Walgreens Company-Paid Disability Plan for Hourly Team Members

Summary Plan Description

Prepared by the Walgreens Human Resources Department for eligible Walgreens Hourly-Paid team members

Walgreen Co. (“Walgreens” or the “Company”) is pleased to provide its team members with a comprehensive package of health and welfare benefit options as described in the Walgreen Health and Welfare Plan (the “Plan”). To assist you in better understanding the disability benefits available to Walgreens team members covered by the Company-Paid Disability Plan for Hourly Team Members, as in effect as of January 1, 2018 we have prepared this Summary Plan Description (“SPD”) booklet. The complete Plan includes contracts and agreements with insurance carriers (“Insurer[s]”) and third-party administrators who provide and administer benefits, this SPD, including any Summary of Material Modifications, and summary plan descriptions covering other benefits that are not covered by this SPD. You should read the information provided in this booklet so that you will have a full understanding of the benefits provided and the other relevant terms and conditions of the Plan. Throughout this document the term “Company” means Walgreen Co. and its subsidiaries and affiliates whose team members are eligible to participate in the Plan, unless the context is limited to a particular subsidiary or business unit. See “Administrative Facts” at the end of this booklet for the name of the legal entity of the Company that is the official plan sponsor of the Plan, and therefore the Company for purposes of formal approvals and governmental filings.

Please understand that the Company reserves the right to amend, modify or terminate this Plan, including any benefits provided under this Plan or the amount of required contributions, if any, at any time and for any reason. You will be notified of any changes to the Plan within a reasonable amount of time, but not always prior to the time the change goes into effect. To determine the proper benefits at any given time, it is necessary to consult the Plan and SPD that is in effect at the relevant time.

In the event that any term or provision in the SPD is in conflict with any of the terms or provisions of the Plan, the terms or provisions in the Plan document will govern. The Plan as used herein refers to this SPD.

Important Notice

This booklet contains information in English of your Plan rights and benefits under this plan. If you have difficulty understanding any part of this booklet, contact the Walgreens Human Resources Department at 800-825-5467

Noticia Importante

Este boletín contiene informacion, escrito en inglés, de sus derechos y beneficios bajo este Plan. Si es difícil comprender cualquiera parte de este boletín, por favor de ponerse en contacto Walgreens Human Resources Department at 800-825-5467.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa Walgreens Human Resources Department at 800-825-5467

如果需要中文的帮助，请拨打这个号码 Walgreens Human Resources Department at 800-825-5467

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' Walgreens Human Resources Department at 800-825-5467

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Disability Plan Checklist

If you need to be off work for more than seven calendar days due to a disabling condition (illness, injury or pregnancy), you must file a claim to be considered for a disability benefit under this Plan. Use this checklist as a guide to make sure you take all the necessary steps for filing a disability claim.

- ✓ **Information needed for filing a disability claim** – please have the following information ready when making a call to the claims administrator, Sedgwick CMS:
  - Your name, address, telephone number, Social Security number or Employee ID number and personal e-mail address;
  - Your job title, work location and address, work schedule, manager/supervisor's name and telephone number;
  - Your last day worked and nature of your disabling condition; and
  - Your treating physician's name, address, telephone number and fax number.

- ✓ **Filing a disability claim** – call Sedgwick CMS to report a disability claim at 877-872-0911 (TTY 901-531-4554) within 15 days of the beginning of your leave.
  - If you call prior to the actual start of your claim Sedgwick will set-up the information you give them, but your claim will not be activated until you or someone on your behalf calls to confirm your actual disability on or after your first day of absence.
  - You must call to submit a claim for disability benefits within 60 calendar days of becoming disabled.
  - For pregnancies, you must have either delivered your baby or be disabled by your pregnancy prior to delivery. Your doctor will need to provide documentation verifying you can no longer perform the duties of your own occupation.

- ✓ **What to expect once your claim has been reported**
  - After your claim has been reported, a confirmation of your claim submission will be mailed to you the next day, along with an information package to assist you in understanding the claim process and your responsibilities.
  - Sedgwick CMS will review your claim, request any needed information from you and your doctor and call you with a claim decision as soon as all required documents have been reviewed. It is important for you to sign and return the "Reimbursement Agreement" included in the packet – and available on-line at Sedgwick's site. Any approved claim payments will be deferred pending receipt of that signed form.
  - You may track the status of your claim on Sedgwick's ViaOne Express site. Go to ***https://claimlookup.com*** on your computer and create a new user account.

- ✓ **Inform your doctor**
  - Let your treating physician know he or she will be contacted by Sedgwick CMS regarding your disabling condition. His/her sending a complete report of your medical condition to Sedgwick is critical to the evaluation of your claim.
  - Give your treating physician a signed authorization to provide information concerning your disabling condition (authorization forms are available from Sedgwick CMS or your treating physician's office).

- ✓ **Certain state-mandated programs** – additional claim filing requirements apply if you work in **California, New York, New Jersey, Rhode Island, Washington, Massachusetts, District of Columbia, or Hawaii.**
  - You may obtain forms or instructions on how to file for state or commonwealth disability plan benefits from your work location, state disability benefit claims office or possibly your treating physician's office.
  - If your disability claim is approved and you work in one of the states listed above, your Walgreens disability benefits will not be paid until a copy of your state/commonwealth disability pay notice, including benefit amount, is received by Sedgwick CMS.

- ✓ **Work-related disabling conditions** – notify your manager/supervisor immediately if your disability is due to a work-related injury or illness.
  - **Important**: even if your disabling condition is work-related, you must also file a disability claim with Sedgwick CMS to be considered for benefits under this Disability Plan.
  - Work-related injuries or illnesses will be reported to the workers' compensation claim administrator by the Team Member by calling 877-872-0911.
  - Benefits from this Disability Plan may be deferred until you receive notice of a final Workers' Compensation award and you send a copy of that notice to Sedgwick CMS.

- ✓ **Returning to work**
  - You will need a release from your treating physician indicating the date you are able to return to work.
  - This release form must be given to your manager/supervisor when you return to work. A copy must also be sent to Sedgwick.
  - You must call the Walgreens Human Resources Leave Department at 800-825-5467 to report the day you return to work.

Company-Paid Disability Plan for Hourly Team Members Resource Guide

If you have a question about:	Resource	Contact Info
Filing a disability claim and questions about your claim until it is approved	Sedgwick CMS Disability Center	877-872-0911 TTY: 901-531-4554
Questions about benefit payments after your disability claim has been approved	Walgreens Human Resources Leave Department	800-825-5467
Questions on eligibility for coverage under the Disability Plan	Walgreens Human Resources Leave Department	800-825-5467
Filing an appeal (following a disability claim denial)	Sedgwick CMS Disability Center	877-872-0911 TTY: 901-531-4554
Last Chance Program	Walgreens Human Resources Employee Relations Department	800-825-5467
Unpaid leave of absence	Walgreens Human Resources Leave Department	800-825-5467
Medical benefits and/or COBRA	Benefits Support Center	855-564-6153
Voluntary Disability Plan Benefits	Prudential	800-842-1718

If You Are Having a Baby

Pregnancy is treated in the same manner as an illness under this Plan. This means you must either have delivered your baby or be totally disabled by your condition prior to that date to be eligible for disability benefits. (The waiting period and annual Short Term benefit period maximums also apply.)

Pregnancy disabilities are covered as any other disability during the time that you remain totally disabled by that condition. There is no automatic approved period following delivery.

After your approved disability leave (paid and unpaid) ends, a personal leave or Family Medical Leave (FMLA) may be available for additional time off. For more details, see the “Other Leaves” section.

Introduction

The Walgreens Company-Paid Disability Plan for Hourly Team Members provides a source of income if you become ill, injured or pregnant and are unable to work. The Company pays the full cost of this coverage.

Under this Plan, if you are disabled, after a seven calendar day waiting period, you are eligible to receive benefits each calendar year which equal your full base pay for up to two weeks, and half pay for up to an additional ten weeks. **Effective January 1, 2019, if you are disabled, after a seven calendar day waiting period, you are eligible to receive benefits each calendar year which equal your full base pay for up to six weeks, and half pay for up to an additional six weeks.** See the "Offsets to Benefits" section for details on which other benefits can reduce your disability benefits under this Plan.

To file a claim, you must contact Sedgwick CMS. Sedgwick works with you and collects the information needed to determine if you are eligible for benefits.

Eligibility

To be eligible for coverage under the Company-Paid Disability Plan for Hourly Team Members, you must:

- Be an active employee, working in the United States, excluding Puerto Rico locations;
- Be paid on an hourly-basis (excluding hourly-paid pharmacists or registered nurses and hourly-paid team members who have a Benefit Indicator (BI) of 20 (Assistant Store Managers), 510 (Coordination Pay Band Team Members) or 511 (Analysis Pay Band Team Members, who are eligible under a different plan);
- Work an average of 30 or more hours per week for the most recent 52 weeks (or since your start date if less than 52 weeks);
- Have at least 181 days of continuous service;
- Be actively at work or on approved paid time off or a regularly scheduled day off on your initial date of coverage or when the illness or injury occurs. If you do not meet this requirement on your date of initial eligibility or onset of illness or injury, that coverage will be deferred until you return for one full day.

You are not eligible for coverage if you are:

- A team member who has company-paid disability coverage available through a different plan.
- A team member of Healthcare Clinics (HCC) whose payroll is not processed from Walgreens' payroll system.
- On a personal leave of absence when the illness or injury occurs.
- A team member who is covered by a collective bargaining agreement, unless that agreement specifically provides for your right to coverage by this Plan.
- A temporary or seasonal team member.

If you have questions about your eligibility, employment status or the Plan's terms or conditions, contact the Walgreens HR Shared Services Leave Department at 800-825-5467. A general inquiry will not be treated as a benefit claim or appeal. To file a claim for disability benefits or appeal under the Plan, you must follow the procedures described in the "How to File a Claim" and "Procedures for Reviewing Claims" sections.

Enrollment

Once you meet the eligibility requirements, you are automatically covered by the Plan, subject to the "actively at work" requirement. You do not need to enroll or contribute to the cost of this coverage.

Loss of Eligibility

Your coverage under this Plan ends when you no longer meet the Plan's eligibility requirements. You will no longer be covered by this Plan when any of the following occur:

- Your 52-week average is below 30 hours per week.
- You are no longer actively working for the Company in a position eligible for this Plan.
- The Company discontinues the Plan.
- You are still an active employee, but your date of disability is more than 30 days after the latest of (i) your last day worked, (ii) the end of an approved Family Medical Leave under the Family Medical Leave Act or (iii) the end of an approved vacation.
- You participate in a strike against the Company or do not report to work on a scheduled workday due to a strike related issue. This will cause a break in service. Coverage will not be in effect during a break in service, and will not reinstate until the employee does return to work for one full day.
- You are on an approved personal leave of absence.
- Your employment ends (as determined by Company Employee Policy).
- You die.

If You Are Not Eligible

If you are disabled, but not eligible for paid disability benefits, you may be eligible for an unpaid medical leave. For more details, call the Walgreens HR Shared Services Leave Department at 800-825-5467. You should apply for an unpaid medical leave to protect your employment status if you are not eligible for a paid medical leave or are appealing a denial of paid medical leave.

Regaining Eligibility

If you lose eligibility for this coverage and then you later become eligible, you will regain eligibility for this Company-Paid Disability Plan. When you regain eligibility, you will be covered as a newly eligible team member.

Responsible Parties

All benefits under this Plan are paid directly from the Company, and the Company is directly responsible for the final adjudication of your disability claims. Sedgwick CMS acts as the claims administrator/ adjudicator for this Company-Paid Disability Plan.

Plan Benefits

You must be considered "totally disabled" or be an eligible active participant in the Company's Last Chance Program to receive Plan benefits.

Total Disability: You are considered totally disabled whenever you are unable to perform the material and substantial duties of your job and are not working at any other job (excluding any job that you started prior to becoming disabled and that can be performed despite your disability). You must be under the care of a licensed healthcare provider appropriate for your disabling condition and be following a prescribed course of medical treatment. Sedgwick CMS (the Claim Administrator) must approve your total disability in order for you to receive Plan benefits.

Last Chance Program: You are eligible for one period of benefits during your lifetime, without needing to prove total disability, if you are actively participating in the Company's Last Chance Program (part of the Company's Drug-free Workplace Policy). You are eligible for Plan benefits while on leave through the Last Chance Program effective as of your first day absent due to substance or alcohol abuse and to the earliest of: your release to return to work; the date you no longer participate in the Last Chance Program; the end of your maximum benefit period for the calendar year; and when you engage in any new occupation for wages or profit while on disability leave. Your employment may also be terminated when your disability leave ends unless you return to work. Once you are released to return to work (full-time, part- time or intermittently), your disability benefits stop. (The Plan waiting period also applies). For more information on the Last Chance Program, contact the Human Resources Employee Relations Department at 800-825-5467.

Your Benefit Level

If you are approved for Plan benefits, your salary as of the date your disability begins affects your Plan benefit. Certain maximum benefit amounts and coordination with other disability-related income also apply.

Maximum Benefit per Calendar Year

Full-Pay up to:	Half-Pay up to:
2 weeks	10 weeks

Effective January 1, 2019, Maximum Benefit per Calendar Year

Full-Pay up to:	Half-Pay up to:
6 weeks	6 weeks

Weekly pay is determined by multiplying your hourly rate times your 52-week average weekly work hours (or your average since date of hire, if less than 52 weeks).

Waiting Period

Before benefits begin, there is a waiting period of seven calendar days, not to exceed the equivalent of one work week, beginning with your first regularly scheduled work day missed due to a disability. The date your disability began must be confirmed by your doctor.

Available paid-time-off (PTO), sick or vacation time may be paid to you during this waiting period. However, sick or vacation time may only be used if no PTO is available. To receive pay for this time, it should be requested by contacting your manager. A maximum of 5 current or banked sick days (for non-PTO team members) or the equivalent amount of PTO time for all other team members will be paid during the 7-day waiting period, regardless of the team member's work schedule.

If you become disabled by the same or related condition within 30 days after you return to work, the waiting period is waived, regardless of the year in which it occurs. If you become disabled by the same condition after you have returned to work for more than 30 days, the waiting period applies. The waiting period also applies if you become disabled by an illness or injury unrelated to your previous disability at any time after returning to work.

Additional Voluntary Coverage Available

Additional voluntary disability coverage may be available for you to purchase, which would provide an additional benefit to you. Please see the Voluntary Disability Plan for Hourly Team Members Summary Plan Description (SPD) or go to the Benefits Support Center website at **www.BenefitsSupportCenter.com** to apply online, or call

the Benefits Support Center at 855-564-6153 for information.

The Voluntary Disability Plan for Hourly Team Members is intended to coordinate with any benefits available through this Walgreens Company-Paid Disability Plan for Hourly Team Members. In all cases, there is a benefit waiting period before the Voluntary Disability Plan will begin payments. This benefit waiting period is the earlier of the end of your Company-Paid Disability Plan benefit, or 13 weeks (84 days), per the following chart.

Hourly Team Members Disability Pay Coordination					
Week of Disability	Available PTO from Walgreens	Walgreens Full-Pay Disability Benefit	Walgreens Half-Pay Disability Benefit	VOLUNTARY 2-Year Income Replace Plan Option Pays	VOLUNTARY 5-Year Income Replace Plan Option Pays
1 week waiting period	7 day waiting period (Full pay to supplement from PTO, sick or vacation time, if available)				
2 – 7		Full Pay			
8 – 13			50% of Pay (PTO, sick or vacation, if available to supplement)		
14 – 117				60% of Covered Pay (PTO, sick or vacation, if available to supplment)	60% of Covered Pay (PTO, sick or vacation, if available to supplment)
118 – 273					60% of Covered Pay (PTO, sick or vacation, if available to supplment)

Hourly Team Members Disability Pay Coordination Effective 1/1/2019					
Week of Disability	Available PTO from Walgreens	Walgreens Full-Pay Disability Benefit	Walgreens Half-Pay Disability Benefit	VOLUNTARY 2-Year Income Replace Plan Option Pays	VOLUNTARY 5-Year Income Replace Plan Option Pays
1 week waiting period	7 day waiting period (Full pay to supplement from PTO, sick or vacation time, if available)				
2 – 7		Full Pay			
8 – 13			50% of Pay (PTO, sick or vacation, if available to supplement)		
14 – 117				50% of Covered Pay (PTO, sick or vacation, if available to supplment)	50% of Covered Pay (PTO, sick or vacation, if available to supplment)
118 – 273					50% of Covered Pay (PTO, sick or vacation, if available to supplment)

Benefits under the Voluntary Disability Plan may begin earlier than 13 weeks after the onset of your disability, if your benefits under the Company-Paid Disability Plan end sooner than 13 weeks. For example, if you were disabled for six weeks earlier in the calendar year, and received five weeks of Disability Plan benefits from the Company-Paid Disability Benefit Plan for Hourly-Paid Team Members, some of your calendar year benefits would be used. If you were later disabled from a different condition in the same calendar year, your benefit under the company-paid Plan would only last six weeks, so you would have a shorter benefit waiting period before your Voluntary Disability Plan benefits would begin.

Benefits in a New Calendar Year

The total maximum benefit period you can receive in a calendar year, for all periods of disability in that calendar year combined, is limited to 2 weeks of full pay and 10 weeks of half pay, and starting January 1, 2019 6 weeks of full pay and 6 weeks of half pay. If a disability continues into a new calendar year, only remaining disability benefits from the prior year would be available. Once you return to work, you are eligible for the benefits that apply to the new year if you:

- Are at work for at least 30 days before a recurrence of your original disability or related disability, or
- Become disabled by an unrelated disability after returning to work for one full day or more.

If you do not meet either of these criteria, your benefit period and amounts are limited to those remaining from the previous year, if any.

Supplementing Your Half-Pay

If you exhaust full pay benefits under this Plan, available PTO, sick or vacation time can be used to supplement half-pay benefits, so that the combination of the two equals your normal full-pay amount. Available sick or vacation time may be used even if you have PTO time available.

You will be sent a Disability Half Pay Supplement Form by Sedgwick. Complete and return this form to Sedgwick if you would like to use PTO, sick or vacation time to supplement your partial disability benefit.

Company holidays will not be paid while you are on a disability leave.

Recurrent Disabilities

If you become disabled again after you have returned to work after a disability leave, the following rules apply to the way your benefits are paid:

- You are limited to a combined maximum of 2 weeks of full pay and 10 weeks of half pay each calendar year, for all periods of disability combined. Effective January 1, 2019, you are limited to a combined maximum of 6 weeks of full pay and 6 weeks of half pay each calendar

year, for all periods of disability combined. If a disability continues into a new calendar year, benefits will be limited to those remaining from the prior year, until you meet the criteria in the section "Benefits in a New Calendar Year".

Coordination with Other Disability- Related Income

If you receive disability-related payments from any other source, such as state-mandated disability plans, workers' compensation, government programs, other employer sponsored programs, or any other Company-paid disability plan, your Company disability benefits will be adjusted so your total income from all disability related sources equals the benefit described in this booklet. These other benefits are considered offset benefits. Your disability payment cannot be processed until you give Sedgwick CMS a copy of the award notice from these benefit sources. If your income from outside sources is greater than what you would receive under the Company Plan, you will not receive payments under this Plan.

Disability benefit days that are coordinated with other benefit plans or programs are fully charged as disability days even if you receive a partial or no benefit after coordination. In the examples below, you would be charged a full disability day even though you received a partial or no benefit under this Plan due to the benefit received from another source.

You are required to apply for all other income benefits you are eligible for and appeal any claim denial. If you fail to do so, your benefits under this Company-Paid Disability Plan will be reduced by the amount of estimated benefit you could have received if your claim had been approved. If you received benefits under this Plan, and are later awarded benefits from one of the sources listed, you must reimburse the Plan for any overpayment the award causes. Plan benefits may also be delayed or denied while primary offset benefits are pending.

Offsets to Benefits

Suppose your covered pay is $1,200 per month. If you are receiving a monthly benefit check of $650 from an offset source, then your disability pay per month under this Plan (disability payments are normally paid on a bi-weekly basis) would be $550 while you are eligible for full-pay disability benefits. Any voluntary deductions, such as those for benefits and charities, would be taken from your disability payment. In this example, once you become eligible for half-pay disability benefits, you would not receive anything under this Plan. This is because your offset source disability benefit of $650 is greater than the $600 (half-pay) disability benefit you are eligible for under the Plan. Your disability benefit under this Plan is not reduced by any dependent benefit you receive from an offset source.

Workers' Compensation

If you receive workers' compensation pay, that offset benefit is increased to take into account that it is income tax free. This will further reduce your benefit from this Plan. For example, suppose your average gross weekly pay is $250, and your after-tax pay is $233. If you are receiving a weekly benefit of $150 from workers' compensation, then your disability benefit from this Plan would be $83 ($233 -$150) while you're eligible for full disability benefits. Any voluntary deductions such as benefits and charities would be taken from your disability payment. In this example, once you become eligible for half-pay disability benefits, you would not receive anything under the Company-Paid Disability Plan because your workers' compensation benefit of $150 is greater than the $116.50 (half pay after tax) in disability benefits to which you would otherwise be entitled.

State Disability Payments

If you receive state or commonwealth mandated disability payments from New York, Rhode Island, New Jersey, California or Hawaii, your Company disability benefits will be reduced by the amount of the state or commonwealth mandated benefit. For example, suppose your normal gross weekly benefit is $250. If you are receiving a weekly check of $150 from state disability, then your Company disability pay would be $100 ($250- $150) while you're eligible for full disability benefits. Any voluntary deductions, such as those for benefits and charities, would be taken from your disability payment. In this example, once you become eligible for half-pay disability benefits, you would not receive anything under the Company-Paid Disability Plan because your state disability benefit of $150 is greater than the $125 (half-pay) disability benefit you would be eligible for under this Plan.

Subrogation

If the Plan pays disability benefits for an illness or injury caused by an act or omission of a third party, the Plan will be subrogated to all of your rights of recovery from that third party. Any time you are eligible to receive benefits under the Plan, you must immediately notify Sedgwick of the name of any third party against whom you might have a disability-related claim as a result of your sickness or injury (including any insurance company). For example, if you become injured in a car accident, and the person who hit you was at fault, the person who hit you is the third party whose act caused your injury. This requirement for reimbursement does not apply to benefits you receive from any "no-fault" provision of

your own automobile insurance policy, but does apply to coverages you purchase for uninsured and underinsured third parties determined to be liable for your loss. You must cooperate with Sedgwick and the Walgreens Human Resources Leave Department by providing information about your disability and by agreeing to sign, currently and in the future, any necessary documents to enable the Plan to be subrogated on your claim, and by participating in any action to recover before any benefit will be paid by this Plan. To enforce the Plan's subrogation rights, the Plan may:

- Place a lien against a third party to the extent Company Plan benefits have been paid;
- Bring an action on behalf of the Plan, or on your behalf, against the third party;
- Cease paying benefits until you provide the Human Resources Leave Department or its agent with the documents necessary for the Plan to exercise its rights and privileges of subrogation; and
- Execute and collect against any of your assets if you have dissipated monies that should have been repaid to the Plan, failed to cooperate with the Plan or prejudiced the Plan's ability to recover its payments.

Third Party Reimbursement

If the Plan pays you disability benefits for an illness or injury caused by an act or omission of a third party, the Plan has the right to be repaid for any Plan benefits you receive from any settlement, judgment or insurance proceeds from (or on behalf of) that third party. You must repay the Plan on a first dollar basis (meaning that the Plan has a right to be repaid first from any monies you receive). The Plan has a right to be reimbursed whether or not the third party admitted liability for the payment, whether or not a portion of the settlement, judgment or insurance proceeds was identified as a reimbursement of any particular expenses, and whether or not you are made whole by the settlement, judgment or insurance proceeds.

You agree, by accepting benefits under the Plan, to provide the Plan Administrator with a lien, to the extent the Plan has paid or will pay disability benefits, to be filed with the responsible party or insurance company of the responsible party. You also agree to make direct and immediate reimbursement if you receive award monies from or on behalf of the third party. You agree that the Plan has a lien on any fund, account, or asset into which you deposit or commingle monies that you received which were subject to repayment to the Plan. In addition, you agree that the Plan may execute and collect against any of your assets if you have dissipated monies that should have been repaid to the Plan and waive any defenses based on the inability to trace the specific monies.

If you do not reimburse the Plan from any settlement, judgment or insurance proceeds, the Plan may reduce or suspend current or future disability benefits payable to you until the Plan has been fully reimbursed, as well as have the right to take any civil actions to recover any Plan overpayments. If you fail to promptly reimburse the Plan, your monthly benefits may be withheld entirely until the overpayment is fully recovered.

Right to Recover Overpayments

The Company or its designated agent has the right to recover from you any amount determined to be an overpayment. You have the obligation to repay the Company any such amount. Rights and obligations in this regard are set forth in the reimbursement agreement you are required to sign when you submit a claim for benefits under this Plan. The agreement confirms you will repay all overpayments and authorizes the Company, or its designated agent, to obtain any information relating to other income benefits. An overpayment occurs when it is determined that the total amount paid on your claim is more than the total of the benefits due under this Plan.

The overpayment equals the amount paid in excess of the amount that should have been paid under this Plan.

An overpayment also occurs when payment is made that should have been made under another group plan. In that case, the Company, or its designated agent, may recover the payment from one or more of the following:

- any other organization; or
- any person to or for whom payment was made.

The Company may recover the overpayment by:

- offsetting against any future benefits payable to you or your survivors, and/or
- demanding an immediate refund of the overpayment from you, and/or,
- taking civil actions to recover any Plan overpayments.

You agree that the Plan has a lien on any fund, account or asset into which you deposit or commingle monies that you received which resulted in an overpayment of benefits or were otherwise subject to repayment to the Plan. In addition, you agree that the Plan may execute and collect against any of your assets if you have dissipated monies that resulted in an overpayment to you or that should have been repaid to the Plan and waive any defenses based on the inability to trace the specific monies.

Your Plan benefit amount will not be reduced by any future cost-of-living increases granted by a provider of offset benefits after the determination of your initial

benefit. In addition, your benefits under this Plan will not be reduced by any disability benefits received from any individual policy or other disability plan that was not sponsored by or paid for in whole or in part by the Company or another employer. As part of your claims/appeals rights described in this booklet, you have the right to appeal any overpayment recovery or demand.

Other Company Benefits during Disability

While your approved medical leave continues, and during the time you are considered an employee, contributions will be deducted from your disability benefits for all benefit plans in which you remain eligible to actively participate (including medical, dental, vision, flexible spending health care account, voluntary life insurance, voluntary personal accident insurance, voluntary disability and Profit Sharing (401(k)) plans, but not including Flexible Spending Account dependent care). If you remain on an approved medical leave after all your paid benefits are exhausted or your disability benefits are insufficient to pay for your benefit coverage, the Company waives the required premium for your health, dental and vision coverage (and continues your Company-paid life insurance) until your Company-approved medical leave ends, but not beyond 12 months from the start of your leave of absence (the "Benefits Termination Date"). Your premiums will not be waived if you are on a personal, military or family leave, and in those cases, you will be required to repay any premiums paid by the Company during your leave.

If your net disability benefit is not sufficient to cover the cost of your other benefits, you will need to pay the difference. Contact the Human Resources Leave Department at 800-825-5467 for details on how to pay for your coverage.

If your disability continues after the Benefits Termination Date defined above, your medical, dental, vision and life insurance coverage will end (subject to the benefit described below). If you subsequently return to work, your eligibility to resume medical, dental and other benefit plan coverage will be based on the terms of the applicable plan(s).

After the Benefits Termination Date defined above, you and your eligible dependents will be eligible to continue your health coverage under COBRA. (You will receive information and enrollment materials at that time.) If you enroll in COBRA, and you remain totally disabled, then your medical COBRA premiums will be waived for the remainder of that calendar year or until you cease to be disabled, if earlier. Contact the Benefits Support Center at 855-564-6153 for information on the status of your benefit coverage or how to continue your coverage by paying premiums.

If, due to a leave of absence or other circumstances, the amount of your pay from the Company is not sufficient for the company to deduct full premiums for your voluntary coverage under this Plan, you must contact the Benefits Support Center at 855-564-6153 to make arrangements to pay for your Plan coverage. If you fail to do so, your coverage will terminate after a period of 60 days of unpaid or partial-paid coverage.

Extended Life Insurance When Disabled

Company-Paid Life Insurance

Your company-paid life insurance coverage can be extended beyond the first 12 months of a disability at no cost to you. You must apply for and be approved for a total disability extension of life benefit (referred to as a Waiver of Premium benefit), by the insurer of that plan, for any time period beyond the first 12 months of your approved medical leave of absence. You also need to be under age 60 on the date you became totally disabled to be eligible for this extension. You should apply for this extension once you have been disabled for 9 or more months, and before 12 months of disability. Contact the Benefits Support Center at 855-564-6153 or call Prudential Group Life Claims at 800-524-0542 or email grouplifeclaims@prudential.com for information on how to extend your coverage.

Extended life insurance while disabled will terminate on the earlier of reaching age 65 or the date you are no longer determined to be totally disabled by the insurance carrier.

Voluntary Life Insurance

If, due to a leave of absence or other circumstances, the amount of your pay from the Company is not sufficient for the Company to deduct full premiums for any voluntary life insurance coverage, you must contact the Benefits Support Center at 855-564-6153 to make arrangements to pay directly for your plan coverage. If you fail to do so, your coverage will terminate after a period of 60 days of unpaid or partial-paid coverage.

Your voluntary life insurance coverage can be extended at no cost to you. You must apply for and be approved for a total disability extension (referred to as a Waiver of Premium benefit), by the insurer of that plan, for any time period beyond the first 6 months of your approved disability leave of absence. You also need to be under age 60 on the date you became totally disabled to be eligible for this extension. You should apply for this extension once you have been disabled for 6 or more months, and before 12 months of disability. Contact the Benefits Support Center at 855-564-6153 or call Prudential Group Life Claims at 800-524-0542 or email

grouplifeclaims@prudential.com for information on how to extend your coverage.

Extended life insurance while disabled will terminate on the earlier of reaching age 65 or the date you are no longer determined to be totally disabled by the insurance carrier.

Other Leaves

Unpaid Medical Leave

After your paid disability ends, you may apply for an Unpaid Medical Leave if you are unable to return to work due to medical reasons. To apply for an Unpaid Medical Leave, you must complete the following:

- Request for Leave Form (Form #1372)
- Certification of Health Provider Form (Form #768)

To ensure your service and benefits are uninterrupted, your doctor must provide the Human Resources Leave Department with certification of your continued disability (acceptable to the Company). All leave of absence forms are on the myHR website at myHR > All Forms > Leave Forms. Effective April 15, 2019, all leave of absence forms are available on Ask Walgreens. Forms for additional certification will be sent to you periodically. These must be completed by your doctor and submitted to the Human Resources Leave Department.

Once your leave is approved, you may request that available PTO, sick time or vacation be paid to you. To receive payment for this time, contact the HR Shared Services Leave Department at 800-825-5467.

Family Medical Leave (FMLA)

The amount of time you are on an approved medical leave (paid or unpaid) counts toward the 12 weeks of leave you are entitled to annually under the Family Medical Leave Act (FMLA), if eligible. Contact the Human Resources Leave Department at 800-825-5467 for information on FMLA.

Personal Leave and Combined Duration of Leaves of Absence

If you used all of your time off under Paid and Unpaid Medical Leave and FMLA, or you are not eligible for these leaves, you may be eligible for a personal leave of absence. To qualify for a personal leave, you must have at least six months of service. Personal leave is not automatically granted and must be approved by your Manager, District Manager or Director and the Human Resources Leave Department. During a personal leave, you are not considered an active employee, and your active participation in the Company benefit plans will be discontinued during your leave. Contact the Benefits Support Center at 855-564-6153 to determine which benefits may be continued while on a Personal Leave, and the procedures to follow.

The maximum time you may be off work is generally limited to 12 months from your last day worked. This includes the combined total of all types of paid and unpaid leaves, unless you return to work for more than 30 days between leaves. However, requests to extend medical leave beyond 12 months may be granted on a case by case basis as a reasonable accommodation based on individual circumstances, and if supported by appropriate medical documentation.

For more information on Personal Leaves, visit the myHR website at myHR > Benefits and Welfare > Leaves and Time Off. Effective April 15, 2019, all leave of absence forms are available on Ask Walgreens, or contact the Human Resources Leave Department at 800-825-5467.

Claim Procedures

To be sure your benefits are paid promptly, it's important to follow the correct benefit claim procedure.

How to File a Claim

To submit a claim for benefits under this Plan call Sedgwick CMS Disability Claim Center toll-free at 877-872-0911 or TTY Line (Teletypewriter for the hearing impaired) 901-531-4554. This call should be made as soon as you know your disability will last longer than seven days, and within 15 days of your first day absent from work. If you notify Sedgwick before your disability begins, you or someone on your behalf will need to call once you're actually off work, to confirm the start date of your disability, to have your claim activated.

You must call to submit a claim for disability benefits within 60 calendar days of becoming disabled. If you do not apply within the 60 calendar day period, your claim could be reduced or denied. When you call to file a claim, you will be asked to provide information about yourself, your job, your illness/injury and your doctor. A Sedgwick CMS case manager will, in all cases, contact your manager and your doctor. Sedgwick also will contact you if additional information is needed. Be sure to tell your doctor that he or she will be contacted by the Claim Administrator (Sedgwick CMS) to obtain information concerning your disability. Your doctor will need authorization from you to provide the Claim Administrator with any of your medical information. In most cases, you must provide each doctor with a signed authorization to release medical information. You may use the authorization form provided by the medical provider. You will also be required to sign and return an authorization form for release of information before any

benefit will be approved. Sedgwick will attempt to work directly with your doctor to obtain the needed medical history information, but it is your responsibility to provide these proofs of disability.

If you are unable to personally file your claim, you may have a friend or relative file it on your behalf, following the procedures in this section. If you need to designate someone to authorize the release of any health information, you will need to appoint a person with power of attorney to act in your place. This requires a formal document. It is your responsibility to pay for any charges by your medical provider to furnish medical information or copies of medical records. The company will not reimburse you or your medical provider for these expenses.

When necessary, the Claim Administrator may use the services of outside consultants and other sources to aid in the evaluation of your disability status. The Company and Sedgwick CMS acting as the Company's claims administrator reserve the right to determine whether your disability qualifies for benefits.

As a condition of receiving benefits, you may be required to submit to an independent medical examination (IME), which would be paid for by the company. If you do not complete the requested IME in a timely manner, disability benefits will cease (or not be approved). The Plan and Sedgwick CMS have the right to request an IME but are not obligated to do so.

If you have questions after you have filed a disability claim with Sedgwick CMS, please call the Sedgwick CMS Customer Service Unit at 877-872-0911 or log on to Sedgwick's ViaOne Express site at https://claimlookup.com. After your claim is approved, if you have questions regarding your benefit payment, please call the Human Resources Leave Department at 800-825-5467.

If you are eligible for state or commonwealth disability benefits from New York, Rhode Island, New Jersey, California or Hawaii, you are responsible for filing your separate disability claim for the state/ commonwealth plan. Upon receipt of the Explanation of Benefits (EOB) from that plan, you must provide a copy of the EOB to Sedgwick CMS before any company benefit payment will be made.

***Please Note**: If you are eligible for workers' compensation and/or state/commonwealth disability payments, benefit approval and payment information for those plans must be submitted to Sedgwick CMS in order to receive benefit payments from this Plan.*
It is your responsibility to inform your manager/supervisor of your absence and your expected return-to-work date. You must provide your manager/supervisor with a written release signed by your attending physician prior to returning to work. The Human Resources Leave Department at 800-825-5467 must be notified when you return to work, so you are not incorrectly charged disability benefit time.

Procedures for Reviewing Claims

The claims procedures described below are prescribed by a federal law called the Employee Retirement Income Security Act of 1974 (ERISA). The following disability Claims and Appeals Procedures apply only to disability claims filed on or after April 1, 2018.

Initial Claims Determinations: All formal benefit claims under the Plan will be reviewed by Sedgwick CMS (the Claim Administrator), which will make its decision, based on the information submitted by you, within 45 days after the claim is submitted. By notice to you before this period ends, the Claim Administrator may extend this deadline up to 30 additional days if it determines a decision cannot be made during the initial period for reasons beyond the control of the Claim Administrator. An extension notice will specify the length of the extension and inform you if a decision cannot be made within the deadline because of reasons beyond the control of the Claim Administrator. A second extension of up to an additional 30 days may also be declared. If such an extension is necessary, the notification will include a description of the circumstances requiring the extension and an estimate of the decision date.

Claim Denials: If your claim is denied, The Claims Administrator will send you a notice that will:

- Be written in a manner you should understand;
- Include the specific reasons for the adverse benefit determination;
- Refer to the provisions of the Plan on which the determination was based;
- Describe any additional material or information necessary to perfect the claim and explain why the additional material is necessary;
- Explain the Plan's review procedures including relevant deadlines;
- Include a statement of your right to bring a civil action under ERISA after receiving a final determination upon appeal. The notice will also include an explanation of any applicable contractual limitation period for bringing a civil action under section 502(a) of ERISA, and a description of the calendar date on which the limitations period expires;
- Identify any internal rule, guideline, protocol, standard, or criterion that was relied on in making the adverse benefit determination or, alternatively, a

statement that no such specific rule, guideline, protocol, standard or criterion exists;

- Include a language assistance notice in Chinese, Tagalog, Navajo and Spanish;
- If advice is obtained from medical or vocational experts in connection with an adverse benefit determination that is inconsistent with its decision, an explanation as to why the Claim Administrator disagreed with, or did not follow, this advice without regard to whether the advice was relied on in making the determination; and
- An explanation of disagreement with any disability determination made by the Social Security Administration (SSA), or any view of health care professionals who are treating you or vocational experts who are evaluating your claim to the extent you presented such determination or views to Claim Administrator.

Appealing a Denied Claim - First Level Appeal: To appeal a denied claim, you must send your written appeal to the Claim Administrator within 180 days of receiving notice of the claim denial. You may submit written comments, documents, records and other pertinent information and will be given reasonable access to, and copies of, all documents, records and other information relevant to the claim. It is essential you supply all information or opinions you believe may be relevant to the claim. To be assured of a proper response to the appeal, it must be directed to the Claim Administrator at: Sedgwick CMS, Walgreens ERISA, P.O. Box 14443, Lexington, KY 40509.

Claim Administrator's Review of Appeal: The appeal will be conducted by the Claim Administrator, and the reviewer will be a named fiduciary who is neither the individual nor a subordinate of the individual who made the initial denial. This reviewer will not give deference to the initial benefit determination and will take into account all comments, documents, records and other information that you submit relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

If the initial denial was based on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the medical field. This health care professional will not be an individual who was consulted in connection with the initial benefit determination or the subordinate of any such individual.

Potential Review of Appeal by the Plan Administrator: If either the Plan Administrator or the Claim Administrator determines that the appeal presents material issues that are outside the expertise or purview of the Claim Administrator (such as hours worked, employment status or new or unique procedural or Plan interpretation issues), then the Claim Administrator's decisions will be subject to further review by the Plan Administrator. You will be notified if such a further review will be performed. Unless you are instructed that additional information is needed for this review, you will not be required to submit any further information to the Plan Administrator (although you may do so if you wish). The Plan Administrator's decision will be based on all information submitted by you and any other information the Plan Administrator deems relevant.

Notice of Decision on Appeal: Regardless of whether the Plan Administrator gets involved in the decision, you will be notified of the benefit determination within 45 days of the receipt of the appeal. By notice to you before this period ends, the Claim Administrator or the Plan Administrator, as the case may be, may extend this deadline by up to 45 additional days if it determines that a decision cannot be made during the initial period for reasons beyond the control of the Plan. If any adverse benefit determination is anticipated during the appeal review, you will be provided with the new information or rationale sufficiently in advance of the appeal decision to allow you a reasonable opportunity to respond. An extension notice will specify the length of the extension and inform you that a decision cannot be made within the deadline because of reasons beyond the control of the Claim Administrator.

If the decision on appeal is denied, the Claim Administrator (or Plan Administrator) will provide you with a notice of the denial that will:

- Be written in a manner you should understand;
- Include the specific reasons for the denial;
- Refer to the provisions of the Plan on which the determination was based;
- Inform you that, upon request and free of charge, you are entitled to reasonable access to and copies of all documents, records and other information relevant
- to your claim;
- Explain the Plan's claim review procedures (including relevant time limits) and your right to bring legal action under ERISA;
- Include an explanation of any applicable contractual limitation period for bringing a civil action under section 502(a) of ERISA, and a description of the calendar date on which the limitations period expires for filing any legal action;
- Identify any internal rule, guideline, protocol, standard or criterion that was relied on in making the adverse benefit determination or, alternatively, a statement that no such specific rule, guideline, protocol, standard or criterion exists;
- If the advice of a health care professional or vocational expert was obtained, identify such person

or persons;

- If advice is obtained from medical or vocational experts in connection with an adverse benefit determination that is inconsistent with the appeal decision, an explanation as to why the Claim Administrator disagreed with, or did not follow, this advice without regard to whether the advice was relied on in making the determination;
- An explanation of disagreement with any disability determination made by the SSA, or any view of health care professionals who are treating you or vocational experts who are evaluating your claim to the extent you presented such determination or views to Claim Administrator;
- Include a language assistance notice in Chinese, Tagalog, Navajo and Spanish; and
- Notify you that you can contact the Department of Labor to learn about other voluntary dispute resolution options.

Appealing a Denied Appeal – Second Level Appeal
If your first-level appeal is denied, you may – but are not required to - submit a second level appeal. To do so, you must send your appeal to the Claim Administrator within 60 days of receiving notice of the first-level appeal denial. You may submit written comments, documents, records and other pertinent information and will be given reasonable access to, and copies of, all documents, records and other information relevant to the claim. It is essential that you supply all information or opinions that you believe may be relevant to the claim. To be assured of a proper response to the appeal, it must be directed to the Claim Administrator at:

Sedgwick CMS
Walgreens ERISA
P.O. Box 14443
Lexington, KY 40509

Your second level appeal will not be handled by the same person(s) who handled your first-level appeal. Otherwise, the process and timing for reviewing and responding to your second-level appeal will be the same as described above for first-level appeals.

General Claims/Appeals Information

Both in the context of initial claims determination and in the context of reviewing appeals, there may be situations where the Claim Administrator or the Plan Administrator needs additional information from you before it can make its determination. If that is the case, you will be notified of the specific information that is needed and/or any unresolved issues, and you will be given a reasonable period of time to supply the needed information (generally 45 days). In such situations, the deadlines for responding to the claim or appeal may be put on hold while the receipt of this additional information is pending.

The Claim Administrator and the Plan Administrator will apply their judgment to claims and appeals in a manner that they deem to be consistent with the Plan and any rules, regulations or prior interpretations of the Plan. The Claim Administrator and the Plan Administrator will make their decisions in a manner that they believe will apply the Plan consistently to similarly situated participants.

The authority granted to the Claim Administrator and the Plan Administrator to construe and interpret the Plan and make benefit determinations, including claims and appeals determinations, shall be exercised by them (or persons acting under their supervision) as they deem appropriate in their sole discretion. Benefits under this Plan will be paid or provided to you only if the Claim Administrator or the Plan Administrator, as the case may be, decides in its discretion that you are entitled to them. All such benefit determinations shall be final and binding on all persons, except to the limited extent to which the Claim Administrator's decisions are subject to further review by the Plan Administrator.

You must first utilize the claim and first-level appeal rights described above before you may properly assert any claims in court. If you fully exhaust these rights, but remain dissatisfied with the outcome of your appeal, you may challenge the decision in an ERISA Section 502(a) benefit claim. No such legal action may be commenced more than one year, or later if required by state or federal law, after (i) the date you are informed of the decision on your appeal, or (ii) the date you are informed of the last claim decision if you attempt to file legal action without utilizing all of the required claim and appeal rights. See venue provision in the "Enforce Your Rights" section.

If you believe a violation of the Plan rules related to your claim may have occurred, you may write to the Claim Administrator for an explanation. The Claim Administrator has the option of providing a response within 10 days of your notice.

Exclusions & Discontinuation of Benefits

The Company-Paid Disability Plan does not pay benefits for any disabilities that are a result of the following circumstances:

- from war or any act or accident of war, (whether declared or undeclared), insurrection or rebellion;
- from active participation in a riot, disorderly conduct, or injuries or illnesses sustained while

committing any criminal offense;
- while serving a criminal sentence, or during any period of incarceration;
- from cosmetic surgery or a cosmetic procedure, unless the cosmetic correction is the result of injury, illness, a congenital condition or the result of a complication (this exclusion applies only to short-term benefits);
- where there is not sufficient medical documentation provided to support your claim; or

- any intentionally self-inflicted injury.

In addition, when a disability begins after notice of involuntary separation and within 30 days of the separation date, disability benefits under the Plan shall be limited to a maximum of eight weeks of paid benefits.

Even if you are eligible for coverage in this Plan, your disability benefits will not be approved (or will end) if any of the following occurs:

- you apply for or are receiving unemployment insurance while you are receiving disability benefits (this applies only to the first 12 months of benefit eligibility);
- you fail to provide documentation as requested;
- you submit a fraudulent claim or fail to disclose any material facts when submitting a claim;
- for short-term benefits only, if you engage in any occupation for profit while on disability leave (excluding any job that you started prior to becoming disabled and that can be performed despite your disability);
- you are medically released to return to work or no longer meet this Plan's definition of disability;
- you fail to participate in a recommended rehabilitation program approved by the treating physician; or
- your approved disability leave ends for any reason relating to you violating the terms of your leave of absence under Company policy.

***Please Note**: Loss, restriction, non-issuance, revocation or non-renewal of any license, permit or certification required to engage in an occupation will not be considered a disability*.

ERISA Rights

Your rights under the Employee Retirement Income Security Act of 1974, as amended(ERISA) are explained here.

Statement of ERISA Rights

As an employee eligible to participate in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance policies/contracts and collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance policies/contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies and will inform you in advance of the cost. To view or receive a copy of any plan documents, you should send a written request (noting the specific document(s) of interest) to the following address:
  Health & Welfare Plan Committee
  Walgreen Co.
  108 Wilmot Road, MS#1825
  Deerfield, IL 60015-5143
- 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.
- Receive information about your plan and benefits.

Prudent Actions 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, your union (if applicable), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court, but only after you have exhausted your claims and appeals rights described above. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court after you have exhausted your claims and appeals rights described above. 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.

No action at law or in equity shall be brought in connection with the Plan except in the following venues: (A) all actions arising under federal law must be filed in the United States District Court for the Northern District of Illinois, and (B) all actions arising under state law must be filed in the Circuit Court of Cook County, Illinois.

Plan Amendment & Termination Rights

The Company reserves the right to alter, amend or cancel the Plan at its sole discretion at any time. Modifications to the Plan, including amendment and termination, will be implemented at the written direction of the Chief Executive Officer, Executive Chairman of the Board or the Chief Human Resources Officer of the Company. In the event of Plan termination, claims incurred prior to the date of termination will be paid out of any remaining plan funds. Participation in this Plan does not create a contract or a guarantee of employment or coverage, nor does it give any company or person a legal or equitable right against the Company, its shareholders, directors or officers.

This booklet is intended to provide an easy-to-understand summary of the Walgreens Company-Paid Disability Plan for Hourly Team Members. In the case of conflict with any governing plan document, the Walgreen Health and Welfare Plan document governs.

Administrative Facts

The establishment of this Plan, or any modification to it, does not create a contract or guarantee of employment or coverage, nor does it give any company or person a legal or equitable right against the Company, its shareholders, directors or officers.

Plan Name	Walgreens Company-Paid Disability Plan for Hourly Team Members
Plan Sponsor	Walgreen Co. (The terms "Walgreens" or "Company" used in this booklet include Walgreen Co. or any United States subsidiary or parent corporation of Walgreen Co. that is a participating employer under this Plan.
Plan Type	Short-Term Disability
Plan Administrator and Agent for Legal Service	Health & Welfare Plan Committee Walgreen Co. 108 Wilmot Road, MS 1825 Deerfield, IL 60015-5143
Claim Administrator	Sedgwick CMS 110 Ridgeway Loop Road Memphis, TN 38120 877-872-0911
Type of Administration	Third Party Claims Administration
Plan Year	January 1 – December 31
Plan Number	501
Employer ID Number	36-1924025
Plan Costs	Cost for the Plan is paid by the sponsor, Walgreen Co., from general assets. Plan participants do not accrue rights to Plan assets in the event of termination of the Plan.

Questions

If you have any questions about the Plan, contact the Plan Administrator or Walgreens Human Resources Leave Department at 800-825-5467. The Plan Administrator is available to answer your general questions. However, raising questions or making an inquiry in this fashion will not satisfy the claims procedure requirements described in the "Claims Procedures" section. If you wish to file a formal claim or appeal a claim denial, you must follow these formal claims procedure requirements. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your phone 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 at 866-444-3272 or at ***www.dol.gov/ebsa***.

1/1/2018