

SUMMARY PLAN DESCRIPTION

RETIREE

HEALTH AND WELFARE

BENEFIT PLAN

For

ELIGIBLE RETIREES WHO WERE

SALARIED EMPLOYEES OF

ALEXANDER & BALDWIN, INC.

AND ITS SUBSIDIARIES

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INTRODUCTION

Alexander & Baldwin, Inc. (the “Company”) established the Alexander & Baldwin, Inc. Retiree Health and Welfare Benefit Plan (“Plan”) effective January 1, 1992 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 and explains the Plan’s eligibility requirements.

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.

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, and 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”);
- 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”);
- You are eligible to receive retirement benefits under the Pension Plan; and
- You meet the following age and service requirements:

Age on Retirement Date		Number of Completed Years of Service
55	and	30 or more
56	and	28 or more
57	and	26 or more
58	and	24 or more
59	and	22 or more
60	and	20 or more
61	and	18 or more
62	and	16 or more
63	and	14 or more
64	and	12 or more
65 or more	and	10 or more

Your years of service for Plan purposes 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 will receive Life Insurance Coverage based on the following schedule:

<u>Years Since Retirement Date</u>	Coverage = The Following Percentage of the Lesser of Annual Base Salary or Amount of Life Insurance Immediately <u>Prior to Retirement</u>	<u>Maximum Dollar Amount of Coverage</u>
0	75%	\$50,000
1	50%	\$25,000
2 or more	25%	\$10,000

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. Could I Lose Life Insurance Coverage?

Except to the extent that the Company terminates or revises eligibility or benefits under the Plan, life insurance coverage continues until death.

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 obtain a copy from 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 insurance carrier for each program. Benefits will always be provided in accordance with such documents and contracts.

The Company requires participants to enroll in Medicare (Parts A and B) at their own expense when Medicare first becomes available to them. Also, if the Kaiser Plan is chosen, enrollment in the “Senior Advantage Plan” at age 65 is required.

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

The Company will pay a percentage of a Fixed Dollar Amount (maximum company contribution) for a health care coverage program each month for the retiree if he/she continues to meet eligibility requirements under the Plan. The Fixed Dollar Amount (“FDA”), and the percentage of the FDA the Company pays for each retiree, will be based initially on the retiree’s age and service at the time of retirement, and may change thereafter, if applicable, in accordance with the following schedule:

	Fixed Dollar Amount (FDA)		
	At Ages 55-59	At Ages 60-64	At Ages 65 & Over
Hawaii:*	N/A	\$135.80	\$100.31
Mainland:*	N/A	\$324.69	\$134.92

* If a participant receiving benefits changes residence between Hawaii and any other area, the Company may in its discretion switch benefit coverage to insurer(s) in the new area of residence and make the applicable adjustment in the FDA.

Number of Completed Years of Service	Percentage of Fixed Dollar Amount Payable by Company		
	At Ages 55 – 59	At Ages 60 – 64	At Ages 65 & Over
25 & Over	0%	100%	100%
24	0%	95%	95%
23	0%	90%	90%
22	0%	85%	85%
21	0%	80%	80%
20	0%	75%	75%
19	0%	70%	70%
18	0%	65%	65%
17	0%	60%	60%
16	0%	55%	55%
15	0%	50%	50%
14	0%	45%	45%
13	0%	40%	40%
12	0%	35%	35%
11	0%	0%	30%
10	0%	0%	25%

An eligible participant who elects to obtain coverage is responsible for the cost of coverage in excess of the applicable percentage of the FDA the Company pays. For example (all premiums in the examples are for illustration purposes only; you should check with your Human Resources Representative for the current premium rates):

- A. Hawaii - 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 the retiree's health care coverage is \$249 per month. The Company will pay \$135.80 per month ($\$135.80 \times 100\%$) 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 for the retiree. The FDA will change when Employee A attains age 65 and becomes eligible for Medicare. At that time, the Company will pay \$100.31 and Employee A will pay the difference between \$100.31 and the total health care cost. Employee A will also be responsible for paying the cost of Medicare coverage.
- B. Mainland - Employee B retired from active service with 23 years of service, and is age 64. The FDA for health care coverage is \$324.69 per month and the cost of the retiree's coverage is \$483.62 per month. The Company will pay \$292.22 per month ($\$324.69 \times 90\%$) for the retiree's health care coverage. The retiree must pay \$191.40 for health care coverage, the difference between \$483.62 (the cost of the retiree's health care coverage) and the \$292.22 the Company pays for the retiree. When Employee B attains age 65 and becomes eligible for Medicare, the Company will pay \$121.43 (90% of \$134.92), and Employee B will pay the difference between \$121.43 and the total health care cost. Employee B will also be responsible for paying the cost of Medicare coverage.
- C. Hawaii - 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 age 65+ with Medicare is \$100.31 per month and the cost of the retiree's coverage under the Company's health plan is \$213. The Company will pay \$75.23 per month ($\$100.31 \times 75\%$) 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 for the retiree. The retiree is also responsible for the cost of Medicare coverage.
- D. Mainland - Employee D retired from active service with 24 years of service and is age 58. He pays 100% of the cost of health care coverage until he attains age 60. Beginning on the 1st day of the month following Employee D's 60th birthday, the Company will pay \$308.45 per month ($95\% \times \324.69) for Employee D's health care coverage. Employee D pays the difference between the total cost of the health care coverage and the \$308.45 paid by the Company. When Employee D attains age 65, the FDA will change to \$134.92; the Company will pay \$128.17 per month ($95\% \times \134.92) beginning on the 1st day of the month following Employee D's 65th birthday. Employee D will pay the difference between the

total cost of health care coverage and the \$101.19 paid by the Company. Employee D will also be responsible for paying the cost of Medicare coverage.

9. Can My Spouse Receive Health Care Insurance Coverage?

If you elect to obtain Health Care Insurance Coverage, you may also elect to cover your spouse, 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 (but see question 11 about delayed enrollment). If you die, your spouse will continue to be covered. 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 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, you must also be enrolled in Medicare as soon as you are eligible.)

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

Immediately prior to your retirement, if you meet the eligibility requirements in question 2, your Human Resources Department will provide 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 45 days after your date of retirement. If you fail to make such election as required, 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 1st 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 waive health care benefits at retirement because you or your spouse are covered under a health care plan provided by your spouse's employer, 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 the other 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 coverage by the other health plan terminates.

However, if you return to employment with a company other than a participating company and you are regularly scheduled to work for that company at a rate of 20 hours or more per week for a period of at least 4 consecutive weeks, you will automatically and permanently cease to be a participant of this Plan, and consequently you and your spouse will be ineligible for any health care benefits under this Plan whether or not you subsequently terminate such employment.

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

14. Can I Lose Health Care Insurance Coverage?

Retirees – Generally, your Health Care Insurance Coverage will terminate at your death. You can also lose coverage under the following circumstances:

- 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.
- If you return to work after you retire (see question 13).
- 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 – Your spouse can lose coverage under the following circumstances:

- If you lose your coverage, except by reason of death.

- 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 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.

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).

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. If the Plan is terminated, discontinued with respect to any participating company, or amended to curtail benefits, Plan participants will be notified.

18. Do Plan Fiduciaries Have Discretionary Authority?

Each Plan fiduciary having responsibility under this Plan to make factual finding, to determine eligibility for benefits, or to 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, and 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 you 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 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) (i.e., 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.

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.

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.

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:

Hawaii: Benefits Specialist
Alexander and Baldwin, Inc.
822 Bishop Street
Honolulu, HI 96813
(808) 525-6630

Mainland: Human Resources Assistant
Matson Navigation Company, Inc.
555 12th Street
Oakland, CA 94607
(510) 628-4302

The notification must include all of the following information:

- The employee'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 (1st) 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 employee 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;
- 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 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:

Hawaii: Benefits Specialist
Alexander and Baldwin
822 Bishop Street
Honolulu, HI 96813
(808) 525-6630

Mainland: Human Resources Assistant
Matson Navigation Company, Inc.
555 12th Street
Oakland, CA 94607
(510) 628-4302

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 collective bargaining agreements, 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 from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Plan Administrator and Plan Sponsor:	Alexander & Baldwin, Inc. 822 Bishop Street P. O. Box 3440 Honolulu, HI 96801 Telephone (808) 525-6611
Agent For Service of Legal Process:	Plan Administrator
Plan Year:	Calendar Year
Employer Identification Number:	99-0032630
Plan Number:	599
Source of Funding:	Employer and Employee 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	Metlife One Madison Avenue New York, NY 10010	Life insurance	Self-funded
Health care including prescription drugs	Hawaii Medical Service Association 818 Keeaumoku Street Honolulu, Hawaii 96814 (for Hawaii beneficiaries)	Preferred Provider Plan 65-C Plus (for individuals age 65 or over)	Self-funded Insured (Prescription drugs are self-funded)
	Kaiser Foundation Health Plan, Inc. 3288 Moanalua Road Honolulu, Hawaii 96819 (for Hawaii beneficiaries)	Health Maintenance Organization (HMO) Senior Advantage (for individuals age 65 and older)	Insured
	Kaiser Foundation Health Plan, Inc. 1350 Treat Blvd., Suite 390 Walnut Creek, CA 94597 (for Mainland beneficiaries)	HMO Senior Advantage (for individuals age 65 and older)	Insured
	CIGNA 1999 Harrison Street, #1000 Oakland, CA 94107	Preferred Provider and HMO	Self-funded
		Preferred Provider Organization (for individuals age 65 and over)	Self-funded
	PacifiCare of California 2300 Clayton Rd., #1000 Concord, CA 94520	Preferred Provider Secured Horizon (for individuals age 65 and over)	Insured