Plan Administrator to determine whether or not the expense is an eligible expense and should be reimbursed, or the third-party administrator will notify the Eligible Retiree, or Beneficiary if applicable, that his or her claim has been denied. The 30-day time period may be extended for an additional 15 days for matters beyond the control of the third-party administrator, including in cases where a reimbursement claim is incomplete. The third-party administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete and resubmit an incomplete reimbursement claim.

(b) Claims Substantiation. An Eligible Retiree, or Beneficiary if applicable, who seeks Benefits may apply for reimbursement by submitting an completed claim form to the third-party administrator as instructed on the form, setting forth:

- the name of the individual(s) on whose behalf the expenses have been incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement; and
- A statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The completed claim form shall be accompanied by itemized bills, invoices, or other statements from an independent third party (*e.g.*, a hospital, physician, or pharmacy) showing the name of the individual for whom the expenses have been incurred and the amounts of such expenses, together with any additional documentation that the third-party administrator may request.

ARTICLE 5
BENEFIT CLAIMS AND APPEAL PROCEDURES

5.01 In General

The Committee is responsible for establishing rules and regulations under which the Plan operates. Interpretations of this booklet, and other matters relating to the operation of the Plan, are the sole responsibility of the Committee. The Committee may delegate, however, the responsibility for any Benefits determination to a service provider. The Committee, or its delegee,

has the discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. The Committee will decide appeals of denials of claims by a third-party administrator, or may delegate the responsibility for deciding appeals to a third party, in which case all references to the Committee shall be deemed to refer to its delegee in the provisions governing appeals.

5.02 Legal Actions

No legal action concerning a denial of benefits under the Plan may be commenced against the Plan, its Committee, or any representative of the Plan until the claimant has exhausted all of the administrative remedies set forth under the foregoing claims procedures.

5.03 Claims and Appeals

Claims for benefits may be made by filing a claim with the third-party administrator in one of the following ways:

Online:

https://www.bpas.com/VEBA-115Trust/employees_veba_account_access.htm

Mail: Flex Corp
820 Gessner, Suite 1225
Houston, TX 77024

Fax: (866) 254-2942

(a) Timing of Notification of Decision: The claimant will be notified of the third-party administrator's decision on a claim within a reasonable period of time, but no later than 30 days after receipt of the claim, or 180 days after receipt of the claim if third-party administrator determines that such extension is necessary due to matters beyond control of the Plan. In this circumstance, third-party administrator will, within the initial 30-day period, notify the claimant of the special circumstances requiring an extension of time and the date by which third-party administrator expects to make a decision.

(b) Content of Notification of Claim Denial: The notification described in Section 5.03(a) will include:

i. The specific reason(s) for the adverse decision;

ii. Reference to the specific provisions of the Plan on which the decision is based;

iii. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

iv. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following a denial of an appeal.

(c) Appeal of Claim Denials: If a claim is denied, the claimant may appeal the denial by filing a written appeal with the Committee within 120 days of receipt of notification of a denial. The following procedures will apply to the appeal:

i. In support of the appeal, the claimant may submit written comments, documents, records and other information relating to the claim, and the Committee will provide the claimant upon request and at no charge with reasonable access to, and copies of, all documents, records or other information relevant (as defined in section 2560.503-1(m)(8) of title 29 of the Code of Federal Regulations) to the claim.

ii. In reviewing the appeal, the Committee will take into account all materials and information submitted by the claimant relating to the claim (even if not submitted or considered in connection with the initial claim).

(d) Timing of Notification of Decision on Appeal: The Committee will notify the claimant of the initial benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the Committee, unless the Committee determines that special circumstances (such as a need to hold a hearing, if the Committee's procedures provide for a hearing) require an extension of time for processing the claim. If the Committee determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Committee expects to render the determination on review.

(e) Content of Notification of Decision on the Appeal: The notice will be in written and will include, in the case of an adverse decision:

i. The specific reason(s) for the adverse decision;

ii. Reference to the specific provisions of the Plan on which the decision is based;

iii. A statement that the claimant is entitled to receive, upon request and at no charge, reasonable access to, and copies of, all documents, records or other information relevant (as defined in section 2560.503-1(m)(8) of title 29 of the Code of Federal Regulations) to the claimant's claim for benefits; and

iv. A statement of the claimant's right to bring an action under section 502(a) of ERISA.

ARTICLE 6
ADMINISTRATION OF THE PLAN

6.01 Administrator

The Committee is the "Plan Administrator" as this term is defined by subsection 3(16)(b) of ERISA.

6.02 Named Fiduciary

The Committee is the "named fiduciary" within the meaning of section 402(a) of ERISA, responsible for administration of the Plan. The Committee, however, may delegate in writing any of its powers or duties under the Plan to any person or entity. The delegate shall become the fiduciary for only that part of the administration which has been delegated by the Committee and any references to the Committee shall instead apply to the delegate.

6.03 Powers and Duties

(a) The Committee will administer the Plan in accordance with its terms.

(b) The Committee is hereby provided with all powers necessary to carry out the Plan's provisions including, without limitation, the right to appoint and remove the Trustee, the right to employ a third-party administrator, or a collection agent, and the right to seek to enforce (through court process or other means available under applicable law) all rights of the Plan (including, without limitation, all rights the Plan may have to recover benefits paid or payable to Participants from any other source).

(c) The Committee is empowered to determine questions arising in the administration, interpretation and operation of the Plan and, in so doing, may consult with, and rely upon, such legal, accounting, actuarial, financial, insurance or medical consultants as it deems necessary or proper.

(d) The Committee has the authority to delegate its powers under this Section 6.03 to others, including, without limitation, to the Trustee or a service provider, provided that the Trustee or such other third party, as the case may be, shall have agreed to exercise such powers.

(e) Any determination by or on behalf of the Committee shall be conclusive and binding upon all Participants and Beneficiaries, and all other persons interested in the Plan or asserting claims under the Plan, all of whom shall be treated in a uniform and non-discriminatory manner.

(f) The Committee will keep (or shall cause to be kept) such records of its proceedings and decisions and shall keep all such books of account, records and data as may be necessary, in its judgment, for the proper administration of the Plan.

(g) The Committee from time to time in its discretion may establish rules governing the operation of the Plan and the transaction of its business and shall have the complete discretion to interpret the provisions of the Plan. The determination of the Committee as to any disputed question shall be conclusive. Subject to the requirements of the law, the Committee shall be the sole judge of the standard of proof required in any case and the application and interpretation of this booklet, and the decisions of the Committee shall be final and binding on all parties. Furthermore, benefits under this Plan will be paid only if the Committee decides in its discretion that the applicant is entitled to them under the terms of the Plan. Accordingly, it is intended that any review of an exercise of discretionary authority by the Committee by a court or an arbitrator is to be limited to whether the Committee' decision was a clear abuse of its discretion.

(h) The Committee may prescribe procedures to be followed and the forms to be submitted by Participants, and Beneficiaries as applicable, and to request and receive from all Participants, and Beneficiaries as applicable, such information as the Committee shall from time to time determine to be necessary for the proper administration of this Plan.

(i) The Committee may rely upon the information submitted by a Participant, or a Beneficiary as applicable, as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant, or Beneficiary as applicable. The Committee will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Committee.

(j) In the event of a mistake as to the eligibility or participation of an Eligible Employee, or the allocations made to the Participant Account of any Participant, or the amount of Benefits paid or to be paid to an Eligible Retiree, or Beneficiary if applicable, the Committee shall, to the extent that it deems administratively possible and otherwise permissible under section 105 of the Code, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the amounts or distributions to which he or she is properly entitled under the Plan.

ARTICLE 7
PRIVACY REQUIREMENTS

7.01 Privacy Policy In General

It is the policy of the Plan to protect the privacy of information related to your health, health care, and payment for health care. This Protected Health Information ("PHI") is protected from improper use or disclosure under State and/or Federal laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Regulations promulgated thereunder ("Privacy Regulations") by the U.S. Department of Health and Human Services ("DHHS"). The Plan has adopted policies and procedures to safeguard any PHI it receives or creates. Service providers to the Plan have entered into Business Associate agreements concerning the use and disclosure of PHI. PHI is not released outside the Plan without your written consent, except as may be necessary for treatment, payment, plan administration, and health care operations, including utilization review, determinations of medical necessity and appeals, research, public health and law enforcement, and other uses permitted by law or regulation. The Committee is permitted to use the PHI only to the extent necessary for the Committee to perform administrative functions, including appeals, and use of summary health information to establish premium rates, and to assess, modify, amend, or terminate the Plan. For uses and disclosures of PHI that are not permitted or required by the Privacy Regulations or law, the individual's authorization must be obtained. Certain medical information will not be released without the individual's specific written permission, such as mental health records, genetic testing results, and HIV information.

7.02 Your Right to Privacy

You have the right to receive a notice describing how medical information about you may be used and disclosed, and how you can get access to this information. You also have the right to inspect and copy your own PHI and to request that your information be released to a third party or specific address by signing a written release. You also have the right to request restrictions on

certain uses and disclosures of PHI; however, the Plan is not required to agree to a requested restriction. You also have the right to amend or correct your PHI, and the right to receive an accounting of certain disclosures of PHI. Your written permission is not required to for use and disclosure of PHI for treatment, payment, health care operations, public heath purposes, law enforcement purposes, other purposes as provided by the Plan's policies and the Privacy Regulations, or for purposes for which you have signed an authorization.

7.03 Privacy Requirements—General; Definitions

The following privacy provisions shall apply with respect to the Plan:

(a) General. The provisions of this Article 7 will be interpreted in accordance with the regulations issued by the Department of Health and Human Services ("DHHS") under 45 CFR parts 160-164, which are incorporated herein by reference.

(b) Definitions.

(1) Protected health information ("PHI") shall have the meaning set forth in 45 CFR § 160.103 – generally, information that relates to an individual's medical condition, the provision of medical care for that individual, or the payment for that individual's medical care that identifies the individual to whom it relates and is created or received by the Plan, a health care provider, an employer, or a health care clearinghouse.

(2) Privacy Officer shall mean the individual designated by Committee to develop and implement the Plan's privacy policies and procedures, including responding to and providing more information about matters covered by the privacy notice required by 45 CFR § 164.520 and responding to: (i) complaints under Section 7.05(b)(2), (ii) requests for access to PHI under Sections 7.04(f) and 7.05, (iii) requests for amendments to PHI under Sections 7.04(f) and 7.06, and (iv) requests for accounting of disclosures under Sections 7.04(f) and 7.07.

(3) Designated Record Set shall have the meaning set forth in 45 CFR § 164.501.

7.04 Uses and Disclosures of Personal Health Information By the Committee

(a) The Plan will disclose PHI to the Committee only for the purposes of plan administration functions that the Committee performs for the Plan as described in (b) below.

(b) PHI may be used and disclosed by the Committee only for the purposes of determining eligibility for Plan participation, deciding Participant appeals, quality assurance, auditing and monitoring Plan service providers and monitoring Plan employees, if any. The Committee will not use or disclose PHI except as permitted or required by the Plan or by law, and will not use or disclose PHI for any employment-related actions or in connection with any other employee benefit plan.

(c) Disclosure of PHI to the Committee is conditioned upon the Committee's certification that this booklet incorporates the provisions of this Section 7.04 and that the Committee agrees to comply with the provisions.

(d) The Committee will ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the restrictions that apply to the Committee's receipt of PHI.

(e) The Committee will report to the Privacy Officer any use or disclosure inconsistent with the uses or disclosures permitted under this Section 7.04.

(f) The Committee will make PHI available for inspection, will make PHI available for amendment, and will make available the information required to provide an accounting of disclosures on the same terms as the Plan does so under Sections 7.05, 7.06 and 7.07 below, respectively.

(g) The Committee will make its internal practices and records relating to the use and disclosure of PHI received from the Plan available to the DHHS upon request.

(h) Except as otherwise required by law, the Committee will return or destroy all PHI that it receives from the Plan and shall retain no copies of such information when no longer needed for the purpose for which disclosure was made.

(i) If any individual receiving PHI under this Section 7.04 fails to comply with the provisions of this Section 7.04, the Committee shall determine the consequences of such noncompliance based on the particular facts and circumstances of the noncompliance.

7.05 Participant Access to PHI

(a) Subject to the provisions of (b)(2) below, a Participant may obtain access to inspect and obtain a copy of PHI about the Participant in a Designated Record Set (not including psychotherapy notes and information compiled in reasonable anticipation of or for use in a civil, criminal, or

administrative action or proceeding) by filing a written request with the Privacy Officer.

(b) The Plan will act on the request within 30 days of receipt of the request (or 60 days in the case of requests for PHI maintained off-site), as follows:

(1) If the Plan grants the request, it will inform the Participant and permit the Participant in a timely manner to inspect and/or obtain a copy of the requested PHI in the form or format requested by the Participant, if readily producible in such form or otherwise in a readable hard copy form or such other form as agreed to by the Plan and the Participant.

(2) The Plan may deny the Participant's request for access for reasons permitted under 45 CFR §164.524(a)(2) (unreviewable grounds for denial) or §164.524(a)(3) (reviewable grounds for denial), in which case it will provide the Participant with a written denial explaining the basis for the denial, a statement of the Participant's review rights (if applicable), and a description of how the Participant may complain to the Plan.

(3) If the Plan is unable to act on the request within the required time, it will extend the time by no more than 30 days and will provide notice to the Participant of the reasons for the delay and the date by which the Plan will complete its action.

(4) If the Plan does not maintain the PHI that is the subject of the request but knows where it is maintained, the Plan will inform the Participant where to direct the request.

(c) In the case of a reviewable denial, the Participant may request in writing that the Plan have the denial reviewed by a licensed health care professional who is designated by the Plan to act as a reviewing official and who did not participate in the original denial decision. The Plan will provide the Participant with written notice of the determination of the reviewing official and will comply with such determination.

7.06 Amendment of PHI

(a) A Participant may request the Plan to amend his or her PHI or a record about the Participant in a Designated Record Set by filing a written request, including the reason for the request, with the Privacy Officer.

(b) The Plan will act on the request within 60 days after receipt of the request, as follows:

(1) If the Plan accepts the amendment, it will make the appropriate amendment and so notify the Participant, along with (after consulting with and obtaining the Participant's agreement) any relevant persons who need the amendment.

(2) The Plan may deny the request if it determines that the PHI or the record that is the subject of the request was not created by the Plan (unless the Participant provides a reasonable basis to believe that the originator is no longer available to act on the request); is not part of the Designated Record Set; would not be available for inspection under 45 CFR §164.524; or is accurate and complete.

Any denial will be provided to the Participant in writing and will include: (i) the basis for the denial; (ii) an explanation of the Participant's right to submit a written statement disagreeing with the denial; (iii) a statement that, if the Participant does not submit such a statement, the Participant may request the Plan to provide the request and denial along with any future disclosures of the PHI that is the subject of the proposed amendment; and (iv) a description of how the individual may complain to the Plan. The Plan may reasonably limit the length of a statement of disagreement, and may prepare a written response to such statement. The PHI that is the subject of the amendment will be appended to include the request for amendment, statement of disagreement and rebuttal, and the Plan will include such appended material (or a summary thereof) with any subsequent disclosure of the PHI if the Participant has so requested or has filed a statement of disagreement.

(3) If the Plan is unable to act on the amendment within 60 days, it will extend the time by no more than 30 days and will provide notice to the Participant of the reasons for the delay and the date on which the Plan will complete its action.

7.07 Accounting of Disclosures of PHI

(a) The Plan will, upon a Participant's written request to the Privacy Officer, provide the Participant with an accounting of disclosures of the Participant's PHI made by the Plan within the prior six-year period, including the date of disclosure; the name (and address, if known) of the entity or person who received the PHI; a brief description of the PHI disclosed; and a brief statement of the purpose of the disclosure (or a copy of the request for disclosure, if any). Disclosures to individuals or entities to whom the Plan has made multiple disclosures during the accounting period for a single purpose, and disclosures for a particular research purpose for 50 or more individuals, are subject to the special rules set forth in 45 CFR §164.528(b)(3) and (4).

(b) Subsection (a) shall not apply to disclosures to carry out treatment, payment and health care operations; to Participants about their own PHI as provided in 45 CFR §164.502; incident to a use or disclosure otherwise permitted or required under 45 CFR §164.502; pursuant to an authorization as provided in 45 CFR §164.508; to persons involved in the individual's care or for other notification purposes as provided in 45 CFR §164.510; for national security or intelligence purposes; or to correctional institutions or law enforcement officials, as part of a limited data set in accordance with 45 CFR §164.514(e).

(c) The Plan will provide the Participant with the accounting requested within 60 days after receipt of the request or, if the Plan is unable to act on the amendment within 60 days, it will extend the time by no more than 30 days and will provide notice to the Participant of the reasons for the delay and the date by which the Plan will provide the accounting.

ARTICLE 8
GENERAL PROVISIONS

8.01 Benefits Not Transferable

Except as required by applicable law, benefit payments hereunder shall not in any way be subject to the debts or other obligations of the persons entitled thereto and may not be voluntarily or involuntarily sold, anticipated, alienated, encumbered, pledged, transferred or assigned. If any person entitled to a benefit is under a legal disability or, in the opinion of the Committee is in any way incapacitated so as to be unable to manage his or her affairs, the Committee may cause such person's benefit to be paid in such manner as it may in its sole and absolute discretion determine, and any such payment shall fully discharge any obligation of the Plan, Committee, or the Trustee with respect thereto. Distribution in accordance with a Qualified Domestic Relations Order, as defined in section 206(d) of ERISA (as if applicable to the Plan), shall not be deemed an alienation, assignment or anticipation for purposes of this Section 8.01.

8.02 Compliance With Legal Requirements

In addition to the powers of the Committee expressly set forth herein, the Committee shall have the power and authority to take any action required to cause the Plan and the Trust to be in compliance with applicable provisions of law.

8.03 Factual Determinations

Any misstatement or other mistake of fact in any certificate, notice or other document filed with or issued by the Committee shall be corrected when it becomes known. The Committee shall not be liable in any manner for any determination of fact made in good faith.

8.04 Proof of Claims

As a condition of receiving Benefits under the Plan, any person may be required to submit whatever proof the Committee may require either directly to the Committee or to any person delegated by it. Failure on the part of a claimant to comply with such request promptly, accurately, and in good faith shall be sufficient grounds for denying, postponing, or discontinuing benefits from the Plan to such person. If a claimant makes a willfully false statement material to his or her claim or furnishes fraudulent information or proof material to his or her claim, any benefits may be denied, suspended or discontinued. The Committee shall have the right to recover any payments made by mistake or in reliance on any false or fraudulent statements, information or proof submitted by any claimant (including the withholding of a material fact) plus interest and costs (including, without limitation, by recovery through offset of future benefit payments).

8.05 Title to Trust

Except with respect to the right to receive benefits for which a Participant qualifies under the Plan, no individual shall have any right, title, or interest in and to the assets of the Trust or to the contributions thereto, such contributions being made and held in the Trust for the sole purpose of providing benefits under the Plan in accordance with its terms. Neither the Trustee nor the Committee in any way guarantees the Trust from any loss or depreciation, or guarantees payment of any benefit which may become due to any person under the Plan. The Plan's obligation to pay Benefits is conditioned on the availability of cash in each Participant Account and no plan fiduciary or other person shall be required to liquidate any asset of the Trust to generate cash to pay benefits.

ARTICLE 9
AMENDMENT AND TERMINATION

9.01 Amendment

The Plan may be amended by the Committee, by written instrument, at any time and from time to time in its sole and absolute discretion.

9.02 Termination

The Plan may be terminated at any time by the Committee, by written instrument, in its sole and absolute discretion.

9.03 No Reversion or Inurement

Under no circumstances may any assets of the Trust revert or inure to the benefit of the Company, USW, Committee, or their respective successors.

ARTICLE 10
ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protection under ERISA. ERISA provides that all the Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

You may also request to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes responsibilities upon the people who are responsible for the operation of the Plan. The people who operate the 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 former employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for welfare benefits 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 them within 30 days, you may file suit in 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 administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or Federal court after you have exhausted your rights for review and appeal under the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the 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 fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

ARTICLE 11
MISCELLANEOUS

11.01 Name

The name of the Plan is the "Century Aluminum Hawesville Retiree Health Care Reimbursement Plan."

11.02 Committee

The Committee, as originally constituted, consists of the following four individuals:

Chad Apaliski (appointed by USW)
Richard Brean (appointed by USW)
Anne Lofaso (appointed by the Company)
Simone Rockstroh (appointed by the Company)

The Committee may be reached at:

Committee of the Century Aluminum Hawesville Retiree Health Care Reimbursement Trust
60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222

11.03 Taxpayer Identification Number

The Committee's taxpayer identification number is 46-1202594.

11.04 Type of Plan and Administration

The Century Aluminum Hawesville Retiree Health Care Reimbursement Plan is a welfare benefit plan that provides retiree health benefits by reimbursing participants for eligible expenses. The type of plan administration is "contract administration"; that is, the Committee has contracted with BPAS, Inc. to provide day-to-day administrative services.

11.05 Funding

The Plan is funded by Company contributions, plus earning on the investments of such proceeds.

11.06 Plan Number

The number assigned to the Plan is: 501.

11.07 Plan Year

The Plan Year begins January 1 and ends the following December 31.

11.08 Service of Legal Process

Legal process may be served on the Committee at the address set forth in Section 11.02.

11.09 Trustee

Hand Benefits & Trust Company serves at the Trustee for the Plan. Hand Benefits & Trust Company may be contacted at 820 Gessner Road, Suite 1250, Houston, Texas, 77024.

11.10 No Contract

Neither the Plan nor any portion thereof shall be deemed to constitute a contract between the Committee and any Participant.

11.11 Trust Agreement Controls this Booklet

This Plan and Summary Plan Description is subject to and controlled by the provisions of the Trust Agreement for the Plan. In the event of any conflict between the provisions of the Plan and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

11.12 Usage

Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vice versa, and the definition of any term herein in the singular shall also include the plural, and vice versa.

11.13 Governing Law

To the extent that state law shall not have been preempted by the provisions of ERISA, or any other laws of the United States heretofore or hereafter enacted, as the same may be amended from time to time, the Plan shall be administered and construed to be in accordance with the laws of the Commonwealth of Pennsylvania.

11.14 References to the Code and ERISA

Any reference in this booklet to sections of the Code or ERISA shall mean the current section thereof or any provision hereafter enacted in substitution therefor.

11.16 No Guarantee of Tax Consequences

The Committee does not make any commitment or guarantee that any amounts paid to or for the benefit of an Eligible Retiree, or Beneficiary if applicable, under this Plan will be excludable from such individual's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Eligible Retiree, or Beneficiary if applicable, to determine whether each payment under this Plan is excludable from such individual's gross income for federal, state, and local income tax purposes and to notify the Committee if the such individual has any reason to believe that such payment is not so excludable.

11.17 Non-Assignability of Rights

The right of any Eligible Retiree, or Beneficiary if applicable, to receive any reimbursement under this Plan shall not be alienable by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

11.18 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

11.19 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.