Walgreens Company-Paid Disability Plan for Salaried Team Members, Pharmacists and Paraprofessionals

Summary Plan Description

Prepared by the Walgreens Human Resources Department for eligible Walgreens Salaried Team Members, Pharmacists and Paraprofessionals

IMPORTANT INFORMATION

This is an updated summary plan description ("SPD") for the Walgreens Company-Paid Disability Plan for Hourly Team Members in effect as of 11/18/2021. This document replaces your existing SPD dated 1/1/2020 and any summaries of material modifications (SMMs).

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"). This SPD along with the Plan are the official document for the benefits described in this SPD.

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 SMMs, and summary plan descriptions covering other benefits that are not covered by this SPD. This SPD, together with any applicable SMMs, constitute your SPD for the Walgreens Company-Paid Disability Plan for Hourly Team Members.

You should review the information provided in this SPD and use this document to find answers to your questions about the benefits described herein.

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 document 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.

The Company reserves the right to amend, modify or terminate the Plan, including any benefits provided under the 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 this SPD that is in effect at the relevant time.

In the event that any term or provision in this 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 SPD contains information in English of your Plan rights and benefits under this plan. If you have questions regarding your Plan benefits, contact the Walgreens Human Resources Shared Services (HRSS) 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:
  - Your name, address, telephone number, 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** – Contact Sedgwick within 15 days of the beginning of your leave. A claim can be initiated on the mySedgwick website. mySedgwick can be accessed via wbaworldwide.wba.com/web/Walgreens and logging in with your OneID and password. On the WBA Worldwide home page, click on Tools and Resources, Time and Leaves, then mySedgwick portal link. Please refer to the chart on Page 3 for contact information.
  - If you initiate your claim prior to the actual start of your leave, Sedgwick will set-up your claim based on your requested dates of disability. Once you have reached your anticipated first date of absence, you must contact Sedgwick to notify them of your first day of absence and Sedgwick will confirm that date with your manager.
  - You must contact Sedgwick 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 healthcare provider 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 and/or emailed to you the next day, along with an information package to assist you in understanding the claim process and your responsibilities.
  - Sedgwick will review your claim, request any needed information from you and your healthcare provider 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 by visiting mySedgwick:
    - WBA home page>Tools and Resources>Time and Leaves>mySedgwick portal
    - You may also call Sedgwick to speak with a representative. Please refer to the chart on Page 3 for contact information.

- ✓ **Inform your healthcare provider**
  - Let your treating healthcare provider know they will be contacted by Sedgwick regarding your disabling condition. It is critical that they send a complete report of your medical condition to Sedgwick for evaluation of your claim.
  - Give your treating healthcare provider a signed authorization to provide information concerning your disabling condition (authorization forms are available from Sedgwick or your treating healthcare provider).

- ✓ **Certain state-mandated programs** – additional claim filing requirements may apply if you live in certain states. Sedgwick will notify you.
  - 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 healthcare provider.
  - Your disability benefit may be reduced by state offset.

- ✓ **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 to be considered for benefits under this Disability Plan.
  - Work-related injuries or illnesses will be reported to Sedgwick by the Team Member. Please refer to the chart on Page 3 for contact information.
  - Benefits from this Disability Plan may be deferred until you receive a final Workers' Compensation award.

- ✓ **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 contact Sedgwick to report your return to work the day you return to work. Please refer to the chart on Page 3 for contact information.

Company-Paid Disability Plan for Salaried Team Members, Pharmacists and Paraprofessionals Resource Guide

If you have a question about:	Resource	Contact Info
➢ **Questions on eligibility for coverage under the Disability Plan** ➢ **Filing a disability claim and questions about your claim until it is approved** **Questions about benefit payments after your disability claim has been approved** **Filing an appeal (following a disability claim denial)** ➢ **Unpaid leave of absence** ➢ **ADA / Reasonable Accommodations**	Sedgwick	Online: mySedgwick.com 877-872-0911 TTY: 901-531-4554 Fax: 866-470-5767 Email: Walgreensleaves@Sedgwick.com Mail: Sedgwick PO Box 14441, Lexington, KY 40512
Questions about benefit payments after your disability claim has been approved	Sedgwick	Online: mySedgwick.com 877-872-0911 TTY: 901-531-4554 Fax: 866-470-5767 Email: walgreensleaves@sedgwick.com Mail: Sedgwick PO Box 14441, Lexington, KY 40512
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Filing an appeal (following a disability claim denial)	Sedgwick	Online: mySedgwick.com 877-872-0911 TTY: 901-531-4554 Fax: 866-470-5767 Email: walgreensleaves@sedgwick.com Mail: Sedgwick PO Box 14441, Lexington, KY 40512
Back on Track	Walgreens Human Resources Employee Relations Department	800-825-5467 Quick form found on WBA World Wide: AskWalgreens Announcements>Quick form>Er Consultation Request Form
Unpaid leave of absence	Sedgwick	Online: mySedgwick.com 877-872-0911 TTY: 901-531-4554 Fax: 866-470-5767 Email: walgreensleaves@sedgwick.com Mail: Sedgwick PO Box 14441, Lexington, KY 40512
Medical/Dental/Vision/Flexible Spending benefits and/or COBRA	Benefits Support Center	855-564-6153 Link on WBA home page or go to www.benefitssupportcenter.com

Voluntary Disability Plan Benefits	Prudential	800-842-1718
Company-Paid Life Insurance	Prudential Group Life Claims	800-524-0542 or email grouplifeclaims@prudential.com
State and Local Paid Sick Leave Laws	Human Resources Shared Services	800-825-5467

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.

After your approved disability leave (paid and unpaid) ends another form of paid or unpaid leave may be available for additional time off. For more details, see the “Other Leaves” section.

Introduction

The Walgreens Company Paid Disability Plan for Salaried Team Members, Pharmacists and Paraprofessionals is a self-funded plan and 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.

If you are disabled under this Plan, after a seven (7) calendar day waiting period, you are eligible to receive benefits each calendar year, which equal your full base salary for up to six weeks. For those team members who work a non-traditional work schedule of shifts that vary from week to week, the plan may count the first 5 missed shifts after your last day worked to be applied to the 7-calendar day waiting period. If your disability lasts longer than six weeks plus your waiting period, your benefits under this Plan will equal 50% of your pre-disability base salary.

Your benefits may be reduced by certain other income sources that are available to you – known as Offsets. See the Benefit Offsets (Reductions) section for more details.

If you are disabled under the Plan and you are able to return to work on less than a normal, full-time basis, and you are in the Long-term Plan Benefit period, you may qualify for residual disability benefits. Refer to the section on Residual Disability Benefits for details.

As long as you remain disabled as defined by the Plan, benefits may continue until you reach your Social Security Normal Retirement Age, unless you become disabled at age 63 or later. In that case benefits can continue beyond the Social Security Normal Retirement Age. There are limitations on the benefit period for certain conditions. If you should die while disabled and after having received long-term disability benefits for at least 180 days, your eligible spouse/partner or children may be eligible for a survivor benefit.

To be considered for Short-Term Disability Benefits under the Plan you must contact Walgreens third-party leave of absence administrator (Sedgwick) as soon as you know your absence will be greater than seven full or partial days (but no later than 60 days from the start of your disability). You may report new claims, obtain information on existing claims, or access and upload documents by utilizing the mySedgwick application. Please refer to the chart on Page 3 for contact information.

Eligibility

To be eligible for coverage under the Company-Paid Disability Benefit Plan for Salaried Team Members, Pharmacists and Paraprofessionals, you must:

- Be an active employee, working in the United States, excluding Puerto Rico locations.
- Be paid on a salaried basis, be an hourly-paid registered pharmacist or paraprofessional, or be an hourly-paid team member who has a Benefit Indicator (BI) of 16, 19, or 20Emerging Store Manager, Store Manager Unassigned, Pharmacist in Charge, Emerging Leader Pharmacist, 510 (Coordination Pay Band Team Members) or 511 (Analysis Pay Band Team Members).
- 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 91 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 company plan, including an executive with a Benefit Indicator of #518 or higher;
- A team member whose payroll is not processed from Walgreens payroll;
- A team member on a personal or student leave of absence when the illness or injury occurs;
- A team member who is covered by a collective bargaining agreement, unless the agreement specifically provides your right to coverage by this Plan.
- A temporary or seasonal team member.

If you have questions about your eligibility or the Plan's terms or conditions, contact Sedgwick. 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. Please refer to the chart on Page 3 for the contact information.

Enrollment

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

When Coverage Ends

You are no longer covered under the Plan on the date you cease to fulfill any of the eligibility requirements described in this SPD (see the "Eligibility" section for more information). Generally, your coverage under the Plan ends on the earliest date when:

- Your average hours worked falls below the minimum required level.
- You are no longer actively working in a position eligible for this Plan (unless you are receiving long-term disability benefits).
- The Company discontinues the Plan.
- You are still an active employee of the Company, but your initial 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 PTO/FTO.
- 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 you return to work for one full day.
- You are no longer considered Disabled under the Plan.
- You are on an approved personal or student leave of absence.
- Your employment ends (as determined by Company Employee Policy unless you are receiving long term disability benefits)
- You die.

If You Are Not Eligible

If you are not eligible for paid Disability benefits under this plan, you may be eligible for another type of leave of absence. An unpaid Medical Leave of Absence may protect your employment status if you are not eligible for a paid medical leave or are appealing a denial of paid medical leave. Contact Sedgwick to discuss all available leaves for which you may eligible.

You may report new claims, obtain information on existing claims, or access and upload documents by utilizing the mySedgwick application available:

- On the WBA home page>Tools and Resources>Time and Leaves>mySedgwick portal
- You may also call Sedgwick to speak with representative. Please refer to the chart on Page 3 for contact information.

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. Sedgwick acts as the claims administrator/adjudicator for the Plan, and the Company is directly responsible for the final payment of your disability benefits.

Plan Benefits

You must be considered Totally Disabled or Partially Disabled or bean an active participant in the Company's Back on Track Program to be eligible for the Plan benefits. Sedgwick will require that you periodically furnish satisfactory Medical Evidence from your healthcare provider(s).

Benefit Type	Benefit Period	Benefit Amount
Waiting Period	First 7 calendar days after your disability begins*	5 days of paid-time-off (PTO)/flexible-time-off (FTO), sick or Vacation, if available
Short-Term Benefit	From day 8 to the end of the first 49 days of disability*	100% of Base Salary
Short-Term Benefit	From day 50 to day 180 of disability*	50% of Base Salary (PTO/FTO, sick or vacation, if available)
Long-Term Benefit	From day 181* of disability up to Social Security F u ll Retirement Age**	50% of Base Salary (PTO/FTO, sick or vacation, if available)

* As described in the "Waiting Period" section below, the waiting period for certain positions is defined by five missed shifts and therefore may be greater or less than seven calendar days. In those cases, the short-term and long-term benefit periods described above remain the same but commence after the actual waiting

period. For example, if the waiting period is 10 calendar days, then the 100% of pay short-term benefit runs from day 11 to day 52, and so on. All similar references in the SPD are subject to this same adjustment.

** *Unless you become disabled at age 63 or later. In that case benefits can continue beyond the Social Security Full Retirement Age. Social Security Normal Retirement Age depends on your birth year. For details, go to the Social Security website www.ssa.gov/retire2/agereduction.htm or call the Social Security Administration at 800-772-1213.*

Total Disability: You are considered Totally Disabled whenever you are unable to perform all of the essential functions of your job and you 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 (where practicable). Sedgwick must approve your Total Disability in order for you to receive Plan benefits. Please refer to the chart on Page 3 for the contact information**.**

Partial Disability: You are considered Partially Disabled whenever you are unable to perform all of the essential job functions of your job or temporary Modified Duty work assigned by your Company for the same number of hours that you were regularly scheduled to work before your Partial Disability, and you are not working at another job (excluding any job that you started prior to becoming partially disabled and that can be performed despite your partial disability). You may be required to and be able to work at least 50% of your normal work schedule. 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 (where practicable). Sedgwick must approve your Partial Disability in order for you to receive Plan benefits. **No benefit will be paid if you do not return to work when you are approved as Partially Disabled.**

Modified Duty: This program provides a temporary Modified Duty work assignment as soon as medically appropriate following an illness, injury, and/or pregnancy. The temporary work assignment enables you the best opportunity to remain at work or return to work and perform meaningful work without aggravating your illness or injury based on the medical evidence provided by your treating provider. The Modified Duty work assignments are temporary, lasting no more than 90 days, or until you are able to return full time to full duty, whichever comes first, and are only available when there is no other effective accommodation to enable you to perform all of the essential functions of the job position.

For more information regarding the Walgreens Modified Duty Program – including eligibility, duration, and the roles and responsibilities of the team member, supervisor, and Human Resources personnel – refer to the Walgreens Modified Duty Policy.

Back on Track 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 Back on Track Program, contact the Human Resources Employee Relations Department at 800-825-5467.

If you are eligible for other benefits as described in the "Benefits Offsets (Reductions)" section, your benefit from this Plan will be reduced. Any benefits you receive from this Disability Plan are taxable income to you and will be subject to all applicable tax withholding rules.

Your Base Salary

Under this Plan, your base salary, or pre-disability earnings, referred to as your prior earnings, is the monthly base salary you are earning from the Company the day before your disability begins. For bi-weekly paid pharmacists this would not include hours worked over your base hours.

Your base salary does not include any bonuses, commissions, overtime pay or other special compensation you may be eligible for.

Short-Term and Long-Term Disability Benefits

Under this Plan, the benefits you receive during the first 180 days of a disability in any calendar year are called short-term benefits, and the benefits you receive after 180 days are called long-term benefits. This is true even if some of your short-term benefits are full pay, and other short-term benefits are half-pay.

Short-Term Disability

You will have 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. See Waiting Period section for details. After the waiting period ends, you will receive a short-term-disability benefit equal to your full base salary for up to the end of the 49th day. Short-term benefits from the 50th day to the end of 180 days of disability will equal 50% of your base salary.

Long-Term Disability

You are eligible for long-term benefits after you have accumulated a total of 180 approved Short-Term Disability days under the Plan.

Short Term Disability Waiting Period

Before benefits begin, there is a waiting period of 7 (seven) full or partial calendar days, not to exceed the equivalent of one workweek, beginning with your first regularly scheduled workday missed due to a disability. For those team members who work a non-traditional work schedule of shifts that vary from week to week, for example Salaried Pharmacists, the plan defines the waiting period as the first 5 missed shifts after your last day worked. The 5 missed shifts may be greater or less than the 7-calendar day waiting period based on the individual schedule. Your healthcare provider will confirm your disability begin date.

Available paid-time-off (PTO)/flexible-time-off (FTO), 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/FTO 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/FTO 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 Totally or Partially disabled from the same or related cause(s) 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 Salaried Team Members, Pharmacists and Registered Nurses Summary Plan Description (SPD) or contact Prudential. Please refer to the chart on Page 3 for the contact information.

The Voluntary Disability Plan for Salaried Team Members, Pharmacists and Registered Nurses is intended to coordinate with any benefits available through this Walgreens Company-Paid Disability Plan for Salaried Team Members, Pharmacists and Registered Nurses. In all cases, there is a Benefit Waiting Period before the Voluntary Disability Plan will begin payments. This Benefit Waiting Period is 13 weeks beginning with your first regularly scheduled workday missed due to a disability. During this waiting period you may receive pay for paid-time-off (PTO)/flexible-time-off (FTO), sick or vacation time (to be used in that order) if you have that time available, or you may receive disability payments from the Walgreens *Company-Paid Disability Benefit Plan for Salaried Team Members, Pharmacists and Registered Nurses*.

Salaried Team Members, Pharmacists & Paraprofessionals Disability Pay Coordination						
Weeks of Disability	Walgreens Paid Time Off (PTO/FTO)	Walgreens Company-Paid Disability Benefit		Voluntary Disability Benefit		
				10% Option	15% Option	20% Option
1 week waiting period	7 day waiting period (Full Pay to supplement from PTO/FTO sick or vacation time if available)					
2 –7		Full Pay				
8- 13			50%of Pay (PTO/FTO sick or vacation, if available to supplement)			
14 – SSNRA*			50%of Pay (PTO/FTO sick or vacation, if available to supplement)	10% of Pay	15% of Pay	20% of Pay

Supplementing Your Half Pay

If you exhaust full pay benefits under this Plan, available paid-time-off (PTO)/flexible-time-off (FTO*), 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 PTO/FTO* time is available. The paid time off used to supplement your disability half pay will be paid via payroll and may be on the same check or on a subsequent check based on the timing of the request that is submitted.

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/FTO*, sick or vacation time to supplement your half pay disability benefit.

* See the FTO Benefit Program document for details on usage of FTO in this and other leave of absence contexts.

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

Definitions & Plan Details

What it means to be disabled

Disability is defined as follows:

Short-Term Disability

For the short-term disability period, "disabled" or "disability" means that, due to illness, pregnancy or injury, you are receiving appropriate care and treatment from a healthcare provider on a continuing basis and you are prevented by your condition from performing one or more of the essential duties of your company occupation. This excludes any second non-company job you started prior to becoming disabled and that can be performed despite your disability.

Long-Term Disability

For the long-term disability period, "disabled" or "disability" means that, due to illness, pregnancy, or injury, you are prevented from performing one or more of the essential duties of your own occupation on a full- time basis and are receiving appropriate care and treatment from a healthcare provider on a continuing basis; and

- For the first 18 months of long-term benefits, you are unable to earn more than 80% of your pre-disability earnings or indexed pre-disability earnings at your Own Occupation as defined below from any employer in your local economy; or
- Following that 18 month-period, you are unable to earn more than 60% of your indexed pre-disability earnings from any employer in your local economy at Any Gainful Occupation as defined below for which you are reasonably qualified, taking into account your training, education, experience and pre-disability earnings.

Your loss of earnings must be a direct result of your illness, pregnancy or injury. Economic factors such as, but not limited to, recession, job obsolescence, pay cuts and job-sharing will not be considered in determining whether you meet the loss of earnings test.

For an employee whose occupation requires a license, "loss of license" or inability to qualify for a license for any reason does not constitute disability.

You may be required to submit to an independent medical examination (IME), sign a written authorization to release medical records and furnish medical records. If you fail to complete a requested IME, furnish requested medical records or provide a written authorization for release of medical records, each in a timely fashion, disability benefits will cease. The Plan and Sedgwick have the right to request an IME but are not obligated to do so.

"Appropriate care and treatment" means medical care and treatment that meets all of the following requirements:

- is received from or under the direct supervision of a healthcare provider who is not related to you, whose medical training and clinical experience are suitable for treating your disability;
- is necessary to meet your basic health needs and is of demonstrable medical value;
- is consistent in type, frequency and duration of treatment with relevant guidelines of national, medical, research and health care coverage organizations and governmental agencies; and
- is consistent with the diagnosis of your condition and its purpose is maximizing your medical improvement.

"Local economy" means the geographic area surrounding your place of residence which offers reasonable employment opportunities. It is an area within which it would not be unreasonable for you to travel to secure employment. If you move from what is or was your place of residence on the date you became disabled, both that former place of residence and your current place of residence will be considered your local economy.

"Own Occupation" means the activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you hold or held with the Company. It may be a similar activity that could be performed with the Company or any other employer.

“Any Gainful Occupation” means any activity for which you are reasonably qualified, taking into account your training, education and experience that would result in earning more than 60% of your indexed pre-disability earnings from any employer in your local economy.

The terms "pre-disability earnings" and "indexed pre-disability earnings" are described under the "Prior Earnings" section.

Maximum Long-Term Plan Benefit Period

Benefits under this Plan stop or reduce as soon as you are released to return to work on a regular, full-time or part-time basis, or you are no longer disabled as defined by this Plan. This requirement is modified by the terms of the Residual Benefit section, discussed later in this document.

If you remain disabled as defined by the Plan, benefits may continue until you reach your Social Security Normal Retirement Age (SSNRA). Your Social Security Normal Retirement Age depends on your birth year. However, if your disability starts on or after age 63, the maximum length of time that benefits may continue is modified, as follows:

Disability begins at age	Maximum benefit period:
63 or 64	36 months
65	27 months
66	21 months
67	18 months
68	15 months
69 or over	12 months

The benefit period may be shorter for certain disabling conditions. (See the "Plan Limitations" section.)

Restrictions Applying to both Short-Term and Long-Term Benefits

In no case will disability benefits be payable after the earliest of the following events:

- you are able to return to work on a regular, full-time basis,
- you are no longer totally or residually disabled (see Normal Residual Disability Benefits sections) as defined by this Plan,
- you file for unemployment (this restriction does not apply to benefits payable after the first 12 months of a disability),
- you are no longer under the regular care of a physician,
- you fail to furnish proof of continuing disability when requested by the company or Sedgwick ,
- you do not participate in an approved rehabilitation program as described in "Mandatory Rehabilitation Requirements" section or
- you die.

Benefit Offsets (Reductions)

If you receive disability related benefits from other sources and/or Social Security disability or retirement-related income, your benefits under this Plan will be reduced, or offset, by the total amount(s) received from these sources as their primary benefit. The “Primary Offset Benefit” amount is the total amount you, the covered employee, receive from other sources. This Primary Offset Benefit amount does not include benefits received from other sources for the benefit of your family members.

Your benefits under this Plan will be reduced by the amount of benefits you are eligible to receive from other sources, such as (but not limited to):

- Social Security disability and/or retirement benefits,
- Workers' Compensation,
- state-mandated disability plans, and other state, commonwealth, and all federal government and federal agency disability benefits from both disability plans and disability benefits from retirement plans, (except for benefits received from the Department of Veterans Affairs or disabilities resulting from military actions or training),
- any other disability plan to which the Company or any other employer sponsors or contributes,
- disability benefits from any employer-sponsored retirement or pension plan, and
- any award in a third-party claim for a loss that caused or aggravated the disabling condition. Special rules apply to determining offsets for third party claims and reimbursement for them. See the following section on Subrogation and Third-Party Reimbursement.

For example, suppose your pre-disability base salary was $6,000 per month and you receive $1,500 per month from Social Security with an additional Social Security dependent benefit amount of $700. Your benefit from this Plan would be calculated as follows:

Base salary	$6,000/mo
Total disability benefit (50%)	$3,000/mo
Primary Social Security benefit*	- $1,500/mo
Benefit after offset	$1,500/mo

**The $700 Social Security dependent benefit is not included as a Primary Offset Benefit*.

Any benefit you receive from this Plan is taxable income to you and will be subject to all applicable tax withholding requirements.

Offset Note: With one exception, all offsets to your disability benefits will reduce your gross (before tax) disability benefit. The one exception is how the workers' compensation benefit offset is handled. Because workers' compensation benefits are not taxable, this Primary Offset Benefit will be increased to include the estimated tax savings. This will have the effect of reducing your Plan benefits by an additional amount which is the estimated tax benefit.

You are required to promptly apply for all other income benefits for which you are potentially eligible and to promptly appeal any other income claim denial. If you fail to do so, your benefits under this Plan will be reduced by the estimated amount of the Primary Offset Benefit you could have received if your claim had been approved. Your benefits may be withheld entirely until you apply for the offset benefit, including appeals of these claims. If you are eligible to receive workers' compensation pay that would result in an offset to your disability benefit under this Plan, then the payment of your disability benefits may be delayed while the determination of your workers' compensation pay is pending. If you receive Plan benefits and are later awarded benefits from one or more of the sources listed, you must reimburse the Plan for any overpayment the award causes. If you fail to promptly reimburse the Plan, your monthly benefits may be withheld entirely until the overpayment is fully recovered. Plan benefits may also be delayed while Primary Offset Benefits are pending.

If you receive other income benefits in a lump sum instead of in monthly payments, you must provide to the Walgreens Human Resources Department satisfactory proof of the breakdown for the lump sum amount attributable to lost income, and the time period for which the lump sum is applicable. If you do not provide this information, your monthly benefit will be reduced by an amount equal to the total lump sum. The company will withhold your benefit each month until the calculated lump sum has been exhausted. However, if the Human Resources Department is given proof of the time period and amount attributable to lost income, any appropriate adjustments will be made.

In the event any benefits eligible as offsets are denied because a claim was not filed in the required time frame, short-term and long-term benefits under this Plan will be reduced by assuming that the maximum offset benefit amount would have been awarded.

Subrogation and Third-Party Reimbursement

Subrogation

Special rules apply to reimbursement if there is a third party involved. If the Plan pays disability benefits for an illness or injury that was caused by an act or omission of a third party, the Plan will be subrogated to all of your rights of recovery. 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 illness or injury (including any insurance company). For example, if you become injured in an automobile accident, and the person who hit you was at fault, the person who hit you is the third party whose act caused your illness or 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 regarding your illness or injury. You must also sign, currently and in the future, any necessary documents to enable the Plan to be subrogated on your claim, and actively cooperate with the Plan and its designated agent in pursuing the action 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 Plan benefits have been paid and are anticipated for future benefits;
- bring an action on behalf of the Plan, or on your behalf, against the third party;
- cease paying benefits until you provide Sedgwick with the documents necessary for the Plan to

exercise its rights and privileges of subrogation; and/or

- 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 benefits for an illness or injury that was 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 and/or agree to reimburse the Plan from any settlement, judgment or insurance proceeds, the Plan will 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.

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.

Benefit Minimums

For the long-term benefit only, your actual monthly benefit (after offsets) from this Plan will be at least 10% of your benefit before reductions for other income benefits, or $100 (whichever is greater).

For example, if your base salary is $5,000 per month, and you are eligible for $4,000 per month from all other income sources, your monthly long-term benefit from this Plan will be calculated as follows:

Base salary	$5,000/month
Total disability benefit (50%)	$2,500/month
Offset for other benefit	$4,000/month
Benefit after offset	$0
Minimum Plan benefit paid	$250/month*

*The greater of 10% of $2,500 ($250) or $100.

Recurrent Disabilities

If you return to work after a disability (and are not eligible for residual disability benefits), meet the Plan's eligibility requirements, and then become disabled again, the following rules apply to the way your benefits are paid.

Short-Term Benefits

- If a disability continues into a new calendar year, the benefit limits from the prior calendar year will apply, such that only the remaining short-term benefits from the prior year will be available.
- When you return to work after a disability that ends within 30 days of the end of a calendar year or extends into a new calendar year, you must return to work for at least 30 days to be eligible for a new benefit period if you are disabled by the same or related condition that caused your most recent disability. If you become disabled by an unrelated condition after returning to work for at least one full day, a new short-term benefit period will begin immediately, subject to the maximum benefit rules for all disabilities in a calendar year.

Long-Term Benefits

If you return to work after becoming eligible for long-term benefits, and then again become disabled, the following rules apply to the way your benefits are paid.

- Your new disability will be considered a continuation of your original disability if you return to work on a full-time basis with the company for less than six months before becoming disabled again. In this situation, your long-term benefits will resume immediately.
- Your new disability will not be considered a continuation of your original disability if your new disability starts more than six months after your return to full-time employment. In this situation, you must meet the eligibility requirements for a new long-term disability. Under certain conditions, this may create a gap in paid benefits between the short-term and long-term Plans.

***Please Note**: You can only receive benefits from either the short-term Plan or the long-term plan. If you meet the eligibility requirements for benefits from both Plans, you will receive benefits from the long-term Plan only*.

Residual Disability Benefits

This benefit applies only to claims during the Long-term benefit period. If your disability is such that you can work — but are not able to earn more than the amounts (80% or 60%) of your indexed prior earnings, as defined later in this document — you may be eligible for a reduced benefit, called a residual disability benefit. This feature encourages you to return to work when physically able.

Eligibility for Residual Disability Benefits under the Long-Term Benefit

A residual disability is any disability that prevents you from performing on a normal full-time basis, one or more of the essential duties of your own occupation, but allows you to work at your own or any occupation, on less than a normal full-time basis. The wages you earn while on a residual disability are called your residual disability wages.

Residual benefits are only available from the long-term benefit, and when you have met all other Plan requirements. Also, this benefit is payable only as long as you meet the long-term disability definition described in the "Definitions" section.

Indexed Prior Earnings

In determining your eligibility for a residual benefit amount, the Plan uses a special definition of pre-disability earnings called indexed prior earnings. Your indexed prior earnings are defined as your base pay on your last regular day of active full-time work (before the initial onset of the disability) adjusted for changes in the Consumer Price Index.

In calculating residual benefits, your prior earnings are indexed, or increased by a factor, to help reduce the impact of inflation. At the end of each 12-month period during which you receive long-term benefits, your prior earnings are increased by the change in the Consumer Price Index for the most recent 12-month measuring period (limited to a 10% maximum change in any 12-month period).

This inflation adjustment applies only to the residual benefit formula. It does not cause an increase in your gross benefit when totally disabled. It also does not increase the disability normal benefit used in the residual benefit calculation (see example).

Special Return-to-Work Benefit

The Special Return-to-Work Benefit is designed to encourage you to return to work as soon as you are able. If you become eligible for long-term benefits and then return to work on a residual disability basis, you qualify for the Special Return-to-Work Benefit for the first 12 months of your return to work. During this time, your normal disability benefit will not be reduced unless your total income from all sources (including this benefit, your residual wages and benefit offsets listed in this booklet) exceeds your indexed prior earnings.

For example, suppose your prior earnings are $6,050 a month, your indexed prior earnings are $6,200, and your residual disability wages are $2,000 a month. Your return-to-work benefit would be calculated as follows:

Example A

Prior earnings	$6,050/month
Indexed prior earnings	$6,200/month
Total disability normal benefit (50% of prior earnings)	$3,025/month
Residual disability wages	+$2,000/month
Total income from all sources	$5,025/month
Return-to-work benefit	$3,025/month

In Example A, your return-to-work benefit equals your total disability normal benefit, since your total income from all sources ($5,025) does not exceed your indexed prior earnings of $6,200.

Example B

If using the same example, your prior earnings are the same, but you earn residual disability wages of $3,500 a month. In this case, your return-to-work benefit would be calculated as follows:

Prior earnings	$6,050/month
Indexed prior earnings	$6,200/month
Total disability normal benefit (50% of prior earnings)	$3,025/month
Residual disability wages	+$3,500/month
Total income from all sources	$6,525/month
Excess benefit ($6,525-$6,200)	$325/month
Return-to-work benefit ($3,025-$325)	$2,700/month

In Example B, the return-to-work benefit is $325 less than the total disability normal benefit, since your total income from all sources cannot be greater than your indexed prior earnings (in this case $6,200).

Normal Residual Disability Benefits

If you are still residually disabled after the 12-month return-to-work benefit period, the Plan will pay a normal residual disability benefit. After the end of the Special Return-to-Work benefit period, your normal residual disability benefit will be calculated by reducing your Plan benefit by 50% of your work earnings, with an adjustment for indexing. To determine the effect of residual disability wages on your benefit:

- Determine your indexed prior earnings, as described in the Residual Disability section.
- Multiply indexed prior earnings by 50% to determine gross indexed benefit.
- Then subtract 50% of your residual disability wages from the indexed benefit.
- The result is your reduced monthly benefit (subject to a maximum equal to your original unreduced monthly benefit amount) during the time you have residual disability wages and continued eligibility for disability benefits.

These calculations are done each month you are eligible for benefits from the Special Return-to-Work Benefit or the Normal Residual Disability Benefit. There can also be other reductions to your benefit based on the provisions outlined in the *Benefit Offset* section.

Example C

Suppose before you became disabled your prior earnings were $6,050 a month and your residual disability wages are $1,500/month. Your indexed prior earnings are calculated according to the Consumer Price Index for the most recent 12-month period (not to exceed a 10% maximum change per 12-month period). Your normal residual disability benefit amount would be calculated as follows:

Prior earnings	$6,050
Indexed prior earnings	$6,200

Indexed benefit @ 50%	$3,100
Residual Disability Wages	$1,500
Indexed benefit	$3,100
Minus 50% of Residual Disability Wages	($ 750)
Normal Residual Benefit	$2,350

Other Benefits

Rehabilitation Benefit

Disabled individuals often need to follow a program of vocational rehabilitation services in order to regain the ability to work productively. If this is the case for you, the Plan will pay for the cost of the services, as long as:

- the services are acceptable to the Plan;
- you enter into an agreement with the Plan on the program and services; and
- the cost of the services is not covered by another plan or program.

Disability benefits will cease if you do not participate in a recommended rehabilitation program that is also approved by the treating physician.

Mandatory Rehabilitation Requirements

Sedgwick, or possibly some other approved Company provider, will work with you when appropriate to develop a work rehabilitation plan. This will allow you to return to work on a full- or part-time basis, in an occupation for which you are reasonably qualified, taking into account your training, education, experience and past earnings. This program could include vocational training and/or physical therapy. During the time you are participating in such a program, you will be eligible for the Special-Return-to-Work-Benefit. If you decline to participate in a Sedgwick -approved work rehabilitation plan, you will no longer be eligible for any benefits from this Plan.

Survivor Benefit

The Plan will pay a benefit to your eligible survivors if you die after receiving long-term benefits for at least 180 days, and you were totally or residually disabled and receiving Plan benefits at the time of your death. The survivor benefit will be paid in a single lump sum and will be equal to three times your most recent gross monthly benefit. There must be an eligible survivor, or this survivor benefit will not be paid. The benefit is payable to your spouse/partner (as defined by the Company for its medical plan qualifications), if living at the time payment is made. Otherwise, it is payable by dividing the benefit amount equally among your eligible children. No benefit is paid if there is no eligible survivor.

Eligible children are your unmarried children, your eligible spouse/partner's unmarried children, your unmarried adopted children, and unmarried children placed for adoption with you prior to legal adoption being final, and all under age 25.

To file a claim for this benefit, your survivor should contact the Walgreens Human Resources Leave Department at 800-825-5467. Please keep this booklet with your other important papers so your beneficiaries will know the correct procedures to follow.

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 do this.

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 medical coverage under COBRA. (You will receive information and enrollment material at that time.) If you enroll in COBRA, then your medical COBRA premiums will be waived for the remainder of that calendar year, or until your benefits under this Plan end, 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 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.

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 for this Plan, for any time period beyond the first 12 months of your approved medical leave of absence. 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.

You must be under age 60 on the date you became totally disabled to be eligible for this extension. 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 your voluntary coverage, you must contact the Benefits Support Center at 855-564-6153 to make arrangements to pay directly for your voluntary life insurance 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 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 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.

Continuation of Leave and Maximum Time Off

The Company policies regarding leaves of absence and employment status are independent of your rights to disability benefits under this Plan. The duration of your disability benefit is based solely on the terms and conditions of this Plan, while the duration of any leave of absence (and your continued employment status) is based on separate policies and legal rules. At the time your paid medical leave commences, the Company or its agent will provide you with information regarding leaves of absence and employment status. If you are receiving disability benefits, your right to these disability benefits will not be affected by any change in your employment status due to an expired leave of absence. The disability benefits will continue until you no longer meet the required definition of disability, or you reach the end of your benefit period.

The maximum leave of absence 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.

If you are eligible for Family Medical Leave under the Family Medical Leave Act (FMLA), the amount of time you are on medical leave (paid or unpaid) will count toward the maximum 12 weeks of leave provided each calendar year under FMLA. Contact the Human Resources Leave Department at 800-825-5467 for information on FMLA.

If your approved disability period ends while you're still considered employed, and you feel you are still disabled, you may apply for an Unpaid Medical Leave of Absence. To apply for an Unpaid Medical Leave, a Request for Leave Form (#1372) must be signed by your Manager or Vice President and submitted to the Human Resources Leave Department for review and approval. Your leave request must be accompanied by a Certification of Health Care Provider for Employee's Serious Health Condition (Form #768).

If your approved disability period ends while you're still considered employed, and for personal reasons you wish to delay your return to work, you may apply for an Unpaid Personal Leave of Absence (or a continuation of Family Medical Leave, if you qualify and have not used up your annual FMLA entitlement). To apply for a Personal Leave, a Request for Leave Form (#1372) must be signed by your Manager or Vice President and submitted to the Human Resources Leave Department for review and approval. If your request is to care for a seriously ill family member, your leave request (Form #1372) must be accompanied by a Certification of Family Member's Serious Health Condition (Form #769).

All leave of absence forms are available on myHR at *myHR > All Forms > Leave Forms*. Effective April 15, 2019, all leave of absence forms are available on Ask Walgreens. If you are approved for an unpaid personal leave (non-FMLA), you will no longer be an active employee and your company-provided benefits will cease. If you want your benefit coverage to continue, contact the Benefits Support at 855-564-6153 to elect COBRA coverage or make arrangements to pay for your benefits by contacting the Benefits Support Center at 855-564-6153.

If your employment ends, and you are later rehired, you must satisfy the normal newly eligible employee requirements to be covered again by this Plan.

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

A claim can be initiated on the mySedgwick website. mySedgwick can be accessed via the WBA Worldwide home page, click on Tools and Resources, Time and Leaves, then mySedgwick portal link. Please refer to the chart on Page 3 for contact information. Alternatively, call the Claim Center toll-free at877-872-0911 or TTY Line (Teletypewriter for the hearing impaired) 901-531-4554.

A claim should be initiated 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 healthcare provider. A Sedgwick case manager will, in all cases, contact your manager and your healthcare provider. Sedgwick also will contact you if additional information is needed. Be sure to tell your healthcare provider that he or she will be contacted by the Claims Administrator (Sedgwick) to obtain information concerning your disability. Your healthcare provider will need authorization from you to provide the Claims Administrator with any of your medical information. In most cases, you must provide each healthcare provider with a signed authorization to release medical information. You may use the authorization form provided by the healthcare 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 healthcare provider 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 Claims Administrator may use the services of outside consultants and other sources to aid in the evaluation of your disability status. The Company and Sedgwick 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 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, please call the Sedgwick 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 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 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. Walgreens 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 (the Claims 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 Claims Administrator may extend this deadline by up to 30 additional days if it determines that a decision cannot be made during the initial period for reasons beyond the control of the Plan. 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 Claims Administrator. A second extension of up to an additional 30 days also may 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 that 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 Claims 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 the Claims Administrator.

Appealing a Denied Claim - First Level Appeal

To appeal a claim denial, you must send your written appeal to the Claims 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 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 Claims Administrator at:

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

Claims Administrator's Review of Appeal

The appeal will be conducted by the Claims 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 Claims Administrator determines that the appeal presents material issues that are outside the expertise or purview of the Claims Administrator (such as hours worked, employment status or new or unique procedural or Plan interpretation issues), then the Claims 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 that the Plan Administrator considers 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 Claims 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 Claims Administrator.

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

- be written in a manner that 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 Claims 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 the Claims 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 Claims 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 Claims Administrator at:

Sedgwick 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 Claims 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 issues that need to be resolved, 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 Claims 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 Claims 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 Claims 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 Claims 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 Claims 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 the final level of appeal you choose to pursue, 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 Claims Administrator for an explanation. The Claims Administrator has the option of providing a response within 10 days of your notice.

Plan Limitations

Some situations are not covered by this Plan, or there may be limitations imposed by this Plan on coverage or benefits.

Pre-existing Conditions

A pre-existing condition is defined as any illness, injury or pregnancy, or symptoms or manifestations thereof, which, during the 90 days immediately prior to coverage under this Plan, caused you or would cause an ordinarily prudent person to:

- consult a medical practitioner, or
- seek or receive medical advice, testing, diagnosis, care or treatment, or
- obtain or use any medical services, supplies, prescription drugs, medicines or appliances.

Pre-existing conditions will not affect your eligibility for short-term benefits. However, no long-term disability benefits will be paid for a disability caused by a pre-existing condition.

This pre-existing condition limitation does not apply if the disability begins more than 12 consecutive months after your Plan coverage becomes effective, and you have been continuously covered by the Plan for that period.

If you lose eligibility for coverage under the Plan, and later regain eligibility, this pre-existing condition limitation will again apply beginning with your new coverage effective date.

Psychiatric Conditions, Alcohol, Drug, Substance Abuse or Dependency

Benefits are limited to a combined lifetime total of 24 months if you are disabled due to mental or nervous disorders or diseases, unless the disability results from:

- schizophrenia;
- bipolar disorder;
- dementia; or
- organic brain disease.

These four conditions follow the benefit levels outlined in the "Plan Benefits" section. "Mental or nervous disorders or diseases" refers to medical conditions of sufficient severity to meet the diagnostic criteria established in the current Official Disability Guidelines.

You must be receiving appropriate care and treatment for your condition from a mental health healthcare provider.

Limitation for Alcohol, Drug, Substance Abuse or Dependency

If you are disabled due to alcohol, drug or substance abuse or dependency, benefits are further limited to one period of disability during your lifetime. You must be participating in an available rehabilitative program recommended by a healthcare provider. An available rehabilitative program is a program available to you through another group plan of the company (such as an Employee

Assistance Program or health plan); or services usually available to the public through local community services at no cost or minimal cost to you. No benefit payments will be made beyond the earlier of:

- the end of 24 months of disability for these conditions;
- the date you are no longer participating in the rehabilitative program;
- the date you refuse to participate in an available rehabilitative program; or
- the date you complete the rehabilitative program.

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 yourdisability);
- 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;
- 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 the 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 themU.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 Plan 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 and 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 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 Salaried Team Members, Pharmacists and Paraprofessionals. 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 Salaried Team Members, Pharmacists and Paraprofessionals
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- and Long-Term Disability
Plan Administrator and Agent for Legal Service	Health & Welfare Plan Committee Walgreen Co. 108 Wilmot Road, MS 1825 Deerfield, IL 60015-5143 800-825-5467
ClaimsAdministrator	Walgreens Appeal Committee c/o Claims and Appeals Management PO Box 7105 Rantoul, IL 61866-7105
Type of Administration	Third Party Claims Administration
Plan Year	January 1–December 31
Plan Numbers	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.

If you have any questions about this 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 (see 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.*

Walgreens

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