

Walgreens Life Insurance Plan

Summary Plan Description



Prepared by the Walgreens HR Shared
Services Department for eligible employees
of the Walgreens family of companies

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This Summary Plan Description booklet describes the life insurance benefits available to Walgreens employees covered by the Life Insurance Plan, as in effect as of January 1, 2016 (the "Plan"). You should read the information provided in this booklet and refer to the plan insurance documents for a full understanding of the benefits provided and the other relevant terms and conditions of the Plan. Throughout this document the term "Company" means Walgreen Co. and its subsidiaries and affiliates whose team members are eligible to participate in the Plan, unless the context is limited to a particular subsidiary or business unit. See "Administrative Facts about the Plan" at the end of this booklet for the name of the legal entity of the Company that is the official plan sponsor of the Plan, and therefore the Company for purposes of formal approvals and governmental filings.

This Plan is governed by the insurance carrier's group insurance policy issued to the Company, and this Summary Plan Description for purposes of describing the various Plan provisions. Copies of the appropriate sections of that policy can be obtained online at the Plan Administrator's website, or by contacting the Plan Administrator listed at the end of this booklet. In the event of any discrepancy between this booklet and the provisions of the insurance policy, the provisions of the insurance policy will govern.

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

Noticia Importante

Este boletín contiene un resumen, 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 Live Well Benefits Center at 855-564-6153.

Important Notice

This booklet contains a summary in English of your plan rights and benefits under this Plan. If you have difficulty understanding any part of this booklet, contact the Live Well Benefits Center at 855-564-6153.

The Life Insurance Plan is a Company-paid term life plan. The Plan provides valuable benefits to your beneficiary(ies) if you die while covered by the plan.

Eligibility

You are eligible for the benefit under this Plan if you:

- are a full-time salaried team member, actively working at least 30 hours per week for at least 30 days, *or*
- are a full-time hourly team member, actively working at least 30 hours per week for at least 90 days, *and*
- are not covered by any other Walgreens company-paid life insurance coverage, *and*
- are actively at work or on approved paid time off or a regularly scheduled day off on your initial date of coverage. If you do not meet this requirement on your date of initial eligibility or any increase in benefit, that coverage will be deferred until you return to work for one full day.

You are not eligible for coverage if you are:

- a Company team member and have company-paid life coverage available through a different plan,
- a team member of Healthcare Clinics (HCC) whose payroll is not processed from Walgreens payroll system,
- 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.

Plan Benefits

If you meet the eligibility requirements, you'll have a death benefit as follows:

Category	Coverage Amount
Hourly Paid team member	\$25,000
Pharmacist or Registered Nurse	1.5 X annual base salary*
Salaried team member	1.5 X annual base salary*

*** Please Note:** Annual base salary is your annualized base salary on the last day you worked before your death, and does not include any bonus or incentive pay. Annual base pay for hourly paid team members (including hourly-paid pharmacists and registered nurses) is calculated by multiplying your 52 week average hours (or average since date of hire, if less than 52 weeks) by your hourly rate and multiplying the result by 52. Benefit amounts are subject to any restrictions/limitations listed in the Certificate of Coverage.

Other Life Insurance

A Voluntary Term Life Insurance Plan is also available to Walgreens employees. Unlike the Company-paid life insurance, coverage under the voluntary plan is optional and paid for by you through payroll deductions. Coverage for your spouse/domestic partner and children is also available under this plan. Information on voluntary life insurance is available on the myHR website, at *Your Live Well Rewards Center* website at www.livewellrewardscenter.com, or by calling the Live Well Benefits Center at 855-564-6153.

Tax Considerations

The Company pays for your term life insurance while you are eligible for this benefit. Per IRS regulations, the value of the first \$50,000 of life insurance coverage paid for by your employer is not taxable to you. You will have taxable income based on the IRS "Equivalent Value" of the portion of your life insurance benefit over \$50,000. The value you will pay taxes on will appear as "IMP LIFE" under "HOURS AND EARNINGS" on your paycheck.

Salaried team members who have life insurance coverage greater than \$50,000, may wish to limit their death benefit to \$50,000 to avoid paying taxes on coverage in excess of this amount. If you'd like to do so, please contact the Live Well Benefits Center at 855-564-6153 or visit *Your Live Well Rewards Center* at www.livewellrewardscenter.com for information on how to limit your coverage.

If you elect to limit your benefit to \$50,000, the change is permanent, even if you later change to a different position with the Company. If you later want to reinstate the normal amount, you will be required to furnish to the insurance carrier evidence of your insurability acceptable to that carrier before the change can take place.

Your Beneficiary

A beneficiary is the person who will be paid the life insurance benefit if the covered person dies. Be sure to designate your beneficiary(ies) on *Your Live Well Rewards Center* website, www.livewellrewardscenter.com, when you enroll. You can designate or change beneficiaries at any time (unless you provide otherwise in your original designation). To designate or change your beneficiary, go to *Your Live Well Rewards Center* website, www.livewellrewardscenter.com, or call 855-564-6153. You will need your beneficiary's full name, address, date of birth and Social Security Number. Any beneficiary change will take effect on the date that the designation is completed online or through the Live Well Benefits Center. However, a beneficiary change will not apply if it is received by the carrier after benefits have been issued for a claim.

If you fail to name a beneficiary on *Your Live Well Rewards Center* website, or if all named beneficiaries die before you, benefits will be paid as determined by the laws of your state of residency. Previous beneficiary designations made on paper or the website of a previous plan vendor will not apply to any benefits for claims incurred 1/1/2016 or later.

However, if a properly executed beneficiary is not designated on *Your Live Well Rewards Center* website, and the circumstances are such that you were not notified prior to your death of this requirement to submit a new beneficiary designation, then the plan administrator and claims administrator shall award the Plan benefit based on the most recent beneficiary designation on file, if any (rather than to your estate).

If you live in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin) and are married, you must obtain consent from your spouse if you designate anyone other than your spouse as your beneficiary.

When Coverage Ends

Your life insurance coverage will end if and when:

- you no longer meet the eligibility criteria described in this booklet as in effect from time to time, or
- the Plan is discontinued.

If you terminate employment with the Company, your life insurance coverage will end on your Termination Date, which is usually the last day you work for the Company. This does not apply to extensions of coverage due to approved periods of disability as described in the section on "Extended Life Insurance Coverage When Disabled".

Coverage under this Plan will also terminate, and not be in effect, during any break in service due to participation in a strike against the Company, or due to an employee not reporting to work on a scheduled work day due to a strike-related issue.

Conversion Privilege

If your coverage ends, other than due to the Plan being discontinued, the Plan's conversion privilege allows you to purchase an individual life insurance policy, for up to the same amount as was in effect for you as an active team member, with premiums payable at your own expense, without evidence of insurability. You must, however, apply for and pay the premium for the individual policy within 31 days after termination of your Company-paid coverage. The individual policy will then become effective on the 32nd day after your group term benefit terminates. Should your death occur during the 31-day period after your company provided coverage ends, the amount of your life insurance will be paid to your beneficiary, even if you have not yet applied for or purchased the individual policy.

If this Plan is discontinued by the Company and not replaced by another plan, the conversion privilege is only available to team members insured by this Plan, or a similar Company plan for at least five years. In this situation, the total amount of individual insurance that you may purchase as a conversion from the Group Contract will not exceed \$10,000. If coverage with the current carrier is replaced with a different carrier, no conversion option will be offered by the replaced carrier.

To convert to an individual policy, contact the life claims administrator, the Live Well Benefits Center, at 855-564-6153 or *Your Live Well Rewards Center* at www.livewellrewardscenter.com or contact Prudential directly at:

The Prudential Life Insurance Company of America
Life Conversions, Mail Stop NJ-11-01-03
290 W. Mount Pleasant Avenue
Livingston, NJ 07039-2729
(877)-889-2070

Coverage During a Leave of Absence

Your coverage will continue during the first 30 days of an absence following your last day worked and then terminate unless you are on an approved paid or unpaid disability leave, or an approved FMLA leave. Coverage does not continue during an approved Personal Leave.

If you are absent for more than 30 days and are not on an approved disability or FMLA leave of absence, your life insurance coverage will terminate. The coverage amount is limited to the amount in effect on your last day worked prior to an approved leave.

Hourly Team Members - Extended Life Insurance When Disabled

Your 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 of life benefit, by the insurer for this plan, for any time period beyond the first 12 months of your approved disability leave of absence. You also need to be under age 60 on the date you became totally disabled to be eligible for this extension. You should apply for this extension once you have been disabled for 9 or more months, and before 12 months of disability. Contact the Live Well Benefits Center at 855-564-6153 or *Your Live Well Rewards Center* www.livewellrewardscenter.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.

Salaried Team Members, Pharmacists and Registered Nurses - Extended Life Insurance When Disabled

Your 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 any time period beyond the first 12 months of your approved disability 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 Live Well Benefits center at 855-564-6153 or *Your Live Well Rewards Center* www.livewellrewardscenter.com for information on how to extend your coverage.

Effective 1/1/2017, 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.

After Retirement

In limited instances, you may be eligible for \$5,000 of Company-paid life insurance after you retire. This would apply to you only if you become eligible for on a grandfathered basis (and elect to participate in upon your retirement) subsidized Walgreens retiree medical and prescription drug coverage. If this applies to you, you will be notified by the Live Well Benefits Center upon your retirement.

Minnesota Life Insurance Provisions

Minnesota law provides employees in that state with longer time periods, in certain circumstances, to continue this group term coverage after termination of regular eligibility. Please contact the Live Well Benefits Center at 855-564-6153 or *Your Live Well Rewards Center at* www.livewellrewardscenter.com, if you work in Minnesota and want more details on these rights.

Filing Claims

In the event of your death, your beneficiary or representative should notify your Walgreens manager, and the Walgreens Human Resources Employee Records department at 800-825-5467. Once these calls are made, the necessary paperwork will be sent out for claim processing. Please see that this Summary Plan Description is kept with your personal papers so your beneficiary knows the procedures to follow and the benefits available from the Plan.

Your beneficiary or representative must complete and properly file the paperwork he or she receives from the Claims Administrator, the Live Well Benefits Center, in order to properly claim a death benefit under this Plan.

Procedures for Processing Claims

All claims procedures followed by the Company and the insurance carrier(s) for this plan are intended to comply with all state and federal laws, including those in ERISA (the Employee Retirement Income Security Act of 1974).

Initial Claims Determinations

All formal claims under the Plan will be reviewed by the Insurance Carrier, which will make its decision based on the information submitted by the claimant within 45 days after the claim is submitted. By notice to the claimant before this period ends, the Insurance Carrier 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 the claimant that a decision cannot be made within the deadline because of reasons beyond the control of the Insurance Carrier.

Claim Denials

If the claim is denied in whole or in part, the claimant will be sent a notice from the Insurance Carrier that will:

- be written in a manner that the claimant should understand;
- include the specific reasons for the denial;
- 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; and
- include a statement of the claimant's right to bring a civil action under ERISA after receiving a final determination upon appeal.

Appealing a Denied Claim

To appeal a claim denial, the claimant must notify the Insurance Carrier within 180 days of receiving notice of the claim denial. The claimant may submit written comments, documents, records, and other pertinent information and will be given reasonable access to, and, if requested, copies of, all documents, records, and other information relevant to the claim. It is essential that the claimant supply all information or opinions that he/she believes may be relevant to the claim. To be assured of a proper handling of the appeal, it must be directed to the Insurance Carrier, listed in the "Administrative Facts About the Plan" section.

Insurance Carrier's Review of Appeal

The appeal will be conducted by the Insurance Carrier, and the assigned reviewer will be a person 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 the claimant submits relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. For disability-related appeals that are based in whole or in part on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and expertise in the field of medicine involved in the medical judgment and is neither the individual nor the subordinate of the individual consulted in connection with the initial denial.

Potential Review of Appeal by the Plan Administrator

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

Notice of Decision on Appeal

Regardless of whether the Plan Administrator gets involved in the decision, the claimant will be notified of the benefit determination within 45 days of the receipt of the appeal. By notice to the claimant before this period ends, the Insurance Carrier 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. An extension notice will specify the length of the extension and inform the claimant that a decision cannot be made within the deadline because of reasons beyond the control of the Insurance Carrier and/or Plan Administrator.

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

- be written in a manner that the claimant should understand;
- include the specific reasons for the denial;
- refer to the provisions of the Plan on which the determination was based;
- inform the claimant that, upon request and free of charge, the claimant is entitled to reasonable access to and copies of all documents, records, and other information relevant to the claim; and
- notify the claimant of his/her right to bring legal action under ERISA.

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 Insurance Carrier or the Plan Administrator needs additional information from the claimant before it can make its determination. If that is the case, the claimant will be notified of the specific information that is needed and/or any unresolved issues that need to be resolved, and the claimant 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 Insurance Carrier 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 Insurance Carrier 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 Insurance Carrier 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 the claimant only if the Insurance Carrier or the Plan Administrator, as the case may be, decides in its discretion that the claimant is entitled to them. All such benefit determinations shall be final and binding on all persons, except to the limited extent to which the Insurance Carrier's decisions are subject to further review by the Plan Administrator.

The claimant must first utilize the claim and appeal rights described above before the claimant may properly assert any claims in court. If the claimant fully exhausts these rights, but remains dissatisfied with the outcome of his or her appeal, the claimant may challenge the decision in an ERISA Section 502(a) benefit claim.

No such legal action may be commenced more than two years, or later if required by state or federal law, after the date you are informed of the decision on your appeal.

Statement of ERISA Rights

As an employee eligible to participate in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance policies/contracts and any collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.*
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance policies/contracts and any collective bargaining agreements, 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 and Welfare 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.

Enforcement of Your Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, you or, following your death, your beneficiary, has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or 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. 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 after you have exhausted your claims and appeals rights described above. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. 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 section titled "Procedures for Reviewing Claims"). 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 telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866 444-EBSA (3272) or using their Web site, www.dol.gov/ebsa.

Administrative Facts About The Plan

Plan Name: Walgreens Life Insurance Plan

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 Year: January 1 – December 31

Plan Number: 501

Employer I.D. Number: 36-1924025

Plan Costs: Costs for this welfare benefit plan are paid by the plan sponsor, Walgreen Co., from general assets. Plan participants do not accrue rights to these assets in the event of Plan termination. Plan benefits are provided by the insurance carrier:
The Prudential Life Insurance
Company of America
Prudential Plaza
Newark, NJ 07102

Plan Administrator and Agent for Legal Service:

Health and Welfare Committee
Walgreen Co.
108 Wilmot Road, MS#1825
Deerfield, IL 60015-5143

Amendment, Termination Rights, and Questions:

The Company, and as applicable the insurance carrier, reserve the right to alter, amend or cancel this Plan at its sole discretion at any time.

Modifications to the Plan, including amendment and termination, will be implemented at the written direction of the Chief Executive Officer, Executive Chairman of the Board or the Chief Human Resources Officer of the Company.

The establishment of this Plan, or any modifications to it, 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.



1/2016

**CHANGES TO THE WALGREENS LIFE INSURANCE PLAN
DECEMBER 1, 2016**

The following changes will be made effective December 1, 2016 to the Walgreens Life Insurance Plan (the "Plan"). Please keep this notice with your Summary Plan Description booklet.

Plan Benefits

Previously under the Plan, hourly-paid team members (who were not pharmacists or registered nurses) were eligible for a Company-Paid life insurance benefit of \$25,000, and all hourly-paid team members were subject to a 90 day waiting period. Beginning December 1, 2016, hourly-paid team members with a Benefit Indicator (BI) of 20 (Assistant Store Managers), 510 (Coordination Pay Band Team Members, or 511 (Analysis Pay Band Team Members) will be eligible for a benefit of 1.5 times base annual salary, after a 30 day wait period or on the 31st day of active employment.

Team Members in the groups identified above who are transitioning from exempt to non-exempt (salaried to hourly) status beginning as of the first pay period in November, will continue with salaried benefits under the Plan, with that slightly earlier effective date.

JANUARY 1, 2017

The following changes will be made effective January 1, 2017 to the Walgreens Life Insurance Plan. Please keep this notice with your Summary Plan Description booklet.

What is Not Covered

Suicide: If a covered person dies by suicide (whether sane or insane*) within two years of the date he or she becomes covered by this plan, there will be no benefit payable.

* In Missouri, suicide while sane is the only limitation.

This notice serves as a Summary of Material Modification (SMM) for the Walgreens Life Insurance Plan, Plan #501, Employer I.D. Number (EIN): 36-1924025. Please keep this with your Summary Plan Description (SPD) and other benefits materials. January 2017