SUMMARY PLAN DESCRIPTION

The Alexander & Baldwin, LLC
Group Health and Welfare Benefit Plan

for

Eligible Employees Who Were Salaried Employees
of Alexander & Baldwin, LLC and Other Participating Companies

Effective January 1, 2014

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Introduction

Alexander & Baldwin, Inc. (the "Company") established the Alexander & Baldwin, LLC Retiree Health and Welfare Benefit Plan ("Plan") effective January 1, 1992 and updated January 1, 2014 to provide retiree medical and life insurance benefits to eligible retirees of the Company. This summary of the Plan describes the benefits that are available to those retirees and explains the Plan's eligibility requirements. Benefits provided to other classes of employees are described in other booklets.

What follows is not the official Plan document but a Summary Plan Description (SPD) that explains the major provisions of the Plan. In case of any inconsistency between this summary and the actual Plan documents, the terms of the Plan documents will govern. The official Plan documents are maintained by the Company and are available for your inspection, as discussed later in this booklet. Important additional details regarding the specific benefits available under the various health care options provided by the Plan are set forth in separate booklets and are a part of this Summary Plan Description.

Although the Company expects to maintain the Plan indefinitely, it reserves the right to amend or terminate the Plan or any part of the Plan at any time and for any reason.

This booklet is intended to serve as a guide to retiree benefit entitlements other than pensions. This booklet is not a contract of employment. The Company reserves the right to terminate an employee at any time and for any reason.

Any inquiries regarding your eligibility for benefits under this Plan should be addressed to your Human Resources Department.

1. What Are the Eligibility Requirements?

You will become a participant of the Plan as of your retirement date if you meet ALL of the following requirements:

- You retire from active service as a full-time salaried non-bargaining unit employee of Alexander & Baldwin, Inc. or any company related to Alexander & Baldwin, Inc. that has adopted this Plan ("participating company");

- You were hired or rehired by the Company before January 1, 2008;

- Your retirement date occurs after January 1, 1992 and on or after your "Earliest Retirement Date" as defined under the Alexander & Baldwin, Inc. Retirement Plan for Salaried Employees ("Pension Plan"). (Individuals who retired on or before January 1, 1992 are eligible for the Plan under the provisions in effect at that time);

- You are eligible to receive retirement benefits under the Pension Plan; and

- You meet the following age and service requirements:

Age at Retirement	At Least This Many Years of Service
55	30
56	28
57	26
58	24
59	22
60	20
61	18
62	16
63	14
64	12
65 or older	10

Your years of service for the purposes of this Plan are calculated in the same manner as "Credited Benefit Service" under the Pension Plan, except that periods of service that are not counted as Credited Benefit Service under the Pension Plan solely because of a benefit distribution which was not repaid upon rehire or the withdrawal of mandatory employee contributions will be counted as service under this Plan.

2. What Retiree Health and Welfare Benefits Are Available under the Plan?

Currently there are two types of benefits available under the Plan. The first, Life Insurance Coverage, provides a death benefit to a beneficiary designated by the participant. The second, Health Care Insurance Coverage, provides health insurance coverage for the retiree. The retiree may also enroll his/her spouse in the health plan selected by the retiree by paying the full cost of the spouse's health insurance coverage.

3. What Life Insurance Coverage Is Available?

Each retiree who is eligible under the Plan and who completes an enrollment form and returns it to the Human Resources Department will receive Life Insurance Coverage based on the following schedule:

Years Since Retirement	Coverage Amount*	Maximum Amount
0	75%	$50,000
1	50%	$25,000
2 or more	25%	$10,000

∗ *Percentage of the lesser of annual base salary or Company-provided life insurance before retirement*

4. Who Pays the Cost of Life Insurance Coverage?

The Company pays the entire cost of the retiree Life Insurance Coverage.

5. How Do I Enroll for Life Insurance Coverage?

You must complete an enrollment form and return it to your Human Resources Department. When you enroll, you will be asked to designate a beneficiary to receive the death benefit under the Plan. You should keep your beneficiary designation current to ensure proper payment of benefits.

6. Is My Life Insurance Coverage Permanent?

The Company expects to provide you with life insurance coverage until your death. However, the Company reserves the right to terminate coverage, revise eligibility or change the benefits under the Plan at any time and for any reason.

7. What Health Care Insurance Coverage Is Available?

The Company will make health care coverage available through one or more health insurance carriers (see the "Directory of Plans" at the end of this SPD). For detailed information on the available health insurance carrier options and benefits provided, please see your HR representative or visit the carrier's website. The provider lists are

available free of charge by contacting the carrier. In addition, a full description of your benefits can be found in the documents and contracts between the Company and the insurance carrier for each program. Benefits will always be provided in accordance with such documents and contracts, which form a part of this Summary Plan Description.

When Medicare first becomes available to you as a retiree, the Company requires you to enroll in Medicare (Parts A and B) at your own expense. Also, if you select the Kaiser Plan, you are required to enroll in the "Senior Advantage Plan" at age 65.

8. Who Pays the Cost of Health Care Insurance Coverage?

The Company will pay a percentage of a Fixed Dollar Amount ("FDA" – the maximum company contribution) for a health care coverage program each month for you if you continue to meet eligibility requirements under the Plan. The FDA and the percentage of the FDA the Company pays on your behalf will be based initially on your age and service at the time you retire and may change thereafter in accordance with the following schedule:

Fixed Dollar Amount (FDA)		
Ages 55-59	**Ages 60-64**	**Ages 65 & Over**
N/A	$135.80	$100.31

Completed Years of Service	**Percentage of FDA Paid by the Company**		
	Ages 55 – 59	**Ages 60 – 64**	**Ages 65 & Over**
24	0%	95%	95%
23	0%	90%	90%
22	0%	85%	85%
21	N/A	80%	80%
20	N/A	75%	75%
19	N/A	70%	70%
18	N/A	65%	65%
17	N/A	60%	60%
16	N/A	55%	55%
15	N/A	50%	50%
14	N/A	45%	45%
13	N/A	40%	40%
12	N/A	35%	35%
11	N/A	N/A	30%
10	N/A	N/A	25%

An eligible participant who elects coverage is responsible for the cost of coverage in excess of the applicable percentage of the FDA the Company pays. Below are some examples. Please note that all premiums in the examples are for illustration purposes only; check with your Human Resources Representative for the current premium rates.

A. Employee A retired from active service with 26 years of service and is age 63. The FDA for health care coverage is $135.80 per month and the cost of health care coverage that the retiree selects is $249 per month. The Company will pay $135.80 per month ($135.80 x 100%) for the retiree's health care coverage. The retiree pays the remaining $113.20, the difference between $249 (the cost of the retiree's health care coverage) and the $135.80 the Company pays. When Employee A attains age 65 and becomes eligible for Medicare, the FDA will change. At that time, the Company will pay 100% of the new FDA of $100.31 and Employee A will pay the difference between $100.31 and the total cost of the selected health plan . Employee A will also be responsible for paying the cost of his or her Medicare coverage.

B. Employee C retired from active service with 20 years of service, is age 66, and has enrolled in Medicare. The FDA for health care coverage for those at age 65 and older is $100.31 per month and the cost of health care coverage that the retiree selects under the Company's health plan is $213. The Company will pay $75.23 per month ($100.31 x 75%) for the retiree's health care coverage. The retiree must pay $137.77 per month for health care coverage, the difference between $213 (the cost of the retiree's health care coverage) and the $75.23 the Company pays. The retiree is also responsible for the cost of his or her Medicare coverage.

The FDA and the examples shown here apply only to individuals who retired after January 1, 1992. Those who retired on or before that date are subject to the provisions that were in effect at that time.

9. Can My Spouse Receive Health Care Insurance Coverage?

If you elect to obtain Health Care Insurance Coverage, you may also elect to cover the person who is your spouse at the time of your retirement, provided you or your spouse pays the full cost for your spouse's coverage and his or her election for coverage is made at the time of your retirement. (See Question 11, below, about delayed enrollment.) If you die, your spouse will continue to be eligible for coverage. If you and your spouse divorce or become legally separated, your spouse will lose his/her coverage. If you marry or remarry after you retire, your new spouse will not be eligible for coverage.

The Company requires your spouse to enroll in Medicare (Parts A and B) at his/her own expense when Medicare first becomes available to him/her. (As noted

previously, once you are retired you must also enroll in Medicare as soon as you are eligible.)

10. How Do I Enroll for Health Care Insurance Coverage?

Immediately before your retirement, if you meet the eligibility requirements in Question 2, your Human Resources Department will provide you with the necessary enrollment forms. At the time you become eligible to enroll in this Plan, you will be given a choice between this Plan and regular COBRA coverage (under the medical plan by which you were covered on your retirement date). If you elect COBRA coverage instead of this Plan, you will not be eligible to enroll in this Plan later. If you elect coverage under this Plan, you will have waived your right to COBRA coverage (except as discussed below). To obtain Health Care Insurance Coverage under the Plan, you must make an election on the forms provided no later than 60 days after your date of retirement. If you fail to make an election within 60 days, you will be deemed to have waived coverage.

When you enroll, you must agree (on a form provided by the participating company) either to make any required payments directly to the participating company on a timely basis or to have such payments deducted from your monthly Pension Plan checks.

If you make a valid election for coverage, coverage will begin on the first day of the month coinciding with or next following your date of retirement.

11. Can I or My Spouse Elect Health Care Benefits under This Plan at a Later Date?

If you or your spouse is covered under a health care plan provided by your spouse's employer and you or your spouse waives this Company's health care benefits at retirement, you will have a one-time opportunity to elect health care benefits for you and/or your spouse under this Plan within 60 days after coverage under your spouse's employer's plan is terminated, provided such coverage is terminated for reasons other than voluntary cessation of premium payments.

12. Will I Be Able to Change From One Health Plan to Another?

At the time of your initial enrollment for retiree Health Care Insurance Coverage, you may choose among the health plans made available by the Company. You may change from one plan to another during the annual open enrollment.

13. What If I Go Back to Work?

If you return to work for any one of the participating companies and are covered by a health care plan provided by that participating company, you and your spouse will be ineligible for health coverage under this Plan until you cease your employment and your coverage by the other health plan terminates.

You must immediately notify the Plan Administrator of any reemployment described above.

14. Can I Lose Health Care Insurance Coverage?

If you have elected this coverage for you and/or you and your spouse, the Company expects to provide you with this coverage until your death. However, the Company reserves the right to terminate coverage, revise eligibility or change the benefits under the Plan at any time and for any reason. You can also lose coverage under the following circumstances:

Retirees

- If you fail to pay your share of premium payments on time;
- If you fail to enroll in Medicare Parts A and B (at your expense) when it first becomes available to you as a retiree, or if you enroll in a Medicare Part D plan separate from one of the Company-sponsored medical plans and that Company-sponsored medical plan states that it will terminate coverage if you elect a different Part D plan;
- If you return to work after you retire (see Question 13); or
- If the Company amends or terminates the Plan, if a participating company discontinues its participation in the Plan, or if the insurance carrier terminates its plan (see Question 17).

Spouses

- If you and your spouse divorce or separate under a legal separation decree;
- If you or your spouse fails to pay the premium for his/her or your coverage on time;
- If your spouse fails to enroll in Medicare Parts A and B (at his/her expense) when it first becomes available to him/her once you have retired, or if your spouse enrolls in a Medicare Part D plan separate from one of the Company-sponsored medical plans and that Company-sponsored medical plan states that it will terminate coverage if you elect a different Part D plan.

15. Special Notices Required by Federal Law

Women's Health and Cancer Rights Act of 1998 (WHCRA) –Under Federal law, a group health plan and a health insurance issuer covering mastectomies must cover (1) reconstruction of the breast on which the mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedemas. The coverage will be determined in consultation with the patient and attending physician. These benefits are subject to the health plan's regular copayments and deductibles.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) – Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarian section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Uniformed Services Employment an Reemployment Rights Act (USERRA) – This Plan will provide benefits to covered participants entering into or returning from service in the armed forces as may be required under the Uniformed Services Employment and Reemployment Rights Act.

16. Will My Health Information Be Protected?

The health plans will protect the privacy and electronic security of your health information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Participants will be separately provided with a notice of the health plans' privacy and security practices.

17. Can the Plan Be Amended or Terminated?

Although the Company intends to continue the Plan indefinitely, it reserves the right to change the Plan (with respect to any and all provisions, contribution rates and coverages) or even to discontinue it under any circumstances and at its sole discretion, through action of its Board of Directors. Any participating company may discontinue its own participation in the Plan at any time for any reason. Furthermore, any insuring or provider company also reserves the right to amend or terminate a plan at any time for any reason. If the Plan is terminated, discontinued with respect to any participating company, or amended to curtail benefits, all coverage under the Plan will be discontinued (or curtailed in accordance with the amendment) immediately. However, you and/or your covered spouse will be entitled to receive health care

benefits for which you and/or your spouse have already paid the entire non-employer portion of the premium prior to such termination, discontinuance, or amendment. You will be notified if the Plan is terminated, discontinued with respect to any participating company, or amended to curtail benefits.

18. Do Plan Fiduciaries Have Discretionary Authority?

Each Plan fiduciary that has responsibility under this Plan to make factual finding, determine eligibility for benefits, or interpret the terms of the Plan has the full discretion and authority to make such findings, determinations or interpretations within the sole discretion of the fiduciary.All such findings, determinations or interpretations will be conclusive and binding on all individuals dealing with or claiming benefits under the Plan (subject to the Plan's claims and review procedures).

19. What Are the Claims and Appeal Procedures for Life Insurance Benefits?

Filing a Claim for Life Insurance Benefits

Your beneficiary may claim life insurance benefits by contacting the Human Resources Representative who will send the beneficiary the necessary claim forms. The Human Resources Representative will also assist your beneficiary ("claimant") in the filing for such benefits with the Claims Administrator (MetLife). The Claims Administrator decides whether the claimant is entitled to any benefits and, if so, the amount of such benefit. To evaluate the claim, the Claims Administrator may request additional information from the claimant.

If the Life Insurance Claim Is Denied

If a claim for benefits is denied in full or in part, the Claims Administrator will notify the claimant in writing within 90 days after receiving the claim.

In special cases, the deadline may be extended for another 90 days, but the claimant will be notified before the end of the initial 90-day benefit determination period of the reasons for the delay and the date by which the claimant may expect a decision.

If the claim is denied, the notice of denial will state the reasons for the denial and the Plan provisions on which the denial is based. It will also inform the claimant of any additional information or material required to perfect the claim, why the information or material is necessary, and the procedure the claimant must follow to have the Claims Administrator review the denial of the claim.

If the claimant does not receive a notice of delay or a notice of denial within the applicable deadline described above, he/she can assume that the claim was denied. The claimant then can proceed to the appeal stage, or he/she may file suit, under Section 502(a) of ERISA, in a state or federal court.

Appeal Procedure

If a claim is denied (or considered denied because the claimant did not receive a written response from the Claims Administrator), the claimant may write to the Claims Administrator to appeal the denial. The claimant has 60 days after the claim is denied to request an appeal.

The appeal will be given a full and fair review by the Claims Administrator. The claimant will be allowed to see all documents, guidelines and other materials that relate to the claim (other than legally privileged documents); submit any issues and comments, in writing, to the reviewer; and, if the claimant wishes, have someone act as his/her representative in the review procedure.

The request for a review must set forth all of the grounds on which it is based, all facts in support of the request, and any other matters that the claimant thinks are pertinent. The reviewer may require the claimant to submit such additional facts, documents, or other materials as the reviewer may consider necessary or appropriate in conducting the review.

If the claimant's appeal is denied, the reviewer will provide the claimant with written notice of this denial within 60 days after the reviewer's receipt of the appeal. There may be times when this 60-day period has to be extended. However, this extension is allowed only when there are special circumstances, which must be communicated to the claimant in writing within the initial 60-day period. If there is an extension, a decision will be made as soon as possible, but not later than a total of 120 days after the reviewer receives the appeal.

The reviewer's final decision on the appeal of the claim denial will be communicated to the claimant in writing and will include references to the specific Plan provisions on which the decision was based.

If the reviewer's decision on the appeal is not submitted to the claimant by the deadlines described above, the claimant should consider the appeal to have been denied.

If the claimant fails to appeal in the manner and by the deadlines specified above, he/she waives the right to request a review and is barred from again asserting the claim; provided, however, that if the Claims Administrator fails to respond to a claim or to an appeal of a denied claim within the applicable deadline, the claimant will have the right to bring suit under Section 502(a) of ERISA.

20. What Are the Claims and Appeal Procedures for Health Care Benefits?

The following claims and appeal procedures apply to all health care benefit claims that are first filed on or after January 1, 2003. However, to the extent the claims procedures described in the individual health plan booklets and other insurance

carrier communications differ from these procedures, the procedures in the individual health plan or insurance carrier booklets/communications will govern.

Types of Claims

ERISA recognizes three types of health claims, each of which is subject to different rules. The three types of claims are as follows:

- **A Pre-Service Claim** is a claim for a benefit for which, under the terms of the plan, prior approval is required as a condition of receiving the benefit.

- **An Urgent Care Claim** is a type of Pre-Service Claim which, if the regular time periods for handling such claim were adhered to, (1) it could seriously jeopardize your life or health or your ability to regain maximum function or (2) it would, in the opinion of a professional provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

- **A Post-Service Claim** is a claim for benefits that is not a Pre-Service Claim. A Post-Service Claim involves payment or reimbursement for medical care that has already been provided.

Appointing an Authorized Representative

You may designate an authorized representative to act on your behalf at any stage of the claims procedures. This designation must be made in writing, following such procedures and using such forms as required by the relevant insurance carrier (or health plan claims administrator, in the case of a self-funded plan – e.g., HMSA, Kaiser, or CIGNA). For purposes of an Urgent Care Claim, a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. (In order to simplify the following explanation of the health plan claims and review procedures, both the health insurers and health plan claims administrators are referred to as the "insurance carrier.")

An assignment of benefits to your health care provider does not constitute a designation of such provider as your authorized representative to act on your behalf in pursuing and appealing a benefit determination. Any such designation must be made under the procedures described above.

The plan will send your authorized representative all materials regarding the claim that you are entitled to receive under the claims procedures. You will receive copies of all notices regarding determinations made under the claims procedures.

Any reference to "you" in these claims procedures is intended to include your authorized representative.

Submitting Claims

A claim for benefits is a specific request for a plan benefit that is submitted in accordance with the Plan's procedures for filing claims. A general request for information regarding a benefit is not a claim.

Pre-Service Claims. A Pre-Service Claim, including an Urgent Care Claim, will be considered submitted when a request for prior approval is made pursuant to the Plan's utilization review procedures or as otherwise described in the summary plan description.

Incorrectly Submitted Claims. Generally, only claims that are submitted in compliance with the plan's claims procedures will be considered. However, under certain circumstances, you will be notified if a Pre-Service Claim has been incorrectly submitted. This notice will be provided only if the request for prior approval was received by a person or entity that is customarily responsible for handling benefit matters and only if the communication contains the following information:

- The name of the claimant
- The specific medical condition or symptom
- The specific treatment, service or product for which approval is requested

Notice of an incorrectly submitted claim will be provided as soon as possible, but not later than 24 hours (in the case of an Urgent Care Claim) or five calendar days (in the case of all other Pre-Service Claims). This notice may be oral, unless written notification is requested.

Post-Service Claims. The individual health plan booklets indicate the party to which Post-Service Claims must be submitted and the timeframe within which the claims must be filed.

Initial Claims Determinations

The timeframes for making the initial determination regarding a claim and the procedures for notifying you about that decision depend on the type of claim and whether the determination is an "adverse benefit determination."

For purposes of these claims procedures, an "adverse benefit determination" means a denial, reduction or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit.

Urgent Care Claims. The insurance carrier will notify you of the plan's initial determination involving an Urgent Care Claim (whether adverse or not) as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt of a claim. If more information is needed in order for a determination to be made, you will be advised of the specific information necessary to complete the claim as soon as possible but in no event later than 24 hours after receipt of the claim. You will be allowed at least 48 hours to provide the necessary information. A determination will be made within 48 hours after the insurance carrier receives the requested information, or at the end of the period you were given in which to provide the information, whichever is later. If you do not provide the requested information within the specified timeframe, the insurance carrier may decide the claim without that information. Notification of any adverse benefit determination will be made as described below in the section called *Notice of Adverse Benefit Determinations.*

Previously Approved Treatment Involving Urgent Care. If you have an Urgent Care Claim that involves a request for an extension of a previously approved course of treatment beyond the period of time or number of treatments, the insurance carrier will notify you of the determination on such claim (whether adverse or not) as soon as possible, taking into account the medical emergencies, but in no event more than 24 hours after receipt of the claim, provided that you requested the extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination will be made as described below in the section called *Notice of Adverse Benefit Determinations.*

If the request for an extension of previously approved treatment does not involve Urgent Care or is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, a determination on the claim will be made as described under *Pre-Service Claims* below.

Pre-Service Claims. The insurance carrier will notify you of the plan's determination (whether adverse or not) regarding a Pre-Service Claim within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 calendar days after receipt of the claim or receipt of any information requested by the plan as necessary to decide the claim. The period may be extended an additional 15 calendar days if the insurance carrier determines that such an extension is necessary due to matters beyond the control of the plan and notifies you of the circumstances that require the extension prior to the expiration of the initial 15-day period. If the extension is required due to your failure to submit information necessary to decide the claim, the notice of the extension will specifically describe the information necessary to complete the claim. You will be given at least 45 calendar days from receipt of the notice to provide the information. If you do not provide the requested information within the specified timeframe, the insurance carrier may decide the claim without that information. Notification of any Adverse Benefit Determination will be made as described below in the section called *Notice of Adverse Benefit Determinations.*

Previously Approved Treatment. If the Plan has previously approved an ongoing course of treatment that is to be provided over a period of time or that involves a specified number of treatments, any reduction or termination of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments will be considered to be an adverse benefit determination. The insurance carrier will notify you sufficiently in advance of such reduction or termination to allow you to appeal and obtain a determination on review of the adverse benefit determination before the benefit is reduced or terminated. Notification of any adverse benefit determination will be made as described below in the section called *Notice of Adverse Benefit Determinations.*

Post-Service Claims. The insurance carrier will provide you with written notification of an adverse benefit determination involving a Post-Service Claim within 30 calendar days of receiving the claim or receiving any information requested by the plan as necessary to decide the claim. This period may be extended an additional 15 calendar days when necessary due to matters beyond the control of the plan, provided that you are notified of the circumstances that require the extension prior to the expiration of the initial 30-day period. If the extension is due to your failure to submit information necessary to decide the claim, the notice will specifically describe the information necessary to complete the claim. You will be given at least 45 calendar days from receipt of the notice to provide the information. Notification of any adverse benefit determination will be made as described below in the section called *Notice of Adverse Benefit Determinations.*

Notice of Adverse Benefit Determinations

Written notification of an adverse benefit determination will be provided by the insurance carrier within the applicable time frames described above. The notice will contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- References to the specific plan provisions on which the adverse benefit determination is based;
- A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
- A description of the Plan's appeals procedures, including applicable time limits, plus a statement of your right to bring suit under Section 502 of ERISA with respect to any Adverse Benefit Determination after an appeal;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;

- If the adverse benefit determination is based on an internal rule, guideline, protocol or other similar criterion, either the specific rule, guideline, protocol or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request;

- If an adverse benefit determination is based on medical necessity or a determination of experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such determination applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request; and

- If an adverse benefit determination involved an Urgent Care Claim, a description of the expedited review process applicable to such claims.

Appealing an Adverse Benefit Determination

Unless the insurance carrier provides a longer time frame for filing an appeal, you have 180 calendar days following receipt of a notification of an adverse benefit determination in which to appeal the determination. The individual health plan booklets indicate the party to whom appeals must be made, and the relevant insurance carrier is the fiduciary for reviewing appeals from denied claims for benefits under the Plan. Except in the case of an appeal involving an Urgent Care Claim, such appeal must be in writing. *If you do not file an appeal of the adverse benefit determination within the 180-day period (or such longer period as specified by the individual insurance carrier), you will lose the right to appeal the determination.*

Special Procedures for Urgent Care Claims. You may request an expedited appeal of an adverse benefit determination. This request may be oral or in writing. Under these expedited procedures, all necessary information, including the Plan's benefit determination on appeal, may be transmitted by telephone, facsimile or other available similarly expeditious method.

You may submit written comments, documents, records and other information relating to the claim. Upon request, you will be provided with reasonable access to and copies of all documents, records and other information relevant to the claim free of charge. You may also request that the plan identify any medical or vocational expert from whom it received advice in connection with the benefit determination, regardless of whether it relied on such advice in making the initial benefit determination.

The Review Process

Review of your appeal will take into account all comments, documents, records and other information that you submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial determination, and will be conducted by

an individual acting on behalf of the Plan who is neither the individual who made the initial determination nor a subordinate of that individual.

If the initial determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the plan will consult with a health care professional who was not involved in the original benefit determination and who has appropriate training and experience in the field of medicine involved in the medical judgment.

Timeframe for the Determination on Appeal

The timeframe in which the determination on appeal must be made will depend on the type of claim involved. In all instances, the period of time for making the determination will begin at the time the appeal is filed, without regard to whether all the necessary information accompanies the filing.

Pre-Service Claims. In the case of a Pre-Service Claim, the insurance carrier will notify you of the determination on appeal within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 calendar days after your appeal is received by the Plan.

Urgent Care Claims. In the case of an Urgent Care Claim, the insurance carrier will notify you of the determination on appeal as soon as possible, taking into account the medical emergencies, but in no event more than 72 hours after your appeal is received by the Plan. The notification will be in writing or will be provided pursuant to the expedited procedures for Urgent Care Claims described above.

Post-Service Claims. In the case of a Post-Service Claim, the insurance carrier will notify you of the determination on review within a reasonable period of time but in no event later than 60 days after your appeal is received by the Plan.

The decision by the insurance carrier is final.

Notification of Adverse Benefit Determination on Appeal

You will receive written notification of an adverse benefit determination on appeal within the applicable time frames described above. The notice will contain the following information:

- The specific reason or reasons for the adverse benefit determination;

- References to the specific plan provisions on which the adverse determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;

- A statement of your right to bring suit under Section 502(a) of ERISA;

- If the adverse benefit determination is based on an internal rule, guideline, protocol or other similar criterion, either the specific rule, guideline, protocol or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request;

- If the adverse benefit determination is based on medical necessity or a determination of experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such determination applying the terms of the Plan to the individual's medical circumstances or a statement that such explanation will be provided to you free of charge upon request; and

- A statement advising you of any available voluntary alternative dispute resolution options, such as mediation, and directing you to your local United States Department of Labor office or state insurance regulatory agency.

21. What Are My Rights to COBRA Continuation Coverage?

A Federal law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act) requires employer-sponsored group health plans to offer certain individuals known as "qualified beneficiaries" the opportunity to elect a temporary extension of health coverage ("COBRA continuation coverage") when there is a "qualifying event" that would result in a loss of coverage under the plan.

Eligibility for COBRA Continuation Coverage

Retired Employees

You will become a qualified beneficiary with respect to a health plan if you will lose your coverage under such plan because of the following qualifying event:

- The Company files a proceeding in bankruptcy under Title 11 of the United States Code.

Spouses of Retired Employees

Your covered spouse will become a qualified beneficiary with respect to a health plan if he/she will lose coverage under such plan because of any of the following qualifying events:

- You become divorced or legally separated from your spouse; or

- The Company files a proceeding in bankruptcy under Title 11 of the United States Code.

Obligation to Notify Plan Administrator of a Qualifying Event

A health plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. Who has the responsibility of notifying the Plan Administrator depends on the nature of the qualifying event.

Bankruptcy proceeding – When coverage is lost due to commencement of a proceeding in bankruptcy with respect to the participating company, the participating company is responsible for notifying the Plan Administrator of the qualifying event within 30 days of the event.

Divorce or legal separation – You or your spouse are responsible for notifying the Plan Administrator when coverage is lost on account of divorce or legal separation. This notice must be provided in writing within 60 days after the qualifying event occurs.

The notice must be sent to:

Human Resources Department
Alexander and Baldwin, Inc.
822 Bishop Street
Honolulu, HI 96813
(808) 525-6611

The notification must include all of the following information:

- The retiree's name;
- The name of the spouse;
- The nature of the qualifying event (divorce or legal separation); and
- The date the qualifying event occurred (date of divorce or legal separation).

A notice mailed to the Plan Administrator will be deemed to have been provided on the date of mailing.

If notice is not provided during this 60-day notice period, your spouse who loses coverage will not be offered the opportunity to elect COBRA continuation coverage.

Maximum Duration of COBRA Continuation Coverage

If health coverage is lost by your spouse due to your divorce or legal separation, the maximum period of COBRA continuation coverage is **36 months**.

If health coverage is lost because the Company files a proceeding in bankruptcy under Title 11 of the United States Code, the maximum period of COBRA continuation coverage for you ends on the date of your death; for your covered spouse, it ends on the earlier of (1) the date of his/her death or (2) the date that is 36 months after your death.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Qualified beneficiaries will have 60 days in which to elect COBRA continuation coverage. This 60-day election period begins on the later of:

- The date of the qualifying event; or

- The date the Plan Administrator provides notice of the right to elect COBRA.

A COBRA election mailed to the Plan Administrator will be deemed made on the date of mailing.

If COBRA continuation coverage is not elected during the 60-day election period, the right to elect continuation coverage will be lost.

Each qualified beneficiary has an independent right to elect continuation coverage. If you or your covered spouse waives coverage during the election period, the waiver may be revoked before the end of the election period. In this case, the COBRA coverage becomes effective as of the date of the revocation.

Please note that your (and your spouse's) right to elect COBRA will not be affected by other coverage you (or your spouse) may have ***before*** *you elect COBRA coverage* (for example, if you have coverage under your spouse's plan at the time your coverage under your employer plan ends). However, if you obtain other coverage *after* electing COBRA, your COBRA coverage will end, as specified under *"When COBRA Continuation Coverage Ends"* below.

Payment of Premiums for COBRA Continuation Coverage

You must pay the full cost of COBRA continuation coverage. Your first payment must be made within 45 days of the date of your election (this is the date the election

form is postmarked, if mailed). If you do not make your first payment for continuation coverage within this 45-day period, the Plan Administrator will terminate coverage retroactively to the beginning of the maximum coverage period.

The initial premium payment must include the premiums for coverage from the date coverage ended. You must pay additional premiums in monthly installments prior to the first day of the month; however, you will be allowed a grace period for such subsequent monthly premium payments. The grace period is set by the insurance company and will be at least 30 days. If your premium payment is not made before this grace period ends, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

Generally, the amount of the premium for COBRA continuation coverage will be 102% of the cost to the group health plan (including both employer and retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

Type of Coverage

In most instances, the COBRA continuation coverage that is offered initially will be exactly the same coverage that you and/or your spouse had on the day before the qualifying event. However, a qualified beneficiary who moves out of the service area of the HMO in which he or she had been enrolled will be offered the opportunity to elect coverage under any other health plan maintained by the Company that provides coverage in the area to which the qualified beneficiary has moved.

Open Enrollment – Qualified beneficiaries who have elected COBRA continuation coverage have the same opportunity available to similarly situated covered retired employees to change their coverage options.

When COBRA Continuation Coverage Ends

A qualified beneficiary's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occurs:

- The premium for coverage is not paid for in a timely manner;
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have;
- After the date of the COBRA election, an applicable pre-existing condition limitation expires under the covered individual's new group health plan;
- After electing COBRA, the qualified beneficiary enrolls for Medicare; or
- The Company no longer provides group health coverage to any of its employees.

Notification of Address Changes

The Plan Administrator will send all notices and other important information regarding COBRA to a qualified beneficiary's last known address as shown in the Company's health plan records. In order to protect your and your spouse's COBRA rights, you must notify the Plan Administrator in writing of any address change.

Conversion Coverage

At the end of the COBRA continuation coverage period, you may have the right to convert to an individual policy if such a conversion policy is part of the group health plan at the time your coverage ends.

For More Information

If you have questions, please contact:

Human Resources Department
Alexander and Baldwin, Inc.
822 Bishop Street
Honolulu, HI 96813
(808) 525-6611

22. What Are My Rights under ERISA?

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office at 822 Bishop Street, Honolulu, HI 96813 and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report 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 all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report and updated summary plan description. You may be required to pay 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

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

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You will be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your health coverage.

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit under the Plan 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 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 which is denied or ignored, in whole or in part, and you followed the Plan's claim and appeals procedure, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance form the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about 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.

23. What Is the Plan's Right to Subrogation and Reimbursement?

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your spouse's behalf that were:

- Made in error;
- Due to a mistake in fact; or
- Advanced during the time period of meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your spouse misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your spouse that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested; or
- Reduce a future benefit payment for you or your spouse by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan may pursue reimbursement for any legal claims that you may be entitled to that the Plan has paid. Subrogation applies when the Plan has paid benefits for a sickness or injury for which a third party is considered responsible – e.g., an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100% of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;

- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages; or

- Any person or entity who is or may be obligated to provide you with benefits or payments under:
    - Underinsured or uninsured motorist insurance;
    - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
    - Workers' compensation coverage; or
    - Any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a participant in this Plan, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party;

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are itemized, structured, allocated, denominated, or characterized. Such rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits subject to the Plan's right to subrogation and/or reimbursement. Such rights shall be without regard to the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the participant, no-fault coverage, uninsured and/or underinsured motorist coverage). The Plan is not required to help you to pursue your claim for damages or personal injuries or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right;

- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages). No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights;

- Benefits paid by the Plan may also be considered to be benefits advanced;

- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including but not limited to:
    - Complying with the terms of this section;
    - Providing any relevant information requested;
    - Signing and/or delivering documents at its request;
    - Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable;
    - Responding to requests for information about any accident or injuries;
    - Appearing at medical examinations and legal proceedings, such as depositions or hearings; and
    - Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

  Your failure to cooperate with the Plan is considered a breach of contract. If you or your representative doesn't cooperate with the Plan and as a result the Plan does not recover the full value of benefits the Plan has paid relating to any sickness or injury

alleged to have been caused or caused by any third party, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or withhold payment from any future benefits. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan;

- If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid;

- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you;

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval;

- You will assign to the Plan all rights of recovery against third parties to the extent of benefits the Plan has provided for a sickness or injury caused by a third party;

- The Plan's rights will not be reduced due to your own negligence;

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under this section, including but not limited to filing suit in your name. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name;

- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs;

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation;

- Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or withhold from any future benefits the value of benefits the Plan has paid relating to any sickness or injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan;

- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a participant; and

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

24. General Information

Plan Administrator and Plan Sponsor	Alexander & Baldwin, LLC 822 Bishop Street P.O. Box 3440 Honolulu, Hawaii 96801 Telephone: (808) 525-6611
Name of Plan	Alexander & Baldwin, LLC Retiree Health and Welfare Benefit Plan
Agent for Service of Legal Process	Plan Administrator
Plan Year	Calendar Year
Employer Identification Number	80-0819474
Plan Number	501
Source of Funding	Employer and Retiree Contributions. Funding of benefits is either insured or self-funded, depending on the specific program, as noted in the "Directory of Plans." Benefits which are self-funded are paid from the general assets of Alexander & Baldwin, Inc. and its subsidiaries.
Type of Plan	The Plan is classified as a "welfare" plan under ERISA. It provides medical and life insurance benefits.
Type of Administration	The Plan Administrator administers participation and contributions, and the insurance carriers administer claims and process benefit payments.

Directory of Plans

Coverage	Insurance Carrier	Type of Plan	Financing Arrangement
Life insurance	Metropolitan Life Insurance Customer Service Center 177 South Commons Drive Aurora, IL 60504 Phone: 1-800-638-6420 www.Metlife.com	Life insurance	Insured
Health care including Prescription Drugs	Hawaii Medical Service Association 818 Keeaumoku Street Honolulu, HI 96814 From Oahu: 808-948-6111 Toll Free: 800-776-4692 www.hmsa.com	Preferred Provider Plan Health Plan Hawaii Plus (HMO) Akamai Advantage Prime (for retirees age 65 and older)	Self-funded Self-funded Insured (Prescription drugs are self-funded)
	Kaiser Foundation Health Plan, Inc. 711 Kapiolani Boulevard Honolulu, HI 96813 Phone: 808-432-5955 www.kp.org	Health Maintenance Organization (HMO) Senior Advantage (for retirees age 65 and older)	Insured